University of Alberta

Refining Nursing Practice: A Grounded Theory of How Nurses Learn to Nurse Well in the Current Health Care Milieu

by

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To Burl Jantzen, as a small gesture in honour of who you are, and for all you have done and continue to do.

To Margaret (McGifford) Burns (1931-2011), in honour of all the ways my mother made me who I am and for modelling unconditional love and support. Mum was always behind me. And, for all the ways she taught me about people who need nurses.

Abstract

Continuing to provide high-quality care to patients in the present health care system is challenging. As with many contemporary organizations, health care is characterized by change. This grounded theory study examined nurses' workplace learning, with a particular focus on the role of the workplace in improving nursing practice. The data comprised semi-structured interviews of nominated nurses from diverse areas of practice and participant observation on two units in acute care. Nurses with more than ten years' experience working in direct patient care who were known for nursing well were recruited to the study initially, followed by theoretical sampling of nurses at diverse stages. Constant comparison, grounded theory coding, theoretical sensitivity, and memos were used to analyze the data. Nurses' workplace learning is an essential process in the career-long process of refining nursing practice. Refining processes begin with a trigger for learning. These triggers include patient-specific concerns, changes in the workplace, and self-awareness of a learning gap. In the workplace nurses respond to the resulting need to know by engaging in puzzling and inquiring, an iterative process that involves deliberation and drawing on other nurses, physicians, and other accessible resources. Everyday workplace learning and the career-long process of refining nursing practice are dependent on the quality of nursing education and early work experience. Germane conceptual, procedural, and dispositional knowledge and four capabilities, which nurses utilize throughout their careers to discriminate learning demands and develop wisdom, constitute a necessary foundation for nursing practice. These capabilities are (a) setting and

maintaining high standards, (b) having a healthy apprehension, (c) seeing the whole patient picture, and (d) being self-aware. Refining nursing practice is facilitated by mentor-guides, workplace camaraderie, and functional teams. The pressures of globalization, neoliberalism, technical rationality, and managerialism place demands on nurses working in health care. The professionalization agenda, with related decisions to promote academic nursing education and with responsibilities related to ensuring continuing competence, has created preparation practice gaps. Based on this theory, I propose that existing approaches for preparing and supporting nurses for practising nursing in current health care require complementary efforts to accomplish the goal of excellent patient care.

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A story without characters is nothing but words. This story is contingent on the nurses, the main characters, who willingly consented to be interviewed and observed by an unknown researcher. You are an inspiration to me personally and professionally. I learned much from seeing and hearing about your exquisite nursing practice. May you always find catalysts and helpers to sustain you in your commitment to do the best for your patients, regardless of what else is going on. You are refined gold. To you, I offer deep gratitude and humble appreciation.

Thank you to the many faculty members in the Faculty of Nursing at the University of Alberta who have touched my life as a graduate student. When I decided to explore doctoral studies I decided to find the best. I still think I made the right choice. The scholarship and passion for nursing knowledge development and academic education in the Faculty of Nursing is remarkable. I am very proud to be a graduate. Thank you to the inspiring teachers and seminar leaders. A special thank you to those of you who have guided my work and study: Dr. Patricia Marck (UBC-O), Dr. Carolyn Ross, Dr. Christine Ceci, Dr. Karin Olson, and Dr. Alison Taylor (Faculty of Education, University of Alberta). A very special thank you to my supervisor, Dr. Brenda Cameron, whose love and passion for all things nursing sustained us both through this refining journey. It has been an honour to learn from you. May we have the joy of continuing to work together to help the public see and hear what nursing is.

I have not made this journey alone. Like the main characters in my study, I have been truly blessed with friends, colleagues, peers, and supporters who have facilitated my learning (and survival) with camaraderie, help, wisdom, and role modelling. There are too many to name. You know who you are. Thank you! I am humbled by what you have given to me. A few deserve special mention: Silvia, Will, Lenora, Wanda, Rita, Marjorie for all things grounding. Kathy for friendship, cheering, helping me laugh, and reading my work. Martin and Avril for your faithful interest and caring spirits. Christine, Nancy, Carol, and Mary for

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Over these long years since my work unit fell under the axe of rationing health care and I moved into academia my family has been unconditionally supportive and generously helpful. From oldest to youngest, because that is how Mom does it to avoid favorites: Dad, Harvey and Doris, Heather, Rachel, Stuart, Rebecca, Johanna, and Erick, thank you. Thank you is not enough. And, for my mother, who begins the story, I declare gratitude for everything she gave me, including inherited traits.

Burl, my husband, friend, and the love of my life, these words are feeble symbols of what I owe to you. The unconditional and ceaseless sacrifices you offered to me each day, month, and year of this journey are noted. This is as much your labour of love as it is my effort.

Simply, I could not have done this alone.

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Chapter One: Background

As I was completing my dissertation my mother died. Although she had experienced almost ten years of minor health challenges and gradual cognitive decline, it was a sudden death. Less than 12 hours elapsed from the first call until her passing. During that time my sister and I travelled three hours to be with our parents and then sat with my mother in her final hours and minutes. Midway through the day, as my sister and I were walking to the car from the emergency department (ED), I turned to my sister, a professional musician, and said, "If doctors and nurses only knew how little time it took to be helpful." In the few hours that my mom was in the ED we experienced the very best of Canadian health care and the very, very best of nursing and medicine, embodied in one nurse and one physician. My mother received a prompt diagnosis and prognosis and, equally importantly, we all received care. Our family had been discouraged from taking an elderly, forgetful mother to the ED. It would be noisy, crazy, and confusing. On the contrary, we received exquisite care from a calm, gentle, thoughtful nurse and a fully present and caring physician. The interprofessional team was skilful and the communication was seamless.

In the days that followed, and as I slowly returned to this academic work, I reflected on how I was able to say to people "It was a perfect day" in response to their gestures of goodwill and queries into my grief. Mom's death was a good death. I acknowledge that not everyone dies peacefully and that this makes a difference to how I perceived my mother's death. There were many other people

in the ED that day. The beds were full and there were several people in the waiting room. However, I believe that the compassionate, competent, and ethical care we received from the health care team made a profound difference. The nurse's practice mattered. The nurse was knowledgeable (she suspected the diagnosis after her initial assessment), was skilled in her work, and knew how to be with people who were suffering. She embodied what is to follow in this dissertation.

Through my own years of nursing it has become apparent to me that even in a constraining and sometimes hostile environment some nurses get better and better at nursing and some do not. This observation prompted me to ask why this is and to investigate what factors influence the development of the nurses who improve over time. Understanding this process of improving over the span of a career in nursing is the focus of my academic work. Assuming that this phenomenon was related to professional development, and hoping to use the findings to inform clinical education for the organization in which I was working, I explored positive learning experiences of first-line nurses using narrative inquiry during my Master's program. Study results identified workplace learning rather than formal education as the primary type of professional development (Jantzen, 2004). For my doctoral research I built on my previous work and conducted a grounded theory study to answer the question "How do nurses learn to nurse well in the current health care milieu?"

The answer, which I develop fully throughout this dissertation, is that some nurses continually refine their practice to provide excellent nursing to patients with diverse needs within a constantly changing health care system. Refining practice begins during nursing education and the early years of work experience and continues throughout nurses' careers, even within the dysfunction of some workplace environments. Influences that support nurses' workplace learning include having easy access to knowledgeable and skilled nurses, working with a functional health care team, and experiencing camaraderie in the workplace. Nurses are able to engage in workplace learning even within unhealthy and less supportive workplaces by drawing on knowledge of previous supportive environments. A key finding in this study is the importance of setting and maintaining high standards, for oneself and others, with the goal of "doing my best for the patients." Refining nursing practice culminates in nurses who are very knowledgeable, skilled, and increasingly focused on excellent patient care, in spite of the enormous changes and challenges of the health care environment. These nurses become the safe, competent, and compassionate "last line of defence" (Shulman, 2010, p. ix) between the vagaries of the health care system and their patients.

Why was this study necessary, beyond satisfying my own personal interest? We need to understand nurses' workplace learning because it is so

critical to the professional development and continuing competence[1] of key members in the health care team. My experience corroborates research which suggests that registered nursing practice matters to better patient outcomes (Clarke & Aiken, 2003; McGillis Hall, 2003; Tourangeau et al., 2007) and that nursing is essential to current health care (Canadian Nurses Association [CNA], 2009a, 2009b[2]; Shaha, 2010). The move to academic education, intended to enhance nurses' knowledge for future nursing practice, is failing to adequately prepare nurses for current health care (see among others Benner, Sutphen, Leonard & Day, 2010; Casey, Fink, Krugman, & Propst, 2004; Kelly & Ahern, 2009, p. 916). Current continuing competence policy based on reflective practice is inadequate to ensure safe, competent practitioners (Eraut, 1994, p.13; Nelson & Purkis, 2004). I am not advocating a move back to nursing schools or traditional apprenticeship models from academic education. Neither am I suggesting that nurses give up reflecting on their experience for ongoing learning. What I propose based on this work is that these approaches to preparing and supporting nurses for practising nursing in the current health care milieu need development and complementary efforts in order to accomplish the goal of excellent patient care. Complementary efforts can be located in the everyday work of nursing.

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[1] Competency and competence, often used interchangeably and/or incongruently, have specific meaning underpinned by fundamental differences. I have retained spelling used by specific authors for the initial discussions and explore this more fully in Chapter Two.

[2] A summary of research related to registered nurse staffing levels and quality of care and two fact sheets are reported to be available throughout the 2009 CNA annual report however they were no longer available on the website in August 2012.

Theorizing nurses' workplace learning is, therefore, a fundamental step to inform action.

In this chapter I introduce the reader to the study. I begin with the research questions. I then situate the study in the contexts of nursing and health care. Situating this study within nursing involves a discussion of the professionalization of nursing and a brief overview of nursing as a discipline. This broad overview of nursing is followed by the development of a particular definition of the health care workplace used in the study. In the next section I situate myself as the researcher and then provide a brief description of the study and key benefits. I demonstrate the value of the study by problematizing nurses' workplace learning and outlining gaps in the published literature. I conclude this chapter with a brief summary of the importance of this theory of refining nursing practice and an outline of remaining chapters.

Research Questions

The purpose of this research was to develop a substantive theory related to the overarching research question: How do nurses learn to nurse well within the current health care milieu? The focus of this project is on experienced nurses who are engaged in direct patient care. For the purposes of this study nurse is defined as a registered nurse (RN). In keeping with grounded theory methods, the initial research question was broad and was accompanied by guiding questions. The following two sub-questions were used to explore the role of the context on the process of learning to nurse well in data analysis and theorizing. How does the

place in workplace learning influence and inform the development of the nurse? What is the interaction between the workplace, nursing practice, and self, that facilitates learning for nurses?

Situating and Grounding the Inquiry: Nursing and Current Health Care

At the time of the study, the participants were all working in one regional area in 21st century Canadian health care (British Columbia). Throughout the dissertation I highlight aspects of the Canadian context that are unique as they relate to the study design, findings, and recommendations. Although there are unique features related to the cultural and geographical location, in this introduction I want to outline some broad global developments in nursing and in health care. Important changes in nursing over the past several decades intersect with this study. There have been many important developments, including increasing use of technology and changes in the scope of practice of registered nurses; however, to situate the study I focus on the themes of professionalization and the development of nursing as a discipline. Both technological and scope of practice changes are significant for nurses in direct patient care. Advances in, and increasing use of, technology are evident in the constant learning demands placed on nurses by the health care milieu. These constant learning demands are apparent in the findings and discussion chapters. Changes in scope of practice for registered nurses, legislated provincially, also translate into triggers for learning. Technological and scope of practice changes exemplify the constantly shifting health care milieu. Following the analysis, theorizing, and subsequent review of

the literature I concluded that professionalization and the related development of nursing as a discipline are overarching themes and have influenced so much of what has changed over the span of the nurses' careers. Nursing education, continuing competence requirements and professional development, and the significance of the registered nurses' (RN) role in health are informed by developments in nursing, as a profession and as a discipline.

Nursing professionalization.

Along with many other occupations in the 20th century, nurses collectively sought out status as a profession. The professionalization agenda occupied many nurses' attention and created many of the tensions discussed in the literature and coffee rooms (Salvage, 1988; Porter, 1998, p. 518). Professionalization and the related case for establishing nursing as a unique discipline have also shaped tensions *between* the academic literature and nursing practice coffee rooms, as nursing leadership and theorists promoted an occupational strategy that often was detached from practitioners' work (Porter, 1992). The tensions between educational and employment institutions, nurses and external forces, advocates for academic education and those against, and between labour unions and professional associations, are systematically outlined in Turkoski's (1995, p. 83) analysis of professionalism discourse. The collective commitment to professionalism and disciplinary knowledge has influenced the purpose and conduct of nursing education and professional development. Nursing education and professional development have become the battlegrounds, victims, and

beneficiaries of the drive for professionalization and unique disciplinary knowledge. In the section that follows I briefly describe the professionalization landscape.

Does nursing warrant the status of a profession? Is this nurse practising as a professional? These are two ubiquitous questions that inhere in academic nursing conversations. Although the definition of profession has varied with each generation, over the course of the past century one common conviction was that nursing was or could be a profession (Mansell & Dodd, 2005, p. 197; Porter, 1992). Most champions of professionalization used a set of criteria, often called the trait approach, although a definitive list of traits continued to be a point of dissention (Porter, 1992, p. 721). These criteria included the need for a unique knowledge base, autonomy in decision making, self-regulation, and a commitment to altruism and distinct service to society (Colyer, 2004; Herdman, 2001; Mansell & Dodd, 2005; Risjord, 2010). The professionalization of nursing was thought to be facilitated by developing core nursing knowledge. The need for a unique nursing knowledge base motivated both the disciplinary drive for nursing knowledge development with empirical research through a nursing science (Rutty, 1998, p. 248) and repeated efforts to move nurses' educational preparation into academic settings (Herdman, 2001). The emergence of professional associations, licensing or regulatory bodies, and formal code of ethics; the promotion of political activity; and the need to monitor and regulate competence are directly related to professionalization concerns.

Nursing as a profession was also promoted and often studied in relation to the professional identity of the individual nurse (Ohlen & Segesten, 1998; Skar, 2009). Professional socialization or socialization into a professional identity is an important aspect of nursing education and socialization in the workplace (Byrne, 1987; Clark, 2004; Dingwall & Allen, 2001; MacIntosh, 2003; Mooney, 2007). In the discussion chapter I will return to the significance of professional socialization as it relates to the study and resulting theory.

The idea of progressive development of nursing through professionalization has been the subject of critique over the past two decades (Herdman, 2001; Porter, 1992; Turkoski, 1995). Approaches to professionalism across disciplines have been critiqued and new ones proposed, including functionalism, the power school, and postmodern approaches to professional expertise (Frost, 2001). Herdman (2001) notes that a philosophy of history as progress has been rejected by postmodern philosophers and then accuses nurses of "nursing scientism" (p. 8). According to Turkoski (1995), professionalization, particularly as it has been defined in the American literature, is based on patriarchal, hegemonic, social constructions that are antithetical to caring nursing and modern health care settings. Turkoski argues this professionalism has served to oppress nurses throughout the past century. Fuller (1995) also critiques the Anglo-American model of professionalism, arguing that professionals often come from dominant social groups and therefore collectively marginalize ethnic and non-dominant groups (p. 467). Professionalism is said to contribute to a de-

valuing of nursing "tasks" and, by discouraging labour activity and unions, has contributed to the ongoing devaluing of nursing work (Turkoski, 1995). Herdman furthers this claim and argues that nurses became blind to the "reality of nursing decline" (p. 7). Certainly, the professionalization literature and many of the histories of nursing are permeated with the language of uphill climb and positive progress, even in the presence of observations about the loss of autonomy accompanying a shift to hospital-focused nursing in the 20th century (see among others Mansell & Dodd, 2005). Although there has been a sustained critique, the idea of progression toward professionalism in nursing prevails.

As pervasive as professionalization has been, the case for nursing as caring is equally ubiquitous in nursing discourses (Nelson & Gordon, 2006). One sustained critique of professionalization has focused on how it negated or undermined the caring and feminine roles of nursing (Liaschenko & Peter, 2004). In response, Benner and Wrubel (1989), Bishop and Scudder (1997), and recently Sellman (2000, 2011) promote the idea of nursing as a practice. In addition, many agree that a mid-century emphasis on knowledge work and the professionalization of nursing resulted in ignoring the body work of nursing (Lawler, 1997; Sandelowski, 2002). More recently, in response to heated debate in the UK, Gallagher (2005) calls for critical reflection on the implications of promoting professionalism on caring and "everyday practice" (p. 14). Liaschenko and Peter (2004) extended the critique of professionalization for its "anti-caring" stance to nursing as a practice, and then argue for a re-conceptualization of nursing as

work. As they see it, nursing as work – with an ethics of work – removes the moral burden of nursing within oppressive and economically rationalized health care systems.

Transforming the relationship between medicine and nursing was an important intended result of professionalization for nursing (Rutty, 1998). The desire to create an equal rather than subordinate relationship with medicine fueled the professionalization agenda for many nurse academics (Porter, 1992). Professionalization was a means to achieve social closure for "collectivities" such as nursing (Porter, 1998, p. 63). As a collective, nursing has engaged in dual social closure through attempting to usurp medical power while excluding others through licensing and registration (Porter, 1998, p. 70). Herdman (2001) and Fuller (1995) argue that professionalization has had a negative effect on nurses' relationships with other health care providers, particularly unregistered aides and care workers who are marginalized by discussions regarding autonomous practice. Nursing has not achieved the level of autonomous practice or economic status of medicine. However, certainly the occupational infrastructure of nursing is no longer controlled by medicine (Porter, 1998, p. 75). Over the past decade, primarily driven by state or government objectives, the relationship between medicine and nursing has been more influenced, if only theoretically, by interprofessional practice discourses (IPP) (Colyer, 2004).

Two criteria for professionalization are directly relevant to nurses' workplace learning and therefore to this research project: self-regulation and the

possession of a unique body of knowledge. Self-regulation involves a corporate, professional commitment to oversee initial licensing as well as ensuring continuing adherence to professional requirements through the setting of continuing competence standards and evaluation of individual nurses. In Canada the use of reflective practice for meeting individual continuing competence requirements has been promoted as policy. As I have suggested above, developing and maintaining a unique body of knowledge requires academic (baccalaureate) education and the integration of "nursing knowledge" into practice.

Being a professional nurse involves a commitment to autonomous practice, with a responsibility to be self-reflective and to engage in ongoing evaluation of one's competence in practice (CNA, 2000). Current policy in relation to professional development and continuing competence in Canada has been criticized for being too focused on the individual nurses, failing to accomplish the intended purpose, and concerningly effective in "accomplishing industrial control over professional practice" (Nelson & Purkis, 2004, p. 252). While re-registration previously was linked to a minimum number of hours worked, or a combination of education and hours worked, demonstration of competence currently focuses on a process of individuals reflecting on the past year of nursing practice and identifying their own learning goals for the upcoming year based on professional standards and quality indicators outlined by provincial regulatory bodies (CNA, 2000; College of Registered Nurses Association of British Columbia [CRNBC], 2006; Emerging licensing issues, 1996; Lundgren &

Houseman, 2002). The evaluation of competence lies primarily with the individual nurse. In some provinces peer feedback is included and although random audits are conducted virtually no evidence is required to support it[3]. Who should be responsible for evaluating and facilitating competent nursing practice? Hodges (2007) suggests that Canadian regulatory bodies are demonstrating "naive reliance" in a "comfortable delusion that individual health professionals will engage in a continuous process of self-reflection … and thereby improve their practice" (p. 177). In this dissertation I theorize how nurses learn to nurse well in the current health care milieu which may inform reframing how professional bodies ensure ongoing competence of their nurses (Jantzen, 2008).

Nursing knowledge is another key concern in the promotion of professionalization. What is nursing knowledge and how is it developed? The recent work of Risjord (2010) and the development of the Doctorate of Nursing Practice (DNP) programs in the US (Reed & Shearer, 2011) have initiated a productive turn in the nursing knowledge discourses (see also Reed & Lawrence, 2008). Risjord, a philosopher with an interest in the philosophies of science, medicine, and nursing, outlines the problem of the gap between nursing knowledge and theory, and nursing practice. As an outsider (non-nurse), his observations regarding the relevance gap is refreshing and instructive. In an historical outline of nursing's development, collective decisions, and their

[3] Audits involve a variety of processes with some provinces requiring an electronic submission. Most do not require substantial evidence being submitted. A compilation of provincial requirements is available on request from the author.

outcomes, he presents one cause or interpretation of the relevance gap. Risjord's examination appears to assume that this historical outline and the related development of nursing, primarily an American phenomenon, is representative of international nursing. A comparison of global nursing history and nursing knowledge development over the past centuries is beyond the scope of this project. Two points must be made, however. American nursing theory and the related professionalization agenda had enormous influence internationally (Ketefian & Redman, 1997). This is clearly outlined in Herdman (2001), who interestingly was situated in Hong Kong at the time of her publication. Second, Risjord develops his critique based on nurse theorists and metatheorists in the USA over the latter half of the 20th century. Important and abundant nursing research, some more recently conceptualized as "evidence-based practice," has been conducted beyond the narrow scope of (grand) nursing theory and conceptual models and is chronicled in the following discussion regarding nursing as a discipline.

Risjord (2010) asserts that a relevance gap exists and posits that it is related to decisions in the 1970s to model the discipline of nursing after the natural sciences with a positivist worldview. He proposes a solution that may or may not stand the test of time, but within his argument is a clear call to bring nursing knowledge development back to practice in a bottom-up model of nursing knowledge development. This proposal is echoed in Reed and Shearer's (2011) collection of models for advancing nursing knowledge in the context of DNP and

foreshadowed in Eraut (1994, pp. 40-58; see also Maeve, 1994[4]). Risjord and Reed and Shearer acknowledge that nursing should not have tolerated a gap for this long. This key concern, a relevance gap between academic nursing knowledge development and nursing practice, overarches the challenges I will return to throughout this dissertation, namely an unacceptable preparation practice gap (nursing education) and problematic continuing competence requirements.

Nothing in this study refutes the value of professionalism for nursing and the associated changes in education and professional development. However, this study supports and extends the recent calls for educational reform (Benner et al., 2010; Frenk, Chen et al, 2010) and the recent challenge to existing Canadian continuing competence requirements (Nelson & Purkis, 2004). This broad discussion regarding nursing knowledge development and the existing problematic gap between academia and education and policy, which I have begun here, is revisited in the literature review and theory discussions which follow.

Nursing as a discipline.

Although the professionalization agenda pervaded the past century, the desire and drive for a unique nursing knowledge base, and more specifically a *disciplinary* knowledge, became a dominant focus of nursing discourse mid-century. Undergraduate and graduate courses point to the importance of nursing theories for a unique nursing knowledge base. In my own doctoral program, I

[4] Maeve (1994) claims a feminist and critical theory examination of nursing knowledge development and criticizes the high ground of academia, based on Schon's work. She proposes a "bedside scholarship" for nursing (p. 15).

focused on conceptualizing my research within metaparadigm concepts and at one point asked the question, “Will the study of nursing work environments further nursing science if it excludes a discussion of human health in relation to nursing actions and the nurse?” Debates about worldviews such as totality and simultaneity (Risjord, 2010) or various others such as unitary-transformative, reaction, reciprocal interaction, and simultaneous interaction (Fawcett, 1993); the merit of grand and middle range theories; the merit of human science and nursing science for the discipline of nursing (Northrup et al., 2004); the metaparadigm deadlock (Thorne et al., 1998); and the superiority of quantitative research over qualitative research are all part of the disciplinary quest. As part of this quest, much ink has been spilled by academics and doctoral candidates in an attempt to redress the growing gap between nursing practice and nursing knowledge development.

A central tenet of the dominant nursing disciplinary structure was a focus on the close relationship between nursing theory and research, which was intended to result in theory-guided practice. This relationship was promoted as a conceptual-theoretical-empirical (C-T-E) structure by Fawcett (1992). In this model, research begins with a conceptual model followed by an iterative process of testing and formulation. This research process is a formal, systematic, rigourous process of inquiry regarding theoretical concepts and propositions (Fawcett, 1999). There is evidence that the discipline of nursing has been somewhat successful in discipline-specific knowledge development efforts,

including the hundreds of citations that support the presence of theory-guided research and empirically confirmed nursing theory (Fawcett, 1999). During this period of time, between the 1970s and now, an enormous amount of nursing knowledge development including disease-specific programs of research has occurred outside of this particular CTE structure promoted by American metatheorists (e.g., Bakker, Fitch, Green, Butler, & Olson, 2006; O'Leary, Estabrooks, Olson, & Cumming, 2007; Olson, 1993; Olson, 1996; Olson, 2007; Olson, Hanson, & Michaud, 2003; Olson et al., 2002; Olson et al., 2004; Olson et al., 2008; Olson et al., 2011; Tsang, Carlson, & Olson, 2007[5]). For a brief period of time nurse theorists travelled around the globe promoting the use of their theories for nursing education in universities and colleges. Thorne et al. (1998) note that "despite an apparent common project…model builders quickly developed discrete projects that involved promotion of their own particular framework" replete with efforts to create communities of scholars with the "purpose of developing and furthering particular models" (p. 1258). Cameron (1998) argues that nursing theories were too narrowly defined and often incorporated conceptual ideas from other disciplines without examining the fit with nursing. Nursing theory and tidy representations of practising nursing often failed to address the realities of everyday nursing practices: the unpresentable (Cameron, 2006), the marginalized (Hall, 2004), and the sociopolitical (Georges,

[5] When read chronologically this set of publications, and also those not included in this selected list, powerfully demonstrates the use of diverse methodology and interdisciplinary research around pertinent questions in relation to cancer care.

2005). Use of nursing theories has waned and much less emphasis seems to be placed on nursing theory in nursing research today.

Jacqueline Fawcett exemplifies the nursing metatheorist during the emergence of a discipline of nursing. She made significant contributions to the development of nursing knowledge as a metatheorist, a nursing scholar and, for some, a visionary. Fawcett (1978) contributed a structural hierarchy of nursing knowledge and demonstrated a diligent commitment to the relationship between nursing theory and nursing research. Her earliest influential work appeared in the first issue of *Advances in Nursing Science* in 1978, the same year as Donaldson and Crowley's (1978) foundational article, "The Discipline of Nursing." Her scholarly work has provided the discipline of nursing with a framework for the analysis, synthesis, and critique of nursing theory and nursing research and *the* metaparadigm concepts that have influenced nursing education globally (Fawcett 1984, 1989, 2005). Jacqueline Fawcett's four-decade career spans a period of significant change in society, educational institutions, and the discipline of nursing. Recently, she has argued that if nursing continues to ignore conceptual models we risk losing a distinctive body of knowledge. Her proposed solution involves developing and utilizing discipline-specific knowledge through discipline-specific research and practice (Fawcett, 2003). Fawcett (1999) stresses the need for clarity regarding a disciplinary hierarchal structure, a common language, and parsimonious definitions, a position consistent with the positivist view of knowledge development (Risjord, 2010).

During the 1970s, scholars such as Fawcett (1978) and Donaldson and Crowley (1978) were laying a foundation for nursing knowledge development. Fawcett, along with her peers, argued convincingly that without this particular kind of disciplinary knowledge development nursing would never achieve voice or power at the policy table or in academe. The problem, according to Risjord (2010), is that Fawcett, along with many of the dominant, primarily American, voices took up nursing knowledge development in a particular way. This particular way was rooted in positivism, depended on a hierarchal philosophy of science, and contributed to the relevance gap that is evident in this study. In addition, while nursing was attempting to achieve professionalization as distinct from medicine, nurse scholars chose the same gendered path of knowledge (Herdman, 2001; Wall, 2010, pp. 153-154). The recent emergence of nurse-led clinical research using a variety of methods and contributing to evidence-based nursing (DiCenso, Guyatt, & Ciliska, 2005) does not fit the dominant nursing theory discourse outlined in key disciplinary texts (Alligood & Tomey, 2010; Chinn & Kramer, 2011; Cutcliffe, McKenna, & Hyrkas, 2010; Meleis, 2007; Polifroni & Welch, 1999; Reed, Shearer, & Nicoll, 2004). Although much of the clinical research conducted contributes to practice settings through the evidence-based, or evidence-informed, movement I posit that it remains poorly linked to disciplinary nursing knowledge development to date. Beyond supporting the call for educational reform and reframing continuing competence requirements in Canada, this dissertation also explores how Risjord's (2010) conceptualizations of

theory coherence and of practice-unified theorizing might reformulate our understanding of nursing knowledge and learning in practice.

Situating the Study in the Health Care Milieu

This theory of refining nursing practice is situated at a particular point in the evolution of nursing as a profession and as a discipline. It is also situated within a specific context: current health care in Canada. The broad research question and my academic interest are focused on workplace learning and the health care milieu, and thus I need to carefully define these terms. In order to understand and delimit the context of nurses' workplace learning, I explored how the terms place, space, workplace, and health care environment are used in the relevant literature prior to conducting the study. Many of the related terms, including workplace, context, environment, and system, often relate only to organizational and institutional factors. I selected the phrase "health care milieu" in the broad research question for important reasons. In the following section I provide the pertinent background to this research decision.

Use of the phrase "the health care context" elicits diverse images. Some may imagine institutional structures while others may imagine specific hospital settings. In framing the research question, I examined the use of terms describing "context" in the nursing and health geography literature and attended to environment as an important term in the nursing literature, as a nursing metaparadigm concept.

Florence Nightingale's body of work is very much concerned with space and place (Andrews, 2003b, p. 270). In *Notes on Nursing* Nightingale (1860) considers the central importance of micro-environmental conditions – the conditions of air, light, temperature, sound, pure water, efficient drainage, and ambiance. She also considered the central importance of microsocial conditions, or nurse-patient proximity (Malone, 2003). Informed by the military and imperialist culture and the environmental determinism of her day, Nightingale identified the spatial inequalities that contributed to health and illness, as well promoting the essential features of a patient's immediate environment that would contribute to reducing suffering. Nightingale (1863) devoted an entire book to *Notes on Hospitals*[6], in which she argued that the place of nursing was to be a place of healing. Many years later Jacqueline Fawcett (1984) named "environment" as one of nursing's metaparadigm concepts, although nursing research has virtually ignored this metaparadigm concept (Andrews, 2003b). "Environment refers to the nursing participant's significant others and physical surrounding, as well as to the nursing practice setting" (Fawcett, 2005, p. 36). While Fawcett gives a salutatory nod to the nursing practice setting, the focus is primarily the patient. This is laudable. What is often missed, however, is the complex interplay of the two meanings inscribed on a singular place.

[6] Interestingly, although *Notes on Nursing* is readily available in library in re-printed versions, *Notes on Hospitals* is much more difficult to access. A digitalized version is available from Google.

Although their discussion of environment is brief, likely reflecting the lack of attention given to it in nursing research and theory, Thorne et al. (1998) argue that a multi-layered view of environment is necessary to an integrated mandate for nursing research, theory, and practice. This multi-layered view would allow nurse researchers to enhance our understanding of the individual patients' everyday experiences and immediate context, and also expose sociopolitical structures that constrain health and inform nursing practices. A multi-layered conceptualization includes the immediate context, everyday life, and sociopolitical structures and ideologies that underpin everyday life for patients and nurses. Although the metaparadigm concept of "individual" in this sense has been expanded to include family and community, the focus remains primarily individualistic (Thorne et al., 1998, p.1262). Metaparadigm concepts, and specifically environment, have remained peripheral to nursing practice, theory, and research. Environment, as an integral aspect of the patient's health and the nurse's healing care, needs to be explicit in nursing research. Over the past decade this has occurred, primarily as the result of the work of Gavin Andrews (2002, 2003a, 2003b, 2006; Andrews & Shaw, 2008; Carolan, Andrews, & Hodnett, 2006) and the emergence of health geography.

Kearns' (1993) landmark paper prompted a re-conceptualization of place and space in medical geography and launched the health geography discipline. At this point health geographers began to attend to the meaning of places in health care delivery and what was happening *inside* the locales they had dutifully studied

and mapped (Andrews, 2002, p. 227). This led to increased attention to health and "its qualities and associations with place rather than simply on the spatial aspects…" (Andrews, 2003a, p.241). Andrews (2003a, p. 232) contends that during the past two decades a geography of nursing has been emerging, particularly where scholars are attending to the relationship between nursing/nurses, place, and space.

In the nursing literature there is significant confusion with regard to the meaning ascribed to place (Carolan et al., 2006). There are four overarching themes: situatedness, healing places, displacement/disembodiment, and the nurses' workplace (Carolan et al., 2006). The place of nursing is discussed in terms of physical space, in terms of the health care team, organizationally, and relationally. Very recently it has also been described as a community of health care professionals (Austin, 2007). Diverse meanings of commonly used terms such as "place" or "context" have complicated the analysis of the "workplace" in nursing research. Andrews (2002) contends that it is not possible to "separate the experience of health and health-care from the place in which it is experienced" (p. 231). If it is true that it is not possible to separate this out, what do we mean when we argue that environment, space, or place needs to be incorporated into our nursing research? Is it ever otherwise? This study was designed to examine the relationship amongst the nurses, their workplaces, and their learning. Before defending the term milieu in the research question, I discuss the literature from the field of adult education.

Much of the adult education literature on workplace learning refers to institutional and organizational meanings. Workplace learning literature is subsumed under adult education, which includes diverse aspects of learning through adulthood, including formal, informal, non-formal learning (Eraut, 2000), continuing education, university extension education, religious education, organizational learning, and more. Fenwick (2006) reports a meta-review of the workplace learning literature and notes that "workplace may designate a small business or large corporation, a high-tech project-based firm or a manufacturing plant" (p. 266). Although much is written about the situated nature of learning and knowledge and the importance of contextual distinctions, workplace is most often a generic term. Unfortunately, the related assumption is that therefore, "theories of work and learning may universally apply" (Fenwick, 2006, p. 266). What have been left aside in considerations and theoretical development in the workplace learning field are site or place, temporality, scale, scope of activity, and economic contexts (Fenwick, 2006).

Workplace learning literature often presents the workplace in nested layers, moving from organizations, to teams and communities, to individuals (see among others Cross & Israelit, 2000). Workplaces can be places of preparation for professional practice, such as in the apprenticeship model or clinical placements for nursing students. Workplaces are also places where professionals work and continue to learn. Throughout my reading I observed that, although rarely defined and articulated, references to the workplace virtually exclusively refer to

organization as corporation or task-oriented team. Much of the learning that occurs, or needs to occur, in workplace learning is related to solving organizational or systemic problems, and the "place" is the particular "setting" of the research or learning intervention (see among others Engestrom, 2001; Fuller, Unwin, Felstead, Jewson, & Kakavelakis, 2007). Unwin et al. (2007) shed some light on the complexity of work*place* when suggesting that the "organisation of work, level of employee involvement, organisational performance, and the broader economic, regulatory, and social context" (p. 333) are all contextual factors that shape the workplace in workplace learning. What is missing from this list is the material aspect of the workplace, or the health care milieu.

In the adult education literature the focus of "workplace" has been on teams and organizations. This relational perspective is also evident in the sociology literature pertinent to nursing, such as the work of May (1992), who argues that the social relations between patient and health care professionals, particularly nurses, are the site of work. As we have seen, the nursing literature includes diverse and often poorly delineated definitions of place. In practice very little attention has been paid, or respect given, to the role of the built environment on nurses' quality of work life (Rechel, Buchan, & McKee, 2009). "The limited evidence available so far suggests that well designed and sustainable healthcare facilities improve the health and well-being of healthcare workers and result in improved staff recruitment, retention and performance" (Rechel et al., 2009, p. 1029). While much attention has been paid to organizational influences on

nursing practice and identity, "little attention is paid to the *material* aspects of organization, and the part that these many play in shaping nurses' work" and workplace learning (Halford & Leonard, 2003, p. 201). The physical, as well as social, aspects of the place of nursing were important considerations in this study.

According to Picheral (1994), epidemiologists and geographers have adopted a narrow definition of environment and subsequently discarded a term in their specific vocabulary – *le milieu.* "The latter term is not limited to the physical and biological conditions of a location but also includes its social, economic and cultural features. Above all, *le milieu* is not … a simple neutral and undifferentiated variable" (Picheral, 1994, p. 1589). This term, derived from French without exact translation into English, is richer and more inclusive than other commonly used terms. I proposed to study how nurses learn to nurse well in the current health care *milieu* because, in my view, milieu captures the physical, social, and institutional aspects of the nurses' workplace that might otherwise be missed. In this study, the milieu contains the social and economic aspects of health care, often captured by the terms institution or organization. The milieu contains the cultural features of the nursing and interprofessional teams, as well as the culture of the broader nursing profession, as well as the physical and existential meanings of space and place of nursing. Throughout the proposal I use the terms workplace, environment, and place of nursing interchangeably, as they are used in the related literature. When I employ the term milieu I intend to evoke

the broad, rich, and inclusive notion of the context of nursing practices described above.

The image of the current health care milieu in the literature is not a pretty picture. Much is made of the rationalization and restructuring of health care in the past 20 years (see among others Cartier, 2003; Cho, Laschinger, & Wong, 2006; Rankin, 2003; Rankin & Campbell, 2006; Street, 1992). Interpersonal relationships and team work are plagued by horizontal violence and bullying (Bartholomew, 2005; Duchscher & Myrick, 2008; Johnson, 2009; McKenna, Smith, Poole, & Coverdale, 2003; Simons & Mawn, 2010). Examination of the global health care milieu is also concerning, particularly in regards to health equity and stable workforces (Frenk, Chen et al., 2010). While the broad paint brush sweep is bleak, my own experience suggests that there are pockets of functional teams and excellent patient care.

Situating the Researcher

My recent experience in nursing within the health care milieu stimulated the questions and influenced the research decisions in this study. Since graduation in the mid-1980s, my work experience in direct patient care has been limited to the acute care and critical care setting. Over these years and through that experience I have developed relationships and observed many nurses. In 2002, after the unit I was working on was closed, I began three years work in a non-contract supervisory role. As an evening and weekend patient care coordinator (PCC) I visited every unit in the hospital on every shift. In negotiating patient care

with staff I observed that some nurses continue to develop, sustain, and nurture excellence in nursing practice throughout their careers, often in spite of challenging situations. I also noted poor care on some units and by some nurses. As I have suggested earlier, the observation that some nurses continued to learn and maintain good nursing practice over many years informed my first study (Jantzen, 2004) and motivated my decision to pursue doctoral work.

At the same time as I began doctoral studies, I left my patient care coordinator job and became an undergraduate nurse educator. In this capacity I have worked on several units as a nurse educator within the hospital and residential care settings. During these same years I have been mother, daughter, and friend to individuals requiring health care. While writing my research proposal and again over the final months of dissertation writing I too became a patient. Although I am very knowledgeable of the system, we experienced numerous disappointments and frustrations and at times observed and experienced poor nursing practice. We too frequently failed to find individuals who "value the ill" (Frank, 1991). My sadness about these experiences has given me pause and prompted more questions. My experience and observations of everyday nursing have clearly motivated me to conduct this study.

My role as the researcher is explored more fully in Chapter Four as reflexivity, along with a complete discussion of methodology and conduct of the study. A brief overview of the research design follows.

Study Overview

This grounded theory study was conducted over the course of a year from May 2010 to May 2011 as partial fulfillment of my doctoral degree requirements. Data collection entailed participant observation and interviews. I conducted participant observation of six nurses on two acute care units within the local health authority. I also attended the education sessions offered to the units' staff during the time frame of the study. I interviewed 17 participants in total from diverse health care settings. The early participants (observation and interview) were all nurses with more than 15 years of nursing practice experience. Most of the participants had more than 20 years' experience, and one participant graduated over 40 years ago and was still working in an on-call role in her practice area. Theoretical sampling included nurses with less than ten years' experience, physicians, and nurses from specific practice areas, including a clinical nurse educator. Data analysis and theorizing utilized grounded theory techniques outlined in Charmaz (2006), Glaser and Strauss (1967), Glaser (1978), and Schreiber (2001).

Benefits of the Study

I began this chapter by expressing my interest in how nurses get better and better at nursing over the span of their careers. I have also highlighted the value of workplace learning for improving practice and have pointed to larger issues regarding continuing competence. Nurses learn from nursing practice (MacLeod, 1996). Some might claim, however, that the process I am describing is so obvious

as to be common sense. In this latter case, the nurse shows up for work, practices nursing, adds experience, and over time and through diverse situations, gains knowledge which is evident in nursing well. I problematize this common sense case because of the ease with which common sense is perverted and as way of highlighting the benefits of the study. It cannot be a given that nurses learn from nursing practice without taking into account characteristics of the nurse, the learning environment, and the role of (nursing) knowledge in nursing practice. We must assume that in some situations nurses may learn the wrong thing or be prevented from learning.

Problematizing the common sense case to clarify assumptions.

The common sense position is founded in empirical research, theoretical literature, and a colloquial belief in learning from experience. We seem to *know* this to be true. This knowledge dictates what we understand to be happening for nurses throughout the health care system. In fact, over the past 25 years a number of studies have highlighted the significance of nurses' workplace learning, centred on learning from nursing practice experiences (Campbell, Nilsson, & Andersson, 2008; Currie, 2008; Daley, 1998, 2001a, 2001b; Ferguson, 2006; Hood, Olson, & Allen, 2007; Jantzen, 2004, 2008; Billett & Henderson, 2011a; MacLeod, 1996; Pyles & Stern, 1983; Tabari-Khomerian, Kiger, Parsa-Yekta, & Ahmadi, 2007; Wolf & Zuzelo, 2006)**.** Within the field of workplace learning and in the discipline of adult education, there is strong evidence supporting learning from experience, both within the workplace and the lifeworld of the worker (Billett,

2001, 2004; Boud, Cressey, & Docherty, 2006; Boud & Garrick, 1999; Boud & Miller, 1996; Eraut, 1994, 2004a, 2007; Fuller et al., 2007; Leadbetter, 2008; Marsick & Watkins, 2001). In contrast to the burgeoning workplace learning field, the effectiveness and impact of formal continuing education remains questionable (Daley, 1997a; Eraut, 1994, p. 25; Griscti & Jacono, 2006; Lundgren & Housemen, 2002; Slusher et al., 2000). It is important to ask, is this empirical and theoretical work sufficient grounds for what we *know* to be the case?

Dewey, the pioneer of experiential learning theory, observed that while education and learning are a basic aspect of living, not all experience is educative. Some experience is "mis-educative" or teaches us something that is incorrect or limiting for our overall development (Dewey, 1938, p. 25). It is possible that unexamined experience and practice may teach nurses poor practice. Beyond learning from experience, terminology in workplace learning also needs to be examined. Fenwick's (2006) meta-review of work-learning studies published between 1999 and 2004, referred to previously, identified blurred, problematic, or absent definitions of both "work" and "learning." In her view these terms have expanded or collapsed to include all of life. The problems of definitions, blurring of work-life-learning boundaries, and the important but often ignored problem of mis-educative experience together cause one to question assumptions regarding this phenomenon.

Unwilling to accept first or naive views of developing the ability to nurse well in nursing practice, I have begun by questioning and problematizing the

common sense understanding outlined above wherein the nurse works, gains experiences, and eventually acquires knowledge, which is then applied to patient care. According to most experiential learning theorists, the nurse must show up fully engaged, capable of noticing (Boud & Walker, 1990; MacLeod, 1996), and open to new possibilities (Mezirow, 1990). And, the learner must have time for reflection on the experience (Boud et al., 2006; Boud & Walker, 1990; Owen & Stupans, 2009; Schon, 1983; Taylor, 2010, p. 42). Yet adequate time, reflection, and full engagement in the experience are not necessarily givens in the busy, and constantly shifting, rationalized health care environment.

Also, in the common sense case, the nurse is assumed to be spending his or her work time practising nursing. Yet many researchers argue that nurses currently spend a significant amount of time managing the health care system, governing populations in relation to health, circulating patients, or managing the work of others, which results in less time for providing individualized patient care (Allen, 2004; Holmes and Gastaldo, 2002; Purkis, 2002; Rankin & Campbell, 2006). As I have observed in my own practice, not all nurses, even those within the same workplace, gain expertise and wisdom from their experience. Instead, over time, some nurses become static and increasingly disengaged, and focused on auditable tasks.

The final aspect of the common sense case I want to problematize is the notion of nursing knowledge/s and the relationship of nursing knowledge/s to nursing practices. Is this learning related to specific kinds of knowledge, most

obviously experiential knowledge (Benner, 1983), or is the scope of learning and knowledge more inclusive? Returning to an earlier point, values and beliefs regarding disciplinary knowledge, the nature of nursing, and the nature of nursing practice knowledge, defines what specific knowledge is required and learned in nursing practice. In addition, epistemological assumptions determine how one views the relationship of knowledge to practice. One may, for example, believe that in practice nurses access prior knowledge, utilize knowledge, translate knowledge, construct knowledge, or enact knowledge. This raises the question of how or whether the content of nurses' workplace learning fits with or constitutes nursing knowledge.

In summary, I have described the purpose and focus of the study and problematized common assumptions regarding learning in the nurses' workplace, nursing knowledge, learning from the experience of practising nursing, and nursing well as being merely about knowledge. In problematizing nurses' workplace learning I suggested that the empirical research has informed our thinking. In the following section I briefly explore this literature.

Highlighting gaps in the existing literature.

Since the early 1980s nurses have been doing research on the development of clinical expertise and learning from nursing practice (Benner, 1982, 1984; Benner, Tanner, & Chesla, 2009[7]; Bonner, 2003, 2007b; Cioffi, 2001; Ferguson, 2006; MacLeod, 1996; Pyles & Stern, 1983). Over the past few decades we have

[7] The first edition of Benner, Tanner, & Chesla (2009) was published in 1996.

come to value workplace learning as central to the development of individual professionals. However, very little research on workplace learning has been conducted on nurses or within the health care milieu of direct patient care recently (Eraut, 2007). Important studies have focused on the individual learner (MacLeod, 1996), on learning in particular contexts (Bonner, 2003, 2007b; Pyles & Stern, 1983), and on novice nurses (Ferguson, 2006; MacIntosh, 2003). One grounded theory study exploring "competence development" in nurses has been conducted in Iran (Tabari-Khomerian et al., 2007). No studies have explicitly explored the role of the context, or workplace, on this learning in experienced nurses however. I developed the research question and study design to address this gap in existing knowledge.

I have chosen to focus on experienced nurses for this study because of the uniqueness of this cohort. While historically few nurses remained in nursing over the span of their adult lives, changes in the sociopolitical culture have resulted in many more nurses remaining much longer in their careers than in the past (Hatcher et al., 2006; Rafferty & Clarke, 2009). Most of the relevant nursing literature and the work of Eraut (2007) has focused on how nurses move from education into practice and from early experience up to five years (see among others Duchscher, 2008). Unlike other studies, my study was timed to examine the career-long trajectory of this unique cohort prior to their retirements.

Over the past ten years a number of studies have drawn attention to the problems resulting from changes in nursing education. These studies, which I will

discuss in detail in Chapter Two, suggest that the gap between preparation and practice is increasingly problematic. Because nursing education and early work experience was identified by the participants as critical to their workplace learning and their ability to continue to improve and nurse well, I extended my proposal literature review into nursing education and new graduate transition. The literature is clear that there are growing problems for new graduates. Based on my findings I suggest that initial, preparatory learning is potentially significant over the span of a nurse's career and therefore warrants thoughtful evaluation and incisive action. No studies to date have examined the role of early workplace learning on later workplace learning and professional development. This study's unique exploration of the interaction between the nurse, nursing knowledge, and the nurses' workplace bridges a gap in our knowledge of this complex process.

Chapter One Conclusion

In this chapter I have introduced the reader to the background, benefits, and academic context of the study. I have also situated this study in my own program of research and personal experience. In Chapters Two and Three I summarize the relevant literature as a way of situating the study in the related discourses, and then in Chapter Four I outline the study methodologically. In Chapter Five I introduce the reader to the resulting theory and the key findings. Chapter Six explores the theory in light of extant literature with reference to implications and recommendations. Chapter Seven concludes this dissertation

with a summary of the key findings and recommendations and outlines areas for further exploration.

I have argued that the move to professionalization and the establishment of nursing as a discipline have influenced nurses' workplace learning and professional development. The participants in this study have developed their nursing practice over the same decades as the discipline of nursing developed in a particular direction. This study speaks to how experienced nurses have refined their practice over the past decades of significant change for nursing and health care, and theorizes how lifelong learning can be nurtured for better patient care. The resulting theory is multifaceted and addresses both the trajectory of career and lifelong learning and the daily learning of everyday nursing practice. In conclusion, the substantive theory developed in this study is a step toward identifying the skills and attitudes of lifelong learning in nursing and the aspects of the nurses' workplace that facilitate refining nursing practice.

Chapter Two: Nurses, Education, and Workplace Learning

In the following two chapters I situate this study in the existing literature. The first literature review chapter is focused on the first phrase in the research question, "How do nurses learn to nurse well?" and the second literature review chapter is focused on the current health care milieu. The question of how individuals learn has consumed people for centuries. Much has been written. With professionalization nurses and academics have paid more attention to nursing's unique knowledge. Regulatory bodies, nurses' associations, and academics are very interested in how this unique knowledge is developed, both for individual practitioners and for the discipline. Practitioners develop and maintain some of this knowledge base through nursing practice situations. This chapter begins by discussing learning for professional practice *in* the workplace. Then, before shifting the focus to preparatory learning in nursing education I explore the question, "How have nurses learned to nurse well in the past?" I begin by clarifying terms.

Learning throughout one's career has been referred to as professional development, staff development, continuing education (CE), continuing professional education (CPE) or development (CPD) (UK). In nursing it has been associated with re-licensure and continuing competence, and formal and informal learning (American Nurses Association [ANA], 1997; DeSilets & Pinkerton, 2004; Eraut, 2000; Munro, 2008; Nelson & Purkis, 2004). The American Nurses Association's (ANA, 1997) description of continuing education refers to

enriching learning experiences that contribute to quality nursing practice and career goals, as distinct from baccalaureate or graduate education. A focus of continuing education is to "help individual nurses take the initiative and cultivate an aptitude for lifelong learning" (Griscti & Jacono, 2006, p. 450). This definition closely relates to staff development and continuing competence, a growing movement over the past twenty years. Adult education literature and some recent studies in relation to nursing use the term professional development, particularly when examining a broader understanding of learning through a professional's work life (Daley, 2001a; Lundgren & Houseman, 2002; Stein, 1998). The very recent literature refers to professional development as lifelong learning (see among others Frenk, Chen et al., 2010), although the concept of lifelong learning is evident in early nursing CE literature (ANA, 1973; Cooper, 1972). For clarity, throughout this dissertation continuing education refers to formal learning. Professional development refers to both formal and informal learning. Nurses' workplace learning refers to any learning that occurs within the workplace. The process of *refining nursing practice*, which I present in Chapter Five, far extends the limits of these terms and encompasses lifelong learning across domains of learning and beyond minimal continuing competence requirements. I begin with Eraut's contribution because of the close links between his work and the overarching themes in this dissertation.

Learning for Professional Practice in the Workplace

Michael Eraut has sustained an interest in professional knowledge and how that knowledge is learned for over forty years. From the UK, he is considered a leading researcher in how professionals learn in the workplace across disciplines, and is quoted broadly. Because of the volume and breadth of his oeuvre it is impossible to do justice to his work in this chapter. My task is to introduce the reader to his work and demonstrate how Eraut's work informed this study. Michael Eraut's primary interests lie in initial and continuing professional education, informal and workplace learning, tacit knowledge, reflection, and the transfer of knowledge between formal learning contexts and the workplace. He describes his life's work as guided by three questions: What is being learned? How it is being learned? What factors influence the level and directions of the learning effort?" (Eraut, 2004a, p. 248). His work is focused primarily on new and mid-career professionals (Eraut, 2004a). Eraut (1994) brings together themes central to this dissertation: professionalism as ideology, professional knowledge and expertise, professional education and continuing competence. What follows is a selected summary of Eraut's work in relation to this and other pertinent studies of nurses' learning.

Eraut (1985, 1994, 2000, 2003) has spent considerable time exploring professional knowledge. He has developed a number of ways of categorizing knowledge. In his early work he argued that in order to study how professionals use and acquire knowledge in the workplace we need to understand the nature and

development of knowledge, competence, and expertise (Eraut, 1994, p. 8). Professionalism privileges specialized knowledge, expert knowledge, or knowledge for expert practice (Eraut, 1994, 2005). This is not the expert knowledge described by Benner (1984) but the unique practice-specific knowledge of professions. This professional (expert) knowledge is either codified (scientific, theoretical) or personal knowledge. Codified knowledge is also referred to by others, such as Luntley (2010), as public or propositional knowledge. Codified knowledge is subjected to scholarly, often scientific, judgement and is also given status in the education and socialization process of professionals. Codified knowledge is explicit. Cultural knowledge, something Eraut makes reference to in later publications, is poorly defined and often refers to common or shared personal knowledge that has not been codified through traditional means (science, publication, scholarly rigour) (Eraut, 2004b, 2007). Personal knowledge, for Eraut (2000), is "the cognitive resources which a person brings to a situation that enable them to think and perform" including a personalized form of codified knowledge, cultural knowledge acquired through socialization, experiential knowledge, process and procedural knowledge, and self-knowledge (p. 114). Personal knowledge can be both explicit and implicit or tacit. Tacit knowledge has received significant amount of attention in the nursing literature. Eraut (2000) questions the wisdom and utility of research studies focusing on tacit knowledge that is, by definition, either not communicated or not amenable to communication (p. 188). There are also numerous types of tacit

knowledge (Eraut, 2004d, p. 174). Eraut suggests that tacit knowledge is often knowledge that is fully integrated and available to inform action without the need for deliberation or further knowledge exploration. Both the use and development of codified knowledge and the process of acquiring and developing personal knowledge were examined in this study. An examination of tacit knowledge was not the focus of this study, however, given Eraut's lengthy list of problems and cautions associated with trying to study tacit knowledge (Eraut, 1994, 2000). However, Eraut (1994) also warns against attempts to impose any clear dichotomy on knowledge, such as theory and practice or codified and personal knowledge, because when taken to extremes the dichotomies "disguise rather than elucidate the nature of professional thought and action" (p. 19). The distinctions among types of knowledge are less polarized than it often appears in scholarly writing. "What is being learned?" was approached broadly in this study, having considered the difficulty of examining tacit knowledge.

Some professional (codified and personal) knowledge is acquired through formal education. For nurses, this currently occurs in both practice and academic settings. When nursing education was located in hospitals, students also learned cultural knowledge of the hospital, including organizational processes or personalities and preferences of staff, while developing their theoretical or codified knowledge and personal knowledge of practising nursing. Moving nursing education into the academic setting has, to a degree, altered the timing for the acquisition of cultural knowledge. The cultural knowledge previously

acquired during initial professional education now takes place during the early work years.

Eraut (2000) differentiates between explicit and implicit learning and between formal, informal, and non-formal learning. He argues that non-formal learning is a more accurate conceptualization of much learning in formal and informal learning settings. Although continuing education is focused on formal explicit learning, the transfer of this learning to nursing practice involves a different kind of learning related to the use of new knowledge. Learning how to use new knowledge in unique situations is more implicit. Learning in the workplace is often seen as informal learning; however, as we will see in the findings chapter, learning to nurse well is a more integrated process and does not fit well with current categorizations of learning.

A final important distinction that Eraut makes is in relation to theories. Theories used in professional practice can be espoused theories or theories in use (Eraut, 2003, p. 63). They can also be distinguished by the source of the theories: academic sources, community or practice discourses, general public discourses (lay), and personal theories (explicit or tacit). Academic theories are often developed in specific disciplines but are relevant to diverse practices. For example, theory from sociology or biology is relevant to nursing. Those who were promoting unique disciplinary knowledge were very concerned about the incorporation of non-nursing theory into nursing knowledge. Eraut (2003) takes the position that professions are applied fields and therefore use theories from a

variety of formal disciplines as well as develop their own theories (p. 62; see also Risjord, 2010). Eraut (2003) claims some theories are primarily preferred ideology or theoretical justification to sustain a particular identity, are only espoused in educational settings, and often are constructed to be "ideologically attractive but almost impossible to implement" (p. 62). Grand nursing theory, as an attractive ideology with few links to existing practice environments, fits Eraut's description perfectly. When deliberating over the meaning of nursing well I decided that evaluating the use of nursing theory, either grand or middle-range, was of less importance than exploring what Eraut identifies as personal knowledge and theories in use.

In addition to developing categories of knowledge, theories, and learning, Eraut (2000, 2007) also develops a typology of cognition to describe how professionals think in practice. He divides the modes of cognition based on the type of process used in *time* or based on how long, relative to the other modes of cognition, the practitioner has to assess or notice, decide, act and engage in metacognition (elements of any practice). The three modes of cognition are: instant/reflex, rapid/intuitive, and deliberative/analytic (Eraut, 2007, p. 407).

Deliberative cognition, according to Eraut (2000), involves many processes and stages, which include a "unique combination of propositional knowledge, situational knowledge, professional experience and judgment" (p. 128). Beyond these individual processes, context and time (urgency versus adequate time for consideration) have a significant influence on use of this

deliberative mode of cognition in professional practice. Eraut (2000) stresses that what might be classified as rapid/intuitive cognition may shift to more deliberative or analytical cognition in a new situation or under different time constraints. Eraut's work on deliberative cognition in the workplace adds complexity and depth to existing conceptualizations of intuition in the nursing literature, beginning with the work of Benner (1983, 1984; Effken, 2007; Lyneham, Parkinson, & Denholm, 2008; McCutcheon & Pincombe, 2001; Ruth-Sahd & Hendy, 2005; Ruth-Sahd & Tisdell, 2007; Tanner, 2006). Within the nursing literature there has been a sustained critique of an "intuitive grasp" (English, 1993; Eraut, 2000; Gobet & Chassy, 2008; Mitchell, 1994; Nelson & Gordon, 2006; Paley, 1996, 2004; Purkis & Bjornsdottir, 2006; Rolfe, 1997). Eraut (2000) suggests Benner and Dreyfus do not adequately defend their view that deliberation becomes redundant in intuitive decision making (p. 127). Rather, when decision making involves the intuitive mode of cognition the individual may utilize "implicit monitoring, a meta-cognitive process" similar to Schon's "reflection-in-action" (Eraut, 2000, p. 127). Suggesting that personal knowledge, as defined above, is merely intuition ignores the explicit and implicit use of codified and personal knowledge in diverse situations. Failing to acknowledge the various modes of cognition undermines the complexity of decision making and knowledge use in professional practice (see also Gobet & Chassy, 2008; Baker, 1997).

Eraut (2007) proposes what he calls an epistemology of practice. In this epistemology of practice he brings together the types of knowledge (codified, cultural, and personal), the nature of performance in professional practice (thoughts and actions), elements of practice (assessing/noticing, deciding, acting, and metacognition monitoring), and modes of cognition (instant/reflex, rapid/intuitive, and deliberative/analytic). This epistemology of practice explains how expertise is developed. Developing expertise, in Eraut's sense, is the "learning to nurse well" of the research question. Reification of one theory of expertise development (Benner, 1984) in nursing discourse has failed to account for the complexity of developing expertise and has therefore limited the depth and breadth of many related studies in nursing. I designed my study of learning to nurse well to address this gap and explore how knowledge enacted in diverse nursing practice situations is acquired. Similar to Eraut, I explored factors that influence the learning effort. This seemingly simple area of interest - understanding how nurses use and acquire knowledge in the current workplace – may contribute to understanding the nature and development of nursing knowledge, competence, and expertise.

I have sparingly used the words expert and expertise in my writing thus far. This is because of the many varying interpretations and mis-interpretations of expertise. Having outlined the complicated nature of learning to nurse well using Eraut's work, I now introduce and develop this term. Eraut studied the development of expertise over many years (Eraut, 1994, 2005). In his book

(Eraut, 1994) he devotes a lengthy chapter to summarizing, comparing, and critiquing various theories of expertise development of the time. This discussion includes a careful analysis of the Dreyfus model of skill acquisition. He briefly mentions Benner's development of the Dreyfus model for nursing; however, he critiques this more thoroughly in Eraut (2000, 2005). Expertise and the idea of expert knowledge are directly linked to professionalization. For Eraut and others who have studied the development of expertise it is the development of knowledge that sets one apart as a professional with a professional practice. To complicate matters further expertise is often equated with competence in professional practice. The distinctions between competence and expertise are important to this work; therefore I explore the meanings of competence before continuing.

The competency movement began over 35 years ago, across disciplines. Variations in definitions of competence and competency exist. The diversity relates to the inclusion or exclusion of behaviour, performance standards, and cognitive and affective skills; and the fundamental underpinnings of the concept. Competency, originating in the US, was coined to describe generic predictors of job success and effective performance. An individual's competency related to his or her total capability and was not linked to specific jobs (Manley & Garbett, 2000, p. 349). Competence, defined and developed in the UK more recently, "stresses the job, not the person, and focuses on minimum standards rather than superior performance" (Manley & Garbett, 2000, p. 349). Competent is also used

to distinguish a stage on the continuum from novice to expert, in Benner (1984) and more informally in lay and public discourses (Eraut, 1994, p. 166-168). Cowan, Norman, and Coopamah (2005) recommend a holistic definition of competence that I have summarized as the ability of someone working within an occupational area to do what is required through the integration of knowledge, skills, attitudes, and judgment. The recent pressure to measure "nursing" to allow for easy movement of nurses across the European Union (EU) has prompted the development of a tool to assist nurses to measure their "competence," as in their ability and use of nursing "competences" (Cowan, Wilson-Barnett, Norman, & Murrells, 2008). Use of the UK definition reflects a general tendency toward the more pragmatic, job-related knowledge and skills over the broader, generic qualities of "competency." Although critiqued for being reductionistic with a "weighty compilation of units and elements" that can distort and understate nursing practice, competence frameworks are contextual, evolving, work-role focused, and—if defined more holistically as above—seem to be the best option for assessing beginning and experienced nurses (Manley & Garbett, 2000, p. 350). Competence, then, relates to the minimal requirements of nursing practice. Nursing expertise relates to the range of capacities, including knowledge, skills, and dispositions, that are drawn on in patient care. As I explore in the following chapter, when nurses in Canada use the term *continuing competence* it conjures up something quite different from any of these usages.

Benner's model of novice to expert has resulted in significant debate over the meaning of expert in nursing (English, 1993; Manley & Garbett, 2000; Paley, 2006). Nelson and Gordon (2009) critique the novice to expert "delineation of expertise" arguing that the idealistic view of the experts (including expertise in the ethical domain) reduced the achievements and competencies of most (imperfect) nurses to inexpert. Expert is the final, most advanced, level of skill acquisition embedded in the Dreyfus model. At the expert level individuals use particular cognitive processes for decision making. In fact, at the expert level the "thinking" is "not-thinking." Eraut (2000) argues that understanding advanced expertise involves analysis of various types of knowledge and cognition.

New categories for nursing knowledge.

Following Eraut (2004a) I explored what was being learned, how it was being learned, and also what factors influenced the learning effort (p. 248). The participants in my study were learning for professional practice. Although Eraut's work informed the study design a recent book by Billett and Henderson (2011a) shaped my thinking while completing this dissertation. What follows is not an epistemological treatise. It is also not a conceptual framework I utilized in the analysis of the data. It is merely one set of categories for professional (nursing) knowledge that I find particularly pertinent from a comprehensive book on workplace learning, *Developing Learning Professionals* (Billett & Henderson, 2011a). There are many other typologies and sets of categories (Benner, 1984; Eraut, 1994; Luntley, 2010). Billett and Henderson (2011a) name two forms of

domain specific professional knowledge: canonical and situational knowledge. These are comprised of three types of knowledge: conceptual, procedural, and dispositional. These categories are particularly useful when we consider the possibility, proposed by Billett and Henderson and incorporated into the discussion chapter, that nursing knowledge in all of its forms and types is constructed in the practice setting. This claim is made sensible and also provocative when we consider the possibilities of *both* canonical and situational knowledge being constructed in the practice setting. The nurses in this study were learning *both* canonical and situational knowledge (or what Eraut [2000] labeled codified and personal knowledge) in their workplace learning and professional development.

Canonical knowledge, in Billett and Henderson's (2011a) view, is "knowledge that is required for an occupation … the kind of knowledge which all practitioners are expected to possess and utilize" (p. 7). For the participants, this knowledge has changed and developed since they graduated from their nursing education. Situational knowledge is the form of knowledge that "comprises the requirements to be effective in particular situations … or instances of occupational practice" (p. 7). Canonical knowledge, closely associated with Eraut's codified knowledge, is necessarily abstract and involves "propositions, dispositions, and procedures that exist as an ideal and a requirement" (p. 7). Nurses, in the practice setting, enact this canonical knowledge in particular situations and also develop situational knowledge.

In order to learn and integrate canonical and situational knowledge, Billett and Henderson (2011b) argue the learner plays a significant role. They take the view that gaining practice professional knowledge through "effective participation in and learning from experiences in university and *practice settings* requires a certain set of personal capabilities, including the capability to be an agentic learner" (p. 4, italics added for emphasis). Billett and Henderson (2011b) define an agentic learner as one who independently examines and judges his or her own practice, the outcomes of this practice, and then identifies areas for improvement (p. 4) based on Bandura's (2001) social cognitive theory. Agentic learners engage with workplace learning opportunities and are receptive to supportive guidance (p. 10). This agentic learner has choices to make and work to do. In the same book Newton (2011) found that learning was directly related to how students' "elected to engage" with staff, guidance, and support (Billett & Henderson, 2011b, p. 10). They contend that this capacity to be an agentic learner is essential to being a professional practitioner, regardless of the occupation. These qualities of an agentic learner are evident in the findings and developed in the discussion chapter.

Before moving to the nursing discourses I define the three types of practice professional knowledge listed above, namely: conceptual, procedural, and dispositional (Billett and Henderson, 2011b). Conceptual knowledge is facts, concepts, and associations of facts and propositions (p.6). Procedural knowledge is "the knowledge through which we do things, including thinking and acting" (p.6). For nurses this ranges from knowledge of simple tasks and procedures to

complex processes of enacting nursing care. Dispositional knowledge, for Billett and Henderson (2011b), involves "interest, values, and intentionality, that direct the individuals' efforts in particular ways" (p. 7). I acknowledge that in the nursing literature beyond these three types of professional knowledge there are references to social knowledge, cultural knowledge, personal knowledge, embodied knowledge, and the ubiquitous references to "ways of knowing" (Carper, 1978) and "intuitive knowledge" (Benner & Tanner, 1987). Billett and Henderson (2011b) remind us both forms of knowledge, canonical and situational, involve these three types of practice professional (nursing) knowledge, conceptual, procedural, and dispositional. The inclusion of disposition as a type of knowledge is important to the discussion of the findings.

Nurses' workplace learning: The nursing discourses.

Eraut's work in the broader educational community was very helpful to the study's development because it moved the study beyond the nursing literature. I turn specifically to the related nursing literature now and then return to outline and defend this statement in the concluding paragraphs of this section. Patricia Benner published her landmark study of the development of nursing expertise in 1984. Certainly, the influence of Benner's theory of novice to expert continues to be extensive. Since the early 1980s Benner's body of work has become enormous in scope and in volume. Although less significant in volume, the work of Daley and MacLeod are very closely related to this study and therefore deserve attention. Many others have contributed to our understanding of how nurses refine

their practice over the span of their careers. I have incorporated their contributions above and below as a way of synthesizing a large body of work.

Patricia Benner.

Benner's (1983, 1984) work has been foundational to discourses related to the development of expertise in nursing, caring in nursing, ethical comportment, care ethics, evaluation of student nurses in clinical practice, and clinical decision making. Benner is also often credited with distinguishing between "nursing theoretical knowledge" and "intuitive knowledge" for nursing practice. Benner (1991) alone is cited 121 times in CINAHL to date. The development of expertise (from novice to expert), and her work on caring and ethical comportment in nursing, seem to be the two most contested and admired aspects of Benner's work. Benner was also instrumental in bringing interpretive phenomenology to nursing, although she has been heavily criticized for her use, or misuse, of hermeneutic philosophy (Horrocks, 2004; Nelson, 2004; Paley, 1996, 1997, 1998, 2000).

As with Michael Eraut's work, it is impossible to do justice to the volume and breadth of Benner's work in this chapter. Because there is overlap between this dissertation and Benner's work I highlight key points in order to posit how I see this study as different, and therefore as making a new contribution to how we understanding refining nursing practice. Benner's work was focused primarily on the individual nurse. This study was designed to explore the role of the health care milieu on nurses' learning in practice. Benner drew exclusively on Dreyfus'

theory of novice to expert, a move which has been well criticized (Eraut, 1994, pp. 123-128; Gardner, 2012; Paley, 1996, 2006). Benner's methods are underpinned by hermeneutic philosophy while this study of learning to nurse well utilized grounded theory, informed by symbolic interactionism.

Benner's methods are very influential in two areas of disciplinary knowledge development. Benner was central to the introduction of hermeneutic phenomenology to nursing (Benner, 1994). Second, Benner was instrumental in returning the science of the discipline to the practice of nursing. Benner (1983) argued that if we could understand the "knowledge embedded in expertise" we would be better able to advance and develop the discipline (p. 36). It was a call to study nursing practice. This is mirrored in a number of commentaries (Risjord, 2010) and studies such as Allen (2004), Cameron (1998), and this study. It is important to look at nursing practice *in* its practice context.

In spite of, or possibly because of, the debates regarding Benner's work her idea of expert has been developed and expanded in her own work and the work of others (Benner et al., 2009; Byrne, 1987; Bonner, 2003, 2006, 2007a, 2007b; Bonner & Greenwood, 2005; Bonner & Walker, 2004; Currie, 2008; Daley, 1998; Hanneman, 1996; Hood et al, 2007; Kitson, 2002; MacLeod, 1996).[8] Although within nursing the novice to expert model or theory is attributed to Benner, in other disciplines it is accurately attributed to Dreyfus and Dreyfus (see

[8] I have not cited all of the work of Benner and her colleagues, such as Christine Tanner and Catherine Chesla in this lengthy list; however, their collaborative work is extensive and fully supports Benner's original theory.

among others Eraut, 1994). In her own study Benner sought to describe the domains and competences of nursing (Benner, 2001, p. 40-41), a task that involves 165 pages of her book in contrast with the 39 pages devoted to defining Dreyfus and Dreyfus' model. Many nurse scholars have expanded and confirmed the novice to expert model through similar studies, although the five stages are often used as definitional characteristics a priori[9]. Some researchers also focus on the attributes or qualities of an expert nurse, the development of these qualities, and the *recognition* of expertise as essential to expert nursing (Butterworth & Bishop, 1995; Bonner, 2003; Bonner & Greenwood, 2005; Royal College of Nursing [RCN], 2005; Thomas & Fothergill-Bourbonnais, 2005). The expert nurse has often become synonymous with "the advanced, experienced, excellent" practitioner. As I describe in Chapter Four, the focus of this study was on experienced nurses rather than "expert nurses." The findings will show that nursing well was understood by nominators as something closer to the "advanced, experienced, excellent" end of a continuum.

Barbara Daley.

Barbara Daley (1997a, 1997b, 2000, 2001a, 2001b) has developed her program of research around continuing education for nurses and its relationship to nursing practice. Daley's (1997a, 1997b) initial work reports her doctoral dissertation research. Her overarching interest is the "clinical integration of

[9] Benner (1984) stated each stage was not to classify a "person" but rather describe a type of expertise that was being used in particular situations (p. 15). This contention has been woefully lost in the subsequent literature in which authors purportedly build on her work.

continuing education" (Daley, 1997a), although some of her subsequent publications discuss how nurses construct a knowledge base in clinical practice. Together, her body of work describes the relationship between continuing education and clinical nursing practice, directed primarily at continuing professional education practitioners (Daley, 1997a, 1997b, 2000, 2001b).

Daley's work is grounded in constructivist, transformational learning theory and continuing education. Daley (1997b) links Mezirow's disorienting dilemmas with Benner's paradigm cases. Daley (1998) suggests that reflection on disorienting dilemmas changes the meaning schemes and meaning perspectives for the learner. In her second study Daley (1998) explored if or how novice nurses' professional learning is different from expert nurses, based on the work of Benner (1984). In the study 40 nurses were asked to identify paradigm cases or disorienting dilemmas (Daley, 1998). The findings suggest that disorienting dilemmas do exist, foster reflection, and provide a venue for learning. This corroborates some of the findings of the study I conducted for my master's thesis to explore nurses' positive learning experiences, as the participants described circumstances that would generally be considered negative that they viewed as powerful, positive opportunities for learning (Jantzen, 2004; see also Bauer & Mulder, 2007; Benner et al., 2002; Gunther & Thomas, 2006).

Two aspects of Daley's (1998) study of novice and expert nurses are pertinent to my own research. First, her rudimentary exploration of the relationships among learning, knowledge, and context; and second, her findings

related to the expert nurses. While novice nurses learn through formal mechanisms and concept formation, expert nurses "constructed a knowledge base for themselves in the context of their practice" (Daley, 1998, p. 2). Learning for these expert nurses was active, self-initiated, and involved assimilating new information, past experience, and then differentiating experiences. Based on her contention "that professionals grow in their chosen career as they gain experience within the context of their work setting" (Daley, 1998, p. 1), Daley asked the participants specific questions regarding context. Her findings suggested that the expert nurses' understanding of complex organizational issues is a rich resource for continuing educators. It remains unclear what this understanding is and how a knowledge or understanding of the current health care milieu influences what is learned, how it is learned, and what factors affect what is learned.

Three limitations in Daley's work have informed the design of this study. Daley (1997a) fails to acknowledge the possibility of miseducative experience. Daley's methods are blurred because she uses techniques from grounded theory and claims to use qualitative interpretivist research while using *a priori* theoretical and conceptual frameworks, specifically transformational learning theory (Daley, 1997a, 1998, 2001a). Her research also lacks a clear description of nursing knowledge and an examination of the workplace. Daley (2001b) concludes that "more research is needed on the nature of professional work" because the "process of knowledge becoming meaningful for professional practice is tied

tightly to the nature" of this work across professions (p. 52). This study is one response to this call.

This study extends Daley's work in relation to methods and focus. There were no observational data in Daley's (1997a, 2001a, 2001b) research. This represents a significant gap in her work, as the researcher relies on re-constituted narratives (Carnevale, 1997; Purkis, 1994). The data in her second study of novices and experts was based on reported disorienting dilemmas and paradigm cases; therefore Daley (1998) was not able to see the process over time, throughout a career, but rather was limited to discrete learning events. Daley (1997b) described how disorienting dilemmas facilitated linking continuing education to clinical practice; however, an important question remained. Is this how nurses learn to nurse well and develop in their practice?

Daley and Mott (2000) highlight the changing nature of the workplace context, primarily in relation to economic constraints and the sociopolitical context. Daley's (2000) finding that "nurses often let political systems block their use of new information" (p. 39) is provocative. The findings of this dissertation suggest that the nurses were much more like the social workers and lawyers of Daley and Mott's study who either realized that politics were part of the system and found ways of going around them or considered politics as basically irrelevant to using new knowledge. This contrasts with the nurses in Daley and Mott's study who determined that if they did not have the power to use the new knowledge, they kept it to themselves.

Martha MacLeod.

Daley focused on the link between continuing education and knowledge in professional practice, which is distinct from becoming experienced through practising nursing (MacLeod, 1996). Martha MacLeod's research is primarily focused on the concerns of the nature of everyday practice and its development. MacLeod (1996) states, "I intended to examine directly learning and experience in nursing" (p. vii) because she found that discussions regarding learning were subsumed by talking about teaching. Although MacLeod has studied and published extensively in other areas the focus of the following discussion is on her doctoral study.

MacLeod (1996) conducted a hermeneutic study in Scotland exploring the two taken-for-granted phenomena of everyday nursing practice and day-to-day learning from our work. Similar to this study, MacLeod was interested in how "everyday experience contributes to the development of nursing expertise" (p. 362). Practising nursing and learning from nursing practice both involved intertwined processes of noticing, understanding, and acting (MacLeod, 1994, 1996). She reports the phenomena of knowing-in-practice in MacLeod (1994) and describes how it is the "little things" of everyday nursing practice that are imbued with nursing knowledge and skill. She stresses the importance of articulating the everyday practice of nursing to resist shifts driven by economics, in particular skill-mix. She describes skill-mix as a bureaucratic term for dividing nursing care

into tasks, and then delegating these tasks to auxiliary, less educated, and therefore less expensive staff.

In her literature review chapter MacLeod (1996) carefully outlines the range of experiential learning theories and critiques a general lack of attention to context. She also critiques a common, but false, division between the situation or experience and the subject who interprets the experience (the learner). MacLeod (1996) provides an excellent description of ten ward sisters' experience of becoming experienced while practising nursing. She describes three kinds of learning from everyday practice evident in her findings: watershed events, resonant experiences and "bits and bobs of everyday practice" (p. 48). She describes the ward sisters learning as primarily picking up, absorbing, being instilled in, and occasionally as a sudden insight, all gained through a dialogue with everyday nursing practice experience. Because of the limitations of phenomenology MacLeod (1996) did not develop the role of context on the process of becoming experienced. Another limitation relates to the problem of miseducative experiences. MacLeod (1996) questions whether the ward sisters actually improve their practice or if their "actions merely continue misconceptions or misunderstandings" (p. 126), but reassuringly acknowledges that the patients, the directors, and peers did consider the ward sisters exemplary, experienced nurses.

Martha MacLeod (1994, 1996) has made an important contribution to our understanding of nursing practice. The little things–everyday nursing practice by

excellent, experienced nurses –matter because they are embedded with nursing knowledge and skill. MacLeod (1994) links nursing's lack of voice with the ineffable nature of the complex but taken-for-grantedness of nursing. I am interested in building on this work, nearly twenty years later, because the conditions of health care MacLeod describes from 1986-1990 have only intensified.

MacLeod (1996) acknowledges the problem of overlooking the "structural interdependence of the person and society" (p. 121) in the kind of interpretive research she conducted. Although she does focus on the intersubjective nature of the nursing practice experiences she observes that attention to the broader social world "must await another analysis" (MacLeod, 1996, p. 121). While MacLeod's phenomenology excavated the experience itself, grounded theory is better aimed at identifying the social process of becoming experienced through practising nursing. My grounded theory develops our understanding of what McLeod called "becoming experienced practising nursing" (MacLeod, 1996).

Together, the work of Barbara Daley and Martha MacLeod has drawn attention to the relationship between nurses, nursing knowledge, and place. They have provided us with a description of nurses learning in and from nursing practice. This involves thinking, feeling, and acting (Daley, 1997a, 1997b) or noticing, understanding and acting (MacLeod, 1994, 1996). Interestingly, MacLeod's description of watershed experiences and Daley's (1997b) exploration of disorienting dilemmas all point to a particular kind of learning consistent with

what I observed in my previous research such that participants used learning as a way of redeeming very negative experiences (Jantzen, 2004, see also Eraut, 2004a). Both Daley and MacLeod point to a reflective process, although both identify the limits of this conceptualization. Both scholars have modeled constructively building on the work of Benner.

Learning for Professional Practice in the Workplace Summary.

In summary, I have outlined the contributions of Michael Eraut, Patricia Benner, Barbara Daley and Martha MacLeod and identified the aspects of their scholarship that informed my research. While Benner and MacLeod have focused on learning through nursing practice, Daley and Eraut have worked within the discipline of adult education, and in the fields of continuing education in nursing and workplace learning. As noted above, Eraut's work was very helpful by extending my considerations beyond the nursing literature. Eraut's work is particularly pertinent and therefore helpful for understanding how nurses learn in the workplace for many reasons. Eraut describes and explains the tensions between profession-oriented perspectives and academia (Eraut, 1994, p. 8). His research and related publications exemplify the links of initial professional education to continuing professional education (Eraut, 1994, p.12). Throughout his publications and over decades Eraut has explored the nature of knowledge, learning, and modes of cognition. The resulting depth and level of detail far surpasses the conglomeration of meanings gathered in the nursing literature under a singular idea of "nursing knowledge." Similarly, Eraut (1994, 2004a) increased

our depth of understanding of the concept of expertise. Because Eraut's pertinent exploration of professional knowledge and learning, both informal and formal, occurred across professions (including nursing) it has broad scope and strong credibility. Eraut gave critical attention to the broad, sweeping statements regarding learning from experience. Finally, Eraut (2007) treats socio-cultural and individual theories of learning as complementary (p. 405). Given the interaction of individual nurses with the health care milieu, this is more helpful than defending one perspective over the other.

How Did Nurses Learn to Nurse Well in the Past?

Although the term continuing education, used virtually exclusively in American literature, emerged in the mid-20th century the idea of ongoing learning was not new (Stein, 1998). Long before continuing education became a commodity, before continuing competence was linked to professionalization, and before the plea for lifelong learning was ubiquitous in health care and educational literature, nurses were engaged in improving their nursing practice. The value of professional development to nurses has been linked to establishing credibility in health care and in physician nurse relationships since the earliest religious nurses (Nelson, 2001a).

Early professional development.

"Whatever helps nurses helps the patients. The more we know, the better off our patients are, and that is what continuing education is about" (Yoder-Wise, 2003, p.203). This quotation from an interview with Signe Skott Cooper, a key

leader in the field of continuing education (CE), summarizes the philosophy of CE in nursing. In this philosophy there is a presumed link between professional development and continuing education, nursing well, and improved patient outcomes.

References to ongoing learning began to be documented when registration, professional associations, and common educational requirements became more uniform (Cooper, 1973; Stein, 1998). Historical overviews of continuing education in nursing have focused on institutions and the burgeoning adult education market, primarily in the US (Cooper, 1973; Stein, 1998). These overviews begin with Florence Nightingale's call for ongoing learning (Cooper, 1973; DeSilets, 1998; Stein, 1998). However, a commitment to professional development was evident much earlier in the histories of Catholic nuns who "had a well-established system of novice training…and kept up-to-date on medical and scientific advances" (Mansell & Dodd, 2005, p. 205). With a lifelong vow to God and their religious community, there was a high level of commitment to lifelong learning, mentoring, and (continuing) education (Nelson, 2001a).

Religious nursing sisters, or vowed nurses, have played a significant role in shaping the profession of nursing in Canada, as pioneers, leaders, and innovators (Nelson, 2001a; Paul, 2000; Violette, 2005) Unlike other nurses of the 19th and early 20th century, who left nursing for marriage and childrearing, religious nursing sisters were arguably the first life-time career nurses, and are therefore potentially instructive in understanding what facilitates the ongoing

development for first line nurses. A desire to re-situate the international growth of modern nursing in the world of vowed, religious, or non-cloistered Christian women is central to Nelson's (2001a, 2001b) work. In the next section I seek to re-situate the emergence of professional development for nurses in the practice of these same early nurses.

Although in Canada only two orders were defined as nursing orders many others were involved in health care and even establishing hospitals (Violette, 2005). Regardless of the order, within each hospital a philosophy of care was transmitted from senior to junior workers. The master-apprenticeship system created a uniformity of care and quality. There is evidence this system resulted in exceptional knowledge and skill (Paul & Ross-Kerr, 1995; Violette, 2005). Unlike their cloistered sisters, active nuns were able to engage in their communities and travel freely. Many nursing sisters returned to the motherhouse[10] for retreat and professional development throughout their careers (Paul, 1994).

Prior to conducting this study I reviewed a set of newsletters[11] (published over one year 1959-1960) to evaluate the professional development of a group of

[10] One example is the Institute Marguerite d'Youville, affiliated with the University of Montreal, begun by the Grey Nuns.

[11] The Sisters of Saint Anne was founded in 1850 by Sister Marie Anne (Marie Esther Blondin) in Quebec. Although primarily serving in education the four sisters who arrived in Victoria in 1858 quickly added nursing care to their service. The care of the sick was added to the Congregation's constitution eventually and they established a hospital in Victoria in 1876. The School of Nursing opened in 1900, one of twenty in Canada. In 1972 the SSA withdrew from St Joseph's Hospital; however, they continued to be involved in supervisory roles and in the school of nursing until the school closed in 1981. By the mid-1930s the SSA were offering a BSN program in collaboration with UBC and Seattle University.

religious nursing sisters. Given that only eight to ten sisters were working in the group at the time, there was a remarkable amount of professional development. All of the sisters participated in an activity specifically directed at professional development, including hospital conventions and institutes relating to supervision, curriculum, disaster planning, and medical records. University education was also highly valued as evidenced by the number of sisters who were attending university. Lay nursing staff were also included in educational events, such as a course for graduate nurses on intravenous administration, functional anatomy, and medical terminology. I acknowledge the time period of the review coincides with the emerging CE emphasis in the US; however, the evidence in the published literature of vowed nursing sisters' commitment to professional development begins centuries earlier, as described below.

Determined to ensure that their hospitals were successful, religious nursing sisters recognized the need to be excellent nurses. In a setting of significant opposition there were "strong motivations for them to succeed as nurses, to run efficient hospitals, to work well with good doctors, and to show the world that would have delighted in their failure that they were the best possible nurses" (Nelson, 2001a, p.113). Opposition to the nursing sisters was rooted in Catholic Protestant tensions, medicine's desire to gain and retain power over health care, and in the gendered work of nursing. In many parts of the world the provision of health care and assistance to the poor and marginalized was a missionary activity. Superior service and skilled nursing was the nursing sisters'

weapon against detractors. This often involved being prepared to adjust to increasing demands, including administration and education. I have intentionally included this limited examination from the history of religious nursing sisters to problematize the dominance of American continuing education perspectives evident in all of the extant literature. Not only were religious nursing sisters actively engaged in refining nursing practice, the contextual factors and pressing demands are surprisingly familiar.

Florence Nightingale, with whom the history of nursing often begins, expected that nurses would learn throughout their lives (Stein, 1998). This learning was focused on improved conditions for patients (Cooper, 1973; Stein, 1998). In the late 19th century alumnae associations offered social and educational opportunities (Baer, 1989, p. 169; Cooper, 1975; Stein, 1998). Schools of nursing began provide postgraduate courses to make up for deficiencies in basic nursing education. The quality of these hospital based postgraduate courses varied significantly because of lack of uniform standards; however, it is generally assumed that exploitation of learners by requiring clinical service with little or no remuneration, as with nursing students, was common (Cooper, 1973). Hospital based postgraduate courses were often the only continuing education available to nurses, were linked with an expanding scope of practice, and focused on knowledge and skills for advanced practice, specialty or new advancements. When taught well they formed an important foundation for professional development. These postgraduate courses eventually fell out of favour due to the

lack of theoretical basis and increasing availability of courses for which academic credits were given (Cooper, 1975).

The growth of continuing education.

The field of continuing education has grown dramatically between the early years of nursing and when this study was conducted. The formative years of formalized continuing education, between 1900 and the 1950s, were influenced by the development of nursing as a profession (Stein, 1998, p.247) and have been described above. From the turn of the 20th century forward credit courses and summer programs were developed to address specific educational needs in areas such as teaching nursing, leadership, and public health (e.g., Teacher's College in New York) (Cooper, 1973; Stein, 1998). Around 1920 nursing organizations began developing institutes, workshops, and conferences for active nurses. Refresher courses were devised for inactive nurses, specifically aimed at addressing nursing shortages. At the same time some nurses began to promote university nursing education for public health nursing in Canada (Kirkwood, 1994). The Canadian university extension movement also provided professional development opportunities, paralleling activities in the US (Welton, 1998).

Within ten years of the establishment of nursing institutes, hospitals began offering in-service education with an emphasis on skills, procedures, and policy updates (Cooper, 1973). These in-service educational opportunities flourished in spite of limited administrative and monetary support, and in spite of resistance from nurses who lacked awareness of learning needs. Between the mid-1960s and

1990, the demand for education and the huge amounts of money flowing into continuing education resulted in tremendous growth (DeSilets, 1998, p. 249). During this time colleges, universities, employing agencies, and private, profit-seeking sponsors promoted and provided continuing education in nursing (DeSilets, 1998; Stein, 1998). In order to ensure quality and in keeping with professional self-regulation the ANA began approval and accreditation processes in the US (DeSilets, 1998). Meanwhile some states, beginning with California, initiated the controversial practice of mandatory continuing education linked to licensure (Cooper, 1975, p. 72; Yoder-Wise, 1984c, p. 182). While many criticized this move (Cooper, 1975), when CE became mandatory there was an attitudinal shift towards valuing CE and also ensuring it was done well.

The tremendous growth of continuing education for nurses was a product of economic and sociopolitical factors, primarily in the US. The growth paralleled the focus on the development of nursing as a profession and as a discipline. Over these same decades andragogy, self-directed learning theory, and behaviorist approaches, such as instructional design and competency based programming, dominated adult learning theory (Collins, 1998; Cranton, 1996; Elias & Merriam, 1995) and influenced early CE educators (Cooper, 1972; Yoder-Wise, 1984a, 1984b, 1984c). Increased support for continuing education was directly related to changes in funding for American health care, general prosperity, and optimism (Stein, 1998). Most importantly, during this time CE providers were joined by entrepreneurs (Stein, 1998). DeSilets and Pinkerton (2004) describe a “new

concept of regional CE" which was highly successful, situating CE in resort settings (p. 12). Since then, continuing education has been used as a key recruitment and retention strategy to resolve the nursing shortage (Ledgister, 2003a, 2003b). A perpetual lag between changes in nursing practice and preparatory education is cited as a century long impetus for CE. Continuing education in nursing is directly influenced by the blatantly market-driven segment of American adult education (Stein, 1998). Nursing witnessed the commodification of CE.

By 1970 individuals began to question the effectiveness of continuing education programs on practice and patient outcomes (Furze & Pearcey, 1999). Definitions for continuing education and the continuing education unit (CEU[12]) and designated values for contact hours were developed by the ANA (1973; DeSilets, 1998; DeSilets & Pinkerton, 2004). These actions were related to the plan to formally approve programs, to establish permanent records, and to standardize measures for approval and accreditation. This was in keeping with a desire for accountability, which was considered a professional ideal (DeSilets, 1998). Following significant economic challenges in the 1980s and 1990s less money and a shrinking health care workforce slowed the burgeoning continuing education market (DeSilets, 1998). Questions about professionalization and a fear that continuing education had lost a close link with practice also contributed to

[12] The ANA (1973) originally defined the CEU as 10 hours of participation in an "organized education experience under responsible sponsorship, capable direction and qualified instruction" (p. 29).

less interest in continuing education and a repeated call for evaluation of programs and measurement of outcomes (DeSilets, 1998, p. 251; Yoder-Wise, 1984b, p. 138). More recently many scholars have demanded an evaluation of continuing education, in particular as it relates to patient outcomes and individual and organizational priorities (Eustace, 2001; Griscti & Jacono, 2006; Lundgren & Houseman, 2002; Waddell, 1991). Krugman and Warren (2011) report that while early research in the area of professional development for nursing had deficits, later studies are better quality and provide some evidence of CE for improved patient related outcomes. As a point of comparison, the value of learning through everyday activity has been demonstrated in a number of studies (Daley, 2001b; Jantzen, 2004, 2008; MacLeod, 1996).

Adult education developed similarly in Canada and the United States (Collins, 1998). However, the unique characteristics of Canadian adult education, nursing, and health care continue to shape professional development for Canadian nurses. Canadian adult education celebrates a historical commitment to social transformation and critical education (Scott, Spencer & Thomas, 1998) and is less formalized and more accessible (Collins, 1998). What is missing from some of the Canadian experience is the for-profit, market-driven availability of continuing education. In recent years, Canadian nursing regulatory bodies have chosen a path for ensuring continuing competence that differs significantly from the American model of uniform accreditation (CNA, 2000; DeSilets & Pinkerton, 2004; Nelson & Purkis, 2004). The Canadian policy contrasts with the movement toward, away

from, and back to mandatory CEU requirements (DeSilets & Pinkerton, 2004). In reflections on the history of continuing education there is a consistent call for evaluation of the thing we call "CE" and an acknowledgement of how incredibly difficult this is (Cooper, 1972, p. 583; DeSilets & Pinkerton, 2004; Yoder-Wise, 1984a).

Changing dynamics in professional development.

Changes in continuing competence requirements, shifts in the demographics of nursing and career longevity, and the increased pace of Western daily life have combined to influence changes in professional development. Changes in nurses' professional development occurred within the broader context of adult education. In the 1990s a shift occurred in adult education. There was a shift from educational and community institutions and associations to adult education in the context of work (Fenwick, Butterwick, & Mojab, 2003). While the idea of lifelong learning is still valued both within and outside educational institutions, the focus within educational institutions is on completing particular programmes of learning (Collins, 1998).

Issues of accessibility, affordability, and utility pervade the historical and contemporary literature (Richards & Potgieter, 2010; Schweitzer & Krassa, 2010). As early as 1929 there was a tension between providing in-service education during working hours or on nurses' days off (Cooper, 1973, p. 10). A lingering attitude amongst individual nurses that in-service education was not necessary and complaints related to a lack of financial support from employers, lack of

documented effectiveness, and ineffective programs pervades the history of continuing education (Cooper, 1973, p. 10; Slusher et al., 2000). These themes continue to be evident in recent studies (Barriball & White, 1996; Penz et al., 2007). MacKinnon (2010) identified a number of challenges in accessing continuing education for rural nurses in B.C. Geographical isolation, workloads, small networks, and economic challenges are key issues (MacKinnon, 2010, p. 40). One study found that age was also a barrier, in that older nurses had less access to CE (Wray, Aspland, Gibson, Stimpson, & Watson, 2009).

While in Canada the responsibility of nurses' professional development has increasingly shifted to the individual's ingenuity, the US has shifted back to CEUs as the key competence requirement. These units are currently based on contact hours of study, defined as fifty minutes of learning through course attendance or formal clinical education (ANA, 1997). I discuss the Canadian situation thoroughly in Chapter Three. Henderson, Fox, and Armit (2008) describe a comprehensive framework for "clinical, professional, and organisational learning" to promote lifelong development of nursing staff in Queensland, Australia[13] (p.1; see also Billett & Henderson, 2011b). Despite being heavy with language regarding efficiency, organizational agendas, and knowledge and social capital, this model deserves consideration for the Canadian setting. The framework acknowledges the multifaceted, structured, and coherent approach

[13] Currently, the program is titled The Queensland Health Nursing and Midwifery Staff Development Framework and has not been copyrighted or undergone extensive evaluation (personal communication, Henderson, July 2012).

required to address the learning needs of nurses across the continuum from student to mentor (Henderson et al., 2008, p. 64). Three accessible diagnostic tools have been incorporated into the framework (Henderson, Briggs, Schoonbeek, & Paterson, 2011). The modules and structured pathway include both individual learning and organizational programs and requirements. The comprehensive approach including orientation, transition, and continuing and ongoing education is being utilized across a larger geographical area for maximum portability.

For well over a hundred years professional development has played a role in maintaining nurses' competence through educational institutions, hospitals, employers, private business, and nursing associations. The recent focus of continuing education has been on skills related to nursing practice or administration and teaching. Overall, the development, the delivery, and the popularity of professional development have paralleled the larger field of adult education. It is also evident that economics have played a significant role in the evolution of continuing education. More importantly, the desire for nursing to be recognized as a profession, based in a particular Anglo-American trait theory, has shaped policy around ongoing learning. As I argued in Chapter One, professionalization of nursing also propelled the movement of nursing education to academic settings. Before describing the landscape in which the study was conducted in Chapter Three I explore literature related to nursing education and early work experience.

Nursing Education and Early Work Experience

> The goals of this book are to document the conflicting views that nurse educators and nurse employers have about the work role and competency of the newly graduated nurse; to identify and delineate the difficulties that many nurses experience in their first jobs; to present effective work-entry procedures to help overcome school-to-work transition problems; and to offer educational strategies that can be used by those in both service and academic settings in planning programs that will obviate many of the new nurses' difficulties. (Benner & Benner, 1979, p. 5)

I have included this quotation at length in order to acknowledge that in many respects, nothing is new. These are the first sentences in Benner and Benner's (1979) preface. Early references to reality shock began with Kramer's (1974) seminal book. The constancy of the argument is particularly poignant in view of one of the most recent studies on nursing education that returns to many of the same themes (Benner et al., 2010). And, it is somewhat ironic that I am arguing that this study is truly contributing to our knowledge given that the above statement was made over thirty years ago.

Benner and Benner (1979) go on in the next sentence to stress that "the nature of the school-to-work transition … has a significant influence on subsequent career development" (p. 5). Although the focus of my study was on experienced nurses I was led to explore literature related to nursing education and early work experience because of the findings. It should not be entirely surprising

that nursing education cannot be severed from nurses' workplace learning. And yet, it seems there is a strong line of demarcation in our thinking. There is learning in professional preparation and then there is work. In reality, the line is very blurred and, as I discuss in the following section, much depends on where you are positioned in relation to graduation and licensure. Generally, nurse educators argue that the workplace needs to change, and in fact the curriculum revolution leaders would argue that the health care milieu needed, and still needs, *complete* transformation and emancipation (Chinn, 1989; Purkis, 2007; Tanner, 1990, 2007; Tornyay, 1990). Meanwhile, practitioners and employers insist that nursing education is continuing to fail to prepare "for the realities of the workplace" (Candela & Bowles, 2008, p. 266). My findings point to one of the problems of failing to address this concern. The following paragraphs are a synthesis of the pertinent literature regarding the complex process of learning professional knowledge with the aim to avoid entrenching polarizing views.

Although eloquent arguments for the strengths and values of baccalaureate education began much earlier (Johnson, 1966), the move to baccalaureate education for entry to practice has been a central area of focus in the published research in nursing education over the past two decades (see among others Clinton, Murrells, & Robinson, 2005; Roxburgh et al., 2008). University degree preparation for professional practice has been a feature of the professionalization of many occupations and the resulting issues are common (Eraut, 1994, p. 7-12). In the nursing literature, there was an early emphasis on proving the usefulness of

baccalaureate education followed by a recent emphasis on readiness to practice and problematic new graduate transition. It appears that nursing scholars, regulatory bodies, nursing educators, and nurse employers alike all share a concern for what Slaikeu (2011) calls the preparation practice gap. In an article in the *Nurse Leader*, a publication aimed at nurses who design, facilitate, and manage care in the US, Slaikeu (2011) lists factors that contribute to the preparation practice gap in the health care and in academic environments. It is a very concise summary of much of what has been written over the past two decades. She points out that educational institutions in the US[14] have been charged by the National League of Nurses (NLN) to evaluate their curriculum for relevance. She also points out that both environments have already tried to solve the problem by adding layers of solutions and a creating an even more fragmented system.

Literature supporting baccalaureate education for nurses has proliferated in the past two decades. Some studies suggest that baccalaureate nurses do well in the current health care milieu, particularly in relation to critical thinking (Duchscher, 2003, p.15); better patient care (Kalisch, Landstrom, & Williams, 2009); and proficiency in leadership, research and decision making (Giger & Davidhizar, 1990). Other studies find no difference (Clinton et al., 2005; Girot,

[14] Slaikeu (2011) and many other references relate to the US. A focused effort to explore the effectiveness of pre-licensure nursing education occurred in the UK over a decade ago. Therefore, some of the recalcitrant American issues are unique. For example, the US is still undecided on baccalaureate education as entry to practice. Due to significant differences we need to be careful about drawing conclusions across national boundaries.

2000). Regardless, the debate continues. A central point of discussion is that nurses and employers have had reservations about the shift to baccalaureate education and are primarily fearful that graduates would have limited clinical skills (Watkins, 2000; Wheeler, Cross, & Anthony, 2000, p. 843). In the UK this resulted in guidelines for "fitness-for-academic award," "fitness-for-professional purpose," or "fitness for practice" (Clinton et al., 2005, p. 84; Wheeler et al., 2000, p. 843). These guidelines represent an attempt in the UK to maintain academic education for nurses by addressing the central concern related to clinical or workplace preparedness.

Most recently, in their extensive review of nursing education in the US, Benner et al. (2010) uphold and strengthen the recommendation for baccalaureate education for entry to practice (p. 5; see also Bartholomew, 2010). In addition, Benner et al. highlight the critical importance of clinical placements using experiential and situated learning (pp. 41-56). Length and quality of practice placements were also referred to frequently in my study and the findings support the argument that practice placements are a key leverage point in transforming nursing education. Gallagher (2004) observed, "The transfer of nursing education in to tertiary institutions inevitably meant a reduction in the quality of learning time spent in practice settings" (p. 265). It has been difficult to achieve adequate clinical education while delivering an academic education. Rather than suggesting we abandon academic education I take the view that university degree preparation

continues to be essential for professional practice for nurses; however, the problem of practice placements cannot be ignored.

The line of demarcation between nursing education and early work experience is most often framed as a problem. This problem has been described in various ways, including the preparation practice gap (Slaikeu, 2011), practice education gap (Benner et al., 2010, p. 4), (un)readiness to practice (Wolff & The Coalition for Entry-level Registered Nurse Education, 2007; Romyn et al., 2009), and the relevance gap (Risjord, 2010). Historically, this gap was subsumed under the theory practice gap which has received significant attention in nursing since the 1980s (Risjord, 2010). According to Romyn et al. (2009) one thing is agreed: a gap exists. I concur, however problematic the metaphor of a gap is (Gallagher, 2004). The literature regarding this recalcitrant problem or preparation practice gap can be divided into three perspectives. There are those who point to solutions in nursing education. There are those who identify changes that are required by employers to adapt the workplace. Finally, there are those who are not concerned about a preparation practice gap, arguing that new graduates should not be expected to be safe for many months or up to a year following graduation. I begin the following discussion with this latter point, move to a focus on nursing education, and then conclude with a discussion of the workplace.

Although much has been written about variations of the relevance and preparation practice gaps over many decades, overall the empirical research is limited and primarily descriptive (Frenk, Chen, et al., 2010, p. 1924; Gaynor,

Gallasch, Yorkston, Stewart, & Turner, 2006; Winfield, Melo, & Myrick, 2009; Wolff & The Coalition, 2007, p.11). Authors quote a few studies, with very small and focused samples (Young, Stuenkel, & Bawel-Brinkley, 2008), and some arguments are very poorly constructed and defended, for example Morrow (2009). Based on the paucity of empirical research in the area of evaluation of nursing education Roxburgh et al. (2008) (UK scholars) argue that curricular changes are being made without the requisite rigourous, multi-centre studies for "curriculum evaluation …which investigates content, process and outcome. Without such research, curriculum change will be uninformed" (p. 881). In relation to the emerging nursing education debates, this doctoral study is a beginning step in a proposed program of research intended to explore key germane themes: professional knowledge and learning, competence, and the development of expertise in the current health care milieu.

A preparation practice gap? Not a problem!

Not everyone would share the view that the preparation practice gap is a problem that needs to be solved. Some of the literature suggests that new graduates do not need to be prepared for existing health care environments (Duchscher, 2008; Romyn et al., 2009; Wolff, Pesut, & Regan, 2009). This is often founded on Benner (1984) and Benner, Tanner and Chesla (2009). Benner's work has been developed, extended, and critiqued as I have described in the first section of this chapter. It is very commonly utilized in relation to new grad transition, albeit too often inaccurately.

In her recommendations based a grounded theory of new graduate transition Duchscher (2008) stated, “It is unreasonable to expect undergraduate educational institutions to prepare graduates to competently perform all of the skills required by a contemporary acute care workplace” (p. 448). I explore more of Duchscher’s work and recommendations in the section on attributing blame to the workplace; however, this statement reflects a common belief (see also Candela & Bowles, 2008; Romyn et al., 2009; Wolff et al., 2009). Some assume that even the best nursing education program cannot prepare nurses to work and therefore residency programs are required (Casey et al., 2004; Pine & Tart, 2007; Tanner, 2010).

Nursing is not unique in its challenges regarding preparing professionals for the workplace (Billett & Henderson, 2011a; Bondi, Carr, Clark, & Clegg, 2011; Dunne, 2011; Eraut, 1994; Luntley, 2011). Eraut (1994) argues, based on his initial decades of research, that a clearer articulation of professional knowledge and stronger links between academic education and educators and professional practice environments is necessary.

Benner’s work does not support the argument that nursing education cannot prepare nurses for the workplace. Using Benner’s theory to discount the problem of a preparation practice gap has resulted from misappropriation of her theory in relation to the novice and advanced beginner nurse. In Benner’s (1984) theory novice nurses provide safe, competent patient care. In Benner’s view, at times nurses use the type of knowledge and expertise Dreyfus identified as

novice. Novice practice is founded more in rules and principles (Benner, 1984, p. 13, 20-22). Further to this, if it were the case that there is no problem to be solved Benner et al. (2010) would not have argued passionately for the urgent need for dramatic changes in nursing education: "Indeed, a major finding of our study is that *a significant gap exists* between today's nursing practice and the education for that practice, despite some considerable strengths in nursing education. Simply requiring more education will not be sufficient; *the quality of nursing education must be uniformly higher*" (p. 4, italics added). Benner and colleagues were well aware of the trajectory involved in developing nursing expertise based on Benner's (1984) theory of novice to expert. Novice practice was taken into consideration, and yet they make recommendations for "transforming" nursing education, a point that is made and then developed throughout the subsequent pages of their book (Benner et al., 2010). Rather than taking the position that "there is no problem," Benner et al. (2010) make recommendations for nursing education and nursing residency-like transition programs. Because of the common use of Benner's theory of "novice to expert" to disregard the gravity of a preparation practice gap it may come as surprise to read this argument. As early as 1979 and as late as 2012 Benner discussed this gap. This study corroborates and extends her conclusions.

Evaluating nursing education: Implicating education.

In Canada, the US, and the UK, recent comprehensive studies evaluating the effectiveness of current nursing education to prepare nurses for the current health

care milieu shift at least partial blame for the preparation practice gap on nursing education. Although I focus on three reports (Benner et al., 2010; Frenk, Chen et al., 2010; Wolff & The Coalition, 2007), numerous other studies corroborate these three reports (see among others Newton & McKenna, 2007). The first study I discuss was commissioned by the Coalition on Entry-level Registered Nurse Education in British Columbia (BC), the jurisdiction of my study (Wolff & The Coalition, 2007). Data collection occurred between April and June 2006, and was followed by an identical study in Alberta in 2007-2008 which reported very similar results (Romyn et al., 2009). These studies follow similar studies in the UK on what they call the "fitness for practice" debate a decade earlier (Roxburgh et al., 2008). A second key study relates to health care professionals broadly and was reported in the *Lancet* (Frenk, Chen et al., 2010). The third one, which I have already referred to, is a very extensive and comprehensive examination of nursing education in the US led by Patricia Benner (Benner et al., 2010).

The Coalition on Entry-level Registered Nurse Education conducted a study involving participants from practice, administration, regulation, and education to explore various views on "readiness to practice" (Wolff & The Coalition, 2007). A key strength of this robust study is the development of the linchpin concept of "readiness" and the identification of points of tension. The findings suggest readiness means "(a) having a generalist foundation and some job-specific capabilities, (b) providing safe client care, (c) keeping up with the current realities and future possibilities, and (d) possessing a balance of doing,

knowing and thinking" (Wolff & The coalition, 2007, p. 6). I will return to these findings in the discussion chapter; however, I want to reiterate the clear assumption that nursing education should be ensuring that graduates have "competencies that are foundational to their practice and transferable" to diverse settings and situations (p. 6) and that nursing education often does not provide this (see also Romyn et al., 2009). The report reinforces the view that new graduates in general are limited in their capacity to move seamlessly into practice. Although the authors do not provide specific solutions there was general agreement that the very discourse on "readiness to practice" needs to stop or be redefined and nursing education needs to change.

Frenk, Chen, et al. (2010) are also clear that health professional education must change. The *Lancet* commission concluded that "Professional education has not kept pace with the [changes in health care] largely because of fragmented, outdated, and static curricula that produce ill-equipped graduates" (p. 1923). The authors summarize two generations of reforms over the century and then outline what needs to characterize the next, third generation, of reforms. Transformative learning and interdependence in education are the proposed outcomes. These outcomes require engagement at all levels – local, national, and global; increased investments globally; and socially accountable accreditation (p. 1924). Health professional education needs to move to competence-driven education through health education systems rather than university based or academic centres. They also state that we need evaluation and research regarding "which innovations

work under which circumstances" (p. 1925). Health profession education needs to utilize core competences beyond knowledge and facts, to include "patient-centred care, interdisciplinary teams, evidence-based practice, continuous quality improvement, use of new informatics and integration of public health" (p. 1933). This is education with a focus on lifelong learning, critical inquiry, and a renewed sense of socially responsible professionalism (p. 1933). The repeated call for more and better research is, in my view, the critical first step. However, researchers need to examine how to better prepare professionals to practice.

Although the authors of the *Lancet* report make few recommendations specific to nursing education, they reiterate a key point drawn from the Carnegie Foundation study by Benner et al. (2010): "Although nursing has been effective in the promotion of professional identity and ethical comportment, the challenge remains of anticipating changing demands of practice through strengthening of scientific education and integration of classroom and clinical teaching" (Frenk, Chen et al., 2010, p. 1932). This brief statement is an excellent summary of a lengthy report with many recommendations and is a powerful beginning point. Findings from the broader deliberations and consultations focus on educating to core competencies and skills, increasing interprofessional education, and increasing funding to provide requisite support for nursing education globally in order to improve health equity. Taken together these three robust studies suggest that nursing educators need to (better) prepare nurses to work in today's practice environments while at the same time helping students develop the capability to

adapt to new realities of practice, be locally responsive, and be globally connected (see also Roxburgh et al., 2008).

A number of influential authors have studied practice professionals' education in a post- apprenticeship era (Billett & Henderson, 2011a; Dunne, 1996, 2011; Eraut, 1994). Each author outlines the historical move from training to academic education. Each author develops a critique of technical rationality that concurrently influenced education and practice disciplines (Schon, 1983; Sellman, 2012). These authors reiterate a point alluded to throughout these background chapters: the professionalization agenda required a shift from apprenticeship education to academic education in order to promote professional practice. Because of the sociopolitical setting of the time empiricism and technical rationality has had an enduring influence and has created a preparation practice gap. A key counter-approach, to address the gap, is being made that further educational reforms need to be primarily informed by professional practice (Benner et al., 2010; Billett & Henderson, 2011a; Reed & Shearer, 2011; Risjord, 2010; Sellman, 2012).

Rolfe and Gardner (2006) point out that academic education as entry to professional practice occurred at the same time as the university seemed to some to be losing or outliving its function and when the university was, and continues to be, "in ruins" (p. 636). Nursing, along with many other professions, has a different relationship to practice than traditional disciplines, such as mathematics or history. Practice is not directly related to research and scholarship and it does

not generally take place in the university. “The theoretical study and the practice of nursing are usually separate and distinct activities … in separate and distinct locations” (Rolfe & Gardner, 2006, p. 638). Nursing, similar to other practice professions, presents challenges to achieving the theoretical study of university, academic education. At a time when the university is succumbing to a market model within a research industry and producing work-ready products (nurses), academic leaders need to pay close attention to both the ideals of academic education and practice.

Taken together, these arguments and reports suggest that there is a problematic disconnection between professional education and professional practice environments, including nursing. Unlike those who teach in medicine, many nurse educators do not maintain a clinical practice. The factors contributing to a preparation practice gap are numerous. One commonly cited solution is to repair workplace environments, specifically toxic health care.

Troubled workplaces and blaming practice.

Descriptions of the current workplace are generally not positive. Most of the pertinent recent publications (1995 and following) begin with one or all of the following claims: there is a global nursing shortage; new graduates are not adequately prepared to deal with the negative environment; negative transitions from education to practice result in high attrition numbers; the negative nursing culture of horizontal violence and “eating our young” are rampant and directly contribute to the nursing shortage as a result of high attrition rates. Some argue

the workplace environment is too hostile, patriarchal, and medically oriented. These authors argue that it is unrealistic to expect nurses to be ready to work or should ever be expected to work in the current environment. Ellerton and Gregor (2003) develop an argument that is echoed in much of the literature. They suggest nursing education has focused on health care policy, health promotion, and reform of the health care system while, in Canada, health care institutions have increased acuity, with fewer beds and shorter lengths of stay, and require nurses to have an increased scope of practice. This creates a growing gap between education and the new graduates' workplace.

Realistic expectations of staff are important to successful transition from education to practice. "A shift in the culture of the current practice environments is required for successful transition" of graduates into the current health care milieu (Wolff & The Coalition, 2007, p. 11). According to Wolff and The Coalition (2007) new graduates receive mixed messages, primarily due to the realities of the workplace. While experienced nurses and employers expect to see new graduates function safely and competently with stable patients, the typical nursing workload is often very different, with primarily unstable, complex patients in high volumes, which does not allow for this luxury. Can a shift in culture accommodate these circumstances?

Many of the recent studies about new graduates have focused on the unwelcoming nature of the health care milieu (Kelly & Ahern, 2009). New graduates find the workplace rigid, with rituals and routines set in stone (Mooney,

2007). In this context many new graduates are stressed, powerless, and silenced (Mooney, 2007, p. 78). Other graduates experience "role conflict and inner conflict" (Kelly & Ahern, 2009, p. 914). Many other studies point to consistently high levels of stress, lack of confidence, difficulty with communication both with other professionals, such as doctors, and with patients and family, and lack of comfort and confidence with specific procedures (such as caring for a dying patient, IV starts, Code Blue).

In Canada, Judy Boychuk Duchscher's work on newly graduated nurses is commonly cited and seen as definitive (Duchscher, 2001, 2003, 2008, 2009; Duchscher & Cowin, 2006; Duchscher & Myrick, 2008). Her initial phenomenological research on the very early months of new graduates supported Benner's theory regarding advanced beginners. Using a critical feminist lens Duchscher has focused her program of research on the relationship between new graduate transition and the oppressive, hostile workplace environment (Duchscher & Myrick, 2008). Her recommendations are primarily aimed at the workplace (Duchscher, 2008, p. 442). In Duchscher and Myrick's (2008) poststructuralist, critical feminist review of the literature on the new graduate experience they clearly state their "deconstruction is to raise awareness of the nefarious nature of the oppression that continues to prevail in the work-life of the NG [new graduate]" (Duchscher & Myrick, 2008 p. 193). New graduates experience significant stress working with physicians in the workplace (Duchscher & Myrick, 2008; Kelly & Ahern, 2009). Cowin (2002) also argues for more supportive

workplaces for young nurses (Cowin & Jacobsson, 2003; Duchscher & Cowin, 2004, 2006). Duchscher and Myrick suggest that new graduates and seasoned nurses experience dissatisfaction and distress in the acute care hospital setting and these problems relate to power, oppression, and patriarchy in the workplace and "misogynistic domination" (p. 197).

At the heart of much of the literature is a disconnection between the codified knowledge and professional socialization of nursing education, and the current health care milieu. The disconnection results in disillusionment and an overall loss to health care. "Role ambiguity, and the internal conflict that it precipitates, transforms the creative and inspiriting energy of these new and vibrant nurses into job dissatisfaction and career disillusionment as they face overwhelming constraints to the application of both their intelligence and their caring in daily nursing practice" (Duchscher & Myrick, 2008, p. 195; see also Kelly & Ahern, 2009, p. 914). Duchscher and Myrick (2008) point to a picture of "creative, inspiring, energetic, fresh, vibrant new graduates" that is not completely congruous with the recent work explored at length in previous sections. This is not to say Duchscher and Myrick are wrong. Rather, there is a varied description of new graduates. This contrast is explored in the findings and discussion that follows.

Duchscher and Myrick (2008), citing studies from 1990 to 2001, suggest the disconnection occurs because the health care environment is corporatized and medicalized. Nurses in these environments use a prescriptive, reductionistic

approach to thinking about nursing theory and practice. This contrasts with the social justice, humanistic focus of undergraduate education (p. 196). This is similar to the findings of an extensive research program lead by Heather Spence Laschinger that explores the influence of work life environments on new graduates intent to remain in the workplace (Cho et al., 2006), perception of effectiveness (Laschinger, Wilk, Cho, & Greco, 2009), response to incivility in the workplace (Smith, Andrusyszyn, & Laschinger, 2010) and the impact of the environment, including cost of new graduate burnout (Laschinger, Finegan, & Wilk, 2009a). Cho et al. (2006) noted that within 2.5 years 66% of the new graduates surveyed in Ontario experienced emotional exhaustion (p. 52). As I stated in Chapter One, the painted picture is often bleak. I explore factors that positively influence learning in the workplace in the findings and discussion chapter. With Slaikeu (2011) I contend that solutions to the preparation practice gap should be shared rather than fragmented. I explore this fully in the discussion and concluding chapters.

Residencies, transition programs, and new graduate mentorships have been proposed. The regional health authorities have expended significant funds on a variety of mentorship programs. Casey et al. (2004) surveyed 270 new graduates using the Casey-Fink Graduate Nurse Experience Survey and propose recommendations for the workplace, including residencies, mentors, closer relationships between educational institutions and workplaces, and more extensive orientation programs to increase the confidence and competence of new

graduates. A follow up quantitative study (Fink, Krugman, Casey, & Goode, 2008) provides robust support for a residency program to ease transition (see also Krugman, Bretschneider, Horn, Krsek, & Smith, 2006). Other models for supporting the development of new graduates over the first 12-18 months of practice are being implemented and evaluated in Australia (Newton & McKenna, 2007) and the US (Bradley et al., 2007; Schoessler & Waldo, 2006a, 2006b). Some positive results in terms of reducing new graduate turnover rates have been demonstrated (Newhouse, Hoffman, Suflita, & Hairston, 2007; Schoessler & Waldo, 2006b, p. 288).

The existence of horizontal violence, particularly toward new graduates, is also significant. We know horizontal violence is common in nursing workplaces (Daiski, 2004; Eggertson, 2011; Johnson, 2009; McKenna et al., 2003). Horizontal violence in nursing has been examined and written about extensively and recently attracted the attention of the Canadian Nurses Association in a cover story (Eggertson, 2011). On average, more than half of nurses have experienced workplace bullying[15], and the negative impact of bullying on new graduates is even more significant (Eggertson, 2011, p. 16, 18; Simons & Mawn, 2010). Johnson (2009) explored workplace bullying in the international literature and concluded while there continued to be difficulties with definitions it is clearly a significant problem, is impacted by organizational environment, and is consistent

[15] The numbers vary from 12% up to 70%, depending on the study, the definitions, and the degree and personal nature of the violence being discussed, according to Eggertson (2011).

with oppressed group behaviours. Verbal aggression is also a problem although the degree of prevalence remains unknown (McLaughlin, Gorley, & Moseley, 2009, p. 738). McKenna et al. (2003) argue that it is essential that verbal aggression, workplace bullying, and horizontal violence are clearly differentiated in research reports because the broad definition of horizontal violence, namely "interpersonal conflict" (p. 95), is far too non-specific. The description of the workplace I have developed here is a prelude to the following chapter where I explore the sociopolitical climate in health care. I return to the topic of positive and negative workplace environments and the important role of a supportive workplace environment for nurses' workplace learning in the discussion chapter.

New graduates have high expectations. Wheeler et al. (2000) investigated how high expectations are realized in the context of workplace demands and attitudes and concluded that these new graduates want the workplace to allow for good nursing, the kind of nursing that they were taught to emulate (p. 851). Newton and McKenna (2007) conclude however, that for the new graduate nurse the first year is immensely challenging and "preparation of undergraduate student still appears unable to reduce reality shock and ease transition" (p. 1231). It is important to consider the problem may lie across the gap, not merely in the workplace.

A New Metaphor.

I want to incorporate Gallagher's (2004) findings of a literature review on the theory practice gap into the discussion here and propose a new metaphor.

Gallagher found four categories of images related to the theory practice gap in the literature. There is the image of built structure (spanning or bridging the gap), a dividing or splitting gap (schism, chasm, gulf, divorce), blended combination (integration, blending, fusing, healing, harmonising), and finally regulating the size of the gap (widened, narrowed) based on intentional or unintentional actions. Gallagher drawing on Lakoff and Johnson (1980) writes, "The gap arises from the metaphors of the container and conduit, which are foundational metaphors for the transmission, acquisition and storage of knowledge" (p. 265). Three tenets sustain these metaphors. First, nursing educators and practice advocates sustain a belief that the space between the containers can be narrowed or that the contents of the containers can be poured from one space into the other. Second, gaps respond to manipulation. Third, significant to this discussion, student nurses (a third container) can show or demonstrate "integration" of one container (theory) into another container, the workplace (practice) (Gallagher, 2004, p. 265). Although I continued to use the gap metaphor throughout this chapter to be consistent with the literature, I propose another metaphor for future deliberations. By shifting our conceptualization of knowledge development to include the possibilities of developing codified and personal knowledge across settings we can conceptualization nurses' learning along a contiguous line. This is revisited in the discussion chapter.

Nurses' learning begins with initial professional education and continues on with various professional development activities and learning through

practising nursing. The exact point of "entry to practice" shifts and evolves with changes to nursing practice. A simple example may be helpful. In the mid-1900s a graduate nurse did not need to know how to initiate an IV because this was within the physician's scope of practice. Currently, a graduate nurse needs to be able to initiate an IV safely, competently, and consistently well. Therefore, new graduate preparation or the initial education required has moved to include IV initiation. Clearly, addressing the preparation practice gap requires responsive curriculum.

There is a growing body of evidence to suggest that nurses and other health care professionals are graduating unready to practice in the current health care milieu. As I describe in Chapter Five, this literature is consistent with the findings. A key limitation of the nursing literature is that the focus of evaluation has been on self-report. Self-report is a notably ineffective measure of competence and adequate educational preparation. The limitations of self-report and interview data informed my research decision to include observation and should also inform research recommendations. Although this study was focused on experienced nurses' workplace learning the observation and interview data strongly corroborated the subsequent review of literature regarding "readiness to practice" and evaluation of contemporary nursing education. In Chapter Six I argue that solutions lie along a continuum and that in order to resolve these issues we need to consider important contributing factors including: academic education with all this entails; the frequently negative tone of nurses' workplace environments; the dynamic nature of health care *systems*; and finally, the conceptualization of

nursing (professional) knowledge. Important influences on health care and educational systems are the focus of the following chapter.

Chapter Three: The Sociopolitical Landscape

In this chapter I continue to situate this study in the existing literature. My focus here is on the current health care milieu as it relates to nursing. Whereas the previous chapter attended to issues related to nurse's and nursing's knowledge and how that is learned, this chapter explores self-regulation and related issues of continuing competence, nurses' roles in improving patient outcomes, and the influences in the social and political realms that have shaped current practice.

This research study was situated in the health care milieu of British Columbia, Canada in the early 21st century. When I was reading the literature to prepare for the study and then again when I returned to the literature with emerging categories I observed certain perspectives and areas of focus in nursing were unique to a particular time period and sociocultural setting. The question and my methodological decisions - including how I analyzed and theorized the data - are similarly influenced by our shared history and the present situation. In what follows I offer a view of nurses' workplace learning in the contexts of nursing and 21st century health care. There is difficulty in describing a "current" landscape when the author is also situated in the ever changing landscape. I acknowledge the difficulty and fragility of this describing. In this review of the literature I draw on others who share this task. Having acknowledged the potential limitations of this account, I begin.

Nursing and the Health Care Landscape

> Nowhere else do the advances of modern research enter so directly into the sociopolitical arena of our time as they do in this area [of health]. (Gadamer, 1996, p. vii)

Health care and nursing have been shaped by a host of forces. The practices of nursing are influenced by historical forces (McPherson, 1996), culture, material concerns, and other health care disciplines, including medicine. Sociopolitical factors have exerted significant influence on nursing leadership despite a lack of acknowledgement or recognition by nursing authors (Antrobus & Kitson, 1999). In the following discussion I highlight three pertinent arenas where sociopolitical influences act on the practice of nursing in Canada. Although many of the sociopolitical factors worthy of exploration exert primary influence on the academy I have selected influences that act directly on nursing practice. Much of the literature and activity related to professionalization have occurred far away from nurses working in direct patient care. I have chosen the three influences discussed below because of their pertinence to the research question; however, this is only a partial exploration of this important topic. I will discuss the 1) multiple, polyvalent definitions of nursing[16]; 2) the Canadian competence model (of self-reflection) for public accountability, licensure and registration; and 3) workplace change related to neoliberal political agendas.

[16] I acknowledge a debt to Drummond (2004) for the notion of nursing as polyvalent, which I have adapted to this discussion of nursing.

The Multiple, Polyvalent Definitions of Nursing

Sociocultural images of nursing and expectations for nursing care are dynamic and diverse. A singular conception of nursing currently does not exist. Instead, nursing has been considered a vocation, a profession, a practice, a professional practice, and quite recently, work (Liaschenko & Peter, 2004). I will follow the lead of Liaschenko and Peter (2004) and explore each of these, in addition to two emerging definitions of nursing. These multiple and polyvalent conceptualizations have influenced nursing practice, a term that will also become problematic. In what follows I point to the influences "of the time" to demonstrate the way in which nursing practice has been, and continues to be, shaped or constituted by the context.

Nursing: Vocation, profession, practice.

Nursing has historically been conceptualized as a vocation because of the early association with religious orders and Florence Nightingale (Nelson, 2001a, 2001b; Paul, 2000). Nurses were viewed as altruistic, servile individuals, subordinate to a higher calling, and who were engaged in virtuous work. Although it is not generally acknowledged, "[nursing] sisters were among the best-educated cohorts of women in the country" (Nelson, 2001a, p. 162). Nightingale too stressed the importance of an educational base and scientific evidence, in the form of carefully documented and analyzed patient data, however many consider Nightingale's greatest contribution was to "champion nursing as a respectable occupation for women" (McPherson, 2005, p. 78) and worthy of society's best.

Unfortunately this contribution etched feminine care onto modern nursing (Nelson & Rafferty, 2010, p. 8).

In the past century the dominant view of nursing as a vocation shifted to nursing as a profession (Mansell & Dodd, 2005). As I have discussed in Chapter One this agenda was difficult to establish and promote (Dingwall, Rafferty, & Webster, 1988; Dingwall & Allen, 2001). This view of nursing continues to be stymied by nursing in the hospital setting where nurses "work in complex hierarchies … subordinate to organizational structures, professional agendas, and … medicine" (Liaschenko & Peter, 2004, p. 489; see also Chambliss, 1996). One solution was to elevate professional nurses to managerial roles. Porter (1992) argues the shift of the professional nursing role to manager resulted in "power, prestige, and remuneration" but also created "distance from the bedside" and a devaluing of role of the nurse in direct patient care (p. 721). Currently, as nursing is pressured to delegate care of the *body* to care aides and family members, the practice of nursing is being moved away from the "bedside" toward institutional work, as described by Allen (2004, 2007). While this has the appearance of being congruent with professionalism we need to critically examine this change in view of the fact that the professionalism of medicine is not called into question when physicians engage in body work (Cameron, 1998, 2004, 2006; Fawcett, 2003; Lawler, 1997).

Nursing is also conceptualized as a practice. This conceptualization is generally assumed to be developed out of Alasdair MacIntyre's writing and in

particular his explication of internal and external goods (Liaschenko & Peter, 2004; Sellman, 2000). Benner (1991) elaborated on MacIntyre's thinking by contrasting nursing tasks and techniques with nursing practice conducted in a relational context. Bishop and Scudder (1997) also argued that nursing is not an art or a science but a practice, because of the inherent moral good that is done through holistic care. "A practice is a communally developed human way of being that fosters human good" (Bishop & Scudder, 1997, p. 333). This view was developed in order to move beyond the religious association with vocation and to respond to the pervasive dominance of technical rationality and empiricism of the time. Liaschenko and Peter (2004) argue that nursing as a practice is limiting, elitist, and fails to incorporate the influence of "textually-mediated knowledge … and social organization of knowledge" on nursing (p. 492). Nelson (2006) is particularly critical of Benner's development of nursing as practice. In keeping with the approach of Sellman (2000), I take the position that nursing is best described as a practice profession. This is explored further in the discussion chapter (see also Dunne, 2011).

Thus far I have discussed the multiple definitions of nursing work as vocation, profession, and practice. Each conceptualization was a reflection of the historical and sociopolitical context. "Each of these conceptualizations is situated in specific historical periods in which various social factors shaped the ways in which nursing understood and understands itself" (Liaschenko & Peter, 2004, p. 489). Women were constrained in what they were able to do occupationally,

therefore some joined religious orders and became nurses. The professionalism project was aimed at legitimacy, power, and autonomy within a constraining political milieu (Mansell & Dodd, 2005). Nursing as a practice was influenced by the emerging influence of virtue ethics, hermeneutic philosophy, and neo-Aristotelian thought (Nelson, 2004, 2006).

These social and politically influenced definitions of nursing have created tensions and, for some, an untenable situation. Patients, family, and society continue to expect the vocational nurse to altruistically serve his or her patients (Nelson & Gordon, 2006). This altruism is supported in the professional ideal and is linked to obligations to serve and protect the public. Many consider nursing to be a moral endeavor that has communally developed a way to promote human good, regardless of how well this is understood or actualized. As society projects diverse conceptualizations a burden is placed on nurses to fulfill expectations in the practices of nursing without adequate accounting for contextual factors. These contextual factors include policies, regulations, organizational hierarchies, and day to day limitations, such as reduced or inadequate staffing.

I have extended an example presented by Rankin and Campbell (2006) to emphasize this point further. In surgical day care settings the nurse is required to rigidly adhere to estimated length of stay limits in order to ensure that all the booked patients receive their procedure. When a patient presents with a problem that has not been adequately accounted for, the practice of the nurse is influenced, or even directed, by hospital policy, pressure from supervisors and managers,

physicians, and material concerns. There are only so many places to put (care for) patients. In this example, the practice of nursing as a moral endeavor is juxtaposed against organizational efficiency, and more problematically in my view, the moral obligation to the subsequent patients who also require medical intervention. How do nurses who are committed to nursing well learn to act well in these kinds of situations?

Because previous conceptions failed to mitigate some of the negative effects of organizational and regulatory constraints and to better address the current moral challenges related to economic discourses Liaschenko and Peter (2004) propose a shift in the conceptualization of nursing to the idea of nursing as nursing, with an ethics of work. This conceptualization, however, has not been taken up in the nursing literature, to date. Two conceptualizations of nursing that deserve some discussion are evident in recent literature. These are nursing as an intermediary or nursing as system work and nursing as knowledgeable body work.

Nursing as intermediary with system work.

Rankin (2003) and Rankin and Campbell (2006) reveal the effects of restructuring and economic reform on nursing work in the Canadian setting (see also Rashotte, 2005; Vujicic, 2003). In their view nursing work has shifted from patient care to managing and caring for the system. Although not entirely distinct from the intermediary role (Allen, 2004) this system-work represents a dramatic, but also insidious turn for nursing. This theme is evident in the earlier work of

Holmes and Gastaldo (2002) and Purkis (2001, 2002) who demonstrate that nursing practices contribute to the management of society.

Allen (2004) conducted an extensive review of published ethnographies of nursing and observed that nursing is primarily an intermediary role, in contrast with claims in the professional literature that it is an unmediated, caring, interpersonal relationship and technical expertise. Allen summarizes nursing work into bundles of activity observed under the following categories: managing multiple agendas; circulating patients; bringing the individual into the organization; managing the work of others; mediating occupational boundaries; maintaining a record; obtaining, fabricating, interpreting, and communicating information; prioritising care; and rationing resources. Allen states, "a failure to acknowledge and value nurses' practice has created a chronic tension between the job nurses are educated for and that which they actually do" (p. 281). To return to the point developed in Chapter Two, nursing education must also therefore prepare individuals to manage systems, circulate patients, manage multiple agendas, and mediate occupational boundaries. Nurses, and the public, encounter the polyvalent pull between the individualized caring practices, which are the focus of some conceptualizations of nursing, and the actual intermediary roles of the nurse. Allen (2007) also implicates nursing educators through sustaining an "idealized" nursing mandate which fails to match the realities of practice.

It is important to consider what Allen (2004) and the ethnographic researchers she studied actually did. These researchers have pointed out what is

happening, in a manner that sociologists are wont to. Allen's description, therefore, should not be automatically construed into what nursing practice *only* is, or what nursing should be. Nor, because I suggest that researchers might also miss "what else is going on," should this be seen as complete. What Allen's work should do is highlight for us the way in which other sociopolitical influences have shaped, and are shaping, the current practices of nursing in the Western setting. This needs to be examined critically, questioning the relationship between these bundles of activity and the neoliberal agenda of health care in the US, UK, and Canada, where the majority of studies were conducted. As the findings suggest, nurses who are known for nursing well become relatively impervious to some of the intermediary demands of the milieu in favour of nursing. I define and describe relatively impervious in Chapter Five and Six.

Nursing as knowledgeable body work.

Nelson and Gordon (2006) draw attention to another disjunction in nursing practice: the contested space/s in nursing between the caring discourse and knowledgeable, physical body work and care of the ill. Although Nelson and Gordon and contributing authors may be creating an exaggerated division between body work and conventional notions of caring, and place an enormous amount of blame on Benner, their book re-presents the dark side of the "virtue script" around, and within, nursing. Keighley (2006), one contributor, argues that the recent emphasis on health promotion has led to a lack of interest in acutely ill people and the resulting shifting of care of the sick to less educated workers. My

personal observation is that many of my former students are disappointed by the unpleasant and highly demanding job of caring for the ill. Much has been said about the effect of devaluing care of the body and physical labour or body work (Lawler, 1997) on lower pay and the routinizing of nursing work (Chambliss, 1996; Herdman, 2001) and the invisibility of nursing work (Bjorklund, 2004; Canam, 2008). These authors make a compelling case for re-constituting nursing as knowledgeable body work. This conceptualization of nursing fits the findings in this study, but is not without challenges, not least of which is the question of the relationship between professionalism and knowledgeable body work. I will explore this further after presenting the findings. Can new and evolving approaches to professionalization allow for re-construction of nursing as a practice profession?

Together these observations of two emerging conceptualizations are an important reminder of the power nurses have in their privileged position of proximity to patients in their nursing. It is also a reminder of the multiple, polyvalent definitions and expectations with which nurses deal. To conclude this discussion I ask: who decides how nursing is defined or conceptualized—the nurse, the manager, regulatory bodies, the physician, the consumer? In the absence of a clear case for nursing, from nursing, others will decide. Because we are always situated in history, and shaped by it, I question if a unified mandate could ever exert equal influence on nursing practice as the dominant sociopolitical agenda. If nurses fail to define the nature of nursing (Kikuchi, 1992, 2003; Thorne

et al., 1998; Thorne et al., 2004) there is little we can do to resist the hegemonic influences of the context, in whatever time and place that may be.

Canadian Continuing Competence: Self-reflection, Public Accountability, Licensure

I will return now to a key argument in Eraut (1994) linking professionalization, continuing competence, professional knowledge, and learning. Professionalism gives primacy to:

> the professional knowledge base. The problem which the concept of a profession is said to provide an answer is that of the social control of expertise. Experts are needed to provide services which the recipients are not adequately knowledgeable to evaluate. So how can clients be protected against incompetence, carelessness and exploitation? If state control is unacceptable … the control has to be vested in the experts themselves. Hence the emphasis put by the professions on moral probity, service orientation and codes of conduct. (Eraut, 1994, p. 2)

As I have described in Chapter One, continuing competence is linked to professionalization in nursing. Regulatory assurances of continuing competence are protection from incompetence, carelessness, and exploitation. It is directly related to the promise of disciplinary knowledge and expertise. I outlined the evolution of the competence discourses in Chapter Two. In the following section I explore Canadian policies that purport to protect the public. I then develop a critique that was begun by Nelson and Purkis (2004) and argue that a faulty

approach influences, or more importantly, fails to *positively* influence the practice of nursing. As Eraut (1994) reminds us professional development has a public accountability component.

The Canadian competence model.

Canadian nurses, as licensed professionals, are by law accountable to the Canadian public for the work that they do. To this end, nurses must maintain competence. Regulatory bodies, with a provincial or territorial rather than national mandate, define practice and describe boundaries, including requirements and qualifications (CNA, 2007).[17] The CNA promotes a framework that "promotes good practice, prevents poor practice and intervenes when unacceptable practice occurs" (CNA, 2007, p. 1). Continuing competence programs are required to assure the public that these goals are met. Canadian regulatory bodies have adopted mandatory competence requirements relying primarily on individualized assessment and self-directed learning strategies (National Working Group for Continuing Competence [NWGCC], 2000). Prior to the 1990s, re-registration for nurses in Canada was linked to a minimum number of hours worked or a combination of education and hours worked. The current continuing competence requirements for nurses began to be incorporated into regulatory practice in the mid to late 1990s (Nelson & Purkis, 2004). Although the primary goal of continuing competence is protection of the pubic, another proposed purpose is

[17] In the final stage of writing this dissertation the provincial regulatory bodies unilaterally formed a new regulatory body distinct from the CNA, historically the national professional association, in 2011 which was announced in a public news release March 1, 2012.

enhanced professional growth (Campbell & Mackay, 2001; Mantesso, Petrucka, & Bassendowski, 2008). Recent requirements in the UK involve working a minimum number of hours (450) or completion of a refresher course *and* undertaking continuing professional development, defined as 35 hours of learning over three years, maintaining a profile, and complying with random audits (Munro, 2008; Nelson & Purkis, 2004). In the US, continuing competence programs and demonstration of competence by individual nurses are also linked to institutional accreditation (Arcand & Neumann, 2005). Policy and implementation of mandatory competence requirements varies across jurisdiction. I use an American example from Mayo Clinic (Arcand & Neumann, 2005) to draw a contrast with the continuing competence policies in Canada and specifically British Columbia. According to Arcand and Neumann (2005), at the Mayo Clinic there is an institution-wide program in which all nurses, regardless of role, are assessed for competence when hired and then annually. This formal, "ongoing competency [sic] assessment evaluates the knowledge, skills, attitudes, and behaviours that reflect the [changing] functions of nursing practice" (Arcand & Neumann, 2005, p. 247). This process is linked to accreditation of hospitals within the state.

Across Canada the individual nurse assesses his or her own competence. The Canadian approach was implemented first in Ontario, Alberta, and British Columbia, at the same time as repeated health care reforms occurred (Nelson & Purkis, 2004). It is very important to note that the Ontario regulatory body

articulated a clear intention that an individual nurse's competence should be supported by organizational attributes that support a continuing competence *program* (CCP) (Campbell & Mackay, 2001; Mantesso et al., 2008). In British Columbia, demonstrating continuing competence involves individual reflection on practice over the year previous and an identification of learning goals for the following year. No documentation of this process is required; however, nurses are randomly audited.

The common practice of continuing competence contrasts with a clinical promotion program evaluated by MacKay, Grantham, Ross, Brown, and Beanlands (1990). This Canadian study examined one "clinical promotion program." This program was accompanied by a claim that formal recognition of competence was a means of preventing the exodus of clinically competent nurses away from direct patient care. The researchers found that over time clinical competence improves when it is evaluated and recognised by others. This evaluation and recognition should not be equated with the peer feedback process of Canadian CCPs (Mantesso et al., 2008) but rather be compared with the Royal College of Nursing (RCN) Expertise in Practice Project (EPP) aimed at recognizing and rewarding expert nurse practice (Manley, Hardy, Titchen, Garbett, & McCormack, 2005). The Queensland Health Nursing and Midwifery Staff Development Framework (Henderson et al., 2008), developed in Australia recently and mentioned previously, is another very different model for continuing competence.

Both the need to monitor and regulate continuing competence and the purported value of the RN role in health care have been shaped by the development of nursing as a discipline and profession over the past century. Nursing regulatory bodies claim responsibility for overseeing individual nurses' competence, initially and throughout their careers.[18] At the heart of this discussion is the question of who evaluates the competence of a working professional nurse. The three most obvious options are the individual nurses themselves, employers, or patients.

Calman (2006) conducted a grounded theory study on patients' view of competence in their nurses and reported two key findings. First, patients associate competence with technical skills and knowledge, and beyond this threshold of competence they appreciate the interpersonal skills that go along with this. Second, the patients were reluctant to evaluate competence and assumed that if the nurse was working the employer was ensuring competence. Calman's findings suggest that the type of knowledge required for nursing was not something that patients could evaluate; rather, only another nurse was capable of assessing or offering an objective account of nursing competence. This echoes Eraut's (1994) contention above. The CNA takes the position that "promoting continuing competence is the shared responsibility of individual nurses, professional and

[18] Regarding the board composition, at the time of this writing the CRNBC Board had five nurses practising in direct patient care, two nurses working in some form of education, two nurses working as administrators, and five non-nursing individuals, three of whom were lawyers.

regulatory organizations, employers, educational institutions and governments (CNA, 2007, p. 3). Patients are not mentioned, nor is there currently any effort to formalize this; however, there is often reference to "the voice of the consumer" in organizational documents and informal discourse.

Self-reflection, self-assessment, and continuing competence.

Criticism of the existing Canadian approach to evaluating continuing competence relates to the ongoing de-valuing of the knowledge and skills necessary for competent practice and a misuse of reflection as a tool for learning. Nelson and Purkis (2004) argue that the Canadian model of continuing competence required by law, "constitutes competence as a *moral* attribute, as opposed to exposing the effects of professional knowledge and skill on patient health outcomes" (p. 248). An (un)intended effect of "a mandatory exercise in reflection, [is] an absence of a material and accountable link between education, regulation, and practice" (Nelson & Purkis, 2004, p. 250). It is this effect that prevails upon the practice of nursing. There is no accountable link between nurses' practice, their competence, and formal or informal education. Regulatory bodies in Canada have increased the gap between practice, regulation, and knowledgeable practice by reinforcing the lack of real accountability for *every* registered nurse in Canada, *yearly*.

Canadian mandatory competence requirements have a dependent relationship with reflective practice theories. Although reflective practice is considered by some as a "knowledge framework that can guide the practice of

nursing" (Mantzoukas & Watkinson, 2008, p. 132) there is enormous debate about the legitimacy of reflection as a learning tool or learning process within nursing and within education (see among others Burton, 2000; Eraut, 2004c; Gustafsson, Asp, & Fagerberg, 2007; Mackintosh, 1998). In a previous publication I begin a critique of the use of reflection for nurses' professional development (Jantzen, 2008). I reiterate this critique here, that if we grant the usefulness of reflection in learning from experience, the process required by the regulatory bodies bears no resemblance to reflection in learning theory. Rather, it is a disengaged process of looking back over a year of practice, remembering how it was, assessing gaps in practice, linking this with quality indicators (constructed as an external standard), and planning future learning. The implementation of mandatory reflection for ensuring protection of the public is particularly ill-advised given the focus on examination pre-registration and the convincing evidence that self-assessment is not accurate (Hodges, 2006, 2007). In a series of articles in *The Journal of Continuing Education in the Health Professions* the authors demonstrate that self-assessment in relation to continuing competence requires diverse data sources, performance standards, formal practice audits, diverse feedback methods and internal capacity related to critical reflection (looking back and reviewing), mindfulness (reflection-in-action or being aware in the present), openness and curiosity (Sargeant, 2008; Silver, Campbell, Marlow, & Sargeant, 2008). Self-assessment is a complex and somewhat problematic practice. Another serious problem with policies dictating mandatory reflection is

the inability of the individual to adequately account for the sociopolitical realities of the health care milieu. Nurses are rarely independent practitioners whose quality of care is solely their responsibility. The reflective practice approach to continuing competence, the ideology informing it based in liberal individualism, and the dogma associated with reflective practice and learning, together these place an unconscionable burden on the shoulders of the conscientious nurse.

Competence requirements are artifacts of the sociopolitical influence of government legislation and regulatory bodies on nursing practice. Bradshaw (2000) highlights the need for some "measures or standards by which to judge what I knew, what I *should* know, and most importantly, which I *did not* know" (p. 319). This point reinforces a key issue. What is required of nursing? And, who is best placed to evaluate and remediate the individual nurse, as a knowledge worker? Hodges (2007) suggests that a mentor, teacher, or coach guiding self-assessment would "fit better with evidence of how competence works" (p. 177). Continuing competence programs similar to the one outlined by Arcand and Neumann (2005) seem preferable for assuring the public that it is protected from incompetence, carelessness, and exploitation. This is costly; however, it would shift sole responsibility for public accountability off the shoulders of the individual nurse. I concur with Nelson and Purkis (2004) by suggesting that sociopolitical influences perpetuate a lack of clarity, foresight, or motivation to combat this effective re-constitution of the Canadian registered nurse as moral rather than competent.

In Calman's (2006) study the competence of the nurse was taken for granted because he or she was employed, and by *association* monitored. She concluded, "What may be of help would be if educator and regulator were more transparent about systems of self-regulation to maintain trust" (Calman, 2006, p. 724). Would current continuing competence policies withstand public response if the public understood them? It is important now to return to the definition of competence from our previous discussion: the ability to do what is required for a job or task through the integration of knowledge, skills, attitudes and judgment. We need to ask how the existing policies of Canadian regulatory bodies evaluate competence. And then ask what script or agenda has allowed regulatory bodies to absolve themselves of this responsibility – given the evidence. Either they do not know or do not want to know what is required of nurses to do the task. Hodges (2006) points out that discourses, always associated with power, emerge "because there are important sociological, political, economic and cultural contingencies that made them possible. ... [and] for what is considered legitimate" (p. 696). He prompts us to ask "What does [this] discourse make possible?" (p. 696) and I would add, to whose advantage is it to maintain the existing practice for continuing competence?

Turkoski's (1995) sociohistorical discourse analysis of *American Journal of Nursing* highlighted the ways that nurses' language and ideology of professionalism have been influenced by particular ideological purposes that served to hide the dominant economic influences on the practices of nursing. In

particular, she argues that a net loss of individual professional autonomy occurred at the same time that nurses were promoting increased autonomy through professionalism. Accountability for expert, unique professional knowledge is at the heart of autonomous practice and therefore professionalism (Freeman, McWilliam, MacKinnon, DeLuca, & Rappolt, 2009). Nurses are currently accountable to their regulatory bodies for this, although a key problem in relation to Canadian continuing competence requirements is the lack of actual accountability.

What is clear from a brief overview of history, policies, and practices of professional development for nurses in the Canadian setting is a general shift away from institutional commitment and toward individual responsibility. This focus on the individual is just one of the dominant influences of the sociopolitical context within Canada and globally. Eraut (1994) asks the key question, "So how can clients be protected against incompetence, carelessness and exploitation?" (p.2) In Canada, because individual nurses, provincial associations, and national professional associations have failed to fulfill their responsibility to ensure competence by relying on the nurses themselves registered nurses have left themselves vulnerable to increased "state" policies.

The Neoliberal Political Agenda in Nurses' Workplaces

The influence of neoliberalism on the practices of nursing practice will be made explicit in the following discussion; although a comprehensive examination of liberalism, in its various interpretations, is beyond this scope of this paper and

beyond my expertise. Therefore, I rely on the political ideological underpinnings of liberalism outlined in Annette Browne's (2001) discussion of the influence of liberalism on nursing science. The central tenets of liberalism are, according to Browne, "individualism, egalitarianism, freedom, tolerance, neutrality and a free-market economy" (p. 118). Neoliberalism, new classical (libertarian) or modified liberalism, places primary value on free-market capitalism (Soanes & Stevenson, 2008). Neoliberalism is currently exerting a dominant influence on Western society (Cartier, 2003). The practice of nursing is not exempt.

Liberal ideology has influenced nursing in two ways (Browne, 2001; Harding, 1992): first, with overt actions and explicit directives; and second, by influence *on* rather than through institutions as liberal ideology exerts power through dominant social values, hegemonic discourses, and dogma (Browne, 2001; Harding, 1992). Antrobus and Kitson (1999) found that the "political ideology of the governing party [was] an overwhelming authority" and as a result "politics and policy were in fact driving the professional agenda and therefore the leadership agenda" in nursing (p. 749). An example of the first manner of influence might be policy that requires mandatory reflection for re-registration. Uncritical adoption of the mantra that "patients are best cared for at home" is an example of neoliberal influence by a dominant health care value. While there are no explicit directives that I get my patients home as fast as humanly possible, over time and through a variety of means this idea was incorporated into my thinking as best practice. The mantra is driven by a need to minimize the number of

patients in acute care beds in order to save money. The burden of care is shifted to friends or family and, in the absence of these, home support workers. While the notion of being at home seems superior to hospital care, underpinning this message—mediated in discharge planning meetings by liaison nurses who are given directives from their mangers—are questions of who, how, and what care is provided at home (Funk, Stadjuhar, & Purkis, 2011). There is a two-directional relationship of ideology and practice at work (Ceci & Purkis, 2009; Holmes & Gastaldo, 2002; Purkis, 2002). Nursing becomes part of the dominant political, ideology through its practices: "Each reinforces the legitimacy of the other" (Browne, 2001, p. 120).

Canadian social and political discourse is so imbued with individualism that it is difficult to see how things might be otherwise. Liberal individualism is closely linked with the Enlightenment, empiricism, and the centrality of the individual as a rational agent (Browne, 2001; Taylor, 1991). Individualism also underpins patient-centred practice, particularly when informed by models of self-care (Browne, 2001). Patient-centred practice is ubiquitous in nursing education and literature. This philosophy is rooted in a humanistic belief in the dignity of all humans and individualistic ideology. Patient teaching is often centred on helping individuals to find ways of helping themselves out of a health crisis, presumed to be somewhat of their own making, through health promotion and empowerment. In other situations, a reluctance to intervene on behalf of family concerns is informed by the belief that the patient, as a rational agent, could and should

choose action individually. It is apparent to me now that competing ideologies created the discomfort I felt animating this discourse. The logic of patient-centred practice and patient choice fails to account for the logic of good care (caring practices) where both health care professional and patient are both actively involved in the practice of managing and dealing with disease (Mol, 2008).

"Equality of opportunity" is also a very important defining feature of liberalism (Browne, 2001, p. 122). At the heart of Canada's health care system is the belief that Canadians should have access to health care in an "egalitarian" way (Romanow, 2002). This value is lived out most virtuously by nurses who provide exemplary care to all of their patients, regardless of the structural constraints or socioeconomic barriers at play. Nurses, however, often carry out the tasks of neoliberal rationalizing when deciding who deserves, or requires, the scarce resources of hospital beds and surgical slots. Browne (2001) reminds us that equality of opportunity has trumped actively seeking to benefit the least advantaged. She suggests problems arise in our practice when we inaccurately conclude that failure to get good health care is an individual matter. Egalitarianism is strongly embedded in our thinking and appears to be a meritorious sociopolitical influence. Because of social inequities, however, individuals are not actually able to live equally, or have equal opportunity. Failure to recognize the relationship between liberal ideology and equality of opportunity hampers efforts to resist or transform neoliberalism toward the purpose of providing *nursing* care to the sick and promoting health.

Within liberal ideology, freedom means that individuals are free to pursue personal goals as long as this does not impede the personal goals of another (Browne, 2001). This ideal within nursing practice allows for an enormous amount of resources to be used to meet the needs of patients experiencing barriers and limits to their personal goals because of illness. Browne (2001) argues that this is directly shaped by societal conceptions of the good life. Tolerance and neutrality are closely linked with freedom of individuals. Nurses often accept verbal abuse in an effort to be tolerant. The underpinning belief in state, government, and health care neutrality can silence the voice of critical perspectives. In nursing practice, historically, this has resulted in virtual silence on issues of moral and political nature. Introducing the language of critical theory into the nursing vernacular has provided an alternative to the dominance of these liberal tenets of tolerance, freedom and specifically, neutrality (Browne, 2000).

Neoliberalism has compounded the effects of social restructuring and rationalization of the system. Myrick (2004) claims that "Neoliberalism redefined the connection between governments and their peoples to privilege a global market over social good" (p. 25). Myrick shows the influence of neoliberalism and globalization on universities; some of the same observations could be made of nursing practice. Health care institutions are, like universities, "highly politicized microcosms of the broader society" (Myrick, 2004, p. 26), particularly in becoming corporate in their structure and increasingly driven by free market ideology. This is most obvious in the public-private health care debate. It is also

present in the foyer of many hospitals where unhealthy markets such as Tim Horton's welcome patients and visitors into the health care milieu. Health and nursing care have become a commodity, rather than a service. The prevalence of this idea is astonishing. For example, in an article highlighting the emotional labour in nursing, Henderson (2001) says, "Emotional labor implies a relationship between the carer and the cared for and can be viewed as a *commodity* to be factored into considerations of the value of caring work" (p. 136, italics added). Nursing practice is experiencing a conflict of goods.

Economic restructuring in health care is propelled by neoliberalism (Cartier, 2003). Among many consequences, a reduction in social services and numerous other cost-saving strategies are direct results of a "diminished role of the public sector, deregulation of markets, increased privatization" (p. 2292). The severe downsizing and restructuring driven by neoliberalism that occurred in many Western countries, including Canada, in the 1990s dramatically affected nurses' work environments (Laschinger & Leiter, 2006, p. 265; Newman & Lawler, 2009). In contrast with a socialist agenda for government redistribution of resources, the neoliberal agenda requires minimal government involvement and maximum individual responsibility. Cartier (2003) brilliantly outlines the effect of demographic changes, the implementation of a diagnosis-related group (DRG) approach to hospital management and neoliberalism on the meaning of *place* in the hospital, to return to an earlier discussion. She notes that one result of rationalizing services to the elderly is "place switching" or moving the elderly

from and between places and eventually out of place (Cartier, 2003, p. 2299). This rationalization of services is ever present in the practice milieu. The demands of economic restructuring have a sustaining pressurizing effect.

The tone of Browne's (2001) article suggests that liberal ideology is *the* problem with nursing science. She argues that nursing has been influenced by this dominant ideology regardless of whether it serves the interests of our patients, individual nurses, or the discipline. In this brief exploration of the influence of liberalism on the practice of nursing, I too have developed the darker side more convincingly, for myself and also for the reader, than the positive side. Myrick (2004) points out

> We must be ever mindful of the potential of the corporate agenda to eclipse our commitment, … dull our senses to our moral obligation to the notions of social justice and a civil society … Otherwise, we will be continually be at risk of unwittingly perpetuating a corporate philosophy as opposed to a human philosophy from which patient care derives. (p. 28)

For nursing, I think it is important that scholars continue to expose and name the sociopolitical influences on nursing practice, including liberalism, in the manner of Myrick (2004), Browne (2001), and many others (e.g. Wall, 2010), and then reflect collectively on what this means to the practice of nursing in order to both resist and/or transform them to our advantage. We need to find new alternatives and adaptive responses. Sellman (2012) highlights the potential value of practical wisdom, based on Aristotle's virtue *phronesis*, as an alternative conceptualization

of competence for counteracting the managerialism and related discourses of efficiency grounded in the dominant technical rationality and positivist views of knowledge. This is an area for future exploration.

Nurses must continue to work to articulate what we are and what we do. It will mean answering the questions I have posed throughout this section. Who decides what the practice of nursing is? Who evaluates and assesses continuing competence? What is at stake in continuing to legitimize liberal ideology in the practice/s of nursing? Arguably, the reason that competence has become so problematic for nursing is that the purpose of nursing has become so indistinct. Therefore, a "first step to defining and determining competence … must be a precise definition of the purpose of nursing practice and what it constitutes" (Bradshaw, 2000, p. 320). The lack of agreed definition seems to have created enough fog that neither regulatory bodies, nor healthcare institutions, nor individual nurses are able define and evaluate good nursing practice. It seems that there is little motivation to clear the fog. For in failing to articulate a definition and thereby failing to create a reference point for evaluation of the knowledgeable worker who is fulfilling the goal of providing *nursing* care to the sick and promoting health, it is then a simple next step to replace nurses with unregulated or less educated and lower paid workers, to de-professionalize, and to avoid examining the milieu as part of ensuring competence.

Nurses are "powerful at the same time that we are situated historically in a non-privileged position" (Holmes & Gastaldo, 2002, p. 564). By acknowledging

and becoming informed about the sociopolitical factors that are prevailing on the practice of nursing in Canada, nurses are better prepared to resist these influences. We must realize that nursing can be powerful in legitimizing these influences or transforming them to fulfill the goal of providing *nursing* care to the sick and promoting health. The power and danger of becoming relatively impervious to the health care milieu is explored in detail in the findings and discussion chapters.

Nursing practice has been profoundly influenced by the broader social, cultural, and political contexts throughout history. This is no less the case now. Through the first two chapters and in the previous section I have outlined numerous aspects of nursing and the health care milieu that informed nursing practice as we know and understand it. I have summarized the pertinent literature in relation to nurses' workplace learning, the sociopolitical landscape, and situated this study in the historical evolution of professional development for nurses. I framed the discussion to date by describing how professionalization has affected policy and practice in regards to professional development. I have identified gaps in our existing knowledge. In order to demonstrate that this study is warranted I address one lingering question. Why does it matter? Is nurses' knowledge and competence primarily about professionalism for the sake of nursing, or is there a clear case linking nurses' improving their practice on patient outcomes?

Registered Nursing Practice Matters

The current policies regarding continuing competence de-value the knowledge and skills necessary for competent practice. Nelson and Purkis (2004) argue better policy would involve a "material and accountable link between education, regulation, and practice" (p. 250) and expose the "effects of professional knowledge and skill on patient health outcomes" (p. 248). What do we know about how nursing well affects patient health outcomes?

Within nursing workforce research, Rafferty and Clarke (2009) observe that although we still do not have clear or strong research in order to well defend our existence, there are common themes. There is remarkable consistency across jurisdictions. There is growing evidence we need to protect and reward the existing talent pool (Hatcher et al., 2006). Importantly, there are modifiable factors in the workplace that can improve the wellbeing of workers, the delivery of care, and engagement at work. While "the *precise* nature of the association of nurse staffing with nurse and patient outcomes remains hotly contested" (Rafferty & Clarke, 2009, p. 876, italics added), there is growing evidence that patient outcomes are linked to level of staff education and attributes of the nursing environment (Kazanjian, Green, Wong, & Reid, 2005). There is also growing optimism that although extensive problems with work environment, work design, and staffing exist, the problems are amenable to managerial and policy intervention (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Milisen, Abraham, Siebens, Darras & Dierckx de Casterlé, 2006; Siebens et al., 2006). It is worth

noting here, and being reminded in the following section, that the focus of the arguments in the pertinent literature is directed at managers, senior administration, and governments.

A key assumption I made in the proposal phase of the study was that if we theorized how nurses refine their practice through workplace learning we would be better positioned to conduct focused research and also implement policy to support nursing to provide excellent patient care. There have been a number of international studies over the past decade linking nursing care to patient outcomes (Van den Heede, Clarke, Sermeus, Vleugels & Aiken, 2007). There has also been careful, replicable examination of the relationship between adverse events and work environments, nursing satisfaction, and burnout (Laschinger & Leiter, 2006; Manojlovich & Laschinger, 2007). Individual nurses do not provide nursing care in isolation. Rather, based on a systematic review of the studies between 2001 and 2004, Kazanjian et al. (2005) stated, "Workplace environmental attributes of hospital-based nursing practice have an effect on outcomes of care, including mortality" (p. 115). Quality nursing care depends on a quality context.

Until recently, definitions of quality nursing care and nurse-sensitive indicators for research have been elusive (Izumi, Baggs, & Knafl, 2010; Kazanjian et al., 2005). Based on a hybrid model of concept development using the literature and interviews with patients having advanced illness, Izumi et al. (2010) identified, defined, and listed key attributes of quality nursing care as competence, caring, professionalism, and demeanor. Although there are variations

in quality care attributes between patient populations this recent scholarly examination of quality nursing care potentially lays a foundation for instrument development and further exploration of the relationship between nursing practice and patient outcomes (Izumi et al., 2010, p. 312).

Although all of the participants in this study seemed to be clear about their essential role in their patients' wellbeing there is pervasive fear among registered nurses that we are dispensable and invisible (Antrobus & Kitson, 1999; Bjorklund, 2004; Canam, 2008; Liaschenko & Peter, 2004). As a collective group, nurses seem to suffer from an ongoing existential crisis or existential fear (cf. Bauman, 2006). MacLeod (1994) and Wolf (1988) both show how actions "imbued with meaning, knowledge and skill ... revealed to be knowledgeable practices when their relationship to the specific context, the particular time and place of the practices, is illuminated" (MacLeod, 1994, p. 365). It is difficult for managers, particularly if they lack clinical competence, to see how or when these actions are knowledgeable practices. These "wee things" do contribute to patients' evaluation of the competence of their nurses, however (Calman, 2006, p. 723). As purportedly simple tasks are delegated to the lowest paid staff these nursing actions lose their importance and because of the difficulty for non-nurses to recognize the "meaning and knowledge" in the actions, the implications of this shift remain unacknowledged and unknown (Wolf, 1988). The participants in this study do not fit the description of a dispensable workforce, despite recalcitrant

beliefs that management would wish that this were so.[19] Similar to studies by MacLeod (1996) and Wolf (1988), this study fully supports the critical value of nurses for health care. For example, during observation I made note of the relative absence of physicians. Overall, patients spend minutes with their physicians and hours with their nurses. This proximity and presence is a critical determinant of the quality of the health care environment.

Given the extensive and convincing evidence produced by the international hospital outcomes research I posit that the burden of proof may need to shift to the managerialists and government bodies to defend rationing nursing capital (Clarke & Aiken, 2008). In spite of some mixed results and difficulty establishing causal relationships and despite the impossibility of conducting experimental and RCT level research Kazanjian et al. (2005) suggest that research into *how* nursing work environments can be improved and the related quality of improving nursing care. Key possibilities for exploration include "promoting respectful relationships among health care providers, empowering nurses to make decisions, investing in nursing leadership to extent career trajectories, developing standards of practice that foster quality of care" (p.115). However, implementation of any organizational change will not empower nurses, "if there are not enough of them" (p. 115). Based on my review of the workforce literature, only a fraction of which is reported here, any collective existential crisis should be

[19] Throughout the study the nurses continually expressed the belief that the directors and managers were fixated on replacing some RNs with unregulated care aides. They were correct.

easily countered. Unfortunately, this optimism is based on assumptions that research evidence is "true" and that stakeholders in the sociopolitical landscape are paying attention. What do we know of how nursing well affects patient health outcomes? In summary, nursing matters to patient care and good nursing matters even more.

Chapter Three Conclusion

A proposed benefit of this study was to explore the nursing practice setting as a rich learning environment, building on the work of many other scholars. I have problematized the assumption that all experience leads to improved nursing and better patient care. I have argued that good registered nursing practice matters and is endangered because of sociopolitical influences, specifically managerialism and neoliberalism, mediated within the current health care milieu. I have posed the question that if the public was aware of current continuing competence requirements for nurses in Canada, would this instill trust?

It is important to challenge the existing sociopolitical discourse as it impinges on nursing, particularly in nursing education. Heather Clarke (2010), in an undergraduate nursing textbook titled *Realities of Canadian Nursing*, suggests that nurses are more empowered, more prepared to act politically (both individually and collectively), and "becoming more powerful and exercising more control on the factors that influence their working lives. The nursing profession's history of political action and policy influence is something of which every nurse can be proud" (p. 87). It is my view that this voice of a Canadian nursing policy

expert is incorrect. In this landscape of constant changing, shifting, and increasing globalization and managerialism nurses could be, or maybe already are, merely collateral damage (Bauman, 2011[20]).

I end the background chapters of this dissertation with a personal note. I have argued that we need to consider the possibility of common themes and threads through history. In the previous chapter I noted that the current contextual factors and pressing demands for practising nurses are surprisingly similar to those of the historic religious nursing sisters, namely, proving oneself and one's profession to detractors and responding to power issues (where managerialism has replaced medicine) through nurturing an ongoing commitment to superior service and skill. In the findings chapter I report on nurses who, I claim, act as if they are relatively impervious to the milieu. Even as the characters, words, and sentences, move onto the page a chill moves up my spine. For in saying this may be the case, what movement, what force will emerge to show the case as otherwise?

[20] The term from Zygmunt Bauman (2011) relates to poverty and the powerless in a global society and I hesitate to equate the status of nursing within the health care milieu with the real and increasingly horrendous collateral damage of which he writes against.

Chapter Four: Methodology

Research is always situated in a particular time and place. In the first three chapters I set out to describe the current nursing, health care, and sociopolitical landscapes in which the study was conducted and to demonstrate that this study is important to our understanding of how nurses learn to nurse well in the current health care milieu. In this chapter I repeat the research questions, describe the grounded theory methodology, and report the grounded theory methods used in the study. I provide my rationale for selecting grounded theory, re-situate myself as the researcher, and then describe the methods. Although there are various conventions for organizing methodology chapters I have chosen to describe the study chronologically, or as it occurred, beginning with the question.

This study was conducted to answer the research question, "How do nurses learn to nurse well within the current health care milieu?" and builds on my previous study exploring positive learning experiences of first line nurses (Jantzen, 2004, 2008). This inquiry is the second stage of an emerging program of research on nurses' workplace learning. The following two sub-questions were used to explore the role of the context on the process of learning to nurse well in data analysis and theorizing. How does the *place* in workplace learning influence and inform the development of the nurse? What is the interaction between the workplace, nursing practice, and self, that facilitates learning for nurses? Having established broad research questions I made the decision to use grounded theory.

Rationale for Choosing Grounded Theory

Grounded theory, developed over the past century by sociologists, is one of the qualitative research methods that have been used extensively in the discipline of nursing (Schreiber & Stern, 2001). The positive contribution of grounded theory for developing nursing knowledge has been recently re-affirmed by Benoliel (1996) and Risjord (2010). Glaser and Strauss (1967) proposed grounded theory as a way to "discover" theory embedded within the data through systematic, concurrent collection and analysis of data. The method was enormously influenced by the symbolic interactionism of Blumer (1969) and Blumer drew heavily on the pragmatism or more accurately the pragmaticism (Teel, 2011) of Charles Peirce. The originators were motivated by a desire to shift social science away from the extreme positivism permeating sociology at the time and were specifically reacting against the focus on grand theory (Glaser & Strauss, 1967; Suddaby, 2006). Procedures, including those of data collection, are inherently linked to the basic propositions of symbolic interactionism (Manis & Meltzer, 1978). Within all styles of grounded theory data may be drawn from multiple sources including interviews, observations, and field notes (Benoliel, 1996, p. 416; see also Glaser, 1978; Glaser & Strauss, 1967; Morse et al., 2009). Unlike other methodologies grounded theory rarely relies on interviews only for data collection (Suddaby, 2006). In grounded theory the researcher identifies the basic social problem the participants' experience. This may not be the problem or focus that the researcher initially sets out to study (Glaser, 1978). The basic social

process is what the participants use to resolve or manage the basic social problem. This basic social problem integrates the categories in the developing theory. The resulting grounded theory can then be developed into a formal theory using grounded theory methods or further explored using other methods (Glaser & Strauss, 1967; Kearney, 1998).

Choice of methodology is directly related to the purpose and intent of the research project. The originators of grounded theory, and those who have developed grounded theory over six decades, sought to "elicit fresh understandings about patterned relationships" between people and their social world (Suddaby, 2006, p. 636). Grounded theory is well suited for answering questions related to social processes, in this case the process of learning in the nursing workplace, and for moving beyond description to theorizing (Richards & Morse, 2007). My initial study, using narrative methodology, was designed as an exploratory inquiry into professional development for first-line nurses. From the findings I have argued for the need to reframe professional development for first-line nurses (Jantzen, 2008) and have highlighted the value of workplace learning (Jantzen, 2004). My review of the literature corroborated those study findings. Daley (2001a, 2001b), Eraut (2004a, 2007), and MacLeod (1996) have added descriptive and interpretive perspectives to our understanding of nurses' workplace learning. The key purpose of this study was to theorize the complex processes involved in nurses' workplace learning in order to offer recommendations to health care providers and professional associations, thereby

contributing to the improvement of patient care through supporting, nurturing, and enhancing nurses' workplace learning. According to Morse (1997), grounded theory is the method best suited for developing a model and disclosive theory. Through the account of the research methods below and then in the findings chapter the reader will see the way grounded theory worked to assist me in developing a substantive theory of how nurses refine their nursing practice, a process that was intricately complex with overlapping and repeating processes.

Important principles and assumptions from pragmatism and symbolic interactionism have informed grounded theory (Corbin & Strauss, 1990, p. 5). The potential for studying the patterned responses of nurses in their workplace is founded in the premise, based in symbolic interactionism, that humans do not merely react and respond to stimuli from the environment. Social actors have a self, which can be the object of their own action through self-indication (Blumer, 1978). Self-indication is a central mechanism for dealing with the social world, according to symbolic interactionists, because humans notice (make indications) and then act (Blumer, 1978, p. 98). Therefore, conscious life and constructing conscious action is the "continual flow of self-indications" (p. 98). The goal of grounded theory, an interpretive methodology, is to explore the way participants make or construct meaning out of their experiences through interpretation of symbolic communication (Gough, 2002; Milliken & Schreiber, 2001, p. 178; Suddaby, 2006, p. 633). Human behaviour and interactions are made possible

through the use of symbols and their shared meanings (Manis & Meltzer, 1978, p. 6).

Perceptions and internal views influence interpretation of the social world. Change and choice are two principles drawn from symbolic interactionism which are directly pertinent to grounded theory (Corbin & Strauss, 1990, p. 5). Phenomena are "continually changing in response to evolving conditions" and actors "are able to make choices according to their perceptions" therefore "grounded theory seeks not only to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions" (Corbin & Strauss, 1990, p. 5). Grounded theorists pay attention to what is going on in relation to the phenomena of interest and how the participants are interpreting their social world. Participants are in process. These principles, and the resulting assumptions, are central to grounded theory processes and also, the resulting product or theory.

There are common fundamental behavioural patterns shared by humans. Patterned behaviour and shared meanings allow for the possibility to predict interaction, giving stability to social interaction (Milliken & Schreiber, 2001, p. 178). This premise of symbolic interactionism is identified by Reed and Runquist (2007) as a point of particular congruence between the methodology of grounded theory and the ontology of nursing (p. 120). Although an individual career trajectory is unique, I have assumed there are common patterns. My study was designed to identify these commonalities and to weave them into a theoretical

foundation for the development of strategies to enhance professional development. As I have outlined in Chapter One, theorizing nurses' workplace learning is a fundamental step to inform action in regards to preparing and supporting nurses for practising nursing in the current health care milieu.

Essential components of grounded theory, directly linked to symbolic interactionism, are constant comparison, theoretical sampling, theoretical sensitivity (interpretive process and insight), memoing, coding, and saturation. Glaser and Straus (1967) define saturation as the "combination of the empirical limits of the data, the integration and density of the theory, and the researcher's theoretical sensitivity (p. 62). "The procedures of grounded theory are designed to develop a well integrated set of concepts that provide a thorough theoretical explanation of social phenomena under study" (Corbin & Strauss, 1990, p. 5). As with any research method, careful adherence to procedures and essential components of the method positively affects the quality of the results or findings.

Reflexivity: The Researcher's Beliefs, Assumptions, and Motivations

Reflexivity is a key strategy for accounting for the relationship between the researcher and the research study. I include my discussion and demonstration of reflexivity early in the chapter because being reflexive encompasses all the unique aspects of the research study. I, as the researcher, am intimately involved in the study from the first conception and identification of the broad area of interest through to the writing of this thesis. Therefore, the researcher cannot be separated from the study at any point. Knowers and inquirer-researchers are historically and

socially situated (Ceci, 2000, p. 64), and therefore it is important to foreground my assumptions. Epistemological reflexivity (Dowling, 2006, p. 11) was critically important in designing, conducting, and writing the research.

Grounded theory has evolved with diverse claims to ontological and epistemological underpinning (Annells, 1996; Charmaz, 2000). Rather than argue for particular congruence between specific ontological and epistemological underpinnings, I offer to the reader a position that is, at the least, a "comfortable 'fit' personally" (Annells, 1996, p. 380) and to which I have worked to remain consistent with through the study design, conduct, and reporting. This study was conducted from realist ontology and interpretivist epistemology. I maintain that grounded theory, as a method, should be congruent with symbolic interactionism and the related premises. Although many authors assume positivist epistemology with a realist ontology (Annells, 1996; Charmaz, 2000) and link this directly with objectivism, my view is that a purely objectivist approach to social research is untenable. The researcher is never distanced and neutral.

Reflexivity has become synonymous with addressing issues related to the researcher and various aspects of qualitative research, including objectivity and researcher-researched distance (Dowling, 2006), sampling (Cutcliffe, 2000), rigour (Hall & Callery, 2001; Pillow, 2003) and relationships (Dowling, 2006). Dowling (2006) points out that the role of reflexivity varies depending on the methodology and the related epistemological and ontological underpinnings. Broadly, reflexivity involves the researcher attending to the analytic role;

however, in critical methodologies, such as feminist research, reflexivity regarding the politics and position of the researcher throughout the research process is foundational (Fontana, 2004). In most qualitative methodologies the researcher is expected to be "aware in the moment of what is influencing the researcher's internal and external responses while simultaneously being aware of the researcher's relationship to the research topic and the participants" (Dowling, 2006, p. 8). Reflexivity requires a process of being aware of, and acting on, the intersubjective relationship/s between subject and object, or author, other, text and world (Pillow, 2003, p. 179). The key purpose of the following description of actions taken to demonstrate reflexivity is to reassure the reader that issues relating the role of the researcher and the quality of the study have been considered.

Although this is the position I take, poststructural, feminist scholars such as Pillow (2003) question the possibility and the modernist ideology of such a stance. Pillow argues that reflexivity is not merely a methodological tool to demonstrate rigour for the reader or to address problems of representation and legitimacy in postmodern research. Critiquing the use of reflexive strategies such as recognizing and knowing the self in the confessional tale, recognizing the other speaking for themselves for research validity and for rigour (truth gathering), and for transcending the tension and discomfort of being in the research, Pillow promotes (new) complex and uncomfortable reflexive practices. Pillow's key point is that merely being reflexive does not make for better research (p. 177) but

that how reflexivity is practiced matters. This will, in Pillow's view, necessarily involve being vigilant, being more accountable with the struggles, and being messy (p. 193). It is likely that the following confessional tale, with claims to mediate the influence of the researcher on the study, at times represents the methodological tool criticized by Pillow. I include this point in order to caution the reader that reflexivity can be taken up instrumentally in a lingering positivism and, as such, reflexivity has become a convention in diverse methodologies—has become required. Pillow reminds us that there are few, if any, details on how to achieve necessarily uncomfortable reflexive practices and "confounding disruptions" (p. 192). In my attempts to be clear and coherent the descriptions below belie the messiness and difficulty of addressing self in grounded theory research. The key purpose remains, to reassure the reader that issues relating to the role of the researcher and the quality of the study have been considered.

Some would disparage the need for reflexivity in grounded theory methodology, suggesting that a close relationship between the researcher and the study is necessary and therefore does not require the critical scrutiny of reflexivity of some methodologies, such as ethnography (Glaser & Strauss, 1967; Pillow, 2003). In fact, theoretical sensitivity is predicated on a thorough knowledge of the phenomena of interest, however, not for the purpose of proving one's *a priori* theory, or to prove a grand theory, but to develop or construct a theory from data about which one is knowledgeable and interested in (Glaser, 1978). Reflexivity is required to prevent prior knowledge from distorting data analysis and is inherent

in the literature review in grounded theory (McGhee, Marland, & Atkinson, 2007, p. 334). Grounded theory does not require the researcher to act on the reflexive examination of the socio- political questions and limitations of research in the same way that critical methodologies do (Fontana, 2004). Reflexivity in this grounded theory is not like bracketing in some phenomenological research, where reflexivity is aimed at sustaining objectivity (Dowling, 2006, p. 10). Hall and Callery (2001) counter the early view that reflexivity is unnecessary to grounded theory and argue for incorporating reflexivity to enhance rigour, based on the premises of symbolic interactionism.

Assuming the influence of an individual researcher's beliefs and values on research design and theory generation and also the value of moderating this effect, there is merit in utilizing processes and techniques that mediate this influence. In grounded theory such techniques include "ongoing self-reflection ... [taking] personal biases, world-views, and assumptions into account while collecting, interpreting, and analyzing data" (Suddaby, 2006, p. 640). Blumer (1978) suggests that in symbolic interactionism the "student must take the role of the acting unit whose behaviour he is studying" (p. 101). Suddaby (2006) also points out that "exemplary research using grounded theory also requires considerable exposure to the empirical context or subject area of research" (p. 640). In grounded theory the integrated role of the student or the researcher in analysis, interpretation, and resulting theorizing is consistent with its symbolic interactionism roots.

Epistemological reflexivity is required to examine the relationship between the phenomena of interest, nurses' workplace learning, and myself, as the researcher. In this instance I have acknowledged from the start that this is a personal interest, and something that matters to me. In the proposal I made this clear from the first paragraph through to the interview question script. For years I have been curious about why some nurses get better and better, and some don't. I was unsatisfied with the idea that this is merely a matter of personality type or solely dependent on personal choice. This interest or curiosity was developed into a question through my graduate education. As I examine the development of the research questions there were points where this relationship was challenged and tested. A key decision point occurred when a previous supervisor began directing me toward related, but different areas of interest. *This* question, and *this* study, is directly related to what I consider interesting and important. I also believe that this question should be important to others and warranted serious study.

The literature review supported my contention that this study was warranted, relevant to improved nursing practice, and important to Canadian healthcare systems. The review of the literature, as I have described in the previous chapters, also supported the decision to use grounded theory to answer the research question and to build on previous knowledge and related studies (MacLeod, 1996). I argued in the background chapters that the literature substantiates my claims that this study adds to our understanding of how nurses improve over time, that nurses improving throughout their careers is important,

and that registered nursing practice matters to patient care. I have used this corroboration to legitimate my interest and valuing of the study.

In developing recruitment criteria I sought to balance and inform my own values, beliefs, and opinions regarding nursing practice and nursing well. In this I acknowledge that the very selection, interpretation, and incorporation of the literature into the recruitment criteria and suggested definition of nursing well were processes that remain dependant on my judgment and decision making. I made choices and interpreted the relevant literature based on my knowledge of nursing gained from experience and from my exposure to academic debates around the very definition of the nature of nursing. Based on my thorough analysis of literature the criteria were deemed to be fitting.

In grounded theory the quality of the relationship between the researcher and the participants is directly related to the quality of the research produced (Suddaby, 2006). The qualifications I brought to the interview and participant observation could have impacted data collection in many possible ways. The participants may have valued my years of nursing practice experience. They did not stop to explain nursing language or references to workplace features. There was an assumption that I understood what they were talking about. My current role as a nurse educator is also important to the study; however, it is difficult to draw conclusions regarding the positive or negative value of this. Not all of the participants were made aware of my work, although some were. This may have influenced the emphasis on nursing education in the data. Virtually all of the

participants expressed concerns with current nursing education. The participants did not respect many nurse educators (academic or workplace), which may have negatively impacted their perception of my credibility although there was no overt evidence of it.

During the proposal phase of the research study I examined the role of a critical perspective in grounded theory based on my worldview, a worldview informed by my Christian Anabaptist roots. Although initially in the proposal I made claims, based on this worldview, that the study would be informed by critical theory I carefully examined the tenets of critical theory in light of my personal worldview and decided to remove claims of a critical perspective from the study design. This was based on the conclusion that a study conducted from a critical theoretical position would necessarily shift the focus to critical analysis of power, structures, society and cultural factors relating to the phenomena of interest and internal critique (Sherratt, 2006, p. 176, 199-204). This was not the intent of the study. My personal worldview, with a commitment to and motivation for social justice, remains important to everything I do.

In any research endeavour the researcher plays a central role. In the preceding paragraphs I have described the purpose of reflexivity in qualitative research and situated myself in the research study. Although the following sections are a description of the research study as it occurred, my role as the researcher re-emerges in “what I did” and “what I did not do.” Although painfully obvious, it is also true that the writing, the constructing of the story that follows,

is written from my point of view. As a nonpositivistic qualitative inquiry I, the researcher, am not silent nor is the text depopulated, rather this text is my representation of the study and findings (Mantzoukas, 2004).

Research Design

I outline, step by step, each aspect of the research design here. I begin with a detailed discussion of the site selection for observation, as this was required for ethical approval. This is followed by a description of the ethics processes and pertinent ethical considerations, and then the study process in detail. An initial point of clarification is required. In order to facilitate timely ethical approval we made a decision to develop the study under two wings, which were conducted simultaneously for much of the data collection. One wing involved participant observation and interviews with nurses in the acute care setting. Another wing involved interview participants. The observation wing required ethical approval and specific recruitment processes unique to the health authority, as well as University of Alberta ethics approval. The interview wing only received ethics approval from the University of Alberta and therefore participants were not recruited through the local health authority. This allowed for potential participants from diverse nursing practice settings outside of the local health authority.

Before outlining the research study in detail I include a brief overview (see Appendix A for a detailed timeline of data collection and analysis). Following ethical approval I began with sets of observation shifts for five shifts in total. During the observation shifts I was observing for cases or incidents of workplace

learning. I also conducted interviews with the interview only participants. Over the subsequent three months I conducted more observation shifts, including observing clinical education events, conducted a total of 17 interviews of varying lengths, and analyzed the data concurrently. Five months following initiation of the study I presented early findings to two groups of nurses from the two observation units. All data sources were integrated and analyzed in the same manner and a theory of how nurses learn to nurse well in the current health care milieu was developed. Data collection, analysis, and theory development occurred primarily between May 2010 and June 2011. All participants were working in British Columbia at the time of data collection.

Observation Site Selection

Site clearance was required prior to submission of the ethics application. Because of the implications of site suitability for data collection, and because of the health authority's specific protocol, I negotiated the site selection with the Research Capacity Facilitator. In our meetings I explained the purpose of the research study and the proposed recruitment and data collection techniques. Based on the organizational research development goals and the focus of the study we agreed that we would plan for two observation sites: one in a larger centre and one in a smaller urban centre. In the tertiary care centres we eliminated units where existing, somewhat similar, research was being conducted. I reiterated my rationale, described in the proposal, to not use a critical care or speciality unit for observation. Briefly, this decision was based on the fact that most related research

has been conducted within speciality services (see among others Benner et al., 2009; Bonner, 2003; Ryan, Goldberg, & Evans, 2010) and that nurses working in critical care areas and speciality services have often obtained specialty education, access more training opportunities, and can be perceived of as being more advanced in their nursing practice (see also MacLeod, 1996). With the remaining units in mind we intentionally sought out units that employed a significant cohort of experienced nurses rather than recent graduates. The same criteria were used, where applicable, for the smaller urban setting, namely to study a cohort of experienced nurses on a unit not currently involved in any other research project and in an acute care setting that does not provide critical care or speciality services. The Research Capacity Facilitator made initial contacts and then provided me with contact information for three settings.

I approached the three potential site managers as per hospital protocol. I contacted the unit manager within a tertiary care centre to schedule an informational meeting and to obtain site clearance. In addition to a brief question and answer meeting, Health Authority Health Research Ethics Boards (HREB) application forms were used to inform the unit managers regarding the study. At the same time I made a number of attempts to contact managers in two smaller urban centres. Unfortunately, I was unable to obtain site clearance prior to the deadline for submission of ethics applications. I gained site clearance for two units in a larger urban centre; therefore, the participant observation took place on two units within a tertiary care centre.

I selected the acute care setting because of the volume of discrete nursing practice situations available in a setting involving direct patient care. This is consistent with recommendations by MacLeod (1996) following a similar study. Residential care settings were not appropriate because most of the care is provided by residential care aides. Although another option might have been to observe home care nurses this was not feasible because of the travel time required. The acute care setting was considered a good place to collect observational data because it is the most common workplace for first-line nurses (CNA, 2010) and afforded the greatest number of interactions with diverse aspects of the milieu.

Ethical Considerations and Ethics Approval

The study received ethical clearance from the ethics boards at the University of Alberta and local health authority. In the following section I outline the key strategies enacted to ensure ethical standards were met. The project did not involve interventions or actions that directly affected patients, although it did involve observation of patients. Patients under the care of the observation participant were asked to provide informed consent. In situations where the patient was unable to provide informed consent, due to sedation or limited mental capacity, I did not observe the nurses providing care to these patients. The study was considered low risk and received approval through expedited processes.

Ethical recruitment.

Ethical recruitment was an essential step toward a moral project. As noted above, during the ethics application process initial contacts were made with the Research Capacity Facilitator and the Health Research Ethics Coordinator for the health authority. Clear protocols are required by both the ethics boards and were followed rigidly. Prior to any interview or observation the participants were provided with a written introduction to the study. They were also informed of the purpose of the study, the time commitment involved, and who would be conducting the interviews or observation. The participants were given choice regarding where the interviews would be conducted. Access to observation participants was negotiated according to health authority policy. Information for informed consent was provided by a third party for participants in the observation site, as per health authority requirements. Informed consent was obtained from all of the interview participants and all of the nurses, patients, and other staff involved in direct observation.

Confidentiality, anonymity and privacy.

In accordance with the current HREB, strategies were developed and used to provide privacy and maximize confidentiality and anonymity. All names and identifiers, including diagnosis of patients, type of procedures, date and location or place, were removed from written documents. Field notes and interview transcripts were saved to a password protected computer. Consent forms were stored in a locked filing cabinet separate from interview and field note data.

Participants were given code letters and numbers, and this information was not included on any of the consent forms or information letters. A table for participants was saved to a password protected computer. The interviews were transcribed by a university approved transcriptionist or by me. This report has been written at a higher level of abstraction to prevent recognition of specific participants or situations in which the participants were involved. In addition, participant situations were created as composites as a further safeguard against participant identification. Although information has been anonymized to protect identity, given the nature of the participant observation there is a possibility that individuals close to the situation may recognize or believe they recognize specific situations or events. The location of the observation and type of unit and patient care details have not been included because of the ease with which this could be linked to specific individuals. Upon completion of the study written consents and electronic data will be stored in Dr. Brenda Cameron's office for more than five years and not more than ten years. Participants have been informed of the possibility that data may be used for secondary analysis and the processes that would be required in this case.

Duty to report.

In the ethics applications I outlined a process to follow should I become aware of an event that may have had ethical or legal ramifications in relation to patient care. Nothing occurred during my observation or in the interviews that warranted a duty to report. To the contrary, care was delivered according to

provincial professional nursing standards. However, it is important to note that all of the participants were informed, both in writing and verbally, of my duty to report any evidence of direct harm to a patient.

Recruitment of Participants

Purposive sampling, "a type of non-probability sampling method in which the researcher selects subjects for the study on the basis of personal judgment about which ones will be most representative or productive" (Polit & Hungler, 1999, p. 652), is the established manner for finding participants who can best contribute to the generation of data in grounded theory through experience of the phenomena of interest under varying conditions. Inclusion criteria and rigourous recruitment techniques were designed to minimize researcher bias and demonstrate ethical integrity while accessing a cohesive sample. The inclusion criteria were established to gain participants who were knowledgeable about their development and workplace learning, whose nursing practice demonstrated nursing well, and who were able to articulate their experience and ideas.

Inclusion criteria.

Inclusion criteria were initially focused on obtaining participants who have moved past the initial stage of learning (often referred to as novice), who have worked in the health care system through a time of great upheaval, and who are known for nursing well. Nurses who are recognized as nursing well despite the challenges would be able to provide a description of how they learned to do this. I used the literature to inform the inclusion criteria. This literature, synthesized in

the first three chapters, includes numerous studies of nurse retention and intent to leave, the development of expertise, and studies of new graduate transition to the workplace. Sochalski (2002) suggests that many nurses leave the profession within a decade of graduation. Based on a CIHI report, and extrapolating from US data, the numbers of nurses who leave nursing within 10 years of graduation may be well over 10% (S. Clarke, personal communication, August 6, 2009). Ten years was therefore identified as one inclusion criteria for the *purposive* sample.

Researchers have struggled with developing criteria for identifying those who qualify for nursing well or as experts[21] for a long time. As part of the RCN project on recognizing expertise in nursing practice the authors conducted a review of the literature between 1982-1999 on expert nurses and noted that a range of criteria is used for selection or identification of expert, including peer nomination, education, years of work, professional activities, and status (Manley & Garbett, 2000, p.351). Although nomination was the most common approach, few studies outlined the criteria or the rationale. When the criteria were outlined, it varied significantly and the length of time identified as experienced seemed to be primarily guesswork and was often as low as two to five years (Manley & Garbett, 2000, p. 351). These observations corroborate my own analysis of the literature reviewed for the research proposal.

[21] I refer the reader back to previous discussions to recall the various ways that "expertise" has been understood in nursing literature. I am referring here to those who would be helpful in answering the research question of this study.

I developed a set of explanations for nursing well based on an extensive literature review and in consultation with my supervisory committee. This was not a study of expert nurses, regardless of how expert is defined, although some of the participants may be expert in their practice as defined by Benner (1984; see also RCN, 2005). Nursing well, for the purposes of this study, involved being knowledgeable (knows what to do) and using this knowledge; having technical skills and adeptness; being able to identify patients' needs and intervene for healing in an individualized way; and being able to "be with" patients to alleviate suffering (see Appendix B).

A key limitation of many pertinent studies is the reliance on one source of data, primarily interview data (Carnevale, 1997). Nelson and McGillion (2004) examine the consequences of an over reliance on nurses' narratives of nursing practice. They point out that narratives of nursing practice, used extensively by nurse researchers such as Benner (1984; Benner et al., 2009), are particular constructions of preferred narratives. This critique was a key motivator to include participant observation in the research design. Rather than relying on narratives of nursing practice I was keen to observe the nurses in practice and to include contextual factors influencing the nurses' practice. As I have described above, the ethics approval was obtained for data collection in two wings. I begin with a description of observation participant wing recruitment.

Observation participant recruitment.

For the observation wing of the study the unique health authority protocols required for participant observation were followed and ethics approval was granted by both the university and the health authority. After receiving site clearance I conducted brief information sessions during morning ward reports on both units. In addition, my letter for unit staff was emailed to all of the staff by the Clinical Nurse Educator (CNE). The Clinical Nurse Leaders (CNL) also made staff aware of the study and provided them with my contact information through emails, conversation, and written communication. During the information sessions I was introduced by the manager or the CNE. I explained the purpose of the study and the study procedures. I fielded questions and provided contact information. The focus of their questions was on what I was going to do with the results and if they would be provided this information. Other questions centred on the selection of observation participants, the recruitment of interview participants for the other wing, and interview participant nomination criteria. I provided the unit staff with the criteria outlined on the posters used in recruiting interview participants as a point of reference. I sought advice from the staff on how they preferred me to identify myself to staff and patients.

After gaining ethical approval from the University of Alberta and the health authority I met with the unit manager for a second meeting. We began selecting the observation participants by eliminating calendar days when there were students assigned to the unit. A number of factors informed this decision. As

a nurse educator at the local college I have taught many students and wanted to avoid role conflict. We also wanted to maximize confidentiality, minimize the volume of people on the unit for patient safety, and to minimize stress on the staff. For the remaining days the manager identified the nurses which fit the study criteria on each of these shifts (more than 10 years of experience and known for nursing well based on the unit manager's knowledge of their practice). We then identified the nurses that I could follow for a complete set of shifts. For example, the nurse needed to be working her first day shift on the first day identified as appropriate for the observation. This resulted in an initial list of four nurses spanning a six week period of time. Two additional nurses were added when the I was not able to complete a set of shifts with two of the initial participants.

Interview participant recruitment.

After obtaining ethical approval from the University of Alberta for the interview participant recruitment wing I placed the poster in local nursing education institutions and circulated it through nurse contacts across the province and country through fellow doctoral students, my previous master's study participants, and through contacts from alumni from the Royal Jubilee Hospital School of Nursing. Because this institution graduated their last class in 1983 the nominators for participants were experienced nurses and likely to know other experienced nurses who are known for nursing well. The poster included the process for nomination of participants. From this strategy 12 individuals were nominated. The nominated participants were then provided with an information

letter. Four of the 12 chose not to participate after making initial contact. Three additional participants were nominated by two individuals who heard about the study through word of mouth. Over the first three months of data collection many nurses told me about other nurses who I should interview because they were known widely for nursing very well; however, because these nurses chose not to follow the nomination process approved by the research ethics board, or were not able to, I was not able to contact these potential participants. At the conclusion of the interviews I provided the interview participants with information letters and asked that they pass these on to individuals who they referred to in their interviews. This snowballing sampling did not result in any new participants. I interviewed participants within 3 to 4 hours travelling distance in person, and one nurse at a greater distance was interviewed using Voice-over-the-internet (Skype) technology.

Ethical approval for the observation wing did not include permission to circulate the poster in the local hospitals. As noted above, this related to the decision to obtain ethics approval for the interview wing recruitment beyond the local health authority. The Research Capacity Facilitator placed significant limitations on interview participant recruitment if using hospital bulletin boards.

In grounded theory it is not the number of participants recruited to a study that is most significant. Instead, the number of participants and amount of data in grounded theory varies depending on data saturation. The study involved 23 participants, 6 of whom were observed and 17 of whom were interviewed. Morse

(1995) points out the lack of guidance and thought given to operationalizing saturation in the existing literature. Although sources recommend anywhere from 12-35 potential participants recent publications provide substantial evidence that saturation has been gained with 6-12 participants (Bowen, 2008; Guest, Bunce, & Johnson, 2006; Mills, Chapman, Bonner, & Francis, 2007). The amount of data required for saturation varies with the scope of the study, which is quite broad in this case, and the heterogeneity of the participants (Guest et al., 2006). I return to this point after describing the initial data analysis. It is important to note here, however, that no new categories or codes occurred in the final interviews. This signals adequate data collection, or data saturation, in grounded theory.

Some grounded theorists advocate the recruitment of negative cases. Given the focus of the study this is obviously problematic. I did not seek out nurses who are known for not nursing well. I did, however, approach the potential for negative cases in three ways. Because of illness I conducted participant observation with two nurses, selected by the CNL, who were not initially identified by the manager. These two nurses' practice served as a point of comparison in the construction of field notes. Second, I explored the problem of nurses who exhibit poor practice with both interview and observation participants. As a result the data included descriptions of events and individuals who served as a contrast. Third, although not exactly negative cases, during data collection and early analysis I coded frequent references to "asking and learning from others." I then sought out, through theoretical sampling described below, nurses whose

practice are primarily solitary based on their nursing practice setting. Although not negative cases in the sense of poor practice, these data provided a different interaction between the nurse and the milieu.

Describing the participants.

The following description of participants includes the *purposive* sample for both wings (observation and interview) and *theoretical* sample. Of the initial 12 nurses initially nominated to the study I interviewed eight. While organizing and conducting these interviews three additional participants were nominated. Concurrently, I did 119 hours of participant observation on two acute care units in a tertiary care hospital, including week days, weekend days, nights and evenings, and in-service (educational) sessions with a total of six nurses. Although none of the observation participants were willing or available to be formally interviewed off-site I used the same interview questions to elicit discussion at times in the shifts when the nurses were able to talk. The interview and observation participants, and theoretical sample, represented the following nursing practice areas: surgical services, emergency, ICU, pediatrics, obstetrics, neurology, rural community health (home care), maternal health, and public health. In total, I conducted 17 semi-structured, taped interviews. Although the stated criteria included more than ten years of nursing, based on nominations, most of the nurses included had more than 20 years' experience and one had 15 years. In the theoretical sample I interviewed three newer graduates with two years, six years and eight years of experience, respectively.

Although in some methods detailed descriptions of the participants are included, I will not be describing individuals because of the ease with which the nurses could be identified. Nurses who are known to nurse well are noticeable. Throughout data collection I had numerous individuals name the same nurses. When I explained my presence on the observation units ("I am doing a study of how nurses learn to nurse well in the current health milieu") many individuals would affirm the nurse I was working with, even if they were not from the unit. At one point an interview participant discussed and named an observation participant. One of the physicians named a nurse who was nominated, although was not able to participate due to time limitations. In order to protect the confidentiality of the individual nurses and their patients I have decided to forego this convention.

With the exception of the three newer nurses all of the nurses were educated in a hospital or college setting. Only two of all of the experienced nurses from the interview and observation participants had their degrees in nursing. A few of the participants had only worked on one unit in the same setting for their entire career; however, most of the participants had changed specialities, hospitals, geographical regions, and even countries many times. For the nurses who had remained in one area of nursing practice (e.g., surgery) organizational change had altered the kinds of patients and procedures they were working with often, and at times dramatically. Some of the participants worked part-time, some full time and some casual (on-call) basis. All of the participants had worked with

students and new graduates in some context, either as educators, preceptors, or mentors. The participants loved nursing, and, as I describe in the findings chapter, were singularly patient care focused.

Data Collection

Eraut (2000) highlights specific challenges to studying non-formal and tacit knowledge in professional practice. Based on over three decades in this field he notes a common failure to recognize the different types of learning occurring, the various influences on the situation, and the diverse influences on the learning histories of the participants. He recommends two remedial efforts. First, "one should focus on the situation itself – its antecedents, wider context and ongoing interaction with its environment – and the transactions of its participants throughout the period of inquiry" (Eraut, 2000, p. 132). The second is to inquire into the contribution of the situation to the trajectory of learning or ongoing learning process. These two foci regarding workplace learning situations and their contribution to the trajectory of learning informed my interview questions and what I attended to in the observation sites. The two foci are also remarkably consistent with symbolic interactionism and grounded theory methods. I provide examples of how I collected data before moving into a discussion of data analysis; however, consistent with grounded theory, data collection and analysis occurred concurrently.

Interviews.

A key limitation in gaining access to nurses and many busy professionals is lack of time; therefore I designed the study to be as flexible as possible. The participants were interviewed in a variety of settings depending on the participants' wishes and the need for confidential conversation, including coffee shops, participants' homes, and on one occasion the researcher's home. The interview participants were informed that the interviews would be limited to one hour; however, in most cases the participant was keen to continue the discussion. One interview continued for almost two hours, and after the recorder was turned off for the second time, the participant made further comments, which I jotted down on paper. The initial interview guide is included in Appendix C.

The initial interviews began with open-ended questions regarding the participant's career trajectory, education, and general thoughts about learning at work. Later interviews included questions about emerging categories. For example, after observation and the initial three interviews I noted that nurses learn from others in the workplace and, surprisingly to me at the time, they learn from physicians. With the fourth interview participant I asked, "What is your experience of learning from doctors?" Recent discussions of theoretical saturation and rigour suggest that more structured, rather than completely unstructured, interviews result in earlier saturation and less irrelevant data or dross (Bowen, 2008; Guest et al., 2006; Morse, 1995). In order to balance the recommendation for more structured interview with reflexivity and the need to allow the

participants and resulting data to speak for itself (Glaser & Strauss, 1967) I included some structured questions and some periods of an open-ended question about a broad topic (Tell me about how you learn at work) followed by responsive prompts (Can you give me an example? Can you tell me more about that? That is helpful, what else do you think of?).

Eraut (2000) utilizes "situationally located styles of interviewing and researcher-initiated suggestions" with the acute awareness that "there will always be multiple representations of the knowledge embedded in any complex situation" (p. 121). I had proposed follow up interviews with observation participants (and this information was included in the information letter); however, as noted above, this did not occur. Time, specifically a lack of time, is a key barrier to research with nurses in direct patient care. I explore this more fully in the limitations discussion.

In order to explore the various types of knowledge in use in particular nursing practice situations Eraut (2000) recommends attending to discourses common to the participant's workplace, suggesting types of knowledge and inquiring into their use. He stresses the importance of relationship development and the need to allow time for second and considered responses in order to inquire into knowledge that is implicit in the situation. Over the span of a 12 hour shift, or even more so, over a set of shifts, I was able to attend to specific examples of common discourse and ask pertinent questions during a lull in activity. This also occurred through the dark hours of the 12 hour night shifts. The first time this

occurred I asked to record the conversation; however, this created some discomfort and became impossible with the constant flow of patient-centred needs and so I made the decision to not use the recorder in the observation setting. Although I did not record these conversations they were noted in the field notes and became theoretically sensitizing (Glaser, 1978). When certain types of learning situations recurred, such as learning a new skill or procedure, learning in a new environment or learning about an unusual patient situation, I was able to compare and contrast them in the data analysis.

The interviews were audio-taped and transcribed as soon as possible following the interview and transcriptions compared with the audio-record for accuracy. I transcribed the first and fourth interview as a way of becoming more intimately involved with the data, to begin analysis, and to evaluate the interview techniques. Field notes were kept during participant observation. These field notes included descriptive and interpretive data of interactions and the context (Montgomery & Bailey, 2007). Although field notes often evolve into more interpretive notes, Montgomery and Bailey (2007) contend that "they remain as an element of data from which memos are created" (p. 77).

Field notes.

Although observation participants were selected collaboratively prior to the initiation of data collection we made necessary adjustments to the study plan. Over the six weeks of focused observation I was only able to follow through with this for two full sets (2 RNs, 6 12 hour shifts). On my first day with the third

nurse I noted that she was very fragile and stressed because her best friend, a nurse from her workplace, had died two days prior, and so I opted to only follow her for one shift. In another situation, the nurse that I was to follow came on with a migraine and had to leave the unit. In collaboration with the CNL another experienced nurse was selected for that day; however, because of the rotations I moved to another nurse for the second day and then returned to the original nurse for the final evening.

Over six weeks I was able to do eight twelve hour shifts (two of which were nights), one 9 hour day shift and one 5 hour evening shift. I also spent 6 hours observing in-service sessions related to IV initiation and 2 hours observing in-services related to hand hygiene. This resulted in a of 119 hours of participant observation.

During the observation shifts I became aware of unique features of the unit – piloting residents and fellows for physicians, staffing with RNs only, and self-proclaimed consistent use of care plans. At the time of data collection the health authority along with numerous other health authorities in British Columbia were focused on improving the use of care planning for improved patient care.[22]

Although Bowen (2008) suggests stopping data collection when it fails to uncover any new thematic idea in relation to the emerging theory (p. 145-147) this was very difficult to operationalize. Glaser (1978) argues that when the

[22] I made numerous attempts to acquire a written copy of the research that informed this focus and was repeatedly thwarted by administrative assistants and Professional Practice Office (PPO) leadership. In several informal conversations the study was named but a rigorous reporting of the findings eluded me.

researcher achieves interchangeable incidents saturation has been reached and further data generation is unnecessary (see also Glaser & Strauss, 1967, p. 68). In later analysis I noted that no new core categories emerged; however, I did find that subsequent interviews informed the developing theory as they did provide additional instances.

Data Analysis

Grounded theory requires concurrent data collection and analysis (Glaser & Strauss, 1967; Corbin & Strauss, 1990). Corbin and Strauss (1990) clearly outline the specific processes for data collection and analysis in grounded theory, emphasizing the importance of early coding to inform subsequent data collection. I began analysis after my second set of observation shifts and the second interview, and continued throughout the data collection and beyond. Data collection also continued even while early drafts of the findings were being written. As I developed concepts, categories, and conjectures regarding the basic social process (BSP) I conducted further interviews focused on extending my understanding of the concepts in the theory. During the latter phase of analysis or theoretical coding (Charmaz, 2006) I began listening to the interviews and reviewing the transcripts. Returning to the data helped me to confirm, and continue to constantly compare incidents, codes, concepts, and categories.

Grounded theory data analysis is an interpretive process, beginning with careful reading and open coding. There are dangers of being descriptive or losing the question and purpose of the study in the data. Suddaby (2006) suggests the

solution lies in living in the tension between mechanical technique and interpretive, creative insight, or what Glaser and Straus (1967) described as theoretical sensitivity. Bowen (2008), Mills et al. (2007), and Guest et al. (2006) report replicable processes of analysis in grounded theory. What follows is a narrative description of the data analysis process that is intended to reveal the creativity, reflection, and sensitivity required of grounded theory analysis (Suddaby, 2006).

Coding.

The chronological field notes were analyzed in the same manner as the interview transcriptions. I began with first level (Schreiber, 2001), open (Glaser, 1978) or initial coding (Charmaz, 2006). These open codes are inherent to substantive coding (Glaser, 1978). I began by printing out the field notes on paper and coded them chronologically. After the first set of field notes I moved the field notes and interview transcripts into NVivo and shifted to NVivo to determine the effectiveness of the software. Subsequent early coding was done using NVivo, however as I moved to higher levels of abstraction, and theoretical (Charmaz, 2006) or third level coding (Schreiber, 2001) I also utilized Word documents and pen and paper. All pen and paper diagrams and clustering of codes were dated and filed.

Open coding involved using the original neutral questions of grounded theory (MacDonald, 2001, p. 131), looking for single units of meaning (Schreiber, 2001, p. 69-70), and then assigning codes to suggest what each line indicates,

often using participants' own words. What is this a study of? What does this incident indicate? And what is actually happening in the data? (Glaser, 1978, p. 57) While I was open coding I also began to draw the physical layout of the milieu showing the observation participant in relation to her workplace; however, this did not contribute to subsequent data analysis other than to show proximity, a point I develop in the discussion. As data bits were analyzed recurring open codes were then grouped into emerging categories. I then analyzed the data and open codes by making constant comparisons. Constant comparative analysis is a key intellectual strategy articulated by Glaser and Strauss (1967) to discover theory in the data and involves testing tentative ideas and concepts against existing and ongoing data. Provisional categories were then identified and used to re-code the data, as second level coding (Schreiber, 2001) or focused, selective coding (Charmaz, 2006).

Memos.

Memoing, or making chronological notes about the thinking processes and decision making rationale, is very important throughout analysis and is particularly important in moving from open coding to theoretical codes or third level coding. Montgomery and Bailey (2007) stress the importance of meticulous attention to detail when creating theoretical memos: "Memos are a way of capturing and preserving conceptual analysis" through deconstruction and reconstruction (Montgomery & Bailey, 2007, p. 77). My early memos served to document early theorizing and reflections on emerging patterns, and also recorded

research decisions. Late in analysis some of the memos were coded for emerging categories. Some memos became early drafts of the findings.

Concepts and categories.

As the data were coded with increasing abstraction I then sorted the data according to the categories and examined the data for patterns and relationships among the categories. For this process I used some of the foundational coding families identified by Glaser (1978) and then reconceptualised by Charmaz (2006). I found the 6Cs (cause, consequence, condition, context, covariance, and contingency) assisted me in identifying the properties of the categories. I also used the phases and dimension coding families for identifying the relationships between the categories and constructing the theory. The use of coding families is purported to assist in understanding the processes and mechanisms in the data. Wuest (2007), quoting Glaser (1978), highlights the key role of the theoretical sensitivity of the observer in conceptualizing the data (p. 247).

Although the data collection went through ethics approval as two distinct wings, the interview data and the field notes from the participant observation were coded as one data set. As codes were identified and then examined for patterns and relationships I constantly compared the data sources including nursing practice areas, interview or observation data, years of experience, and then considered theoretical sampling data. Constant comparison and theoretical sampling are essential to rigour in grounded theory studies. Analysis of data across data sources enhances category development, saturation of the categories,

and when present reveals negative cases. Through the analysis there were no codes, categories, or patterns unique to one data source. A unique aspect of observational data was behaviour that I was able to observe but that would be difficult to report in a semi-structured interview (pausing, waiting, studying the patient's movement, organizing tools on the desk and med-cart). This is made clearer in the findings chapter.

I continued coding and data collection through July, generating over 800 codes. In this process of line by line (open) coding I began collecting the codes into broader codes, or collapsed similar codes into one fitting code, then grouped these into categories, comparing incidents of the categories, as the basic units of analysis (Corbin & Strauss, 1990, p.7). Constant comparison is the key method by which grounded theory is developed (Glaser & Strauss, 1967, p. 105). I compared incidents of each category and then compared incident with properties of the categories, integrating the categories in the theory (Glaser & Straus, 1967, p. 105-109). "The generation of theory occurs around a *core* category (Glaser, 1978, p. 93). As Glaser (1978) outlines, some studies may have more than one potential core category and therefore the researcher chooses[23]. In this case, I focused theory development around the key research question and the key word, learning. By the beginning of September I had begun to generate second and third level codes, or categories and the relationship between these. Steadman (2005) notes that

[23] In the most well-known work of Glaser and Strauss three grounded theories were developed, of which Glaser (1978, p. 94) cites two.

> Grounded theory in its purest form, treats every 'explanation' of data as a hypothesis that should be rigourously tested by search for counter examples. Coding in this paradigm is thus a tentative enterprise to start with, subject to false starts, recasting of the codes and readjustments as the research progresses. (p. 10)

Coding, memo-writing, and diagramming the developing theory were very useful techniques for theory construction. I returned to these three techniques repeatedly throughout the analysis process and found them extremely useful when I sensed that my thinking was moving away from the data. In keeping with many other grounded theorists I contend that the techniques of constant comparative analysis, increasingly abstract coding, theoretical sampling, writing memos and drawing the theory using coding families was very helpful in ensuring the substantive theory fit with the data. Having identified the *core* category as processural and answering the basic social problem (Glaser, 1978, p. 96), outlined in the findings chapter, I used the core category as a basic social process to integrate the categories and their properties.

Theoretical sampling.

Theoretical relevance directed later sampling. In grounded theory, "the researcher chooses any groups that will help generate, to the fullest extent, as many properties of the categories as possible," and help develop emergent categories (Glaser & Strauss, 1967, p. 49). Saturation will be achieved most quickly if theoretical sampling is used (Morse, 1995, p. 149). Bowen (2008) also

stresses that theoretical sampling is critical to theoretical saturation noting that sample *adequacy* is a preferred concept to sample size in naturalistic inquiry. Later participant recruitment and data collection should therefore be directed by theory development. As particular codes and categories were identified in the initial analysis I considered potential types of participants who would have specific relevance to those categories. "Learning from physicians" was one early category. I approached the study participants and CNLs to nominate physicians who they have learned from, and then interviewed two physicians whose practice was focused on patients in the acute care setting throughout the hospital, rather than unit or specialty specific. I also recruited a few nurses who were at various stages or phases of their careers to develop the emergent categories. One of these nurses was recommended by an early interview participant and was also a shift partner during my observation shifts.

For theoretical sampling I also interviewed the CNL, the CNE and two area experts. I approached two of the observation participants for follow up interviews however both declined due to personal time constraints. After an initial 12 interviews I determined that I had interviewed or observed nurses from the following nursing practice areas: surgical services, emergency, ICU, Pediatrics, Obstetrics, Neurology, and rural community health (home care). I had conducted two theoretical sampling interviews (8 year graduate and RN from Maternal Health). I then sought out a public health nurse.

Member-checking.

Member-checking is considered important to rigour in grounded theory methods (Bowen, 2008), although Morse, Barrett, Mayan, Olson, and Spiers (2002) caution the use of member checking for establishing rigour, reliability, or validity in qualitative research generally. Concerns relate to the synthesized nature of the final product and in seeking to be responsive to participants' concerns one may in fact invalidate the work. In early September I contacted the CNE and unit manager to apprise them of my progress in data analysis. I asked that the staff be made aware that I was working on data analysis and continuing to conduct interviews. I also attended three ward reports and two lunch breaks through the fall to "show my face" and inquire into the various issues that had emerged in the data collection (hand hygiene audits, IV initiation training, Systems Wide Initiatives). In each of these contacts the staff asked about the findings and if they would be told "what I had found out."

In response to these requests and with the intent of member checking I requested to meet with observation participants to share interim findings. During the fall Dr. Brenda Cameron and I presented these findings in two sessions on the units. Although the intent was to engage in member checking to seek validation for the emerging categories and theories, some nurses attended who had not been direct observation participants. In total twelve nurses participated. I provided the unit staff with a summary sheet of the research purpose and methods, followed by the categories and codes along with a *preliminary* diagram of the theory. The staff

affirmed the findings and provided further instances of some of the codes and categories. We asked the staff further questions regarding the systems issues and how they manage or deal with the milieu. We also inquired into how the nurses have learned to resist when necessary because it appeared that this was unique to this group of nurses. These sessions were recorded, transcribed, and analyzed.

Following the member-checking sessions I began to group some of the codes into broader categories. I then began writing up one of the broadest and what seemed to be the most significant category at the time – asking others. After several more months of data analysis I sent a brief summary to the CNE on the observation units. I also sent the CNE and a unit manager a two page summary of the tentative theory and a diagram prior to writing the final draft of this dissertation.

In the final phase of analysis and writing I provided both the interview participants and observation participants whom I was still able to contact with a summary of the theory. One observation participant responded with affirmation and commented that it was very helpful for her to read the analysis of what she was not always aware. Interestingly, although Morse et al. (2002) note concerns about individual participants recognizing highly abstract or theoretical findings, this participant "saw it." I also invited a very experienced practitioner who recently moved to nursing education to read the findings chapter. The findings strongly resonated with her experience and were deemed to be highly relevant.

Two interview participants responded to the email affirmatively but neither followed up with further comments.

Theory Development

An important step during data analysis is moving from the macro to the micro level, often characterized by iteratively moving up or back to the research question or phenomena of interest and then down into the line by line coding. Glaser and Straus (1967) note, "by comparing where the facts are similar or different we can generate properties of categories that increase the categories' generality and explanatory power" (p. 24). These two processes, moving from macro to micro levels and comparing similar and different properties, promote rigour in the grounded theory methods and move categories and concepts from description to theorizing.

The timing and use of literature for analysis in grounded theory is critical. A key consideration was to avoid returning to verification and deductive research with preconceived concepts and ideas, while at the same time fulfilling the responsibility to be knowledgeable in the field. Once core categories are developed, or the theory is "sufficiently grounded and developed" (Glaser, 1978, p. 31), Glaser (1978) recommends reading in the field while making memos and then "integrating relevant literature into the theory, which is being sorted into memos" (p. 117). The literature is constantly compared to the data to scrutinize and judge the "fit with emerging concepts and theory to better ensure the rigour of the findings" (Schreiber, 2001, p. 58). Through the analysis process I read key and

also new publications regarding some of the emerging categories. Although some researchers describe using the literature as secondary data (Mills et al., 2007), this is not consistent with recommendations by key scholars in the field (Glaser, 1978; Richards & Morse, 2007; Schreiber, 2001; Stern, 2009). In grounded theory, categories are developed from the data, and then literature is used to "compare and contrast your emerging data with the previous knowledge … and placed in the context of what is already known" (Richards & Morse, 2007, p. 192).

When is a theory a theory? Analysis ends when the theory is highly abstract and accounts for all of the data, answers the research question, and the basic social process is clear. In the final stage of analysis I listened to the interview data and reviewed the field notes again with the basic social process and categories in mind, while writing about the findings in light of the literature. While listening to the interviews I asked questions. Is the participant talking about this category? Does the theory account for this instance of workplace learning adequately? Is this data related to the study questions or has the participant started to talk about something different? Does the theory fit? Does it work?

The most difficult aspect of the later theorizing was depicting the theory in diagrams that adequately account for the complex milieu, processes that are in the past within a process that continues to occur over time, and processes that occur "in the moment" of nursing. Time and place were difficult to diagram. However, this iterative process of diagramming, staying grounded in the data, asking questions, analyzing, reviewing the extant literature, and writing resulted in

refining the theory in a rigourous way. This is evident when early diagrams and notes are compared with later diagrams and notes.

Rigour

Within the qualitative research paradigm various criteria for measuring rigour and conceptions for evaluating "goodness in qualitative research" have been proposed (Emden & Sandelowski, 1998, 1999). A central concern of qualitative researchers in various disciplines such as education, social sciences, and nursing has been to match the philosophical underpinnings of the method with the criterion for evaluation. With Emden and Sandelowski (1998) I have concluded that "goodness is as much about where and how the researchers derive their beliefs, assumptions, motivations, and ways of working, as about judgement on research procedures and findings reached via the application of specific criteria" (p. 207). The pursuit of common agreement on evaluating and critiquing qualitative research is also important. Recent arguments for warrants of goodness in qualitative research emphasize the importance of authentic and ethical inquiry (Emden & Sandelowski, 1998, p. 210). Authentic and ethical criteria involve attending to the relational nature of research, including relationships between the participants, the researcher, and the audience. Thorne (1997) stresses the need for accountability in the areas of moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth (p.122-125). In the research proposal I identified the commonly agreed upon evaluation criteria in grounded theory: fit, work, relevance and modifiability as criteria for this study

(Glaser & Strauss, 1967). This latter move, to adopt criteria particular to the research approach, serves to avoid purely modernist notions of reliability and validity or to avoid merely redefining quantitatively oriented criteria, while also avoiding an "infinite regress of meaninglessness" to establish and defend rigour (Emden & Sandelowski, 1999, p. 5). In addition, I also follow the verification strategies designed by Morse et al. (2002) to (re)establish reliability and validity in qualitative research.

What follows is intended to demonstrate to the reader that I have been aware of my own beliefs, assumptions, and motivations to defend the study as an authentic and ethical inquiry (Emden & Sandelowski, 1998, p. 210). I argue that this grounded theory meets the traditional criteria for rigour and then seek to address the issue of reliability and validity through verification strategies (Morse et al., 2002).

Assumptions, beliefs and authentic inquiry.

Throughout the research project I sought to make my decisions explicit and where possible, to include my decisions in this written account. The ethical considerations outlined above are included to offer moral defensibility. I acknowledge my own role as a nurse and nurse educator impacted data collection. I saw with the eyes of a practising nurse and some of the participants identified me as a nurse educator. Some of the data regarding education may have been provided with the intent of shaping and changing my views. I do not belief this detracts from the meaning of the data necessarily and in fact may actually strength

it. The participants may have assumed they were talking to someone who would act – as researcher and as educator. As I note in the findings chapter, one of the sub-processes "becoming relatively impervious" to the environment was evident in response to my presence. I became part of the health care milieu. Clearly the researcher has an effect on the phenomena being studied (Dowling, 2006, p. 17) and in this case they told me they were going to ignore me.

"Researchers both influence and are influenced by" the research (Dowling, 2006, p. 12). How was I influenced by the research? As I analyzed the data and developed the theory I was struck by how impervious the nurses (who are known to nurse well) are to the chaotic, often dysfunctional, health care system. I longed for this ability to set my sights on what is critical and important, and to avoid the vagaries of fluctuating leadership ideas in my own workplace. As I completed my dissertation while working as a nurse educator and as I recognized the importance of nursing education, I was influenced by the study. My teaching changed to focus on the kind of knowledge and skills that I saw demonstrated in the participants. I began to advocate as if the participants were present as a nod of respect and deference to their views. In a more personal way, I began to ask myself, "What would those nurses do?" when I found myself faced with another organizational change or institutional demand in my own work life. I return to these themes in the concluding chapter.

Fit, work, grab, modifiability and other expectations for rigour.

The theory, with categories and hypotheses, must fit or "must be readily (not forcibly) applicable to and indicated by the data under study;" and must work or "be meaningfully relevant to and be able to explain the behaviour under study" (Glaser & Strauss, 1967, p. 3). Central to ensuring this fit and work in grounded theory are the strategies used for "collecting, coding, analyzing, and presenting data" (Glaser & Strauss, 1967, p. 224). I have provided a narrative descriptive of my use of these strategies above. Purposive sampling based on existing knowledge, initial deliberative line by line coding, inductive and deductive thinking, and then theoretical sampling assisted in assuring concepts discovered fit the data. The systematic coding and subsequent data generation further contribute to meeting traditional expectations for rigour.

Constant comparative analysis is critically important for rigour in grounded theory (Bowen, 2008). I iteratively examined the data for cases that contradict the emerging theoretical categories and relationships or for disconfirming evidence, and as noted above I continued data collection to identify negative cases and compare difference in nursing practice areas. Data variation was sought out in theoretical sampling. This is consistent with my view that there are common patterns and processes, but that variation neither negates the pattern, nor does the pattern negate the variation. Both are important to our understanding of human social processes and behaviour.

Reflexivity of the researcher is a recently developed strategy for rigour (Charmaz, 2006) although Pillow (2003) poses important questions regarding reflexivity as a methodological tool. A clear intent in this discussion is to establish a link between the quality of the study and reflexivity while acknowledging that reflexivity is more than a device for demonstrating academic rigour. A review of my memos and documents of writing about the categories should reveal a connection between the data, the process of recognizing codes and categories, and also the developing hunches and theoretical conjecturing.

Relevance and modifiability, from traditional grounded theory literature (Glaser & Strauss, 1967; Glaser, 1978), are similar to Thorne's (1997) case for disciplinary relevance, pragmatic obligation, contextual awareness and probable truth (p.122-125). I have described techniques used to develop the theory in order to allow the reader to evaluate the trustworthiness of the grounded theory. Ultimately, based on clear articulation of the methods and analyses and the parsimony of the resulting theory, the reader and practitioners will have to determine the usefulness (work), resonance (grab) and, over time, the modifiability in response to further study. I will clearly outline the relevance to the discipline of nursing and the pragmatic application in the final chapter. Extensive review of the literature prior to conducting the study and ongoing and new reviews of the literature during and following theorizing enhanced my contextual awareness. Claims for probable truth (Thorne, 1997, p.122-125) beyond epistemological issues of truth claiming are ultimately a matter of trust in

the researcher, the researcher design, and the reliable conduct of the research study.

Verification strategies for reliability and validity in this grounded theory.

As noted above, Morse et al. (2002) suggest that reliability and validity be maintained in both qualitative and quantitative research. I concur with their concern that too often evaluation and defense of studies' rigour are left to the reader without any responsibility and accountability from the researcher. "Verification is the process of checking, confirming, making sure, and being certain" (Morse et al., 2002, p. 9). Because the processes of verification occurred throughout the entire study, a summary of these processes have already been described in the previous sections.

While proposing and conducting the study I made numerous adjustments and alterations to the research design to ensure congruence between the broad research question, the intent of the study, the determination of best data sources, and then the analytic procedures (Morse et al., 2002, p. 12). Best data sources, including recruiting participants who best represent nurses who are learning and continuing to nurse well, are critical to the study rigour. For example, I was interested in "experienced nurses" who improved throughout their careers. A proposed Delphi procedure for defining "good nurses" was removed from the proposed study and the focus shifted to "nursing well." The choice to include observation data has been thoroughly outlined above. The addition of two

physicians to the theoretical sample resulted from early coding and analysis. In keeping with grounded theory methods I began data analysis after initial interviews and observation shifts. I was responsive and flexible to the line by line coding and frequency of reference to certain codes, adding interview questions about using other health care professionals for workplace learning, their apprehension in the workplace, and their response to new environments and workplace changes.

Thinking theoretically and theoretical sensitivity are essential to rigour in grounded theory (Glaser & Strauss, 1967; Glaser, 1978; Morse et al., 2002). The work of developing and using theoretical sensitivity is difficult and time consuming. I spent hours coding, re-coding, reviewing the coding, and creating hierarchies of codes and categories. I wrote these codes and categories into relationships, and through this writing and re-reading of this writing, interrogated the developing theory for cognitive leaps or unsubstantiated patterns and relationships. During a focused period of early analysis (July 2010) and late analysis (May-June 2011) I spoke with Dr. Cameron weekly discussing the theory and my written analysis of the data. In June of 2011 I also provided my methodologist with an early draft of this chapter to ensure that the study was conducted in keeping with the proposed research design with necessary consideration given to the flexibility and responsiveness required of rigourous grounded theory (Morse et al., 2002).

Methodological Contribution

I do not claim to have made significant methodological contributions. Grounded theory is a very established and well used method in nursing research. Although I had proposed using grounded theory and situational analysis for this study, as the data collection and analysis progressed I made a decision, as outlined above, to continue with the well-established techniques for data collection, analysis, and theorizing. In terms of method, I propose that the key contribution relates to the relationship between the phenomena of interest – nurses' workplace learning – and the use of grounded theory. Most of the research on nurses' workplace learning has been qualitative, specifically phenomenology, and has most often focused on a narrow area of nursing practice (e.g., nephrology nursing, Bonner, 2003) or on a narrow span of time (Cioffi, 2001; Ferguson, 2006).

Thorne (1997), Kearney (1998), and Risjord (2010), among others, highlight the primary value of disciplinary and pragmatic utility in nursing research. Nursing, as a practice profession, benefits most from research that is grounded in nursing practice. Kearney (1998) argues against developing theory "to the point when the phenomenon is no longer recognizable as a discrete experience, or the theory so general as to be rendered clinically useless" (p. 182-3). The study design and research decisions, informed by Eraut's (2000, 2003, 2004a) experience and program of research, have been methodically and chronologically outlined in order to assist other researchers in replicating and extending this work.

In Chapter One I stated that this study explores how Risjord's (2010) conceptualizations of theory coherence and of practice-unified theorizing might reformulate our understanding of nursing knowledge and learning in practice. I contend that this grounded theory of nursing practice fits perfectly with his central thesis that disciplinary nursing knowledge development should occur in *nursing practice*. I also contend that this study fits perfectly with his recommendations and conceptualization of knowledge development as a web rather than a hierarchy. The theory of refining nursing practice forms a node common to the field of adult education and the discipline of nursing (Risjord, 2010). As Risjord (2010) clearly states, grounded theory is a very important method for disciplinary knowledge development, particularly with the epistemological underpinnings of pragmatism and symbolic interactionism. This dissertation demonstrates this well.

Chapter Four Conclusion

In this chapter I have followed the conventions of empirics and outlined the methodology and methods of this study. I have provided rationale for research decisions beginning with the initial questions, defending the choice of method, and describing data collection and analysis. I have worked to situate myself, as the researcher, in the study. In the next chapter I will begin by introducing the resulting substantive theory and then move to a full discussion and recommendations in Chapter Six and Seven.

Chapter Five: Findings

The theory of refining nursing practice is a grounded theory of how nurses learn to nurse well in the current health care milieu. Refining nursing practice involves three categories: getting grounded, needing to know, and puzzling and inquiring. Each category is integral to refining nursing practice and will be discussed in detail throughout this chapter. Refining nursing practice occurs in a variety of workplace settings and nursing practice areas over a number of years. Many participants observed that learning was something they engaged in every day and they expected to continue learning as long as they were working.

As I stated in the introductory chapter, my interest in the development of experienced nurses motivated me to conduct this study. Specifically, I was interested in exploring how experienced nurses in direct patient care continue to learn to nurse well within the current and shifting health care milieu. The participants refined their nursing practice through ongoing learning, both in and away from the workplace. I was also interested in how the workplace context influences nurses' learning. The health care milieu *triggers* nurses' learning. Three specific aspects of the milieu or workplace *catalyze* or facilitate the nurses' learning. These aspects are mentor-guides, functional teams, and camaraderie. Although over their careers the participants worked in diverse nursing practice milieus of varying quality, lifelong learning was evident regardless. This is not to say that unique workplace environments and the health care milieu do not

constrain refining nursing practice, as I will explain below. Although the learning situations differed, there were common triggers, processes, and results.

Basic Social Problem and Basic Social Process

A first job of a grounded theorist is to identify the basic social problem. Determining how to continue to provide vigilant care to patients within the constantly shifting milieu is a basic social problem for nurses providing direct patient care. As with many contemporary organizations, the health care milieu is characterized by change. The clinical nurse leader (CNL) from one of the observation units identified 22 changes influencing nursing practice in the five months prior to the study, and over 50 by the end of data collection. Each of the changes required learning in some domain. For example, organizational decisions trigger learning whether they are perceived to be insignificant, such as changing the phone numbers throughout a hospital, or significant, such as re-locating a specialty service thereby requiring that staff adapt to an entirely new workplace. The volume of changes noted above can both prompt learning and become barriers to nursing well. The context of constant change, and at times the related disruption, is a problem to be solved for nurses who are committed to nursing well.

The nurses in this study were singularly focused on providing the best patient care possible. This desire and commitment to excellent care often collides with aspects of the milieu and then poses a problem for the nurses. Change is not necessarily a problem. Rather, the constant, often seemingly random, nature of

change and the resulting demands on the time, energy, concentration, knowledge, and skill of the nurses create challenges. These challenges relate to the difficulty of being able to maintain the nurses' high standards of patient care when hampered by changes in organizational structure, protocols, practice requirements, and administrative discourses in the workplace. Through getting grounded, recognizing what they need to know in order to respond to their patients' needs, and continually learning (puzzling and inquiring), the nurses refine their nursing practice and continue to nurse well. Consequently, the nurses provide excellent nursing to their patients regardless of the demands, and often dysfunction, of the system they work in**.** I identified *refining nursing practice* in order to provide the best care for patients, *in the crucible of British Columbia's current health care milieu*, as the basic social process (BSP) addressing this basic social problem in my grounded theory.

Refining Nursing Practice: Theory Overview

Learning in the workplace for nurses in the current health care milieu begins with a trigger for learning, which prompts a state of needing to know in order to act. These triggers include patient-specific concerns, change in the workplace, and self-awareness of a learning gap. Nurses respond to these triggers, and the resulting state of needing to know, by engaging in puzzling and inquiring. The properties of puzzling and inquiring include figuring it out, questioning peers, and accessing resources.

Refining nursing practice varies with the nurses' capability for being grounded. The properties of being, and therefore, becoming or getting grounded are (a) setting high standards, (b) maintaining or nurturing high standards, (c) having a healthy apprehension, (d) being able to see the whole picture, and (e) being self-aware. Getting grounded is a condition that positively contributes to refining nursing practice. Nurses utilize this capability throughout their years of nursing across diverse settings.

Refining nursing practice is assisted by catalysts or catalyzing influences. The properties of catalyzing influences are mentor-guides, camaraderie, and functional teams. The nurses in this study were not *dependent* on all of these catalyzing influences; however they highly valued mentor-guides, camaraderie, and a functional workplace.

Over time, some nurses learn to respond to the relentless demands for learning by developing a filter. The result of this sub-process of filtering learning triggers is the capability for being relatively impervious to incessant demands, some of which may not positively contribute to high standards of whole picture nursing. Becoming relatively impervious, a condition which I describe below, is a capability that develops over time and facilitates nursing well for some nurses.

The remainder of this chapter is focused on presenting the findings in detail. I begin by discussing triggers for learning, including the role of the health care milieu. I then discuss the three categories of refining nursing practice: needing to know, puzzling and inquiring, and getting grounded. This is followed

by a discussion of catalysts for refining nursing practice, which function across the categories. I conclude this chapter with a more detailed overview of the theory.

Triggers for Learning

There are three types of triggers for refining nursing practice. Although change in the health care milieu accounted for much of the learning and the most challenging learning, patient-related concerns and the process of self-appraisal also triggered needing to know.

Health care milieu triggers needing to know.

Specific organizational initiatives and directives created many learning instances. These organizational issues, such as disbanding the IV team and care delivery re-design, prompted learning, distress, and frustration. I introduced the metaphor of a crucible, *the crucible of British Columbia's current health care milieu*, in the beginning paragraphs of this chapter and will discuss it further when exploring the category needing to know. The crucible is a fitting metaphor for the demands of organizational and healthcare-related change that has affected the nurses over the past 20-40 years. Although change is a given, and has been so historically, the speed of change in contemporary society has increased. The rationing of resources within health care has exaggerated the effects of some changes (Cartier, 2003). Bauman (2000) proposes that globalization and market capitalism (in liquid modernity) have also increased the burden on individuals to respond to unwieldy challenges. A crucible is a vessel in which substances are

heated to high temperatures to forge a new product. The health care milieu is like a vessel in which nurses experience situations in which they are severely tested. The interactions often produce something new (forging, alchemy) in the form of learning and, over time and through many situations, refinement.

The participants had nursed through many changes in the milieu. At times the learning appeared simple, while some changes, such as staff displacement, closing units, and amalgamating services require significant learning across domains. Even simple learning becomes complex, for example when adding a "one" in front of the department phone numbers or having to shift to a new style of IV pump. Both of these examples are played out repeatedly in the nurses' work day. Each time the nurses "forgot to apply their new learning" by phoning another department without the "one" they got a busy signal. This busy signal did not automatically remind them they had done it wrong, particularly if they were distracted by numerous other important issues. The habitual use of frequently used phone numbers, using both the cognitive and psychomotor domains, was not simple to unlearn. In the case of new IV pumps, the nurses were required to apply their learning repeatedly throughout their shifts as they hung new IV bags, initiated IV administration, and administered IV medications. Dealing with IVs on four to five patients in an acute care setting is continual, cannot be ignored, and exemplifies change that demands learning.

Imposed learning is often difficult and may result in strain. One nurse, who has since retired, experienced multiple organizational re-structuring

initiatives and had been displaced at least four times. The most recent move was very difficult and she "just wasn't able to get her feet grounded" in the new situation. This contrasts with how her colleagues perceived her, however. Unlike the other highly experienced nurses affected by the move, this nurse was considered one who "landed on her feet right side up."[24] During the observation shift she stated she felt overwhelmed "with this new stuff at my age." Neither the changes in technology nor the exposure to new procedures, surgeries, and related care was the key problem. She learned the new equipment with ease; however, the volume of patients and patient-specific information she was required to process in the span of one shift in the new workplace was overwhelming for her. Another key source of her weariness was related to maintaining the high quality of care that she valued. She was committed to prompt responses to patient needs and high standards of care, but at times this was not supported by the actions of her colleagues or her workplace. I observed this throughout the shift I followed her, specifically in response to answering call bells. When a call bell rang in another pod the observation participant walked past the nurse, a relatively new graduate, who was sitting chatting at the nursing station to respond. She did this without complaint; however, after repeated similar instances she did note that it was frustrating when she felt obliged to respond promptly to patients' requests when others did not. Imposed learning is more complex when it is associated with, or exists in the context of, shifts in values. This is particularly so if it undermines the

[24] These two quotes related to one nurse and were made at entirely different points in the data collection with neither speaker having heard the other.

capability of being grounded, including having time to see the whole patient picture and sharing the goal of maintaining high standards of patient care.

One nurse, who worked in the same specialty area for her entire career, also experienced a large organizational re-structuring. Early in the interview she mentioned that she does not like change and stayed where she was because it was within her comfort level. Ironically, the service was re-located from one hospital to another. In this move she also changed from ward nursing to a related critical care unit. The entire staff "had a hard time adjusting." There was a period of over six months where they all "felt like the rug had been pulled out from under them." When I asked her how she was able to get over that hump, although the staff received training and mentoring, she described how there was "nothing at work that did it, I just kept my head down, went to work and did my job." The participant described staying focused on her own nursing and doing the best she could for her patients. She filtered out some of the work-related opportunities and challenges in order to remain grounded and avoid becoming overwhelmed. Following a displacement or workplace redesign some nurses are able transform the stress and grief into personal learning and development. Some workplace related change ultimately facilitates refining nursing practice.

Decisions to purchase new equipment, to implement new processes for acquiring medications, or to implement new methods of documentation created learning demands. These were triggers for learning that required a response. This was made more difficult by the fact that nurses believed that little thought is given

to how a change is going to affect nursing practice and how much learning and re-learning is involved.

In one institution, over the span of at least three years prior to the study, services offered by a specialized IV team were slowly cut back. I discuss this organizational decision to disband the IV team in detail because of the enormous impact this decision had on the nurses at the time I was conducting the study. The stated rationale was to save money. The IV services were cut back and then completely removed during night shifts. Ward nurses had to learn to initiate IVs. The educational institution where most of these nurses received their pre-registration education did not teach this as part of their undergraduate education and maintained this position until two years after the IV services were initially decreased. The ward nurses had not learned IV initiation, nor practiced it with mentors in a learning focused environment. Although all of the nurses in the acute care setting were offered workshops, most of the nurses on the unit did not get adequate time for supervised practice, or any time at all.

Because the IV team remained available on days, few nurses gained enough practice and confidence to initiate IVs. Then, while this study was being conducted, the announcement was made that the IV team would be cut back further and would only be available for specialized skills and difficult IV starts. I attended two of the many half-day workshops that were provided to teach or re-teach the nurses IV initiation. Many of the nurses were pleased, engaged, and excited. Over time I observed that the nurses did try to do their own IVs and only

called the IV team after two initiation attempts (an institutional guideline I was told). Some nurses became local experts with IVs and some of the other nurses continued to avoid IV initiation. These latter nurses stated clearly they "don't want to be practising on their patients" and "don't believe this decision is evidence-based." The findings of my study suggest that the decision forced complicated psychomotor skill learning on experienced nurses in the context of a busy, and often stressful, workplace. The data also suggests the nurses will continue to find ways of ensuring that they are "doing the best for their patients," whether it means becoming excellent at this new skill, or finding ways of ensuring that another nurse does this for them.

"It was so different back then." I recognize that these words prompt cynical or critical responses and disparaging commentary on memories of halcyon days (Dingwall & Allen, 2001) and yet this *in vivo* code is one of the most frequent references across more than half of the sources. This is the perception that informs the interpretation of their world which then shapes the nurses decisions and choices. The world of nursing has changed for the nurses. Technological advances have precipitated change. One nurse describes one technological advance.

> But it was a different world. It was a different nursing world at the time. I remember sort of really struggling with … I had this [patient] who had had a major stroke and I remember feeding her and she would be aspirating. So you're just with the suction and feeding her because we didn't really

> use feeding tubes back then either right? And you had to give them nutrition.

Organizational structures have precipitated change. "The head nurse was the head nurse but they only had one unit to worry about, right?" A few of the unit staff talked about the importance of previous head nurses and their influence on quality of care. The experienced nurses also perceived that they had more support. "The difference for me then was we had great team work. Great nurses who I worked with who had lots of experience and … I thought I was never put in an unsafe situation."

Reallocation of resources has also impacted nursing practice. I observed an interaction between nurses regarding accessing a less-acute place of care for a patient. One of the nurses came to the nurse I was shadowing and said "Where would this patient go? Like where do they go?" The RN observed that everybody is looking for someplace for them to go. An organizational change in another area of service changed the discharge and transfer rules and processes for the participants. In morning report an RN asked about a resource team, and how to access them "now." My field note follows. "The CNL quickly recounts what has occurred with this patient, a few comments back and forth about the team, and the 'new way.' Is this a new procedure? Is this a new process? Changes affecting this unit now." Moving patients through the health care system is time-consuming and often complicated. Every system change is translated into required learning for nurses providing direct patient care.

Role changes also trigger learning. The CNE of the observation unit discussed how changing roles and responsibilities for nurses in direct patient care consume most of her time. For example, she noted in some settings nurses currently don't do anything with Peripherally Inserted Central Catheters (PICC), whereas on her unit the staff currently don't change the dressing. This position was under review. "Because in other places the staff nurses do all the things like that." When asked about the barriers to adding this skill she noted that "infection control is an issue, time is an issue, and proficiency. And, when you are not proficient at something it is going to take you 45 minutes to put in an IV say, and it isn't guaranteed to be successful." The CNE was not arguing for or against the organization change, but was highlighting the implications of learning a new skill in a busy workplace with a high turnover of patients each day.

The combination of constant change, increased technology, and shifts in the culture of the workplace can be overwhelming. One observation participant asked to discuss the study with me prior to the observation. During this conversation she commented, "there is just change, it is always changing … and that is how it will be in the future, everything with technology, and even charting like it is elsewhere." At the end of the shift she commented that she was not enjoying her work anymore. She discussed a recent organizational re-structuring move, the resulting loss of colleagues, and noted, "It just isn't the same anymore. ... If it were like it was I would be fine for a few more years." Learning triggered by large and small health care milieu changes was difficult and demanding.

Patient-specific concerns trigger needing to know.

Patient-related concerns also trigger the need to know and are common and anticipated. The participants were quick to notice subtle changes and inexplicable complaints or comments from the patients. Participants talked about how they respond to a patient situation that is new or confusing to them. During an observation shift a patient presented with three seemingly unrelated symptoms. The nurse pursued this puzzle with another experienced nurse and concluded "it does not look good … this happened to [other nurse] once." The nurses were presented with unexplained changes in levels of consciousness, unusual drainage, and unexpected findings during their assessments. This kind of patient related conundrum triggers needing to know in order to act wisely and for the good of the patient.

On another observation shift the participant was faced with two patient concerns. As she juggled her care I observed her repeatedly re-evaluate the unusual finding and patient situation. Eventually the nurse called a physician and asked for specific intervention. This required coordinating another department and a specialist and organizing the patient for a procedure. The nurse gently persisted in spite of the barriers. When the patient returned from the procedure the findings confirmed that the nurse was correct in her actions and advocacy. Within a short period of time the patient developed another problem. The field notes read: "Thinks, charts, reviews trends and decides … acts … quietly looks at patient for bit." During this time I asked about the physician's role. The nurse responded,

"Yeah, well they just wait for us to say, 'what about this' 'what about that.'" Throughout this shift the nurse's need to know led her to "just keep trying to figure it out," engaging her partner and other nurses. Near the end of the shift the partner observed, "That is the thing about having enough time. You can just keep trying to figure it out … but you need to have enough time."

We can clearly see the relationships among refining nursing practice, triggers for learning, and the categories of getting grounded, needing to know, and puzzling and inquiring. In the example above, the nurse noted "three abnormal findings" that were not easily explicable, even with her extensive knowledge and experience. Because the nurse was grounded, completely focused on her patient, had high standards of care, and sought to see the whole picture, she responded based on her assumption that "something could be wrong" (healthy apprehension). This patient concern therefore triggered her need to know in order to act well. This needing to know resulted in the complex process of puzzling and inquiring that I describe below. In these situations the participants recognized that they needed to learn something in order to be able to move forward in providing safe, competent, compassionate patient care.

Self-awareness of a learning need.

Self-assessment or self-appraisal prompted the nurses to engage in formal learning or to seek assistance. For example, one newly graduated nurse began taking courses in pharmacology and diagnostics in order to address gaps in her basic knowledge. Following an emergent incident, another participant realized she

needed to know more about "what happened." She summarized formal learning and the subsequent career moves.

> When she died, I felt I didn't know enough. Because I didn't think the code had run very well and I realized I didn't have enough knowledge. So then I decided it was time to start learning … an ECG course … then I took level one, two and three and I was really excited. I was really happy learning again and I did really well on the courses and ... then I applied to go into the little five-bed ICU.

In this case, one incident prompted a re-evaluation of her existing knowledge and skills, a recognition of needing to know, followed by seeking out educational opportunities and ultimately a more challenging area of practice.

Participants made frequent reference to identifying a learning need on their own and pursuing this. "So if I didn't feel I was adequate at something, usually I'd ask somebody, 'Where would be the best place to go to get this worked out?'" Another participant reflected on her nursing education and having a "very healthy sense of what I could and couldn't do or what was right and what was wrong." The participants spoke of identifying their own learning needs, of challenging themselves, of "never knowing enough," and of being driven by a sense that they were not smart enough yet, at the same time aware that frequently people tell them "You are such a good nurse." The nurses reported numerous instances of seeking out learning opportunities in response to their self-assessment. Some patient concerns or situations do not occur often. One

observation participant explained that she took a temporary job on a specific unit to challenge herself. She went to a training day and then "we have had two [of those kinds of patients] since then and I got in there and looked after them." Another nurse on the same unit took temporary project jobs and moved sites because she decided it would be a challenge for her. Participants also talked about being unhappy with their skill level and needing to re-learn skills. "So I went back to the books and I started from scratch. I re-learned it. I memorized it. I got myself a routine and so I just did that and having done that once you just don't forget it."

Self-awareness included recognizing learning needs and knowing how best to respond. The participants recognized their own learning preferences and personality styles. For example

> I've always watched for workshops …Why do we always feel we have to learn at least part of our learning in a formal situation? Like why not just pick something and just do it for the heck of it and see if you can do it? But I've always liked to do workshops. I like to maybe learn by videos, maybe like a variety and again because of my personality I like a really big variety of learning situations.

Confidence was a struggle for a few nurses. One stated, "I didn't think I was smart enough and I don't have the staying power to go to university and then [after completing her degree] I got there." Another nurse observed that her learning was related to her self-image. "I know I know a lot and I think it's probably just a self-image thing. I think everyone's smarter than me. I really do.

And I know that they're not but … it is my personality." Some observation participants made negative comments about their practice and more than a few compared themselves with other nurses on the unit or in other areas of practice.

The participants were continually aware that there was always more to learn. "But I just never know enough. I get there and I think well when I get there then … and that's been a driving force for me … one of the driving forces has been I don't know enough." There were common references to the idea that if you are scared of something, you need to learn more about it. "If you're scared of pacemakers, you should get trained." An observation nurse started her career on a unit where they cared for patients following laryngectomies to get over being "afraid of trachs."

A significant number of participants made reference to one course offered by the Palliative Care and Hospice team. A community nurse stated confidently as a closing statement to her lengthy interview, "If everyone took the palliative care course then we would have lots of good nurses!" These are not nurses who are working in areas where they are often required to provide palliative care. "The course was good for me and I am able to use it a lot even though I didn't think so—you know, why take that course now—but it was good." This is only one example of formal learning that was prompted by self-awareness. Self-awareness leads to the recognition of the need to learn across domains and to refine nursing practice.

Needing to Know

Between the complex puzzling and inquiring of everyday nursing and the health care milieu, there is a point of "needing to know" in order to act. This links individual nurses' learning with the health care milieu. The nurses respond to a trigger for learning with needing to know, a point that may last only seconds. Needing to know is more than academic curiosity. It involves needing to know in order to act, in order to nurse. "When we learn is when we have to make a decision." Needing to know is a stepping stone to action and response or, to utilize a different metaphor, a bridge between the triggers and the nurses' responses. In the introductory paragraphs I suggested that *refining* nursing practice occurs *in the crucible* of British Columbia's current health care milieu. In keeping with this metaphor, needing to know, is the point of interaction and resulting reaction that facilitates the refining process.

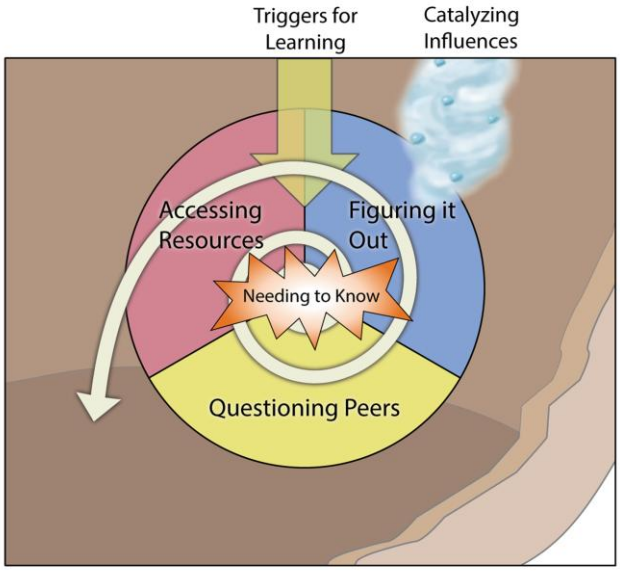
Organizational demands for learning are often beyond the control of the nurses. For example, displacements force nurses to move to a new workplace and often a new area of nursing practice. The required learning increases the nurse's knowledge and skill and may eventually result in increased adaptability. Not all triggers result in refining nursing practice however, as this would quickly become overwhelming and even distracting. The participants developed strategies for learning based on the meaning ascribed to the changes. I explore this at the end of this chapter. Briefly, needing to know in order act involves responding to triggers for learning. It also involves drawing on the capability of being grounded, with all

it entails. The nurses filter triggers for learning through their desire to "do the best for the patient." Not all organizational demands for learning can possibly be met. The nurses focused on responding to triggers for learning that directly impacted their ability to nurse well, as they understood it. Needing to know in order to act, necessary for nursing well, prompts the processes of puzzling and inquiring.

Puzzling and Inquiring

Puzzling and inquiring involves figuring it out, questioning peers, and accessing resources. It was referred to by some participants as "learning on the job." For many of the participants their early work years were "pre computers too, so your textbooks were even out of date. So, I was learning a lot on the go." When these nurses entered the workplace there were fewer requirements for, or less availability of, advanced education or speciality focused education, so they were required to learn in the workplace. "And, we learned on the job. We got trained and we learn on the job." Although there was an acknowledgement that at times the nurse "flew by the seat of my pants most of the time, badgered people" the nurse did not advocate that approach for some learning. For example, one nurse described the "range of 'toughness' of things to learn" and insisted that some skills take lots of education and supervised practice, such as IV initiation. Learning on the job and learning by doing were preferred methods for the participants in relation to many aspects of nursing; however, as one participant stated clearly, "I don't mind learning at work but this is too much." I want to emphasize that although the discussion that follows describes the complex,

Figure 1. Puzzling and Inquiry



iterative process of everyday workplace learning the participants also deeply valued more formal, continuing education and in-service learning, particularly for what they considered “difficult” or “tough” learning.

In Appendix D I present this process of puzzling and inquiring as it occurs through a shift (A Day in the Life). Here, I organize the three properties of puzzling and inquiring based on a sense of proximity, from the internal process of figuring it out, to questioning those near at hand, and then moving to access resources, including other health care professionals. This should not be understood as based on proximity through time. At times, the nurses first figure something out, and then move to ask a colleague close by, and then draw on resources farther afield. The process of puzzling and inquiring in response to a trigger for learning is depicted in Figure 1.

Figuring it out.

Figuring it out involves deliberation. I observed the nurses pause, often with a changed facial expression, and study something. If the trigger for learning was psychomotor, the nurse would study the tools and her own body before acting. If the trigger was a knowledge gap, the nurse would become quiet and read for more information. This process is thought to contribute to nurses' weariness. After a period of figuring it out one nurse turned to me and said, "That is why we are tired at the end of the day. Always thinking and trying to figure things out."

All the observation participants created custom notes at the beginning of their shifts. In reviewing charts and moving to figure out a puzzle, the nurses took the time to interpret and make meaning of data that might otherwise remain unexplored. This often became knowledge of the patient that was considered in light of subsequent assessments, which then informed nursing care. Figuring out what is going on is a personal challenge for the nurses. One participant described her approach to patients as follows.

> And I try to figure out in my head what's going on from the time [we] meet—I do their vitals and I'll talk to them and I'll look at them. And a lot of times, like almost 90 percent of the time I'm right about what they have. I'm listening….and all the while I'm trying to figure out, okay, so this, this and this and I'm trying to add it all up and come up with a nursing diagnosis.

Another participant repeated the same point (figure it out) repeatedly when talking about learning. “You’ve got to figure out….you have to figure out where the problem is, right? So how do you do it? You have to problem-solve. You have to figure it out.” This participant also linked figuring it out with the motivation to be focused on doing your best and learning by doing.

> Hands-on. I’ve got to learn hands-on. I have to see the problem; I have to figure it out and if you make a mistake, like not a serious mistake, but if you make a mistake … so when you’re doing your patient care, you’ve got to find out that. And I just think it goes back to some nurses … just do the minimal work.

Figuring it out involves problem solving, checking out conclusions, persistence and a desire to “fill in the information gaps.”

Questioning peers.

Having established a need to know, if the nurses were unable figure out the puzzle they would ask their peers for insight. Over the hours that I watched nurses working I observed many instances of asking and answering questions. Sometimes the participants moved to asking their partners without an obvious process of figuring it out, sometimes following it, and sometimes they moved to figure out the puzzle together. I do not believe that nurses are completely aware of the number of times that they ask someone in the workplace in order to learn. Although much of the data for this category was from field notes, the interview participants also spoke of the value of learning from others in the workplace. “I

was always willing to ask for, and still do, all the time … ask for opinions from my co-workers." This participant provided a very recent example of noting a subtle, abnormal finding (patient-related concern). She said "Even though I knew what I was seeing, and sure of what I was seeing, and certainly would have acted on it, I called another one of my co-workers in. 'Can you just do a quick assessment?'" Although very experienced in her nursing, this was her usual practice. "And I do that all the time. I have no trouble asking for help." Experienced nurses continue to draw on the collective wisdom of their peers through questioning. In contrast, I observed that some nurses work through their day without asking the observation participant one single question. This was made more obvious because on more than one occasion a nurse from another unit came to ask for assistance from the participant.

This strategy of questioning peers is one aspect of the ritualized pre-shift exchange. Initial questioning was often general or social; however, at times it related to a patient that one of the nurses was particularly puzzled or concerned about. If there was a lingering question from having worked the previous shift, the nurse would take the time to follow up and evaluate the response to her actions. If there was a change in the patient's condition, there would be a question and answer time between the two nurses or with the larger team. Because the participants were committed to getting off work on time this question and answering was quick and efficient.

Learning, support, and camaraderie are included in shift change conversation. For example, at the beginning of an observation night shift the day in-charge nurse gave a quick verbal report that included some patient-related information and then she added information on something that was missed and mixed up. Following an exchange back and forth, the day nurse said three times, "Why did I tell you that?" The nurse responded, "You needed to get that off your chest and I have it"—she smiles, friendly and warm—"now go home." The exchange ends with a quick, silent nod. Embedded in this conversation was a very pointed intent on the part of both nurses to make sure that this near miss did not occur again. There were system things to be learned. [25] And, there was support to be provided.

Questioning peers works in more than one way. Whereas the experienced nurses asked their peers questions constantly throughout their shifts, they also used questions to teach and guide and to reinforce high standards of care. An informal mentoring relationship between experienced nurses and a new staff member or new grad is dependent on the engagement of the new nurse. The data included both productive and unproductive questioning and answering. During the first few months of data collection new graduates were moving into the participants' workplaces. New graduates were given assignments along with another nurse and often were located spatially beside observation participants. One of these new graduates was quite engaged in her learning. The other nurses

[25] There had been a shift of responsibility for a task from the RNs to the Unit Clerk and the transition glitches had not been sorted out completely.

provided assistance and the workload nurse "watched over her." One seasoned nurse said to this new graduate after she asked a rather basic question, "Well, at least I know what you don't know." This nurse made it clear that any questions are better than no questions at all and that her questioning was a very positive contrast to other nurses who do not draw on the experience of the senior staff.

Formal mentoring initiatives are dependent on the process of questioning peers. One nurse described an administrative decision to move experienced nurses into a setting with a significant number of new graduates in order to develop mentoring relationships. The new graduates were struggling to notice and respond to early signs of problems in the patient population. At the time of the study, the experienced nurses were frustrated because of the lack of curiosity or what the participant described as "blasé attitudes." In a similar situation, one nurse shared that the distinguishing feature of a new nurse who was engaged in workplace learning was "whether they asked for help and asked questions, or not."

A failure to ask questions was thought to be a result of a combination of inadequate knowledge or preparation and overconfidence. The participants all stressed their frustration and dismay with the large number of new graduates who are not curious or apprehensive in their practice. They attributed this to a variety of causes that fell into three categories. Too many new graduates lack a healthy apprehension, the education system failed them, or they are distracted by various communication technologies, characteristics explored in the discussion of getting grounded.

Asking your partner.

I observed the nurses ask their partner numerous questions. These questions ranged from background data ("Were you here yesterday? Did the doctor talk to him about his prognosis?"), to specific questions about the meaning of information being gleaned from the chart ("Can you help me figure out why her sodium is so low?"), to service-related care standards ("What do you use here for [this kind of] dressings?"), to contextual questions about organizational processes or recent changes in the institution ("If they have closed that unit, where can this patient go now?"). The questioning occurs between equally experienced and knowledgeable nurses and between experienced knowledgeable nurses and young nurses, new graduates, and nurses new to the unit or service. This kind of question and answer conversation permeated the nurses' shifts, particularly around puzzling or acutely ill patients.

A nurse with experience in a number of fields, including international experience, was being oriented while I was conducting the study. I observed numerous instances where she used "asking your partner" to assist her. She often sought out the observation participant. In some instances her questions prompted a discussion of how something should be done and why it is usually done a particular way on this unit. The answers to these questions provided knowledge to the new staff member, provided insight and information regarding the new nurse to the other staff, and also acted as a way of socializing the new nurse to the unit

culture. These conversations were punctuated with “on other units they” but “here we do it this way because.”

This process of socialization mixed with setting and maintaining unit standards was a key topic of discussion in one of the group sessions. The nurses stressed that asking and answering questions is one strategy they use to keep the quality of patient care to their standards. This included prompting new staff to consider certain aspects of care by asking questions throughout the shift. Even with staff members who continued to struggle the nurses persisted with trying to mentor. The leadership team often worked to provide stability in the rotations to facilitate consistent mentorship.

There was a new organizational directive under the umbrella system-wide initiatives mandating all health care teams to “huddle” throughout the day. Many nurses deemed this a waste of time because they already knew how to keep the team apprised of important information. The participants strongly valued working close to their partners and the larger team. These nurses kept the team apprised of important data throughout the day through “asking your partner” interactions and brief reporting off prior to breaks.

Asking the team.

Ward reports and coffee and meal breaks are occasions for questioning peers. During morning team report the nurses would often ask questions of the team. Questioning peers occurred in virtually every ward report I attended. Two common types of interactions occurred. While one nurse, often younger, new, or

inexperienced, gave report on his or her patients the experienced and knowledgeable nurses would use prompting questions to ensure that the nurse giving report had considered and explored aspects of the patients care that were considered necessary for good patient care. Much was learned by everyone during these interactions. During report one nurse reported her patient was going for specific procedure. An experienced and well respected nurse noted "these patients used to be NPO, they don't do those much anymore." Another nurse queried, "how does she know that?" Then two experienced nurses "speak authoritatively about procedure while the other nurses listen." The questioning and answering were directed at ensuring that the less experienced nurse was fully aware of all the usual procedural requirements and also information that might not be included in hospital policy.

The second common type of asking the team during ward report occurred when an experienced nurse had lingering questions following initial chart checking. The learning that occurred influenced how the nurse met various challenges or puzzles throughout the day as well as subsequent nurse-physician interactions. The availability of the leadership team during this time on day shifts and their clinical competence was evident. During one report four challenging patient situations were raised. In each case one of the leaders asked questions for clarification and then either concurred with the nurses' suggestion or added something new.

Accessing resources.

Accessing resources involves expanding the circle of resources beyond the shift team or those in close proximity. Resources for puzzling and inquiring include staff in the workplace beyond accessible colleagues. They also include non-human resources available in the workplace. Availability and accessibility are essential to this property of questioning peers for refining nursing practice.

Asking area experts.

Area experts are nurses known throughout the organization for their knowledge and skill in specific areas or nurses working in roles related to specific nursing practice areas. For example, during one observation day the nurse was presented with an abnormal finding. She was concerned that this was a signal of a developing complication. She was unsatisfied with her own figuring and the responses to her initial questions. A nurse "area expert" who was seeing another patient on the unit was sitting at the desk charting. The observation participant approached this nurse and briefly described the patient, the illness and treatment, and the abnormal finding. The area expert provided a response and her rationale. In the same set of shifts a nurse came from another unit to ask the observation participant a question of a similar nature. The findings suggest that nurses who are known for nursing well are known broadly for nursing well, and are therefore a resource for learning.

A group of nurses who form the nucleus of a specialty team working throughout the hospital and community acknowledged that they are teaching and

answering nurses' questions all day. Based on their exposure to patients, family, and nurses throughout the health region they also reinforced the evidence that knowledge gaps are common in some nurses and more recent graduates; and reinforced the importance of setting high standards for care, both individually and as a team. Because much of their work involves dealing with unsolved patient related concerns, they stressed the value of strong, basic knowledge and principles, further reinforcing the importance of getting grounded for their own, and others', nursing practice.

Asking physicians.

Physicians have an important teaching role for nurses in direct patient care. Having identified this category I conducted theoretical sampling interviews with physicians whose practice is focused on patients in the hospital setting (specialists, hospitalists). The physicians made it clear that the learning is "a two-way street" in that they learn much from experienced nurses who provide excellent care. Some physicians direct residents and new physicians to rely on the experienced nurses for information and recommendations.

Physicians may not be aware of the positive contribution they make to nurses' learning. One participant stated, "I always listen to the doctors. I always listen to them. I listen to what they're saying, I listen to whoever they're talking about, I listen. Because I learn from it too. I really like to learn from it." Participants who have worked in areas where physicians are specific to a patient

population (such as speciality surgeons) or who have access to physicians throughout the shift (ICU, ER) spoke of this most commonly.

When participants remained puzzled by a problem after questioning their peers, they would seek out the physician. One nurse, after exhausting her resources on the team, including her partner, the team, the CNE, and an "area expert," sought out the physician with her assessment followed by a question: "Can you explain to me what is going on here?" The interaction that followed was didactic and directly applicable to the presenting situation.

Nurses' questions are sometimes perceived as loaded and may be thought of as challenging what the physician was doing. One physician said that sometimes nurses ask difficult but good questions such as "if it was a resident I'd say, 'Well, that's a good question and it would be a useful exercise for you to research that and come back and discuss it.' thereby hiding my [lack of knowledge]." I did observe the nurses guiding the physicians with their questioning and also challenging decisions. Because, as the researcher, I knew what the nurse needed for her patient, I was privy to something the physicians may not have been. I observed that the physicians were not able to differentiate motives behind questions. In these situations it would be difficult to consistently accurately discern whether questions were loaded, challenging practice, or seeking information and assistance. I observed clear questioning and communication, and well-established relationships ameliorate the potential for misunderstanding of questioning between nurses and physicians in the workplace.

Nurses who are known for nursing well are also known for their nursing by the physicians. It is possible the physician responds based on his or her evaluation of the nurse who is asking. The observation participants got respectful and thoughtful answers. This is not always the case. The participants and the leadership team stated that many times nurses ask questions of physicians and they are disregarded, insulted, or ignored. This was a focus during an interview with one of the leadership team. The lack of respect and response was a very strong theme for her, and she admitted it was frustrating. This contrasted with what I saw with the observation participants. Interview participants also spoke frequently about learning from physicians in the workplace.

Both the physicians interviewed and the participants valued a positive relationship with mutual learning in order to provide excellent care for "their" patients. Early in one nurse's career, a patient was bleeding and developing signs of shock. The young nurse (at the time) called the physician very early in the morning and the physician promptly hung up. A seasoned, well respected nurse was "sitting beside me" (located spatially within hearing and speaking distance). The seasoned nurse turned to the participant and said "Pick up the phone and phone him right back again." The nurse remembered looking at her and thinking, "Oh, I don't know about that. I was shaking basically, but the senior nurse was telling me so I picked up the phone and phoned him." The physician then provided the necessary guidance and the patient had a positive outcome. The participant reflected on what was learned and expressed appreciation for the other

nurse's insistence. This learning experience informed subsequent nursing practice based on the commitment to do the best for the patient.

Another "skill" that physicians teach nurses is part of the doctor-nurse game, which I will explore in the discussion chapter. The nurses have all learned how to avoid conflict and maintain the game in order to get the kind of care they need for the patient. The nurses admitted "doing whatever they can" to get what they need for their patients. Some engaged in various ways of manipulating the conversation to set a tone where they physician would give them an order. Others talked about how they recognize that this kind of behaviour feels "diva-ish but it works." Some questions are asked to solicit knowledge. Other questions are asked to guide the physicians' thinking, such as using a question to prompt the physician to think of something that might otherwise be missed. In all of these types of questioning, guiding, manipulating, or information seeking, what is of primary concern for the participants was getting the best care for the patient.

Physicians also contribute to nurses' workplace learning through formal and informal teaching sessions. The informal teaching sessions included learning skills that would save them time or save someone's life in an emergency. Some skills that these nurses have learned from physicians were, at the time, physician functions that over time and in various contexts have moved into the nurses' scope of practice. One nurse talked about learning how to do arterial punctures in a small-town critical care area. Many physicians take the time to use technology to teach nurses about pathophysiology and diagnostics. I observed physicians

showing nurses diagnostic results and imaging in order to explain how the problem was affecting the patients. The physicians interviewed were very clear about their intent. They want the best care for their patients too. They view any teaching they do as a means to this end.

Watching it done.

Whereas knowledge gaps lead to questions, virtually all the participants stressed that they needed to learn by watching how other health care professionals do psychomotor skills and then doing them under the watchful eye of a skilled practitioner. New psychomotor skills and learning to work with new equipment place constant demands on nurses working in the current health care milieu. This kind of needing to know leads to the need to see others demonstrating the skill proficiently and also to have someone provide guidance and feedback when they are new to the skill. One participant stated, "I just *love* watching her insert an IV and I watch whenever I can because I learn so much." This requires a level of availability that may be at risk or missing in many workplaces with few or no highly skilled and experienced practitioners.

Accessing (non-human) resources: Looking it up.

Nurses also inquire of non-human sources. Some of the participants talked about how they use the internet and electronic resources to access information. One nurse explained that she looks up new and problematic challenges at home and brings in what she finds to share with her colleagues. Another nurse observed when she was receiving a patient from the OR following a unfamiliar or "big

surgery" that she would "always look it up beforehand so I never really felt that I didn't know what was going on." The internet has expanded the knowledge available to nurses significantly. One participant described how she accesses the internet

> And, you Google it up, and read a little more. The web has been wonderful. It's been a wonderful technology that has come into the hospital. It really has been. All of us do that. And we will print it out, for the next person to come on if they have that patient again.

I asked her whether they sort through the sources for credible information. They did, and "I think what most of us do is read two or three of them, and so whatever, you know, is the most knowledgeable one." For their own learning, nurses will look up interesting problems or diagnoses even after the patient has been discharged or is no longer under their care. During one morning report one nurse asked about a rare syndrome listed in the patient history. She noted, "I haven't had time to look that up yet. Does anyone have any idea?" None of the nurses were able to answer the question so later I asked her if she had found the answer. "No, he went home, but I wrote it down there, so I will look that up." Many years of this approach to learning creates a reservoir of knowledge. A staff member remarked as she passed by one observation participant, "She's a well of knowledge."

Accessing policies within certain organizations is virtually impossible in some instances, thereby conditioning nurses to ask first by default. Many nursing

procedures are very out of date, often more than thirty years old. In some cases the policy is only available electronically and computers are too often unavailable, slow, or frozen. The nurses did look up procedures; however, initial guidance from their peers assisted them in interpreting the written information.

The current health care milieu presents nurses with many triggers for learning through change. Patient-specific problems and self-awareness also trigger refining nursing practice. Nurses engage in the process of puzzling and inquiring in everyday nursing practice. As I have introduced throughout this chapter, being grounded is a condition that affects how, and if, nurses respond to learning demands and also affects the processes of puzzling and inquiring. Getting grounded and the four properties of getting grounded are essential to refining nursing practice.

Getting Grounded

Getting grounded involves developing strategies that continue to shape the refining process. These properties are setting and maintaining high standards, cultivating a healthy apprehension, seeing the whole picture,[26] and becoming self-aware. Getting grounded begins during educational preparation and the early years of practice. The participants stressed the importance of "nailing down basic nursing[27]" in their educational preparation and the importance of diversity, or broadening their practice, in their early work experience. Getting grounded also

[26] Because the nurses did not make any reference to holistic nursing and because defining holistic nursing is fraught with difficulty I have used an in vivo code for this category.
[27] The participants did not define this term although in what follows I provide examples of some of what they had in the way of groundedness.

refers to the routines and practices that the participants engage in at the beginning of each day with each new patient assignment throughout their careers. Even experienced nurses needed to continually get grounded in order to remain focused in the face of organizational changes influencing, and at times impeding, nursing well.

Getting grounded involves learning skills for providing personal care, family support, and emotional care. One nurse said, "I mean I still do the back washes, the pillow case change, give them a clean nightshirt." Basic (ground level) knowledge and skills are necessary for safe patient care, and returning to basic nursing care was helpful in countering the constant change and shifting protocols of a dynamic milieu. Regardless of the additional complexity, the nurses believed that the basics were essential and without this level of knowledge and skill, development of more complex nursing care was not possible. The nurses argued that being vigilant in providing basic care also involved being alert to subtle changes, thereby keeping patients safe. "These basic steps drilled in from my first encounter and my first year. This is your basic steps. These are the fundamentals of nursing … and you know it's beaten into you; well I shouldn't say beaten into you." Basic knowledge and skills provide the foundation necessary for minimizing harm to patients in a chaotic milieu.

Getting grounded also involves acquiring knowledge of principles that are easily accessed in divergent situations and settings. Two participants talked about moving into new areas of practice after 30-40 years of nursing. "I would still

always use my basic principles that I had learned … this really solid basic you can take with you … it makes the difference? Yeah." In response to my question "What was it like to move from one setting and take what you've learned in your nursing practice and then bring it into this different setting?" a participant said:

> Well I think I was pretty confident that I had good basic skills. There would always be a little bit of trepidation that perhaps maybe I couldn't do it exactly the way they wanted to do it, but I would still always use my basic principles that I had learned.

They felt that their own solid knowledge of principles was a necessary resource for responding to changes and demands for learning.

Some participants shared observations of groundlessness. One nurse expressed her compassion for new graduates she has worked with over the past few years. "I would really like to emphasize ... I just feel that they come in and they are lost souls, and they don't know they are lost souls." This participant articulated a contrast to emphasize the importance of getting grounded early on. She, along with other participants, described some nurses with a sense of wandering lost and unaware that contrasts with the need for a solid or firm grounding.

Inadequate preparation for the current health care milieu makes it virtually impossible for nurses to engage in the level of workplace learning that is required. For example, one nurse with eight years of experience stated very simply: "you can't learn something while working that you have to learn from a book." As a

student this participant was often told, "You will pick that up in practice." In fact, she argued that this is not possible in today's practice environments. The nurses' workload is too acute and heavy to allow for learning things that are basic to nursing care. Realizing this was the case early in her career, as I noted previously, she took courses in her off work hours to learn basic diagnostics and pharmacology along with courses specifically designed to teach new graduates how to care for acutely ill patients. This course content is what many practitioners consider basic to nursing practice in the current milieu. The participants shared their view with me, outlined in the background chapters and discussed more fully in the following chapter, that nursing education needs to address this lack of grounding in pre-licensure educational programs. A solid educational grounding is necessary to refining nursing practice.

Getting grounded also involves gaining diverse pre-registration and early work experience. All of the participants have either moved from one new setting to another, with the clear goal of learning more and expanding their expertise, or they have stayed in the same place and the diversity came to them. Virtually all of the participants talked about how important it was for them to get as broad an experience as possible early in their career. Many started off on general medicine or surgical units. Others talked about starting off where they were most afraid, such as in neurology or, as discussed above, caring for patients with tracheotomies. The diversity was pivotal to their current knowledge and practice. "Go where you fear early on!" describes an attitude evident in virtually all of the

participants' interviews. Being "thrown in" or "jumping right in" suggests that getting grounded involves a level of anxiety and a related demand for action. One participant described the diversity of her first job this way.

> You were literally thrown in and the nurse would watch you and see if you swam; 'cause you had to do all your own IVs, and you would have pediatrics, and I remember feeding babies and toileting grandma—very understaffed, lots of double shifts and lots of learning. It was good.

Although the participants acknowledge the fear, anxiety, overwhelming feelings, and hectic nature of diverse early work experiences, they agreed with this participant that "it was good." The value of those early work challenges was good for their learning, and refining.

Nurses are inundated with an enormous amount of data and stimulation. One of the conditions for learning in the midst of this environment was being organized. Codes relating to getting organized accounted for an enormous amount of data. This aspect of getting grounded involved learning to get organized, being prepared, creating custom notes, establishing rigid routines, and setting priorities. A nurse with less than ten years of experience from the theoretical sample noted: "As a new grad nursing on the unit, I learned a tremendous amount about organization … from more senior and experienced nurses." The participants were very keen on teaching organization. They each acknowledged that they are very organized, and that being organized is essential for nursing well. It is impossible in this study to develop a causal relationship between organizational skills and

workplace learning; however, the findings are strongly suggestive of a relationship between getting and staying organized and the ability to learn in the workplace. Participants talked about "being prepared if something went wrong." Being organized saved time, which allowed the nurses time to read through their charts very carefully and pick up conflicting data which they then pursued. Another nurse linked getting and staying organized to patient care. "When we do [things in an organized manner] the patients don't need to lie there and worry when I am going to come and help them." The nurses valued being organized and working on an organized team.

For the participants in this study getting grounded, as I have described it here, was essential to nursing well, workplace learning, and refining nursing practice. The four properties developed below are learned and established in getting grounded. These are then carried forward throughout nurses' careers. Therefore, although I have introduced the capabilities under the umbrella category of getting grounded, they inform the refining process in an ongoing manner.

Setting and maintaining high standards.

As I have stated in the opening paragraphs, the participants were singularly focused on "doing the best for the patient." Setting and maintaining high standards begins in the getting grounded phase and continues throughout their careers. High standards require being orientated to the goal of "doing my best for my patients" regardless of workplace pressures and impediments. During my first hour of observation, I noted that the participant was clearly focused on

the patients. After I had been introduced, the nurse looked at me indifferently, sat down, pulled her charts closer and said, “Well I guess it is just part of the job.” In fact, at this point, I as the researcher became part of the milieu. This nurse began by ensuring that I did not distract her from doing what she was committed to doing: providing a high standard of care. On numerous occasions a flurry of activity would arise over a problem, such as finding room for the extra nurse assigned to the unit that day or difficulty getting a patient transferred to a more appropriate unit. The nurse would turn her back or attention away from this activity unless it directly affected her patients or was within her responsibility. Various unit problems, and my presence, were something to be disregarded. On another shift a participant made it clear, “I am not going to change my practice for you.” The participants repeatedly communicated that they were “just going to ignore” me.

The nurses’ current, or ongoing, focus on doing the best for their patients was linked to early impressions of nursing care. One participant reflected back over thirty years and stated:

> We had our patient care; the focus was patients, looking after your patients, making sure that they were comfortable, making sure that they were pain free. You know, things like that. And making sure that they understood a lot of the teaching … We spent a lot of time doing that. And that’s really missing right now.

Other participants also talked about this ongoing commitment. One participant with over forty years of nursing experience said:

> I've got so I just have to say—I just have to do my best for my patients and … they'll say, "Well, why don't you just give her a…?" and I'll say "No, I have to do what I know is the best thing.'" I [think], "What you do is up to you but I know that this is the best for that [person] in the long run." And I just have to keep saying this over and over and over because ultimately I have to live with myself.

This participant was not prepared to lower her standards to adapt to others. Doing the best for the patients, regardless of pressure and problems in the surrounding milieu and because of a personal commitment to their professional practice, kept the nurses orientated to nursing well.

When the participants were asked near the end of each interview what it was that had sustained them, an overwhelming majority named their love of the job and the patients. "What does it take to go through a career and nurse well?" They insisted that nurses need to have a passion for nursing, care for patients as if they are your family, and always keep learning. One nurse concluded the interview with this summary of her very lengthy and diverse career: you need to "have a sense of humour, keep on learning, keep your practice fresh, and … you have got to love your patients—that's the biggest thing of all."

The idea of keeping your practice fresh is alluded to by other participants. Keeping your practice fresh in the current health care milieu involves remaining

unsullied or untainted by policies and practices that interfere with patient care. This was linked to being passionate about nursing and not letting yourself become stagnant "'cause I see that too with some of our nurses. They're not open to learning anything new or a different way to do it." Other nurses focused on this relationship between high standards and avoiding become stagnant or sour. "To be an excellent nurse, you've got to like your job, right? If you don't like your job you're not going to be excellent at anything." Refining nursing practice, specifically staying grounded with high standards for care, requires attending to quality of care and being watchful of souring influences. One nurse said, "And I vowed to myself right when I was a student, I will not be like that nurse who is hardened, cold, and negative things." Nursing well may mean having to ignore or actively reject colleagues' expectations that you lower your standards.

The importance of setting and maintaining high standards permeated the data. This was often pitched against organizational decisions that were threatening the nurses' capacity to nurse well. High standards included a shared sense of working with others and rejection of moves that would impede doing the best for the patients. There were many examples of this in the data, but one nurse specifically made many references to keeping her own standards high, struggling when she was pressured to lower them, and teaching others what she considered the basic, little things, like organizing your environment. She had taught a colleague many years before and that colleague "still talks about it today and that was years ago." This participant described her approach as follows:

> And I said, ‘You know, I cannot do this. I can’t work like this … that is just an accident waiting to happen.’ So I taught her … this is how I was taught. This is my expectation. When you are working with me, this is how it’s done. Okay?

Setting and maintaining high standards is demonstrated both as an individual goal and as a quality in some nurses’ workplace. Some participants were explaining how they orient new staff and raise the individual to what they expect in the way of excellent patient care. They had a new nurse they were keeping an eye because of their own concerns.

> It was like two in the morning and we were all just chatting away at the nursing station, like socially chatting, and I just suddenly turned … and I was being very direct, you know, and I said ‘What’s the output? What’s the chest doing and what’s his pain and what’s the vitals doing?’

The nurse described how a co-worker did the same thing about two hours later. Their intentions were twofold. On the one hand they were able to ensure the patient was stable, and at the same time they believed that the new nurse was learning about what it takes to nurse well. This contributed to maintaining the standards on the team. Asking questions of your partner is an important aspect of mentoring that I return to in the following discussion of catalysts for refining nursing practice.

Many of the nurses talked about head nurses, tutors/educators, or colleagues that helped them reach for the unit standard. One head nurse, long

retired, was known for her well-run unit, and some of the participants had worked for her. They attributed the high standard of care on their unit to her original influence. They spoke of her fondly. "It was because if you didn't toe the line the way that she wanted, she made it difficult for you, [if] you weren't functioning at a proper level. She had very high [standards]. The expectation was *that* standard of care." Through a series of mentoring relationships the head nurse's high standards continued to shape nursing practice on the unit.

This focus on doing the best for the patient extends beyond individual nurse-patient interactions to team and organizational approaches. When a team adopts excellent patient care as their orientating goal, it is incorporated into their daily work. It is central. It is not something that is framed on the wall. It is part of their conversations during education sessions, staff meetings, and shift ward reports. The vision for excellent patient care is not an add-on; rather, it has become the rationale for decisions and expectations.

One interview participant, who had worked in many organizations, spoke highly of a previous workplace. She outlined how the administrators enacted significant health care cutbacks during her time there. She stated,

> When [the hospital] was hit with staffing cuts all of the manager-type people that were having coffee a lot in the day disappeared and the bedside nurses were all still there. They seemed to have taken, very much, their vision for the hospital and the care that was going to be given and said

> "Where can we cut without losing that focus?" And so I really appreciated how much they kept that in focus in those choices.

The focus was on "putting the needs of our patients first," a statement still evident in the organizational information. Interactions with colleagues, leadership, and organizations that set and maintain high standards positively contribute to getting grounded and refining nursing practice. Setting and maintaining high standards is incorporated into the mentoring-guiding role. Having this orientating goal of high standards informs the nurses' response to the constant changes and potential dysfunction of the current health care milieu. Setting and maintaining a high standard becomes part of the filtering process informing responses (choices and decisions) when needing to know in order to act. Setting and maintaining high standards begins while getting grounded and is utilized throughout the refining process.

Cultivating a healthy apprehension.

Refining nursing practice involves having "healthy apprehension." Cultivating healthy apprehension begins when the nurse is getting grounded. "I just remember being a new nurse and being afraid for about a year every time I went to work 'cause I didn't know what was gonna happen." Seasoned nurses talked about how, even late in their careers, they always keep in mind that "something could be wrong." There was an awareness of the need for vigilance even when doing routine and repetitive tasks, such as medication administration or initial patient assessments. Repeatedly the interview participants talked about

being “scared spitless” or “scared to death.” This apprehension is not paralyzing fear, which some participants also remembered well. The nurses were constantly aware that their knowledge, actions, and decisions mattered significantly. They were aware that “What I do, and do not do, matters.” The stakes are high in nursing and the nurses in my study were constantly practising out of this awareness.

Many of the participants compared their early profound anxiety and their own ongoing apprehension to other nurses who did not have this attitude. Participants remembered their early fear and were concerned that some nurses have “no sense of being afraid.” They come back to “this whole fear thing” in regards to vigilant practice. Healthy apprehension leads to action “because I think when [you have trepidation] you’re more inclined to go and dig and find out what you should be doing rather than just barreling in.” A number of participants were puzzled by nurses who do not respond quickly to IV pumps beeping or call bells ringing. It was mentioned frequently during observation shifts. “I am in tune, I [hear it] and I just go do it … could be a simple thing, or it could be something else.” One participant explored the contrasts:

> There is no fear in these, in the student now. Absolutely none. I am still fearful. I think you have to be. You know, when you are overconfident that is when you make mistakes. I am fearful, especially when I have some really sick patient, you know, I am fearful.

Healthy apprehension continues to motivate them to respond, which they clearly understand as the point of nursing.

Healthy apprehension is established in the getting grounded process and it is a sustaining influence informing the nurses' ability to notice and respond. For example, healthy apprehension is responsible for the fact that nursing well includes checking on your patients at the very beginning of the shift. One nurse stated that "there is no point in getting ward report on someone who is dead." Another noted, "You know what you've got to do is you've got to look and say what is there today on my list that if I don't do somebody is gonna die and so do that first and know that first."

There was a province-wide exploration of nurses' work in order to reconfigure the health care team while I was conducting the study. One area of concern brought to the attention of staff was the failure to conduct hourly checks on patients. This fact came up repeatedly in my study. The participants were dumbfounded that there are nurses who do not do this. "It is hospital policy, right? So, why aren't they doing it?" Although it is hospital policy, the findings suggest that a healthy apprehension and a commitment to do the best for the patient also motivate the nurses. Following hospital policy to do hourly checks was also linked to their nursing judgement and a profound sense that what they did mattered. Healthy apprehension is cultivated while getting grounded and, as with setting and maintaining high standards, continues to be a motivating attitude throughout the refining process.

Seeing the whole picture.

Getting grounded also involves acquiring skill at seeing the whole (patient) picture. One nurse stressed the importance of the whole patient: "I think when you're looking after a patient, you've got to look after everything. Like because I work in a [organ specific unit], they're just not [organs]." One physician described his desire to help others, including student nurses, to think of the psychosocial and functional levels of the patient even in a fast-paced environment. For another nurse, this needed to include the patients' context or family: "The whole package, to me, is someone who wants to give excellent care and stays very up on current practice but also is incredibly compassionate and doesn't forget or get tired of the families; they are part of the picture." She acknowledged that for experienced nurses the situations are not new, but for the patient and family it is, and therefore nurses need to include teaching, being patient, and understanding in their basic care. Nurses needed to learn to look at the whole situation from a nursing perspective in early education, including "concepts about exploring different nursing theories in order to enlighten or enhance your practice or the idea of looking at people as more than just something to be treated. So therefore coming from more of a nursing perspective." This participant attributed her ability to see the whole picture to the nurses she encountered early in her education.

> I'd met a lot of nurses that were older but I think through their experiences at least incorporated and searched out information, and thought these

> things through, and incorporated [this] philosophy that they'd encountered throughout life into their work. So I guess I was just really blessed to be exposed to people like that. But I also encountered other nurses who were just "I'm here for a pay cheque" and you learn to recognize those people.

Learning to see the whole picture involved being taught didactically, being reminded often, and seeing examples of other nurses who are committed to "see the whole picture" in contrast to those who are not.

Some individuals struggle to meet basic standards of nursing practice because they are unable to see the whole picture. One early interview participant stated this succinctly: "My whole thing with nursing is you've got to have the big picture. You can't have little bits. And so you've got to look at the global thing, right?" This emphatic statement was embedded in a lengthy description, dotted with concrete examples, of learning hands-on in the workplace. The whole picture is important to learning. Not seeing the whole picture is a barrier for learning, which was evident when this particular nurse was teaching, mentoring, and guiding others.

Another participant drew a link between the requisite basic foundational knowledge discussed in the introduction to getting grounded and seeing the whole picture. This nurse was talking about how she had learned so much in her early work experience on a team. She slowly shifted to what she was observing more recently.

> I mean skills are just skills, but if you buckle them down, and you feel comfortable with them, then you can move on to the next step, you know, so you are not so focused on that skill. So, I find because they are lacking that practice that they are so focused on this little skill, and then they don't see the whole thing. The whole enchilada.

Experienced nurses, often diploma or hospital trained, are commonly criticized for being task focused and merely wanting new graduates to be good at skills and tasks (Romyn et al., 2009; Wolff, Regan, Pesut & Black, 2010). These participants, many of whom did not have a baccalaureate education, contradict this stereotype. In their view, getting grounded involves learning to see the whole picture, which is then a condition for being able to continue to learn.

Beyond the solid foundation discussed above, nursing well requires significant, focused concentration in order to "see the whole patient picture." Social media in the workplace was considered a barrier to this "whole patient" approach to nursing. "Why would they not want to talk to their patients and be texting on the telephone instead?" The experienced nurses and also physicians expressed frustration and disapproval regarding use of social media, although they would often add a proviso suggesting that this is a reality that we just have to get used to. I observed that the use of social media was surprisingly common. It was a distraction from the complex thinking and acting that is required in the busy workplace. During break time when the other nurses would be discussing patient and health care related issues and developing their camaraderie, some of the

younger nurses would text throughout their breaks, making little to no contribution to the conversation. The findings do not suggest that social media is a significant problem to, for example, patient safety. The findings do suggest that more experienced nurses and physicians interpret this behaviour as a lack of focus, and it is evident that while there are many opportunities to use social and informal conversations for learning, specifically learning more about the "whole picture" of their patients, social media interferes with this potential.

When interpreting the data related to nursing students and new graduates I gave careful consideration to the recruitment process and criteria and the related characteristics of the participants. Participants were nominated to the study because they were known for nursing well and still working in direct patient care. In contrast, the participants are not nurses who are known for taking short cuts, being indifferent to suffering, or difficult to work with. They were also not nurses who have moved away from direct patient care, the level of care that virtually all nurses begin with. The participants' views of students and new graduates should be considered in light of their high standards for nursing and in light of the key finding regarding their motivation and goal: doing my best for my patients. This fact is important for at least two reasons. The participants *could be criticized for being unrealistic and idealistic* in their expectations of inexperienced nurses, somehow forgetting how it was when they were younger and less experienced. Conversely, the opinion and views of nurses who have high standards for themselves for the sake of the patient *could be considered seriously in light of*

their experience and values, and the related positive outcomes. I considered these points in the analysis of the data very carefully. Was there evidence that the participants were unrealistic and idealistic? What kind of evidence and examples did they provide to support their views? Did my observation data corroborate the interview data on this issue? There was sufficient evidence to suggest that the opinions and views of the nurses should be considered seriously. In Chapter Two and then again in Chapter Six and Seven I contend there is overwhelming evidence in the literature to support the view that current nursing education is failing to prepare new graduates to work *and learn* in the current health care milieu.

Becoming self-aware.

Becoming self-aware involves developing the ability to assess and evaluate one's abilities and knowledge. The participants did not talk about how, when, or why they became self-aware. Instead, in their examples and recounting of learning, they demonstrated this ability by referring to instances of self-awareness, self-appraisal, and informal rehashing, even early in their careers. I have explored this fully under triggers for learning.

I have outlined how nurses refine nursing practice from the initial getting grounded process through needing to know and puzzling and inquiring. Puzzling and inquiring in everyday nursing practice involves an expanding circle of figuring it out, questioning peers, and accessing resources. I have mentioned

aspects of the nurses' workplaces that have nurtured and facilitated refining nursing. I turn to these contextual factors in the paragraphs below.

Catalyzing Influences

In chemical reactions a catalyst is a substance that causes or speeds up the process without undergoing a change itself. In the refining process of improving nursing practice over time and across workplaces there are certain contextual factors and types of individuals within the workplace that facilitate or nurture the process. Although not perfect, the metaphor of a catalyst for learning is fitting. Catalysts for refining nursing practice are categorized as mentor guides, camaraderie, and working as a team or functional teams.

The observation units were supportive workplaces at the time of the study. Each of the participants was able to describe a workplace that facilitated excellent nursing practice. Although certain contextual factors were important in the participants' career trajectory, workplace learning is *not dependent* on these contextual factors or catalysts. Many of the participants also described learning in dysfunctional and unsupportive workplaces. Others outlined learning that resulted from leaving a problematic workplace, thereby learning from a new setting and all of the new situations it presented.

Mentor-guides.

Mentor-guides are critically important to nurses' refining nursing practice. Virtually every participant discussed the importance of good mentors throughout their career. One nurse explained, "I would have to say, most of my learning took

place at work, learning from other nurses more senior than myself, rounding, interacting with doctors … I took classes … but it actually was on site just at the moment" with experienced nurses. Mentor-guides are individuals who are also known for nursing well and for setting and maintaining high standards for the units they work on. Educators train a few key people who are then able to mentor and guide the other staff. Descriptions of mentor-guides were effusive and included words such as "incredible" and "exceptional." Mentor-guides were also described as nurses who are "still learning." The nurses were dependent on good mentor-guides as new graduates. One talked about how these nurses taught her "about organization, how to talk with patients' families and how to deal with social issues that arise on the unit" and also how to deal with crisis situations, who to call, what resources to use, and about "everyday care of the patient such as how long can certain patients sit in a chair and what would I do to deal with a confused, combative patient." Other participants provided examples of learning about unusual techniques for conducting psychomotor skills in uncommon situations and with unique patient problems.

The mentor-guides were also interested in sharing their knowledge and experience with nurses across the spectrum, from students to well-respected peers. The nurses often commended each other and were quick to seek advice from each other, as I have noted above. Mentor-guides used various techniques including sharing similar experiences, thinking out loud, and having others watch them

work. One participant described coaching new nurses through problem-solving complex technology, tubes, and lines.

Mentor-guides are not necessarily individuals with whom the nurse has a long-term and unique relationship. Whereas the traditional notion of mentoring involves a committed and explicit relationship, the participants' learning was often facilitated by brief encounters. In some cases the experienced participants talked about drawing on the knowledge and expertise of someone who was from another area of practice where they felt they were not as knowledgeable. They valued the opportunity of learning from those with diverse experience in the complex workplace. This often overlapped with accessing resources and asking area experts. The participants took the time to question further and to watch other excellent nurses work. The experienced nurses learned from other staff as readily as less experienced nurses, and in some cases even more so. In summary, nurses with high standards of care become catalysts for others' learning and specifically for other nurses who are getting grounded.

One unique group of mentor-guides are clinically competent leaders. Staff nurses are unwilling to learn from educators, nurse leaders, and managers that cannot demonstrate clinical competence. It was almost universally recognized that knowing about everyday nursing practice and patient care was essential for all educators, including pre-registration educators. Those who did not have clinical competence were met with eye-rolling, shrugs, and indifference. In the absence of

any other quality, including good interpersonal skills, nurses were willing to learn from those who had strong clinical knowledge.

Camaraderie.

Nurses who are engaged in refining nursing practice have experienced a strong sense of camaraderie at least once in their career. Camaraderie was one of the most common codes in data analysis. It was evident in the pre-shift socializing, in the banter that peppered break time, and in the pervasive commitment to help one another. The nurses on one of the units had developed a program of exercise and lifestyle changes for weight loss and healthy living. Although it was softly competitive, there was broad interest in the process from many people, both involved and not involved. There was keen interest in encouraging and cheering the "team" on. Another participant described a recent positive shift in her workplace as a move to "more collegiality and readiness to help." She returned to this category later in the interview with a summary statement.

> Working to be part of a strong, supportive team is very life-giving! Connecting with each other outside of the workplace—or at least connecting about their life outside the workplace—gives a lot of room for grace with each other, and fuels the energy of a great workplace.

Some participants talked about breaking into a workplace with a strong sense of camaraderie and having to earn their way in by proving themselves as competent and good team players. Strong camaraderie is nurtured during break

time with stories, jokes, and social conversation. Nurses talked about planning social events, bringing in birthday cakes, and offering to do shift changes to help each other out in their personal lives. I watched for signs of exclusion and social cliques; however, they were not evident. As I noted elsewhere, use of social media during break time is a self-imposed barrier to inclusion. Over time this may negatively affect the level of camaraderie on a team.

One participant noted that quick socializing in a break room alone is not enough to establish camaraderie. It needs to be lived in their practice as well. A core group of the staff on each of the observation units had worked together for many years, although not necessarily continuously. These nurses grieved together over the death of a colleague and frequently inquired into others' lifeworld. Strong bonds are forged over time and through shared experiences. One participant talked about friends with whom she had worked for many years retiring. The strong sense of camaraderie had enabled this participant to learn an entirely new area of practice in response to organizational change.

There was an elitist tone that accompanied some camaraderie that I observed. It was best expressed in a passing comment a nurse made following a lengthy discussion about staffing problems. "Everyone is stupid but us." Although it was a joke, it was intended to let me know that they recognized a sense of arrogance or an elite tone in their workplace dynamic.

Working as a functional team.

Workplace learning is made possible and enhanced by a functional team. The smooth operational capacity of the health care team opens up time for learning in the workplace. This includes being organized as individuals and also as a group of staff on any given shift. Physical workspace that allows for interaction between partners nurtures the processes I have outlined above. Disorganization, and the resulting chaos, is a clear barrier to interactions that have potential for teaching and learning. Dysfunctional system issues and workspace affect learning through everyday practice. Three examples of dysfunction identified by participants were disrespect, distrusting attitudes, and cliques.

Although the participants often talked about this category in a broad statement such as "good teamwork," there were common elements. Good working relationships and willingness to help others were discussed and observed often. This extended beyond the nursing team to the interprofessional team. Participants talked about important learning when another professional, such as a respiratory technician, was available for support and teaching when necessary. Beyond basic respect, working as a team involved acknowledging others' contributions and being supportive when nurses were learning new skills or when someone was new to the unit.

Generally, an important component of working as a team was having pride in the quality of work done by the team as well as by individuals. This component was considered rare, and increasingly so. One participant acknowledged that on

any team there are always some good workers and some not, although this was a significant frustration for many of the other participants. In spite of this, peer feedback on the negative effect of behaviours was not commonly provided. Participants were reluctant to explore this and cited the need to write things down "for the union." They put many areas of perceived poor practice in the "category of 'we have our ways of doing things' but sometimes things happen in the workplace that are problematic." This participant was unclear whether there was anyone in her workplace that would be willing to talk about it and noted that it was "something we are kind of hesitant [pause] we are probably hesitant [because] we don't want to hurt that person … because you are working as a close knit group, [very quietly] that is the difficult part." The nurses focused on demonstrating and describing helpful team behaviour rather than addressing poor practice and behaviour that negatively impacted the team.

Other common elements of a functional team included effective communication, clinically competent leadership, and team "helpfulness." It should not be surprising that effective communication throughout the shifts and very clear communication during ward report allowed other members of the team to know what was going on, which then opened up opportunities for teaching and mentoring. Clinically competent leadership was also important for mentoring and guiding and effective teamwork. Both of the observation units were characterized by a widespread willingness to help others. These factors created a tone that was

conducive to effective patient care and kept the focus of team-related decisions on "doing the best for our patients."

In this section I have described the workplace catalysts for learning. This is an area for further exploration, although the catalysts listed are, in fact, identified in the nursing literature which I review in Chapter Six. The interview participants and my observations do not describe idyllic or imagined environments. There were concrete examples provided to support the value of mentor-guides, camaraderie, and functional teams. These catalysts exist in a large health care milieu which is perceived as demanding, often dysfunctional, and unwieldy. Responding to the larger health care milieu is the focus of the following.

Developing a Filter

Although changes have learning potential, the relentless changes in the health care milieu are exhausting and disruptive. Change is often referred to in negative terms. The findings show that the category of needing to know in order to act is altered somewhat over time and through experience. Developing a filter is also important to refining nursing practice. Although new graduates need to respond to numerous triggers for learning, experienced nurses become more discerning in their reaction and action. This is related to more than the obvious assumption they know more and therefore need to learn less. Part of the refining process is letting some of the triggers go. The choice to respond to triggers for

learning is focused on "doing the best for the patients." High standards directly inform the filtering process.

During a group discussion the nurses talked about how they have been told they need to learn one system or adapt to one new piece of equipment because it was part of a larger transition in equipment or services. In many instances, the promised grand plan for improvement never materialized. Budget restraint and poor planning, or the lived experience of a fluid system, meant that the nurses were left working with something intended to be a small step toward something better (e.g. medication carts, forms for documentation). Over time these failed promises also shape the filtering process. Developing a filter involves discrimination and discernment based on previous experience with the health care milieu. This results in an increased capacity for and sensitivity to filtering out some of the demands of the system, with the key goal of doing their best. This opens up time, energy, and capacity for learning that does enhance patient care.

Becoming relatively impervious.

Over time the participants became increasingly impervious to the health care milieu, filtering out systems issues and related learning demands that did not directly affect their ability to provide excellent care to their patients. One participant, as the designated in-charge nurse, was dealing with a number of systems issues. As I recorded the events in my field notes I wrote, "[the system] is like a song that is playing in the background that you eventually learn to ignore." The nurses speak about the frustrations and their responses to incessant

organizational demands; however, when they are working they are tuned-in to their own patients in their own assignment and the organizational "noise" slides into the background.

Between the first observation shift and the last there was difficulty with various machines, including the ice machine, the blanket warmer, and the pneumatic tube system. Late one evening a maintenance person responded to a requisition for a repair sent many hours earlier. The maintenance person read the request and proceeded to lecture the nurse on how the staff was using too much ice![28] Ice was used to reduce inflammation and pain and offered as ice chips or in ice water for the patients, many of whom were restricted in their intake. The nurse (observation participant) briefly came to the door of her room, listened, then watched the maintenance person retreat without actually fixing the machine, and then replaced her glasses quietly, shrugged her shoulders and returned to her room. I include this example, although the failed ice machine was not a clear trigger or demand for learning, because her response exemplifies the kind of imperviousness the nurses displayed. Because it was late in the evening, her patients required her immediate attention, and she knew where to get ice elsewhere, she allowed the lecture and behaviour to "slide into the background" in order to remain focused on her patients.

Some of the system-wide initiatives being rolled out during the study were aimed at fixing problems affecting patient care. A significant amount of

[28] The tone of the lecture brought to mind staff surreptitiously stealing hospital ice for coolers at home.

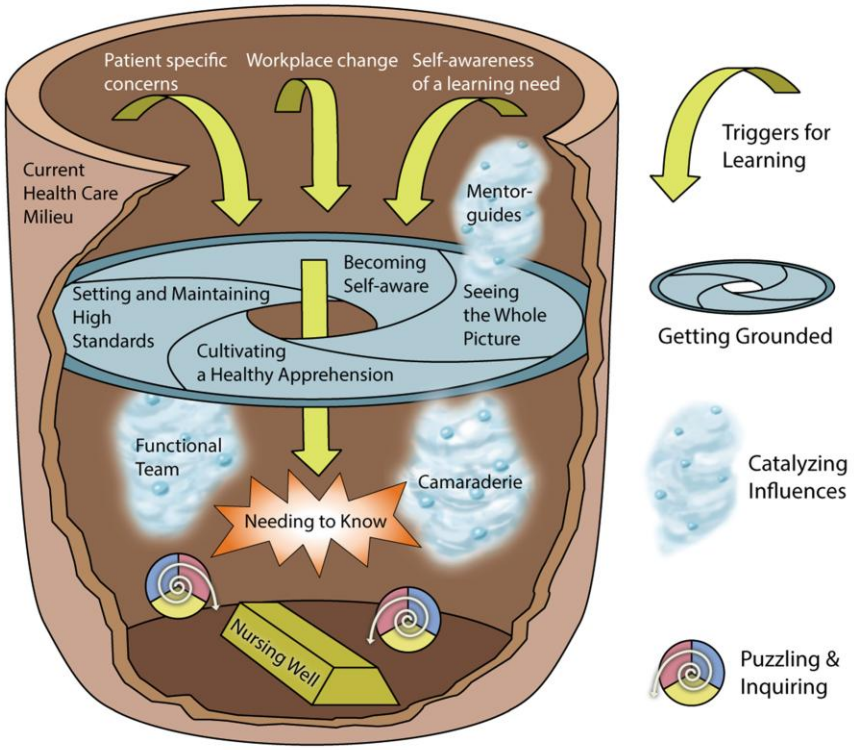
"education" was involved in the roll-out. Poor team communication was to be addressed with frequent huddles. Poor infection control practice was to be addressed with hand hygiene policies, policing, and education. In both of these examples most of the participants noted that these were not problems they would own personally. They were confident in their abilities and their teamwork in relation to communication and infection control. I attended the *mandatory* hand hygiene in-services and noted that the nurses were receptive and positive, although at times amused. One nurse noted as she was leaving, "Well it is good to be reminded of the simple things." Demands for new protocols and policies that are designed to ameliorate poor practice are quickly recognized as such by the experienced, excellent nurse. They know well that soon this too will pass.

Participants avoided, subverted, and also resisted administrative actions. During one shift, mid-afternoon, a high level administrative team came to the unit to purportedly elicit feedback. The nurses were busy and focused on patient care. One participant displayed her suspicions, noting "Three people are standing at the desk to visit … I have no interest in talking to suits. They have that born again smile … They have that look." Following a decision to remove ginger ale from the unit, the nurses hid it. In other situations, when decisions are made to remove tools essential to providing a high level of care, the nurses find ways to "win." In other situations, participants talked about resisting, writing letters, and insisting on maintaining the resources and practices that they deemed better for patients. One participant was discussing other units that have lost precious staffing resources

and stated, “You know, we have fought to keep our patient care ratios and the way it needs to be. Maybe other people don’t know that they can fight too.” When they observed themselves frantically pressing to respond to systemic pressures one day, one nurse turned to another as they crossed paths in a supply room and said “I don’t know why we do this to make it work. Instead we should just work and then they would see the problem of push.” Here we see a strong contrast to the quiet acquiescence reported in Rankin and Campbell’s (2006) studies.

Although the nurses were able to be impervious, there were limits. Many of the participants talked about when organizational decisions went too far. When this happened the nurses would resist or push back with their peers or they would leave. One nurse alluded to this early in the interview, and so later I asked her about a time when system hindrances impeded her ability to meet her own high standards of care. She described an experience that was very upsetting and resulted in an unnecessary death. Instead of leaving nursing, she, like other participants, found ways of maintaining her own standards and found a workplace that better supported this. The choice to leave one workplace opened up new opportunities to learn in a new setting. Importantly, she eventually returned to the previous workplace, her area of passion. With little recourse, the nurses hoped that their resistance and action would eventually result in necessary changes. It seemed to the nurses that not all nurses are willing to resist enough. “I guess they don’t know that they can push back, like we do.” I have described the complex,

Figure 2. Refining Nursing Practice in the Current Health Care Milieu



non-linear capabilities, processes, and catalysts for refining nursing practice. Before exploring the related literature in Chapter Six I summarize the theory.

Refining Nursing Practice: Bringing the Findings Together

Refining nursing practice is the process whereby nurses learn how to provide good patient care in the crucible of the current, constantly changing, health care milieu (see Figure 2). Getting grounded and establishing a strong foundation is necessary for engaging in the refinement process. Getting grounded occurs during initial education and early work experience. Getting grounded continues in new workplace settings. Participants also spent time getting grounded at the beginning of each shift by getting organized, (re)orientated, and focused.

The properties of getting grounded include (a) setting high standards, usually in initial education and preparation, (b) maintaining high standards, (c) cultivating a healthy apprehension, (d) learning to see the whole picture, and (e) becoming self-aware. High standards inform nurses' responses to the constant demands for learning that originate in the workplace and when necessary act as a filter. Although the incessant changes in the institutional environment drive some of the refining process, and therefore play a key initiating role in workplace learning, some changes and demands for learning are filtered out. Using their past experience nurses are careful to focus on responding to learning demands that directly affect their ability to provide care to their patients.

In addition to setting and maintaining high standards, all of the nurses described an ongoing alertness, tension, fear, or sense of responsibility that I have called healthy apprehension. They described being constantly aware that their knowledge, actions, and decisions mattered significantly. Although healthy apprehension is established in getting grounded, it is also a sustaining influence informing nurses' ability to notice and respond to triggers for learning. Getting grounded is necessary for nurses' learning, particularly during times when the workplace does not support or nurture nursing practice or learning.

Refining nursing practice includes various learning situations, such as learning in a new setting or learning from mistakes, and various learning approaches, such as learning by watching or learning from asking questions. For the participants, this also included seeking out courses, continuing education

events or certification, and impromptu lectures from other health care professionals, often physicians. An essential aspect of refining nursing practice involves learning in the day to day and moment by moment situations of nursing practice.

The triggers for learning arise from the external environment or from within the nurse and result in "needing to know" in order to act in the best interest of the patient. This recognition of a knowledge or skill gap could be triggered by the changing milieu, by a patient-related problem, or from self-appraisal. As suggested previously, choosing to respond to the trigger involves a filtering process that becomes increasingly discerning or discriminating over time and experience.

Nurses respond to needing to know with a complex, iterative process that I have called puzzling and inquiring. This repeating process involves certain common actions; however these actions do not necessarily occur in the same sequence or in every instance. Nurses' responses to an identified gap include figuring it out, questioning peers, and accessing resources. Nurses refine their nursing over countless iterations of this process and across diverse workplaces. As they refine their practice they incorporate a commitment to setting and maintaining high standards into their singular patient focus, which in turn can influence the team and larger health care milieu. In this way the nurse becomes one of the catalysts for others' workplace learning.

Catalysts are people and aspects of the milieu that facilitate refining nursing throughout the process, from the initial getting grounded phase through needing to know, and in puzzling and inquiring. Mentor-guides, camaraderie, and working as a team are three important catalysts for nurses' workplace learning. A catalyst is not necessary for every instance of workplace learning and participants were able to engage in puzzling and inquiring in the absence of catalysts in the workplace. All of the nurses, however, named the value of these catalysts for their early learning (getting grounded) and harkened back to those times. One characteristic of working as a team was *sharing the commitment* to set and maintain high standards as a way of acting on their goal of doing the best for the patient.

In summary, refining nursing practice involves learning that is focused on providing the best care possible for patients and results in nursing well. Over time and experience refining nursing practice results in being known as a well of knowledge, becoming a catalyst for others' workplace learning, and becoming relatively impervious to the constant change in the health care milieu. Such nurses are able work collaboratively to set and maintain high standards in the workplace.

As I have already stated, determining how to continue to provide excellent care to patients in the current health care milieu is a basic social problem for nurses in direct patient care. The health care milieu contributes both positively and negatively to nurses' workplace learning. The nature of the milieu demands workplace learning. The barrage of changes, both positive and problematic, forces

nurses to learn. They learn to adapt, they learn new skills, they learn new approaches to complex presentations of illness, and, among many other things, the nurses learn to filter out demands for learning that will not directly contribute to improved patient care. Rafferty and Clarke (2009) posed a challenge for researchers to gather more data on experienced nurses to ascertain the characteristics of nurses who have survived the system; one that I was excited to respond to. "Why do some …. burn for nursing while some burn out?" (p. 877). Refining nursing practice is one answer to this question.

Limitations

Suddaby (2006) notes that the quality of a grounded theory is often related to the experience of the researcher. Because grounded theory is an interpretive process this grounded theory is limited by the lack of experience on the part of the researcher, a doctoral student new to academia and relatively new to qualitative research. This limitation was ameliorated through the assistance of my supervisory committee, including those with significant experience in grounded theory.

In the proposal and in the information letter I outlined the intention to conduct half hour follow up interviews with observation participants; however, as noted in Chapter Four, this did not occur. It was evident after making this request to the first three observation participants that they made a clear separation between work and non-working hours. I respected this. I want to note that one observation participant retired. I met this participant in the spring of 2012 and

posed the possibility of meeting to discuss the study. Although she gave me her contact information which I followed up with, I have not heard from her again. The value of sequential shift observation and the opportunity to ask questions later in the shift does ameliorate this limitation to a degree. I propose that a longitudinal study of the same nature as this study would contribute to further developing this grounded theory and disciplinary knowledge. Time will always be a limitation, regardless: time during shifts, for the nurses, and for researchers and funding bodies.

A third related limitation is that I did not observe the interview participants in their work. In order to saturate the categories and acquire rich and diverse data I made the decision to not limit sampling to nurses who work in one setting. The interview wing of the study was designed to achieve this research goal and to explore diverse aspects of the health care milieu. Due to time limitations and restrictions from HREBs it would have been impossible to gain site clearance and ethical approval to observe the large number of interview participants over significant distance. Clearly, this is a limitation of this and many related studies.

A significant limitation related to this study is the challenge of communication. One of the obstacles I faced when presenting the findings and theorizing was developing ways of communicating the complexity of the data in a manner that is comprehensible to the reader. There are a number of reasons for this which I describe to communicate to the reader what might cloud

interpretation of the presentation. Grounded theory is not descriptive research, unlike some phenomenology, critical hermeneutic research, and interpretive description. Grounded theory requires abstraction through induction and deduction. There are many relationships within the theory. Some of the relationships are in moments and some exist over time. The participants and the data collection process are also moving through time. Therefore, capturing time was very difficult. Time is central to the trajectory of the process of refining nursing practice, over months, years, and decades. Time, moving from one second and minute to the next, is also present in the categories particularly puzzling and inquiring. Getting grounded, one of the categories, occurs both in the daily iterations of nursing work and originally at the beginning of the nurses' career. Early work experience is time specific. Some processes, such as puzzling and inquiring, repeat themselves myriads of time. Written findings, diagrams, and metaphors are fallible re-presentations of lived time. Compared to the complexity of nursing practice, in this written account I was required to show the emerging theory in an all too linear way.

Voice was another challenge in presenting the findings. There are single voices, collective voices, and abstracted voices. Protection of the participants' confidentiality was my primary consideration. In the preceding chapter I have, in the manner of qualitative researchers, worked to preserve the integrity of the data while presenting the theory, with categories, processes and relationships, at higher levels of abstraction. I present the participants' words and actions as direct quotes

and as paraphrased to present the theory and to demonstrate the inductive process outlined in this chapter.

Researching non-formal learning is fraught with challenges related to the difficulty of bringing certain types of learning (e.g., reactive and deliberative) to conscious awareness and the difficulty participants have describing personal knowledge. I acknowledge, therefore, that even the most complete account will, by definition, still lack aspects of tacit knowledge.

As I noted in Chapter Four (Methodology), grounded theories are generated around a core category or a basic social process (BSP) (Glaser, 1978, p. 93-95). I have integrated the three categories with the BSP of refining nursing practice, staying focused on the key research question and the topic of inquiry, nurses' workplace learning. What this study indicates overall is that larger and more in-depth studies are needed to further this inquiry into nursing practice. These reflections crystalized during the final writing and checking of the basic social process and pertain to the complex nuances of studying nursing expertise. This grounded theory prompts further study. For example, during analysis another core category, namely preserving nursing, was considered and left for another study. In another example, the process of getting grounded should be explored further. This would require a large study with diverse sample including nursing students across their pre-licensure education, new graduates, new staff members, and participants that are not recruited for "nursing well." Longitudinal studies of individual nurses would be particularly helpful for integrating the existing

categories. Concept analysis of "becoming relatively impervious" and professional resilience, "becoming self-aware" and attentiveness and "mentor-guides" and critical companionships, using Risjord's (2009) approach, would be productive and contribute to nursing knowledge. Finally, a larger study could show how nurses who learn to nurse well are different from those who languish. Extending this theory through further study is discussed in the final chapter.

Chapter Five Conclusion

In this chapter I have described the findings of this study by explaining the basic social problem, the basic social process of refining nursing practice, and the theoretical categories. I have provided data to demonstrate the categories and identified the relationships between the categories. I concluded the chapter with an overview of the theory and a summary of limitations. In the following chapter I will discuss the theory in light of the extant, pertinent literature and offer implications that arise from this discussion.

Chapter Six: Discussion

My intention is to bring the findings of a study conducted in a particular place and time into the broader context of nursing and adult education and examine how this theory fits with the literature discussed in Chapter Two and Three. I also posit how this study contributes to a new understanding of nurses' career long learning. Nurses' learning is driven by the desire to provide excellent care to patients in the constantly shifting health care milieu through a career long process of *refining nursing practice.* The health care milieu contributes to this process in many ways; however, its primary influence is unequivocal. First, and foremost, the current health care milieu requires learning. There are few, if any, other options.

I organize the following discussion around key findings. I begin with the findings that relate to the health care milieu. In addition to providing triggers for learning, specific aspects of some workplace environments support, nurture, or facilitate learning. I move to key findings related to the individual learner, including the process of puzzling and inquiring and the capabilities of individual nurses' that are important for refining nursing practice. These capabilities include setting and maintaining high standards, cultivating healthy apprehension, seeing the whole picture, and being self-aware. I conclude the chapter with a discussion of the theory as a whole, highlighting how the theory fills gaps in our existing knowledge. Throughout this chapter the findings are shown in light of current knowledge, highlighting corroboration and contradictions.

The Role of the Health Care Milieu on Nurses' Learning

My initial review of the literature resulted in the claim that no studies have explicitly explored the role of the context, or workplace, on the career long process of improving nursing practice or workplace learning for experienced nurses. Therefore, I developed the research question and study design to address this gap in existing knowledge. My decision to include participant observation was motivated by the need to explore influences of the workplace on instances of workplace learning. The current health care milieu both demands and facilitates nurses' workplace learning. The relationship between individual nurses (learners) and the learning context is multidimensional.

Demands for learning.

Organizational demands including re-allocation of resources (e.g. reducing specialty skill resources such as IV team), technological advances, management restructuring, reduction of services (e.g. closure of rehabilitation units, nurse displacement), and the role and scope of practice changes create demands for learning. Introduction of new equipment and new processes, both of which occur continuously, demand learning across domains. Responding to these learning demands is both a problem and an opportunity.

There is nothing wrong with the context of constant change, per se. In fact, change facilitates nursing well. MacIntosh (2003) found that experienced nurses who continued to develop their professional identity established a pattern of "seeking and responding to stimulation" and pursued "learning and growth"

through seeking change in their work life (p. 731). MacIntosh's findings regarding change and learning are corroborated in this study. Organizational leaders can nurture this process by enhancing the catalyzing influences described in the findings chapter, and discussed in detail below.

As I suggest in Chapter Three, many of these changes are not neutral and are motivated by neoliberalism, economic forces, and what is known in some fields as New Public Management (NPM) (Sawyer, Green, Moran, & Brett, 2009). Based on studies conducted in a similar regional area Rankin and Campbell (2006) document how nurses are hooked into the managerial turn and are reorganized to enact the very health care reforms that, the authors argue, are undermining the caring role of nurses. The nurses in my study provide a counterpoint[29] to this description of the compromise of caring in nursing (Rankin & Campbell, 2006, p. 182). Sawyer et al. (2009) claim their study contrasts with much research in that "therapeutic rather than managerial skills and values remained at the core" (p. 362) for their study participants. The nurses in their study drew on their professional identities and "expressed a strong sense of agency when interpreting and negotiating" the NPM informed policies of their organizations (Sawyer et al. 2009, p. 361). In the case of Sawyer et al. nurses did not enact their agency and commitment to patients' needs homogenously. Some integrated the policies into their professional identity with a "positive rationality" (Sawyer et al., 2009, p. 369). Some breached the policies which constrained the

[29] A counterpoint is a musical technique of setting or playing a melody in conjunction with another melody (OED) (Soanes & Stevenson, 2008).

quality of care with a "critical rationality" (p. 368). However, similar to the nurses in my study, all were actors heterogeneously negotiating the organizational demands using their professional identity and grounded nursing knowledge (Sawyer et al. 2009, p. 377).

Filtering triggers for learning.

A key contribution of this study to our knowledge of nurses' workplace learning is theorizing a filtering process. Over time and through experience nurses who learn to nurse well also learn to select and focus their activities on learning that has a direct benefit to their ability to provide excellent patient care. This filtering process involves drawing on the knowledge, skills, and attitudes outlined in findings chapter regarding getting grounded. This is one aspect of becoming the last line of defense between the vagaries of the health care milieu and the patients (Shulman, 2010).

The capability of being relatively impervious is a posture or disposition that is developed over time and through experience. Professional resilience, a related concept, is new to nursing literature (Hodges, Keeley, & Troyan, 2008; Hodges, Troyan, & Keeley, 2010; Scholes, 2008). Hodges et al. (2008) and Hodges et al. (2010) report findings from a grounded theory of new graduates and experienced baccalaureate nurses to explore career persistence in acute care settings in order to design support strategies for new BSN graduates. The core category in their study is similar to "becoming relatively impervious," and although the other findings are not alike, the metaphor is identical. The epigraph

to their first publication is as follows: “A gem is not polished without rubbing, nor a person perfected without trials. Chinese Proverb” (Hodges et al., 2010, p. 80). Resilience, a concept well-developed in literature regarding children and youth, is the ability to recover or adjust to adversity in order to cope, master a situation, or adapt (Earvolino-Ramirez, 2007). Professional resilience is currently undeveloped as a strategy for career persistence, although it is gaining more attention in the workforce retention literature (Scholes, 2008). Professional resilience is a response to adversity and considered an appropriate strategy for dealing with the constant clashing of nursing identity with management oriented health care organizations. Becoming relatively impervious, based on this study, is more oriented toward choosing when to ignore and when to respond to learning demands and daily distractions.

For decades nurses have developed strategies for dealing with distractions in the acute care setting. The whirl of activity brings to mind the elementary school teachers’ classrooms (Dunne, 2011) with the important difference being that the nurse is not in a position of authority to manage or control the activity. Wolf (1988), at a time when the professionalization agenda contributed to academics and nurse leaders eschewing routines and rituals, argued that rituals are useful for managing the health care environment. Well established nursing rituals are important for nurses’ resiliency and for resisting managerial demands that negatively impact patient care. Rather than being meaningless and task oriented, rituals such as getting grounded at the beginning of the shift serve to “impose

order on the easily disordered events of the patient unit" (Wolf, 1988, p. 65). Throughout their careers nurses have found that being grounded facilitated the process of filtering distractions and demands that were not aimed at improving their patient care.

Catalysts for refining nursing practice.

Catalysts for refining nursing practice are diverse. I divide this discussion of catalysts into the specific people and processes that were identified in the findings. Much of the following exploration and integration of the findings with the literature are based on literature searches conducted *after* data analysis and theory development. For example, I conducted a literature review relating to physician-nurse relationships and communication that included many publications on interprofessional practice and education, and the doctor-nurse game. Or as another example, I conducted a literature review of nursing education and new graduate transition and then reviewed literature on mentoring within education (see among others Ousey, 2009), mentoring new graduates (see among others Cho, Laschinger, & Wong, 2006), as well as the general literature on mentoring in nursing. A final example, having identified the value of a functional team, as observed and described by the participants, I conducted an extensive review of workforce literature beginning with Linda Aiken's work in collaboration with a large group of international researchers. Although much of the literature is focused on the relationships amongst workplace qualities, nurses, and patient outcomes I reviewed the literature for corroboration and contradictions in

relationship to workplace qualities, nurses, and nurses' workplace learning based on this study. As I discuss below, in many cases, there was strong corroboration.

***People as catalysts for refining nursing practice: Mentor-guides*.**

The idea of mentors is not new and the value of mentors to new nurses is well documented (Butler & Felts, 2006; Cho et al. 2006; Eraut et al., 2003; Ferguson, 2006; Pyles & Stern, 1983; Ryan et al., 2010). Most experts in the area of new graduate transition list mentors as necessary to successful negotiation of the transition (Hayes & Scott, 2007, p.28; Salt et al., 2008; Wolff & The Coalition, 2007). Clinical mentors (often labeled preceptors in the North American literature) are also necessary for effective nursing education (Mamchur & Myrick, 2003; Myrick, 2002; Myrick & Yonge, 2004; Ousey, 2009). Students depend on mentors for guidance "in learning the rules of the clinical areas and how to become a professional" (Ousey, 2009, p. 178), and how to fit in, feel welcome, valued, and part of the team (p. 181). Mentoring is also important to developing expertise in new or specialty areas (Ryan, Goldberg, & Evans, 2010) and to the development of ethical decision-making processes (Hough, 2008) . Although the value of this type of relationship is almost taken for granted, clear or consistent definitions are elusive (Ousey, 2009; Ryan et al. 2010, p. 184). Following data analysis I chose the term mentor-guides to allow for formal and informal mentoring qualities in the context of the clinical setting, as distinct from the official role of preceptor or mentor (UK), generally considered to be a nurse who facilitates learning, supervises, and evaluates students (Ousey, 2009, p. 176).

Role modelling is a particularly important aspect of formal and informal mentorship. My study corroborates this point and also adds to our understanding of the long term effects of positive role models. With Ryan et al. (2010) my study "clearly demonstrates how informal nurse-to-nurse mentoring is a daily part of nursing professional development" (p. 189). Informal mentoring involves modelling and mirroring. How to *be* as a nurse is modeled and then mirrored by the mentee (Ryan et al., p. 187). My study also suggests that long after the relationship has ended mentor-guides continue to have an influence on experienced nurses and their practice. This influence is then passed on to students, new graduates, and peers. Mentor-guides have long-term importance and therefore should be a focus of our attention in health care organizations.

Clinical expertise, along with strong relationship building skills (Myrick & Yonge, 2004; Ryan et al., 2010), is one of the most significant qualities for an effective mentor-guide. Spouse (2001) noted that being a mentor involves befriending. It also involves being reflective, being encouraging, and listening well (Ousey, 2009).Trust is essential to the relationship. Mentor-guides also set the tone for the team and create a space for questioning (Myrick & Yonge, 2004; Ryan, et al., 2010, p. 187). Ryan et al. (2010) suggest that for new staff mentor-guides are essential for learning affective and relational skills and finding meaning, passion, and intrinsic value in patient care (p. 189). This fits with my study findings focused around sustaining and persisting in nursing practice over

many years by keeping the patient-centred focus, loving their jobs, and maintaining high standards of patient care.

Over a decade ago the UK formalized clinical mentor definitions and requirements (Ousey, 2009) and in 2007 it "became a mandatory requirement" for nursing students to work with a mentor for the duration of the clinical placements (p. 175). These mentors are registered and undergo a triennial review. Students are provided with a process to report problems with mentors. As part of initiatives to graduate practitioners who are fit for practice they have determined that the "role of the mentor in the clinical areas is vital" to learning (Ousey, 2009, p. 176). In the following discussion regarding nursing education I note the critical importance of maximizing students' learning in clinical settings, for which clinical mentors are essential. The findings of my study support the direction taken in the UK regarding mentors. Related recommendations are included in Chapter Seven.

Mentor-guides are reported to be essential to positive early work experience. Cho et al. (2006) identify the role of positive work environments in supporting and enhancing organizational commitment of new graduates. Access to support in the form of mentor-guides was identified as important for preventing burnout in new graduates, particularly when new graduates are being offered more opportunities for learning. Timely communication, emotional support, advice, and hands-on assistance are also important (p. 56). This involves adequate staffing levels and staff qualities that allow new graduates to be involved in team

decision making early on (p. 57). As new graduates move through the transition phases they change from needing prescriptive directives to requiring confirmation and clarification from colleagues (Duchscher, 2008, p. 446).

Recent literature presents the case that the valuing and nurturing of mentor-guides will contribute to workforce stability, the retention of older and experienced nurses, and also results in reciprocal learning and altered practice in peers (Hatcher et al., 2006, p. 5; Clauson, Wejr, Frost, McRae & Straight, 2011). Formally recognizing and valuing the clinical expertise of the mentor-guides is considered increasingly relevant for retention of older nurses (Clauson et al., 2011, p. 154). Capturing and utilizing the keen interests and passions of experienced nurses is a powerful tool for enhancing workplace learning across levels of experience (Clauson et al., 2011) and is strongly supported in this study. In the recent UK policy to accredit expertise, critical companionship is pivotal in the recognition process through facilitating consciousness raising, problematization, self-reflection, and critique in companions or peers (Hardy, Titchen, & Manley, 2007; Manley & Garbett, 2000, p. 355; Manley et al., 2005). The participants in this study, regardless of their educational background, are wells of knowledge and have much to contribute to an ever changing health care milieu. We must learn to value and recognize their wisdom (Clauson et al. 2011; Hatcher et al. 2006; Manley et al., 2005; Ryan et al., 2010).

People as catalysts for refining nursing practice: Clinically competent leadership.

Clinically competent leaders are a catalyst for refining nursing practice by contributing to effective mentoring, being accessible resources, and fostering effective teams. Ousey (2009) argues that clinical leadership is also important for creating the necessary "environment conducive to learning" (p. 176) in mentor/preceptor relationships. Laschinger and Leiter (2006) argue that their study "supports the key role of strong nursing leadership in creating conditions for work engagement" (p. 265). Effective clinically competent leadership can influence both nursing practice environments and health policy (Antrobus & Kitson, 1999, p. 746). In turn, leadership behaviours influence job satisfaction and retention of the aging workforce (Hatcher et al., 2006, p. 19). Longo (2009) also found that caring relationships between peers and nurses and their managers affected job satisfaction and intent to stay (p. 31). In addition to the more obvious qualities such as willingness to help, sensitivity, and supportiveness from leaders (Longo, 2009, p. 27) my study stresses the essential need for clinical knowledge. This is equally true for nurse educators (Watkins, 2000, p. 342). There is little research in this regard beyond identification of the barriers and therefore should be an area for further exploration (Little & Milliken, 2007, Ousey, 2009).

There are enormous challenges and tensions with role renegotiations when a clinically competent nurse becomes an administrator. Wall (2010) highlights this tension in a sympathetic presentation of the necessary balancing of two

responsibilities: managerial and nursing. Even nurse leaders or nurse managers silence expression of clinical needs in order to promote organizational goals (Wall & Austin, 2008, p. 81). In a critique of the rise of managerialism in nursing as a failed professionalization strategy, Porter (1992) posits that nurses in management positions divorce themselves from clinical work (p. 722). MacLeod (1994) also warned that as the clinical leadership role was changed "to embrace greater management responsibility, a better understanding of the nature of clinical leadership and its role in effective patient care becomes more critical" (p. 366). These findings suggest that in fact the clinical competence of the ward sister so clearly revealed in MacLeod's study has been lost, but it is remembered and continues to be valued. The disregard for administrators, regardless of their disciplinary background, was clearly evident in my study and is an echo of extensive research (Clarke & Aiken, 2008, p. 3320; see also Wall & Austin, 2008). The important point I am developing from the findings is that clinical competence and a demonstration of this in decision making did make a positive difference to nurses. Hatcher et al. (2006), in their advocacy for changing health policies to retain experienced nurses, caution us that "excellent clinicians should not feel as though providing bedside care is a second-class role" and that moving into administration should not be the only way to increase salaries (p. 31, see also RCN, 2005).

People as catalysts for refining nursing practice: Physician-Nurse Relationships.

Physician-nurse relationships and communication are linked to nurse retention and patient outcomes (see among others Clarke & Aiken, 2008; Schluter, Winch, Holzhauser & Henderson, 2008; Tourangeau, et al., 2007). Interprofessional conflict, specifically between physicians and nurses, is an ongoing concern (McVicar, 2003), attracting attention in May 2012 *Canadian Nurse* (Eggertson, 2012), and certainly evident in my data. My study also foregrounds the positive teaching and learning relationship between many physicians and nurses. Although anecdotal and small sample studies suggest otherwise, a large sample international study reported that in 1998-9 in Canada 78% of nurses felt the physicians they worked with gave high quality care and 80% described their working relationships with physicians as good (Aiken, Clarke, Sloane, & Sochalski, 2001, p.259). Despite this positive data there is a persistent perception that nurses are regularly oppressed by physicians (Duchscher & Myrick, 2008; Eggertson, 2012).

Wall (2010) argues that the gendered nature of health care has sustained "subtle communication patterns in which nurses make implicit recommendations that allow doctors to use nursing knowledge while maintaining pretence of omniscience" (p. 156). Stein (1968) coined the term the doctor-nurse game and revisited it two decades later (Stein, Watts, & Howell, 1990). Stein, a psychiatrist, published the study in *The American Journal of Nursing* describing the underlying

attitudes that sustains an apparently collaborative relationship while creating serious obstacles to effective communication. The object of the game is for nurses to be responsible, report findings, and make recommendations while remaining passive and ensuring physicians' omnipotence in order to avoid conflict (Stein, 1968, p. 101-102). Although much has changed the game seems to continue. Wall's observation and the persistence of the game resonate with the data. As I have discussed in the findings, during participant observation I noted numerous times where the nurses were clearly directing care through implicit recommendations and questioning with physicians.

Research and commentary on physician-nurse relations highlight power, gender, hierarchy, and professional disparity (Bartholomew, 2005; Ceci, 2004; Svensson, 1996; Sweet & Norman, 1995; Tellis-Nayak, M & Tellis-Nayak, V., 1984). Following Stein's (1968) original description a number of research articles explored physician-nurse collaboration until 2000 when the research appears to have stopped. Over the past decade the focus has shifted to interprofessional education and collaboration that, although pitched as multi-disciplinary, is often focused on improving communication between physician and nurses. What my study adds to this discourse is the importance of effective communication and positive relationships for nurses' workplace learning. I doubt this will be a welcome addition for some nurses, who have spent long years naming and resisting the control of medicine over nursing. Regardless, the findings clearly

suggest that physicians' knowledge is an asset to nurses' development of professional practice knowledge.

Catalyzing processes and practices in the health care milieu.

Because catalysts are so important to puzzling and inquiring, promoting and enhancing catalysts in the workplace has the greatest potential to improve nursing practice and therefore patient care. I have outlined the significance of various people and their contribution to nurses' learning above. Nurses' workplace learning is also dependent on a certain quality of team functioning and culture. In the early chapters I recounted the research decision to use the term milieu as a way of examining the physical, social, cultural, and institutional aspects of the workplace. Therefore, I begin this section with the physical workplace.

Proximal space.

In short, proximity matters. I did not find any references to physical proximity and workplace learning in the existing literature. In order for nurses to engage in the constant puzzling and inquiring of everyday nursing practice they need to be in proximity to other nurses. Although this is not always possible for nurses in remote and isolated practice, it is clearly one of the benefits of nursing in built environments that support this level of interaction. Having nurses charting in pods with at least one or two other nurses within voice and vision range is a catalyst for learning. I have shown in Chapter Five how bringing staff together in ward report is another method of adding proximity when they might be working

outside of easy voice range. Having ward report in a room where all of the nurses are able to be seated comfortably and within voice range may seem obvious; however, many nurses work in areas that do not have a morning ward report or group report early in the shift and at times this is replaced with "huddling" in the hallway, while standing up, juggling pen and paper. One participant talked about how moving into a new facility has changed the way that she is able to mentor and guide new staff, inexperienced nurses, or overwhelmed colleagues. From the start to the end of shift she is not able to physically "see" what is happening for the other team members. The built environment needs to facilitate informal interaction and resulting informal learning. This is an aspect of the health care milieu that should not be ignored.

Functional teams and magnet hospitals.

The findings demonstrated that the functionality of the workplace influenced learning. Many of the participants compared functional and dysfunctional environments and stressed the importance of good teamwork. Functional teams included willingness to help and the positive culture and camaraderie which I discuss in the section that follows. A functional team is more than camaraderie, however. It includes systems, routines, processes, and structures. Functional teams are at least partially the result of processes in the organization or institution. My study did not explore the source of functional teams. This requires different methodology, such as institutional ethnography, and comparative data sources. In order to explore the basis for functional teams I

searched the literature regarding positive health care organizations. It became clear that the findings resonate with the extensive literature related to "magnet qualities." Before I summarize this literature I want to highlight a unique feature of nurses' workplaces. Unlike virtually all other teams, nurses providing direct patient care rarely work on an intact, discrete, consistent team. Rotating shiftwork does not allow for the kind of team functioning that is evident in much of the leadership literature (Goleman, Boyatzis, & McKeen, 2002; Kouzes & Posner, 1995; Lencioni, 2002, 2005; Secretan, 1997; Wheatley, 1999). For this reason, the work on magnet hospitals is particularly important for this study.

The recent literature regarding "magnet" qualities of health care organizations is strongly corroborated in this study. Many robust studies have outlined, supported, or extended research on the qualities of magnet health care environments (Aiken, Clarke, Sloane, Lake, & Cheny, 2008; Erickson, Duffy, Ditomassi & Jones, 2009; Hatcher et al., 2006; Kramer & Schmalenberg, 1988a, 1988b; Scott, Sochalski & Aiken, 1999). International teams of researchers have explored characteristics of positive work environments for nurses and then link these characteristics to quality of care and patient outcomes (Clarke & Aiken, 2008; Manojlovich & Laschinger, 2007; Laschinger & Leiter, 2006; Laschinger et al., 2009; Poghosyan, Clarke, Finalyson & Aiken, 2010). The same workplace qualities that have been extensively defined and defended by researchers internationally are the same qualities that positively contribute to refining nursing practice. The International Hospital Outcomes Study (IHOS), with more than ten

years of data collection and analysis, demonstrated that "variations on organisational properties such as staffing levels, relations with physicians, and perceived support from front-line and top-level managers, have been consistently linked to critical nurse and patient outcomes" regardless of national differences (Clarke & Aiken, 2008, p. 3321). Qualities such as "competent managers, decentralized decision making, investment in workers and recognition of their contributions, and scheduling flexibility ... resulted in higher levels of nurse autonomy, greater control by nurses over resources required to provide good care, and better relations between nurses and physicians" (Aiken, Clarke, Sloane & Sochalski, 2001, p. 256). Hatcher et al. (2006) in their exploration of the importance of the older, experienced nurse to contemporary health care also summarize this list and add esprit de corps, shared governance, recognition and respect, verbal and written acknowledgement, and professional growth and development opportunities to the list (p. 19).

I have a sustained interest in understanding the difference between nurses who get better and better, and those who do not. Rafferty and Clark (2009) in their introductory editorial to a special issue of nursing workforce research in *International Journal of Nursing Research* make a direct request for research on older, experienced nurses. Noting that more nurses are staying in the workplace longer they state, "More data about these nurses and their experiences is needed. What are the characteristics of those nurses who have survived the system? Why do some nurses … burn for nursing while other burn out?" (Rafferty & Clark,

2009, p. 877). In Chapter Five I suggested that this study and the resulting theory of refining nursing practice is an answer to this question. In their description Rafferty and Clark contrast nurses who survive the system and continue to have a passion for nursing with those who burn out.

Extensive research has been conducted on the relationships among nurse burnout, job satisfaction, workplace environments, and patient outcomes including IHOS researchers (see among others Poghosyan et al., 2010). Building on the magnet hospital and IHOS research, Heather Spence Laschinger and colleagues have compared factors related to health care environments that influenced nurses' job satisfaction (structural empowerment, strong leadership, participation in hospital affairs, collegial physician-nurse relations, adequate staffing and resources, and a nursing model of care rather than medical model) and indicators for burnout (exhaustion, depersonalization, personal accomplishment) (Laschinger & Leiter, 2006; Laschinger, Finegan, & Wilk, 2009b; Manojlovich & Laschinger, 2007). The combined work of Laschinger and colleagues suggests "patient safety outcomes are related to the quality of the nursing practice work environment and nursing leadership's role in changing the work environment to decrease nurse burnout" (Manojlovich & Laschinger, 2007, p. 259). This was expanded further to explore work engagement, empowerment, and perceived effectiveness of care (Laschinger et al., 2009b). For new graduates in particular "an empowering work environment was strongly predictive of their feelings of effectiveness" (Laschinger et al., 2009, p. 643) and organizational

structures that enable them to practice according to the standards they have learned in pre-licensure education was the primary determinant of perceptions of effectiveness (p. 644). Key features of an environment supportive of clinical learning for nursing students are also similar and are corroborated in this study (Ousey, 2009).

Studies of workplace stress and moral distress also highlight the same factors: workloads and staffing, the importance of effective leadership, interprofessional conflict, along with monetary issues and shift work (Corley & Raines, 1993; Corely, Minick, Elswick, & Jacobs, 2005; McVicar, 2003). Schluter et al. (2008), in a review of this literature, report poor links between ethical climate, moral distress, and staff turnover and call for rigourous research in this area. Wall and Austin (2008) highlight the importance of team support for ethics related decision making and resilience. Although they found a few examples of positive team influences for supporting practitioners' ability to act ethically, they noted that power imbalance (inter- and intra-professional) and supervisory or organizational silencing, reprimands, and goal incongruence created difficulty dealing with ethical demands of practice. "Emotional, practical, and informational support and the approval of team members" are important when navigating the everyday ethics of health care (p. 79). The same qualities of a workplace that contribute to retention, prevent burn out, improve patient outcomes, and facilitate moral decision-making and an ethical climate, also contribute to puzzling and inquiring and refining nursing practice.

Recent exploration of nurses' retention or intentions to leave either current positions, organizations, or the profession point to the relevance of nurse empowerment, personal background and work/home issues, organizational leadership, and monetary factors (Flinkman, Leino-Kilpi, & Salantera, 2010; Simon, Muller, & Hasselhorn, 2010; Zurmehly, Martin, & Fitzpatrick, 2009). Daiski (2004) explored interprofessional personal relationships in the Canadian context following re-structuring. Although the language is focused on empowerment and dis-empowering relationships, her findings point to the necessity of including staff nurses in decision making regarding their own practice (autonomy), recognizing and valuing their expert knowledge, and the central value of mentorship. Kalisch et al. (2009) conducted a study of not nursing well, of missed nursing care. In their recommendations they repeat the refrain that encouraging deference to expertise and promoting teamwork are necessary to developing a safety culture (Kalisch et al., 2009, p. 8). In summary, features that are evident in the literature repeatedly include nurse autonomy, strong intra- and inter- professional relationships and the organizational commitment that facilitate autonomy and positive relationships (Laschinger & Leiter, 2006, p. 260). Safety, quality care, an ethical climate, and refining nursing practice are all positive outcomes of attending to magnet qualities in the health care milieu. The positive qualities of the health care milieu are remarkably consistent and based on my study positively influence nurses learning to nurse well.

Camaraderie: The social milieu.

Camaraderie is a quality of workplace culture. Camaraderie and collegial support have been identified in divergent research projects. Teekman (2000) identified collegial support as one of the two most important factors contributing to reflective thinking in the workplace, along with practical knowing developed from past experience (p. 1130). Collegiality is cited as important to effective mentoring and learning environments (Ryan et al., 2010, p. 188). Camaraderie and collegiality are important tools to battle conflict and destructive workplace practices (Daiski, 2004). Social support at work, job satisfaction, and intent to stay have been linked in a series of reports (AbuAlRub, 2010; AbuAlRub, Omari, & Al-Zaru, 2009). AbuAlRub and Al-Zaru (2008) recommend that managers find ways of enhancing social support as a retention strategy. Although this study does not negate their recommendation there is evidence that camaraderie is more complex than merely having leadership oriented support. This study reveals a more nuanced camaraderie – that requires a certain orientation toward knowing others outside of their professional role, and taking time to nurture this in pre-shift chatter and socializing.

Lutes (2002) identified five characteristics that contribute to the social and affective aspect of functional teams: respect, trust, levity, understanding for and appreciation of individual team members, and personality factors (p. 141, 145). Lutes proposed that

> a strong social bond among the team members promoted an ability to accept differences between the health science disciplines and individuals, a willingness to have faith that each team member was working toward patient and team goals, an interest in knowing each on a personal level, a willingness to enjoy each other's company, and a willingness to engage in fun and humour ... enhance interprofessional team functioning. (p. 158)

Neither Lutes nor the other studies reviewed explicitly tell us *how* to make camaraderie happen. It is likely that the length of time staff work together influences the development of strong social and affective relationships. This is an area for future exploration.

I have used common language, rather than terms unique to the findings, to explore the types and qualities of people that facilitate and support refining nursing practice in the workplace. A range of facilitators or catalysts have the potential to positively contribute to improved patient care through facilitating improved nursing practice. Catalysts range from individual mentor-guides, to leadership and educators, to team qualities such as functioning well and camaraderie, to broader organizational influences that positively contribute to a well-functioning team, to the built environment. In this final section relating to the health care milieu I return to claims made early in this dissertation.

Place, space, and nurses' workplace learning.

In Chapter One I explored various conceptualizations of the workplace. I argued that beginning with Florence Nightingale nurses' work involved space and

place (Andrews, 2003b, p. 270). Nightingale stressed the importance of attending to and altering the patients' environment, generally referring to hospitals (Nightingale, 1863), including physical qualities, ambiance and microsocial conditions such as nurse-patient proximity (Malone, 2003). She argued that nurses must attend to the essential features of a patient's immediate environment that would contribute to reducing suffering. Andrews (2003b) contends that much nursing research has ignored the "environment," one of the metaparadigm concepts for the discipline of nursing. One of the dangers of specifically focusing on patients and developing the capacity to ignore some of the hospital and broader health care milieu is the danger of not recognizing the effect of place on learning and improving patient care. In their focus on nursing this patient, with this particular set of concerns and needs, the nurse is at risk of neglecting to recognize the overall impact of various issues at play in the greater milieu on this particular patient in this moment in time. Nursing well does involve a delicate balancing act between attending to patients and also to their immediate and broader environment.

Much has been written about supportive work environments for workplace learning (Billet, 2001, 2004; Daley & Mott, 2000; Hughes, 2004; Jantzen, 2004, 2008). What my study adds to this knowledge are some specific factors, behaviours, and routines that enhance nurses' workplace learning. The study provides a local perspective in a particular setting with a unique cohort of nurses (those graduating between the late 1970s and 2000). Nurturing the process of

refining nursing practice across the categories begins with ascribing value to the factors that support nurses' workplace learning. These factors include access to mentor-guides (clinically competent leadership, experts, experienced nurses, and positive role models for setting and maintaining high standards of patient care), camaraderie in the workplace, and functional team work. The findings show physical proximity and the built environment allows for or constrains learning from others.

This study adds to our understanding by theorizing that beyond the previously researched cases for supportive workplaces, catalysts (mentor-guides, positive empowering workplaces, camaraderie and collegial support) have a positive effect on nurses' learning and therefore the provision of excellent patient care. The supportive nature of the workplace is constituted by staff as well as leaders who set and maintain high standards. Processes are also important for facilitating the refining process, across the categories. These processes could include increasing accessibility to necessary resources for learning such as intentionally mixing experienced, mid-career, and novice nurses through rotations. We need to celebrate and continue to nurture the positive and educational relationships between physicians and nurses. This positive portrait of individuals, relationships, leadership, and teams needs to be considered in light of previous descriptions of the health care systems. Within the constantly shifting, rationalized, and often dysfunctional health care milieu there are pockets of nurses and teams that continue to refine their knowledge and care.

The Role and Relationship of the Learner to Refining Nursing Practice

Based on the literature reviewed in Chapter Two and the findings of this study it is fair to say that the workplace is a central site of learning. Nurses providing direct patient care have some unique workplace learning challenges. Learning often occurs simultaneously with challenging and high stakes patient care. The nurses who are engaged in puzzling and inquiring are *concurrently* learning and practising nursing (MacLeod, 1996).

This study makes a major contribution to the existing literature by studying nurses nearing the end of their careers and by conducting data collection across virtually all areas of practice for nurses providing direct patient care. In the previous discussion I explored the findings related to the role of the health care milieu in light of the literature. I shift our attention now to what Billett and Henderson (2011b) call the agentic learner.

In Chapter Two I describe Billett and Henderson's (2011b) contention that in order to learn and integrate professional practice knowledge, both canonical and situational, the learner plays a significant role. This is particularly the case when learning takes place in practice settings (Billett & Henderson, 2011b, p. 4). They propose that this requires a set of capabilities including engaging in choices and making judgements about their own practice, a capability also evident in the data which I have referred to as becoming and being self-aware or self-appraising. What this study adds to the existing literature is a set of capabilities, based on empirical findings, which are properties of getting grounded. I contend that these

empirical findings regarding this set of capabilities have potential to inform changes in nursing education, new graduation transition, and continuing professional education.

Getting grounded.

Getting grounded involves acquiring basic knowledge and skills and developing capabilities necessary for the ongoing refining of nursing practice. Getting grounded involves developing the capacity and commitment to set and then maintain high standards of patient care even in the face of sometimes unalterable barriers in the health care milieu. Getting grounded also involves developing the capacity and commitment to seeing the whole (patient) picture, moving beyond task or skill focused nursing care. Healthy apprehension is cultivated in the initial getting grounded process and relates to a sense that what nurses do and do not do matters significantly, which promotes readiness or anticipation. Becoming self-aware is important for ongoing learning, and refining, in order to evaluate and appraise one's knowledge or skills for excellent patient care (Sellman, 2012). Becoming self-aware also involves the orienting or focusing processes nurses engage in at the beginning of their shifts.

A feature of the current health care milieu is a fast pace with many demands for learning. My findings suggest that in order to respond to the fast paced, continual demands for learning, nurses require a foundational knowledge and level of skill. In order to recognize a knowledge or skill gap (recognizing needing to know) the nurses need a certain amount of background knowledge. In

order to be able to pursue learning opportunities the nurses need to have already become safe, competent, and comfortable with the knowledge and skills required to nurse the kind of patients that present to nurses providing direct patient care, in the hospital, in residential care, and in the community.

Setting high standards.

Setting high standards involves values and valuing. Jensen and Lidell (2009) argue that altruism, a concern for another's wellbeing, is inherent to nursing well, and that conscience is an asset as a driving force, a restricting factor, and a source of sensitivity (p. 34). In their study the "nurses' desire to provide high quality care was strong and related to their professionalism and the conviction that everyone has the equal right to 'good' care" (p. 35). Conscience was also related to recognizing inadequate care, both for the participants in their study and in others (Jensen & Lidell, 2009, p. 36). In this study nurses' feelings of satisfaction and motivation for persisting with refining their practice were related to being able to *do* the best for their patient, not just desire it. This discussion regarding nurses' moral commitment to do the best for patients is pertinent to the entire process of refining nursing practice. Doing the best for patients is central to getting grounded, but clearly cannot be separated from ongoing refining and learning.

Of the four sub-processes developed in getting grounded, setting and maintaining high standards is possibly the most problematic. With the move to academic education, nursing education has been criticized for educating nurses for

an idealized workplace. Yet, I am arguing that setting high standards for patient care is an essential aspect of getting grounded and ongoing refining of nursing practice. There is a tension here. Resolution lies in nursing educators teaching and assisting students to set and then maintain high standards in the kind of environment that exists. Clearly, this requires a critical examination of the oppressive and limiting aspects of the workplace. The primary role of a new graduate cannot be to only criticize and reject the existing workplace. Rather, the primary focus is to develop the capacity and capabilities to nurse well. This is essential preparation for a career of persisting with setting and maintaining high standards. Idealized environments are not conducive to this task, yet strong foundations are, especially when accompanied by the disposition and commitment to high standards. Contrary to the ideology of the leaders of the curriculum revolution we cannot leave it up to unprepared nursing students to revolutionize the health care workplace (Clare, 1993; Tornyay, 1990). This is the work of clinically competence leadership, in practice and also in nursing education.

Seeing the whole picture.

There is nothing new about saying that nurses need to see the whole patient picture. Beginning with Benner (1984) and Benner et al. (1996) scholars have stressed the necessity of seeing the whole picture in order make good nursing decisions (see amongst others Baker, 1997; Cioffi, 2001; Pyles & Stern, 1983). In the Expertise in Practice (Pilot) project (UK) Hardy, Garbett, Titchen, and Manley (2002) found that saliency and the ability to "build a picture of their

patient's wider context of care" was a theme in how nurses describe their expertise (p. 198). This capability involves being able to see relevance in details that the lay person would miss.

An important part of initial nursing education is learning about the whole patient picture, and learning to see, to assess, and to consider, the whole patient picture. This is similar to the kind of learning that Benner et al. (2010) advocate throughout their book. In spite of decades of (such) nursing education, in a keynote address at the *First International Nursing Education Conference,* Thorne (2006) argues for a *new* way of thinking and teaching that is "bio-psycho-social to population-based and back again" in a "dynamic and rapid-cycling intellectual process" (p. 618). She goes on to suggest, "From my perspective, this capacity is and will be the unique contribution of nursing, and we need to ensure that it is effectively learned in the foundational stages if we are to survive as a profession" (Thorne, 2006, p. 618). The kind of thinking that Thorne believes is essential in 21st century nursing, is the kind of thinking that fits with the capacity for seeing the whole picture, something far beyond "motherhood claims about such phenomena as holism – which is individualism in context" (Thorne, 2006, p. 618).

Cultivating healthy apprehension.

Neither focused literature searches nor serendipitous reading across many topics resulted in literature corroborating or contradicting the importance of a healthy apprehension for the development of expertise or good nursing care. Attentiveness from the field of nursing ethics most closely resembles the concept

of healthy apprehension in this grounded theory (Edwards, 2009; Klaver & Baart, 2011; Lindh, Severinsson, & Berg, 2009). Attentiveness has received little examination and there is little clarity regarding its meaning (Klaver & Baart, 2011). Lindh et al. (2009) equate "being attentive and recognizing vulnerability" as a relational level of moral strength (p. 1882, 1885). The focus of their study, and the theoretical literature (Klaver & Baart, 2011), unfortunately ignores the physical, technical, robust activity of nursing practice, and therefore the concept of being attentive remains limited to authentic caring. It is primarily viewed as congruent with good care and necessary for an open relational space (Klaver & Baart, 2011; Lindh et al., 2009). Certainly, being attentive to relational practice is an important aspect of nursing, but this conceptual approach is lacking in the quality of nursing practice evident in this study. Similarly, Edwards (2009) draws on a moral philosopher Joan Tronto to explore the value of a separate ethic of care for nursing. Edwards points to one of the four elements of Tronto's ethics of care, attentiveness and its correspondence with developing moral imagination. This attentiveness is quite simply, becoming aware of patients' needs. This is followed by a moral choice to take responsibility for action, competently and responsively (Edwards, 2009, p. 237). The combined work of Elizabeth Pask (Pask, 1995, 1997, 2001, 2003, 2005) is a very useful resource for extending the findings of this study into educational curriculum. Her exploration of moral responsibility in responding within nursing is thoughtful and scholarly. It is very important to continue to develop a robust understanding of attentiveness that accounts for the

complex nuances of nursing in the current health care milieu *and* the other capabilities of getting grounded.

Becoming self-aware.

Being self-aware is important to refining nursing practice for many reasons. Sellman (2012) suggests that in addition to being essential to identifying gaps or deficits in practice relevant knowledge, it is equally important for defending nursing in the face of marketplace ideology (p. 127) through recognition of ways that one's practice is constrained by the health care milieu (p. 116). Far beyond the confessional mandatory reflection of Canadian continuing competence requirements (Nelson & Purkis, 2004), self-awareness involves incorporating a "deep understanding of the turbulent and dynamic nature of practice, a recognition of the value of some form of critical self-reflection, and a resolve not to allow complacency to jeopardize future practice" (Sellman, 2012, p. 116). Becoming self-aware in the preparatory and early years of nursing practice is necessary for recognizing both one's own abilities and capacities and his or her workplace's limitations, constraints, and problems.

Hardy et al. (2002) associate observation, as a key discursive practice of expertise, with self-awareness. "The ability to 'read people' by responding to and interpreting their non-verbal communicating requires considerable levels of self-awareness" (p. 199). Observation in patient assessment was identified by Hartigan, Murphy, Flynn, and Walshe (2010) as a key competence required for meeting the requirements of challenging situations on graduation. Competence,

self-awareness, and expertise are entwined. For many, reflective practice is also necessary, and might be seen as the practical "glue" that brings developing competence, self-awareness, and expertise together. Sellman (2012) approaches these three topics in developing his claim that *professional phronesis* has an importance place in professional practice. "In the absence of phronesis, individual practitioners may find it difficult to resist the overture of the dominant managerialism in which success is measured in terms that tend to exert pressure for ever-greater efficiency" (Sellman, 2012, p. 127). Based on this study it is not possible to suggest how nurses develop this capability, however, as I have suggested above, through the process of refining their nursing practice these nurses were able to filter and resist, to a degree, the effects of managerialism on their practice. Based on the findings, there is an important role for nursing education in developing this capability in the process of getting grounded.

Getting started getting grounded.

Transforming nursing education to narrow the preparation practice gap involves teaching to the four capabilities described thoroughly in the findings chapter. Nursing education needs to attend to curriculum and pedagogy that teach students how and why to set high standards of patient care and to see the whole (patient) picture. Cultivating healthy apprehension and self-awareness or the ability to appraise one's own practice accurately, also need to be evident in nursing education. In contrast to the concrete, albeit contentious, canonical or codified knowledge necessary for safe nursing practice, these tasks are value-

laden and, some might argue, the evidence of particular discourses regarding nursing practice, and therefore, nursing education. Given the recent scholarly efforts to deconstruct long-held beliefs and values regarding nursing (Nelson & Gordon, 2006) holding forth (these) particular constructions of nursing is decidedly fraught with challenge. Regardless, I am arguing that these four capabilities, however informed by discursive frames, have influenced the development of the participants' practice and workplace learning. In their experience, these are the strengths that they have drawn on to refine their nursing practice.

Socialization, specifically professional socialization, is the pedagogy of getting grounded. Although Benner et al. (2010) propose a new approach, which they call "formation" (p. 87) of a professional identity rather than socialization, I find the distinction is subtle enough to allow me to continue to use the more generally understood idea of "professional socialization" until formation has been explicated more extensively in the literature. In the findings chapter I noted that when a team adopts a vision for doing the best for the patients it is incorporated into their daily work, including shift exchanges and ward report. Wolf (1988) observed that shift change reports are "a major forum for accountability and responsibility for patient care" (p. 66). In both the nurse-to-nurse shift exchange and the team report time essential socialization occurs, between strong role models and new graduates, new hires, and nursing students. "The interactions among the nursing staff facilitated the transitions of the neophyte graduate nurse

into their professional role" (Wolf, 1988, p.66). It is also a testing ground, a point of correction, and a means for setting and maintaining high standards. In the move to increase efficiency in the nurses' workplaces this important ritual is under attack. Those nurses relatively impervious to these attacks continue to use nursing rituals for socialization to excellent patient care.

Early work experience.

The transition from nursing education to early work experience is a period of vulnerability. The early work years are also part of getting grounded. This is an important consideration. In contrast to the view that nursing education involves developing the "mandate" (Allen, 2007; Dingwall & Allen, 2001) of nursing and the role of regulating bodies and professional associations is to describe "license," including scope of practice and necessary work conditions, I am suggesting that developing and then nurturing what Allen calls the "mandate" of nursing continues on "across" or "through" this transition period. Duchscher (2008) reports that "the solid professional identity developed [in their education is] fractured under the weight of performance anxiety and self-doubt" in the first months as a new graduate (p. 444). Kelly and Ahern (2009) argue that new graduates are "unprepared for the socialization process" (p. 915) of their initial workplaces. The early work years should not be a time of fracture, new socialization into a new reality, or a wakeup call. The transition to the health care milieu should be supported by catalyzing influences that continue to hold up the values of high standards, including doing the best for our patients and seeing the

whole patient-related picture with an attitude of healthy apprehension. This transition requires workplace teams that are equally committed to high patient care standards and who resist pressures to succumb to task-oriented nursing.

Fink et al. (2008) noted that new graduates "struggle with articulating the relationship between subtle changes in the patient condition and the larger clinical picture" (p. 347). They need consistent monitoring or supervision and mentoring early on to reduce the fears and lack of confidence in seeing the whole picture. Some of the innovative new graduate development programs trialed and studied incorporate patient related situations and either on-line or face to face education that assist new graduates to consistently work with the "larger clinical picture." One study reports positive results from having a faculty member on-site or readily available for support and assistance for five weeks (Hayes & Scott, 2007). Health care organizations clearly also have an important role in facilitating getting grounded.

The early work years, including the transition year, are an important phase in refining nursing practice. Given the economic rationalization and the clear mandate (focus) on patient care, expectations or requirements and supportive resources must be examined critically in regards to the economic benefits of any workplace transition program. Solutions to supporting new graduations through the early work years cannot increase the work burden of experienced nurses in the constantly shifting workplace.

This study strongly corroborates the work of Kalisch et al. (2009) and Kalisch (2006) on missing nursing care. A lack of habit was cited as a reason for missed nursing care such as ambulation, routine checks and turning, patient teaching, and emotional support. The striking similarity in themes between these studies and the exploration of nurses' work conducted in BC just prior to this study, and the compelling contrast with the participants' practice is critically important. These nurses who are known for nursing well established their practice (got grounded) in their nursing education and early work years, developed habits of practice that assist them in continuing to nurse well, to maintain their high standards, and to preserve their nursing practice. In the concluding chapter I further develop the findings and the corroborating studies by Kalisch.

I have discussed getting grounded and outlined what this study contributes to our understanding of the importance of nursing education and early work experience for refining nursing practice throughout nurses' careers. Developing nursing knowledge in practice is a repeating refrain that I return to in the final chapter.

Puzzling and Inquiring: Nurturing Workplace Learning

The process of refining nursing practice, which I presented in Chapter Five, far extends the limits of my original assumptions regarding professional development and continuing education. Refining nursing practice encompasses lifelong learning across domains of learning and beyond minimal continuing competence requirements. The everyday workplace learning of nursing practice

(puzzling and inquiring) is, however, a central process for refining nursing practice. Puzzling and inquiring is iterative, endlessly repetitive, and relatively simple. It requires little interpretation or lengthy development. It involves the properties of figuring it out, questioning peers, and accessing resources, which I have described in detail in the findings chapter. Workplace learning involves learning by doing, by asking, and—as some would say—"putting their heads together." Catalyzing influences are essential to puzzling and inquiring. Therefore, as I have proposed previously, promoting and enhancing catalysts in the workplace has the greatest potential to improve nursing practice and therefore patient care. For example, questioning peers and accessing resources is dependent on access to other nurses and health care professionals (Munro, 2008). It is also dependent on a level of team functionality that allows for shared time and energy. I argue small but strategic changes could be made to workplace teams to facilitate the everyday process of workplace learning.

With Munro (2008) I contend it is very important to "establish the concept of continuing professional development and *learning through work* as valid, accredited continuing professional development that is part of a lifelong learning trajectory for qualified nurses, because nursing is a practice based profession" (p. 955, italics added). My study also suggests grounded nurses were able to continue to engage in puzzling and inquiring even within unsupportive or less than optimal work environments. I return to the adult education literature to align puzzling and inquiring and its properties with experiential learning theory. In the explanatory

coherence justification for theory, support for the theory or parts of the theory is "distributed across the whole" of related knowledge or "a system of propositions that are mutually supporting" (Risjord, 2010, p. 132). In the following section I integrate this theory of refining nursing practice with existing theory from the field of adult education.

Puzzling and inquiring as (an) experiential learning theory.

As I have described in the literature review chapter, there are many theories of learning from experience from diverse disciplines. Miller and Boud (1996) offer a description of learning from experience that is helpful for this theory of refining nursing practice. For them, experience is the "totality of the ways in which humans sense the world and make sense of what they perceive" and then "learning is the process which takes this experience and transforms it in ways which lead to new possibilities" (p. 8). The nurses in this study reveal a complex process of making sense of the nursing practice situation and transforming their curiosities and puzzles into new knowledge and, over time and through more experiences, into wisdom.

Puzzling and inquiring bears a strong resemblance to what Schon (1983) calls reflection-in-action and the "reflective thinking" that Teekman (2000) identified. Teekman found that self-questioning or what he called "discourse-with-self" was essential to reflective thinking in nursing practice (pp.1130-1131). This self-questioning is very similar to figuring it out. Teekman argues however that self-questioning alone is not sufficient to address lack of information (p.

1133). Teekman's participants used this primarily internal process to structure their thought processes and interpret a situation in order to *act*. My findings also suggest that action is essential to experiential learning in the nursing practice setting. According to Fenwick (2000), all constructivist experiential learning theory share the following premise: "A learner is believed to construct, through reflection, a personal understanding of relevant structures of meaning derived from his or her *action in the world* (p. 248, italics added). The primarily internally focused process of figuring it out cannot be separated from "needing to know" in order to act. Puzzling and inquiring, as an experiential learning process, involves perceiving, making sense, and transforming these perceptions and sense-making through discourse-with-self into knowledge for action.

Reflection (in its various permutations including in-action, on-action) is considered a central component of constructivist experiential learning theories (Fenwick, 2000). Given the numerous critiques of individual focused reflection Hoyrup and Elkjaer (2006) argue that "individual agency is embodied in social structures and that social structures operate through individuals"; therefore, reflection in experiential learning theory should encompass individual and social processes inherent in everyday workplace learning (p. 29). Although these authors fail to move beyond a comparison of various reflective approaches, the elements of a more complex reflective process is evident in these findings. For the nurses, reflection requires being self-aware, a capability for constructing knowledge in practice. Unrelated to experiential learning theories, but equally relevant, Sellman

(2012) suggests developing and using *phronesis* (wisdom) in nursing practice begins with critical self-reflection and "understanding the limits of their own personal competencies" with a will or resolve to rectify the deficits (p. 116). Becoming self-aware enables recognizing the need to know, as a deliberate response to triggers for learning in the workplace. The iterative nature of figuring it out and then moving to questioning peers involves a reflective action that begins as an individual deliberation and becomes a social reflective process.

Billett and Henderson's (2011b) case for the agentic learner in experiential learning, specifically learning in the practice setting, is important to this theory. Gaining practice professional knowledge requires effective participation and the capability to "independently appraise the processes and outcomes of their practice, and make judgements about its efficacy and how it might be improved" (Billett & Henderson, 2011a, p. 4). There is congruence between their claims and this grounded theory. Becoming self-aware is necessary for the agentic learning that Billett and Henderson develop in their work.

In summary, the process of puzzling and inquiring aligns with fundamental aspects of many experiential learning theories. This study of nurses' experiential learning in a constantly shifting health care milieu points to (a) the necessity of becoming self-aware, (b) the complex internal or individual figuring it out and (c) social (questioning peers) processes involved in making sense of the experience, (d) transforming the learning into personal (Eraut, 2007) or situational (Billett & Henderson, 2011b) nursing knowledge, and also the (e) necessary link

to action. This nursing experiential learning theory identifies certain people and processes that have potential to nurture nurses' workplace learning through facilitating puzzling and inquiring.

Chapter Seven: Conclusions

> Professional wisdom … enables good practitioners … to hone in on what is salient and needful. … This sense of attunement lends itself to a picture of the wise as composed and self-possessed. But it may be significantly through experiences of *dis*composure and *dis*possession that wisdom is acquired –just as it is in situations of disruption, even irruption, that it may be most urgently required … We should also bear in mind [what Aristotle] says more generally about virtue: that one gets it right only against the background of countless ways of getting it *wrong.* (Dunne, 2011, p. 24-25)

Although Dunne (2011) was bringing to mind the professional wisdom of teachers, the portrayal fits nurses; and also pertains to the findings in this study. For nurses, maintaining competence, developing expertise, and even acquiring professional wisdom involves the messy disruptions of the shifting health care milieu. In the OED (Soanes & Stevenson, 2008) there is more than one meaning for conclusion. As such, this conclusion chapter is both ending and judgement based on deliberation (Soanes & Stevenson, 2008). In these final pages I bring the various arguments, findings, and discussion to completion, and so it is an ending. I also communicate the conclusions—the judgements—I have, based on my deliberations over the past months and years, regarding what from this study is apt for contemporary health care and nursing. The reader will recognize a shift in this chapter. I intentionally move from using language of the findings and grounded theory to language used more commonly in the broader community. I also move

the findings and recommendations into the broader contexts of nursing and health care and return to issues raised in the beginning chapters.

At the outset I outlined why this study was necessary beyond satisfying my personal interest in how some nurses improve over time, while some do not. I argued that we need to understand nurses' workplace learning because it is critical to professional development and continuing competence of nurses, key members of the health care team. The significance of registered nursing practice to patient outcomes is evident in the literature described throughout the dissertation. The process of learning nursing knowledge, across the continuum from initial professional education through continuing education, has been theorized. I have highlighted the importance of key capabilities necessary to learn and practice high stakes nursing in the constantly changing milieu. Theorizing nurses' workplace learning is, therefore, a fundamental step to inform action. I start by presenting conclusions as answers to the research questions in order to demonstrate rigour and credibility of the research study. I then outline implications for practice, policy, education, and research.

Research Questions

How do nurses learn to nurse well within the current health care milieu?

How does the place in workplace learning influence and inform the development of the nurse?

What is the interaction between the workplace, nursing practice, and self, that facilitates learning for nurses?

How Do Nurses Learn to Nurse Well Within the Current Health Care Milieu?

With MacLeod (1996) I assert that nurses learn to nurse well *in* practice. Nursing practice is the primary site of developing nursing professional practice knowledge. Because nursing is a professional practice (Sellman, 2000), nurses across the continuum from beginning students to highly experienced, advanced practitioners and from beginning students to distinguished scholars, must remain firmly embedded in nursing practice. With Eraut (1994) and Billett and Henderson (2011a) I contend that based on my findings individual (personal) knowledge development must have stronger links to nursing practice.

The learning that occurs in nursing practice extends beyond learning how to provide personal care, highly skilled interventions, or how to address learning gaps regarding patient-specific concerns. As I have described in the preceding chapters, the nurses learned complex systems knowledge, how to communicate effectively with physicians to achieve the best care for their patients, and how to filter organizational demands that do not directly positively impact nursing care. The learning that occurs in nursing practice includes conceptual, procedural, and dispositional knowledge (Billett & Henderson, 2011b).

Nurses are able to learn in the current health care milieu under certain conditions. A foundational level of conceptual and procedural knowledge should be learned in initial professional education. The health care milieu places many demands for learning on nurses because of the dynamic nature of patient care and

the effects of the evolution of managerialism on health care organizations (Kinsella & Pittman, 2012; Rankin & Campbell, 2006). New graduates cannot respond to these demands without requisite knowledge and skills. Therefore, nursing education must attend to conceptual and procedural knowledge necessary for *current* rather than idealized health care settings and current scope of practice (see Hartigan, et al, 2010; Hegarty, Walsh, Condon, & Sweeney, 2009).

Four nursing practice dispositions and skills are necessary for learning in the current health care milieu. First, having and maintaining high standards for oneself and then developing high standards for the workplace is critically important for discerning and discriminating learning demands. "Doing our best for the patient" (therapeutic skills and values, Sawyer et al, 2009) is at the heart of nursing well and workplace learning. Second, having the disposition toward, and the skill to enact, a healthy apprehension and third, a whole patient picture are also essential. Finally, becoming self-aware, again a disposition that requires certain skills, enables nurses to recognize knowledge gaps or deficiencies in their own practice and in the health care milieu (Sellman, 2012). These can then be ameliorated with learning.

The constantly changing and at times dysfunctional nature of the health care milieu, often driven by an agenda that is at odds with nursing well, prompts myriads of learning demands. These learning demands, or triggers, need to be filtered in order for nurses to thrive. By remaining focused on "doing our best for the patient" nurses filter out learning demands that do not meet this criterion. The

findings suggest that over time nurses become relatively impervious to the organizational demands that impede nursing well. The nurses are not completely impervious or immune to the milieu. However, nurses in the current health care milieu are at times able to ignore learning demands that they judge will end up being fruitless. It is a strong testament to the developing wisdom of many nurses that they are able to recognize and name competing agendas or a conflict of goods (Sellman, 2000, 2011) and act on their *nursing practice knowledge.* They become better at recognising "corrupting influences and better able to act in honest, just, and courageous ways" (Sellman, 2011, p. 107). This is a distinguishing feature of nurses who are known for nursing well.

How Does the Place in Workplace Learning Influence and Inform the Development of the Nurse?

The nurses' workplace triggers, facilitates, and constrains learning to nurse well. The most significant effect is to trigger, even demand, learning. As nurses progress in their careers the workplace plays a less dominant role in facilitating and constraining learning. Having access to knowledgeable peers and other professionals, specifically physicians and experts in particular areas of nursing practice, is very important. Dysfunctional teams and health care systems negatively influence nurses' workplace learning. Positive contribution from managers, leaders, and educators is dependent on these individuals having and maintaining clinical competence.

What is the Interaction Between the Workplace, Nursing Practice, and Self, that Facilitates Learning for Nurses?

The interaction between nurses and the workplace is best described as multifarious. The interactions vary with aspects of the workplace at play. I have used the term health care *milieu* because it included the physical, social, and institutional aspects of the nurses' workplace that might otherwise be missed. The decision to use a broad, rich, and inclusive notion of the context of nursing practices was significant and allowed for a robust analysis of how the workplace (health care), nursing practice, and nurses interact. This study showed that when the physical space is examined we can see that working in close proximity enhanced learning to nurse well. When the sociocultural aspects of the team, unit, and organization are considered we can see that collegiality and camaraderie are very important to nurses' learning. When the interactions among administration of health care and nurses' learning is reviewed we experience a disjuncture. Institutional health care and nursing practice have competing agendas. This is particularly evident when institutional health care is dominated by economic efficiency.

In the background chapters I observed with Dewey (1938) not all experience in experiential learning is educative or positive, and I posited that it is possible that unexamined experience and practice may teach nurses poor practice. I included observation in the study design in order to explore this possibility. At the end of analysis I am unable to make claims in regards to miseducative

experiences other than to say it happens. I explored one patient situation in detail with the CNE as the patient experienced an adverse event following a set of observation shifts. The situation was discussed repeatedly in morning report and break-time. Because I was unable to review the chart or discuss the situation with other professionals or staff due to HREB limitations I was unable to gather enough data to analyze the situation accurately. Through my discussion with the CNE the observation was made, which I then memoed, that nurses learn to avoid calling physicians early in their careers due to fear of facing anger or humiliation. To unlearn this miseducative experience new graduates need strong mentoring, clear guidance, and reliable support from more experienced nurses. The problem of miseducative experience remains unexplored or not theorized in this study.

Having answered the research questions above I complete this dissertation by outlining important considerations for practice, policy, education, and research. With Eraut (1994) I contend that "Both the ongoing development and diffusion of good practice depend on the capacity of mid-career professionals to continue learning both on and off the job" (p. 41). I draw some conclusions and describe how I will continue to bring these conclusions into the broader contexts of health care and nursing. I begin with the nurses' workplace.

Practice Implications for Health Care Organizations

Enhancing catalysts for learning is a key umbrella strategy for health care organizations. Beyond the obvious move to implement magnet hospital values into health authorities in Canada, there are many small but important changes that

can be made. The Vancouver Coastal and Fraser Health Authority developed a program to honour and utilize the expertise of experienced nurses (Clauson et al. 2011). I recommend expanding this Legacy Mentor Project to other health authorities. As a result of the project "nurses' expertise was validated, suggesting that the translation of expertise by re-energized nurses is a strategy with potential to enhance retention" of experienced nurses (Clauson et al. 2011, p. 153). This small project, similar to the expansive Expert Practice Project in the UK (RCN, 2005), is a concrete demonstration of the recommendation to value and provide incentive to have nurse leaders remain in clinical practice (see also Antrobus & Kitson, 1999, p. 751). The Expert Practice Project also highlights the value of critical or skilled companionship for professional supervision and the facilitation of reflection, feedback, and support (Manley & Garbett, 2000, p. 355; Hardy et al., 2007, p. 85). The recommendations echo Ryan et al.'s (2010) argument for "providing adequate time, human resources and positive feedback for [informal] nurse-to-nurse mentoring relationships" (p. 189). Changing culture and altering values is not simple or easy but values inform behaviour and action.

Developing and improving partnership relationships is pivotal to transforming nursing education (Frenk, Chen et al. 2010; Thorne, 2006). It is clear "we need to work collaboratively between the nursing education and service leadership community to advance the contributions of the discipline to the fundamental challenge of health system reform" (Thorne, 2006, p. 620). Interestingly, Thorne (2006) links this directly with nurse educators' facility in

knowing "how to work effectively within the academy and the health authority" and an integration of "apprenticeship and mentorship … in which the wisdom of the seasoned practitioner could interact with the idealism of the neophyte (p. 620).

Hatcher et al. (2006), in their *Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace* report (US), point to the need to change organizational cultures. They contend that "nursing practice autonomy and nurse participation in operational decisions is key for nurse retention" (Hatcher et al., 2006, p. 34). Hatcher et al. add that "For too long, organizational cultures have devalued the experiences and contributions of nurses to the health care delivery system" (p. 34). Instead of devaluing and being disrespectful of older experienced nurses these nurses should have their contributions genuinely acknowledge and be "welcomed, accommodated, appreciated, and effectively utilized" (p. 37).

Policy Implications for Professional Associations and Regulatory Bodies

From the beginning chapters, based on my review of the literature, I argued the current Canadian continuing competence policies, based on reflection, are inadequate to ensure safe, competent practitioners, extending existing critiques (Nelson & Purkis; 2004; Hodges, 2007). The significance of the agentic learner (Billett & Henderson, 2011b) does not negate the need for health care organizations to be held accountable for ensuring nurses maintain competence and develop expertise. Given the failure to develop policy to evaluate on-going professional education and the significant amount of data, and relevant literature, demonstrating the need to transform nursing education, it appears that Canadian

regulatory bodies have abdicated their responsibilities to self-regulate and exert the necessary "social control of expertise" (Eraut, 1994, p. 2). Rather than protecting the public against "incompetence, carelessness and exploitation" (Eraut, 1994, p. 2) Canadian regulatory bodies have shifted sole responsibility onto individual nurses.

The findings of this study support the importance of being self-aware in order to identify learning gaps, a trigger for learning. Reflection is important for refining nursing practice. The existing regulatory process, however, remains inadequate for *ensuring* competence. The findings highlight the value of clinical competent leaders, everyday workplace learning, shared commitment to excellence, and access to people and resources for professional development. The findings also support the need for formal continuing education opportunities.

Four discourses of competence are at work in continuing competence policies and nursing education: competence-as-knowledge, competence-as-performance, competence-as-reliable test scores, and competence-as-reflection, with the latter dominating nursing (Hodges, 2006). Hodges (2006) recommends avoiding dominance of any one discourse, and outlines some very helpful recommendations which I develop here.

We need to separate "reflection" from "competence" (knowledge, skills and dispositions for professional practice) particularly in the way reflection has been developed by Schon (1983). We need to make a distinction between self-assessment (an ability), self-directed assessment-seeking and reflection

(pedagogical strategies), and self-monitoring (immediate contextually relevant responses to environmental stimuli) (Eva & Regehr, 2008, p. 14). Becoming self-aware and then using this quality to recognize the need to know in order to act is critically important to refining nursing practice in the current health care milieu. By shifting from a dis-engaged or dis-embodied reflection on a year of past practice to self-awareness we enable individual and social workplace learning. Sellman (2012) calls this move "reclaiming competence" (p. 115). In shifting to self-awareness nurses can replace the dominance of technical rationality, an action which then opens up the potential for both the development of practical wisdom or professional *phronesis* and the capability to understand "the turbulent and dynamic nature of practice" and the constraints of the workplace that are beyond individual control (p. 116). As I have outlined repeatedly, becoming self-aware and the related potential for the development of practical nursing wisdom are powerful devices for recognizing and resisting managerial agendas.

The Canadian "mandatory reflection model legislated by the regulatory authorities has taken the concept from a technique to *build* skill and knowledge, to one that *polices* nurses" (Nelson & Purkis, 2004, p. 251, italics theirs). Hodges (2006) warns nursing regulatory bodies to avoid letting "competence assessment rest on reflection alone, it should remain tied to the development and demonstration of the acquisition of knowledge and skills" (p. 696). Continuing competence policy needs to re-focus on building skill and knowledge. The ongoing challenges that have accompanied the professionalization agenda, with

related responsibilities for self-regulation and autonomous practice, have made it very difficult to avoid polar approaches. Some focus on empirical, canonical nursing knowledge development, (e.g. EBP discourses) and others focus on reflection, intuitive knowledge, and caring practices.

This study offers some points of action for continuing competence policies. Current programs are framed as a means to protect the public, the primary focus of most regulatory bodies. Mantesso et al. (2008) echo this sentiment when stating authoritatively that "Continuing competence programs (CCP) enable nurses to provide the best patient care possible within Canada" (p. 201). Many individuals and collective groups, including the CRNBC, make the unjustifiable claim that current continuing competence requirements based on reflective practice and dialogic peer feedback are somehow linked to "best" patient care. My findings suggest otherwise. I contest this claim and suggest, instead, that doing the best for our patients involves innumerable more important factors including but not limited to: refining nursing practice, getting grounded, responding to the learning demands of a constantly changing workplace with puzzling and inquiring, all in the context of mentor-guides, high standards of care, accessible resources, functional teams, respectful and mutually educational physician-nurse relationships, and under clinically competent leadership. The findings and resulting theory of refining nursing practice suggest reliance solely on self-reflection and current continuing competence policy is fraught with inadequacies.

Professionalization and policy implications.

A full discussion of professionalization and the arguments for re-conceptualizing nursing are beyond the scope of this dissertation; however, I continue to argue the professionalization agenda has influenced nurses and the health care milieu. It is clear that for nursing a problematic shift has accompanied professionalism. In looking back over the past century the ideals of professionalization have remained remarkably stable. Being knowledgeable (intellectual), having a credible education, in a self-regulated body (internally organized), and motivated by altruism remain key attributes of a professional (Porter, 1998, p. 68). I predict that this will not change significantly in the near future. Questions related to knowledgeable practice and knowledge development will persist.

Professionalization cannot be an end in itself. The objective of our resistance, scholarship, philosophizing, and political activity cannot be directed at protecting nursing but rather, the objective of our activity is on the health and wellbeing of those we nurse. This study demonstrates that experienced nurses have retained their focus on their raison d'être: doing the best for the patient. With this focus they have developed into practising nurses who set and maintain high standards, regardless of the health care milieu.

In the same spirit, the profession of nursing and discipline of nursing and nursing education requires ongoing refining. To do this we need to retain our key focus: doing the best for the patients by setting high standards for nursing

education and nursing care. Those responsible for making decisions about nursing education need to continue to explore what reform is needed to meet the mandate of educating registered nurses for the current and emerging health care milieu.

Self-regulation is currently being undermined in Canada. The influence of governments on regulatory bodies is certainly worrisome to many. I have suggested the regulatory bodies have abdicated their responsibility for self-regulation, including their promise of promoting good practice, preventing poor practice, and intervening when unacceptable practice occurs (CNA, 2007, p. 1). Increased surveillance on individual nurses as a fulfillment of self-regulation is equally inadequate. Professional self-regulation will necessarily involve a more active role on the part of regulatory bodies, nursing professional associations, and employers to ensure individual nurses are competent. However, there is also a critical need to regulate and critique the nurses' work environments. We should not abandon professionalization, with autonomy and self-regulation, but we must refine our processes. I do not want to return to a time when it was impossible to distinguish the quacks from the qualified (Leach, 2008, p. 1564).

Finally, in regards to policy we must be cautious when considering implementing everyday workplace learning as a strategy to address quality of care issues. Much of the rhetoric regarding learning at work over the past decades is driven by economic agenda. The value of learning in practice cannot be seen as a panacea to replace quality continuing education, which was also highly valued by the participants.

Education Implications

Initial and continuing professional education cannot be severed. Learning in nursing education, early work experience, and on-going professional development were experienced as one by the participants. References to learning in the workplace included claims about foundational knowledge, early role models, and establishing nursing practice capabilities. After decades of advocating a shift to academic nursing education there continues to be some confusion and mixed messages regarding the definition of "ready to practice" in British Columbia (Wolff & The Coalition, 2007). This is confusion about the line of demarcation between initial and continuing education.

Universities and colleges.

In the following section I do not intend to argue for the transformation of nursing education. Convincing evidence and recommendations are already abundant in the literature (Bartholomew, 2010; Benner, et al., 2010; Eraut, 1994, pp. 6-10; Slaikeu, 2011) and there is clear corroboration between the literature discussed in Chapter Two and my findings. Narrowing the preparation practice gap has become an important focus in the literature over the past decade, globally. The findings of this study reinforce the urgency of addressing this preparation practice gap and suggest that getting grounded has long term implications. What this study contributes is four key aspects of getting grounded that continue to influence nurses throughout their career.

This study has made tentative contributions to developing criteria for requirements for current nursing practice. In saying "you can't learn on the fly what you have to learn from a book" I acknowledge the need for codified knowledge, or more explicitly what Billett and Henderson (2011a) call canonical conceptual knowledge. My synthesis of the nursing education literature revealed common themes. For nursing, canonical conceptual knowledge includes knowledge of common illnesses and presentations (CNA, 2002) and foundational skills. Pharmacology has consistently been identified as a key area for improvement (Candela & Bowles, 2008). Developing the disposition of "knowing the patient" (seeing the whole patient picture) is also foundational (MacLeod, 1994). Frenk, Chen et al. (2010) emphasize that effective education must shift from "fact memorisation to searching, analysis, and synthesis of information for decision making" (p. 1924).

The commonly cited issues of "lack of clinical knowledge and confidence in skill performance, relationships with colleagues ... organization and prioritization as they related to decision making and direct care judgements, and communicating with physicians" deserve immediate attention (Duchscher, 2008, p. 443). Although experienced nurses are willing to mentor new graduates, there are requisite skills and knowledge necessary to meet the demands of the current clinical workplace. The stable and less complex patients that many authors recommend for new graduates are not the kind of patients requiring health care in

hospitals or the community. If they are, they are assigned to the LPN or care aides.

This study supports and corroborates recent recommendations regarding required changes in nursing education. There were remarkable similarities between Benner et al.'s (2010) conclusions and this study. This is most surprising in that Benner and colleagues conducted an extensive and multi-method study with student nurses while I conducted a small grounded theory focused on nurses with more than twenty years' experience working in direct patient care. The message is the same: increased relevance of content and more, high quality, clinical nursing practice are required for effective nursing education. Nursing curriculum needs to constantly evolve to ensure relevance to nursing practice. Clinical nursing practice is a highly valuable site of learning nursing knowledge for professional practice. The dominant view that nursing students learn conceptual knowledge that is translated into nursing practice should be replaced with this new, more robust view of professional practice knowledge (Billett & Henderson, 2011a; Ceci, 2003).

Both of these issues, relevance and utilizing clinical nursing practice, support the continued use of experiential learning theories to facilitate learning in nursing education. I am not advocating a move back to hospital-based nursing schools or historic apprenticeship models. Faculty development on, and curriculum development for, experiential learning theory would leverage significant positive changes to nursing education. Enhancing the relevance of

curriculum begins with clinically competent educators and curriculum developers. Nurse educators must attend to the essential work of maintaining clinical competence. “A hallmark of continuing competence within teaching should include a sustained relevance within a range of [teaching, practice, professional service and research] (Thorne, 2006, p. 620). “How do nurse educators and academics maintain competence in practice, research, and pedagogy?” is an important grounded theory research question.

Competence and incompetence discourses have profoundly influenced nursing education. Frenk, Chen et al. (2010) make strong recommendations to utilize competence-based education even more than is currently the case. The value of competence-based education must be held in tension with the related inherent problems and in consideration of nursing as a professional practice. In regards to specific cautions regarding competence-based education I support the following recommendations outlined by Hodges (2006). In implementing a greater emphasis on competence-based education nurse educators and curriculum developers need to (a) “avoid teaching and testing pure knowledge” (p. 694). We therefore need to integrate knowledge and skills early and anchor these to “clinical, social, cultural and other contexts” (p. 694). (b) “Avoid teaching and testing ‘general skills’ [because] skills are bound to domain-specific knowledge, the learning of which should be integrated with skills development” (p. 694). (c) Limit use of highly standardized scenarios and measures. [Instead nursing educators should] foster expert forms of thinking and embrace variance in the

presentation of situations and cases." (p. 694). In keeping with the recommendations regarding experiential learning theory outlined throughout this dissertation, nursing educators need to (d) "implement reflection carefully. Don't use self-directed learning methods without establishing the capacity for self-assessment" (p. 696). Becoming self-aware, a disposition and skill that is necessary for refining nursing practice, is an important contrast to the uncritical use of reflection common to nursing discourse.

Practice settings.

The limited number of positive practice placements continues to challenge nursing education. Although this has been acknowledged and some sites are choosing to utilize simulation to replace practice experience this is incongruent with the challenge to prepare students for the real, current health care milieu. Accessing and developing the learning potential of nurses' workplace requires close and collaborative relationships with institutional practice partners (Frenk, Chen et al. 2010).

If clinical practice is to become an important site of learning, nursing students need consistent mentors. The critical role of clinical practice mentors or preceptors must be valued, rewarded (with time if not funding), and recognized. In the UK, as I described in Chapter Six, there is a formal process for selecting, registering, and then reviewing nurses to work as clinical preceptors or mentors (UK) (Ousey, 2009, p. 175). Mentors/preceptors support student learning, supervise and assess students in clinical practice, and promote socialization

(Ousey, 2009, p. 176). Various resources are available to mentor-guides, such as a tool-kit developed by Butler and Felts (2006) or the Flying Start™ program currently being used in Scotland (Banks et al., 2011).

Over the past decade the UK has implemented a number of strategies to address the same concerns that are now emerging in the North American literature. According to Roxburgh et al. (2008) there is a paucity of research related to evaluation of nursing curriculum. In response this team of researchers have begun thorough evaluation of curriculum changes responding to fitness to practice concerns in Scotland (Holland et al., 2010; Lauder et al., 2008; Cameron et al., 2011). My recommendations for curriculum reform are partially informed by their research.

New graduate transitions have received enormous amount of attention in the past decade. The picture is bleak in Canada, the US, Australia, and the UK. Again, I recommend we follow the well documented lead of the UK. In one jurisdiction, nurse educators and health care leaders collaborated to develop a transition program called Flying Start™ which has already been evaluated (Banks et al., 2011). Their findings supported the benefit of this program for clinical skills, competence, confidence, and career development. Researchers found that in addition to the implemented program new graduates needed designated time to work through on-line support modules and, in addition to the teaching modules and support resources, mentors continue to be critically important.

My study and the existing literature have shown that mentorship is critically important to new graduates. Unlike Fox, Henderson, & Malko-Nyhan's (2005) new graduates who survived the transition despite the context, and offer only recommendations for increased self-reliance in the absence of preceptor support, the participants highly valued their own mentor-guides, and were keen to provide this service to others. My study offers a new perspective on proposed programs. It is not enough to expend financial resources on lengthy internships or mentorship programs if new graduates do not have the requisite knowledge base, access to catalysts for workplace learning, and a sustained commitment to set and maintain high standards of care. Spending money on internships in environments that are not conducive to refining nursing practice and lacking in catalysts for learning is spending money unwisely.

Implications for Research

This study strongly suggests that certain capabilities influence engagement in workplace learning and refining nursing. Explicating the relationship between getting grounded and lifelong learning is an area for future research. This could begin with studying the workplace learning experiences of new graduates, specifically nurses who did not feel ready for practice or for whom experienced nurses considered unready for practice post-licensure. Further study of new graduates could incorporate observation and chart reviews, as much of research to date is based on self-report and self-perceptions of competence and confidence.

I recommend extending the work of Kalisch et al. (2009) in regards to missed care. Their study could be replicated in the Canadian setting, with additional data collection of chart and documentation reviews. Kalisch et al.'s work could also be extended by incorporating demographics, such as area of practice and years of experience in direct patient care, or by exploring the four dispositions and skills congruent with getting grounded.

Safety, quality care, an ethical climate, and also *refining nursing practice* are all positive outcomes of attending to magnet qualities in the health care milieu. There are important cautions however, as Wall (2010) clearly outlines. Although the findings of this study corroborate the extensive literature on nursing work environments and related "magnet qualities," Wall calls for research that does not obscure issues related to gender, power, and knowledge. This study, using grounded theory, is an important addition to the existing research; however, future studies need to be developed from critical methodologies to explore issues of power.

Professional resilience, a concept similar to what I have called becoming relatively impervious, is worthy of further research. The ability to recognize and address competing agendas between nursing practice and managerialism is important to excellent health care. These both warrant further explication through qualitative and quantitative methods. Grounded theory was well suited to exploring how nurses learn to nurse well and would be equally well suited to explore how nurses develop professional resilience.

Implications for the Discipline

My choice to separate nursing as a discipline and as a profession was carefully weighed. In the following brief discussion I highlight my conclusions regarding disciplinary knowledge. A summary of potential venues for knowledge translation and dissemination is included in Appendix E. Here, I draw heavily on the concluding chapter of Cameron (1998) to show how recalcitrant the issues are. Nursing theory has not "kept pace with" or well represented nursing "in its fullness" (Cameron, 1998, p. 242). Nursing is an enacted profession focused on the health and wellbeing of those in our care, therefore research and theorizing should originate from practice (p. 242).

> The economic, social, political, and ideologic factors that affect nursing practice should be considered in depth and the question asked why the discourse of nursing has been so blind to these entities that so very heavily influence the ability of the nurse to engage in exemplary nursing practice. (Cameron, 1998, p. 243)

Because administrators and nurses have competing agendas, "what is considered nursing expertise and essential to an area of practice should be determined by nurses" (p. 243). Nursing education needs to be attentive to conceptual, procedural, and dispositional knowledge (Billett & Henderson, 2011a, p. 6-8; Cameron, 1998, p. 243). With Reed and Lawrence (2008) I define disciplinary nursing knowledge as "knowledge warranted as useful and significant to nurses and patients in understanding and facilitating human health processes (p. 423).

Conclusion

The re-conceptualization of continuing competence and the call for reforms in nursing education are necessary to prepare nurses to resist the persistent forces of managerialism on nursing practice. The dynamic and challenging nature of nursing in direct patient care is not well understood.

> What is the 'core of nursing' that the public needs to appreciate? We think the public needs to know the depth of the scientific and medical knowledge nurses need to practice safely. The public needs to appreciate the highly developed interpersonal communication skills (that do not come naturally but come as a result of discipline and self-mastery) that dealing with people at critical and challenging life moments demands. The public needs to understand the extraordinary logistical and management skills that are needed to perform nursing work and to co-ordinate and organize the work of others. The public needs to know that nurses are multi-taskers. (Nelson & Gordon, 2009, p. 2)

Nelson and Gordon (2006, 2009), Cameron (1998), and many others are trying to tell a story to convey nursing. Each, in a different way, wants to highlight something of the "core of nursing." In the preceding pages I too have told a story and theorized something of nursing. To Nelson and Gordon's laudable description above I would add, the public needs to understand the complex processes of developing expertise, of refining nursing practice in order to "do the best for the patients in our care."

Nowhere else do the pressures of globalization, neoliberalism, technical rationality, and managerialism enter so directly into the sociopolitical arena of our time as they do in this arena of healthcare (Gadamer, 1996). Here in the crucible of the current health care milieu nurses go about their practice with varying degrees of competence and expertise. I proposed that existing approaches for preparing and supporting nurses for practising nursing in the current health care milieu require complementary efforts to accomplish the goal of excellent patient care. This study has theorized how some nurses continue to nurse well in spite of, and also because of, the health care milieu. We are never free of these pressures but we can be encouraged and quickened by the possibility of refinement in our own diverse ways of going about our practices.

References

AbuAlRub, R.F. (2010). Work and non-work social support and intent to stay at work among Jordanian hospital nurses. *International Nursing Review, 57*(2), 195-201.

AbuAlRub, R. F., & Al-Zaru, I. M. (2008). Job stress, recognition, job performance and intention to stay at work among Jordanian hospital nurses. *Journal of Nursing Management, 16*(3), 227-236.

AbuAlRub, R. F., Omari, F. H., & Al-Zaru, I. M. (2009). Support, satisfaction and retention among Jordanian nurses in private and public hospitals. *International Nursing Review, 56*(3), 326-332.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *The Journal of Nursing Administration, 38*(5), 223-229.

Aiken, L. H., Clarke, S. P., Sloane, D. M., & Sochalski, J. A. (2001). An international perspective on hospital nurses' work environments: The case for reform. *Policy, Politics & Nursing Practice, 2*(4), 255-263.

Allen, D. (2004). Re-reading nursing and re-writing practice: Towards an empirically based reformulation of the nursing mandate. *Nursing Inquiry, 11*(4), 271-283.

Allen, D. (2007). What do you do at work? Profession building and doing nursing. *International Nursing Review, 54*(1), 41-48.

Alligood, M. R., & Tomey, A. M. (2010). *Nursing theorists and their work* (7th ed.). Maryland Heights, MO: Mosby Elsevier.

American Nurses Association. (1973). Landmark statement from the organizing group for the ANA council on continuing education. *Journal of Continuing Education in Nursing, 4*(1), 28-31.

American Nurses Association. (1997). *Guidelines for commercial support for continuing nursing education*. Washington, DC: American Nurses Association.

Andrews, G. J. (2002). Towards a more place-sensitive nursing research: An invitation to medical and health geography. *Nursing Inquiry, 9*(4), 221-238.

Andrews, G. J. (2003a). Locating a geography of nursing: Space, place and the progress of geographical thought. *Nursing Philosophy, 4*, 231-248.

Andrews, G. J. (2003b). Nightingale's geography. *Nursing Inquiry, 10*(4), 270-274.

Andrews, G. J. (2006). Geographies of health in nursing. *Health & Place, 12*(1), 110-118.

Andrews, G. J., & Shaw, D. (2008). Clinical geography: Nursing practice and the (re)making of institutional space. *Journal of Nursing Management, 16*(4), 463-473.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of Inquiry, and postmodernism. *Qualitative Health Research, 6*(3), 379-393. doi: 10.1177/104973239600600306

Antrobus, S., & Kitson, A. (1999). Nursing leadership: Influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing, 29*(3), 746-753.

Arcand, L. L., & Neumann, J. A. (2005). Nursing competency assessment across the continuum of care. *Journal of Continuing Education in Nursing, 36*(6), 247-254.

Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral Communities. *Advances in Nursing Science, 30*(1), 81-88.

Baer, E. D. (1989). Nursing's divided loyalties: An historical case study. *Nursing Research, 38*(3), 166-171.

Baker, J. (1997). Phenomenography: An alternative approach to researching the clinical decision-making of nurses. *Nursing Inquiry, 4*, 41-47.

Bakker, D., Fitch, M. I., Green, E., Butler, L., & Olson, K. (2006). Oncology nursing: Finding the balance in a changing health care system. *Canadian Oncology Nursing Journal, 16*(2), 79-87.

Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review of Psychology, 52*, 1-26.

Banks, P., Roxburgh, M., Kane, H., Lauder, W., Jones, M., Kydd, A., & Atkinson, J. (2011). Flying start NHS (TM): Easing the transition from

student to registered health professional. *Journal of Clinical Nursing, 20*(23/24), 3567-3576.

Barriball, K. L., & White, A. (1996). Participation in continuing professional education in nursing: Findings of an interview study. *Journal of Advanced Nursing, 23*(5), 999-1007.

Bartholomew, K. (2005). *Speak your truth: Proven strategies for effective nurse-physician communication*. Marblehead, MA: HCPro.

Bartholomew, K. (2010). A failure to rescue ourselves. *American Journal of Nursing, 110*(11), 11.

Bauer, J., & Mulder, R. H. (2007). Modelling learning from errors in daily work. *Learning in Health & Social Care, 6*(3), 121-133.

Bauman, Z. (2000). *Liquid Modernity*. Cambridge, UK: Polity Press.

Bauman, Z. (2006). *Liquid times: Living in an age of uncertainty*. Cambridge, UK: Polity Press.

Bauman, Z. (2011). *Collateral damage: Social inequalities in a global age*. Cambridge, UK: Polity Press.

Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*, 402-407.

Benner, P. (1983). Uncovering the knowledge embedded in clinical practice. *Image: The Journal of Nursing Scholarship, 15*(2), 36-41.

Benner, P. (1984/2001). *From novice to expert* (Commemorative Edition ed.). Upper Saddle River, NJ: Prentice Hall Health.

Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. *Advances in Nursing Science, 14*(2), 1-21.

Benner, P. (Ed.). (1994). *Interpretive phenomenology*. Thousand Oaks, CA: Sage Publications.

Benner, P., & Benner, R. V. (1979). *The new nurse's work entry: A troubled sponsorship*. New York, NY: The Tiresias Press, Inc.

Benner, P., Sheets, V., Uris, P., Malloch, K., Schwed, K., & Jamison, D. (2002). Individual, practice, and system causes of errors in nursing: A taxonomy. *Journal of Nursing Administration, 32*(10), 509-523.

Benner, P., Sutphen, M., Leonard, P., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.

Benner, P., & Tanner, C. (1987). Clinical judgment: How expert nurses use intuition. *American Journal of Nursing, 87*(1), 23-31.

Benner, P., Tanner, C., & Chesla, C. (1996/2009). *Expertise in nursing practice* (2nd ed.). New York, NY: Springer Publishing Company.

Benner, P., & Wrubel, J. (1989). *The primary of caring: Stress and coping in health and illness*. Menlo Park, CA: Addison-Wesley.

Benoliel, J. Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research, 6*(3), 406-428. doi: 10.1177/104973239600600308

Billett, S. (2001). Learning throughout working life: Interdependencies at work. *Studies in Continuing Education, 23*(1), 19-35.

Billett, S. (2004). Workplace participatory practices: Conceptualising workplaces as learning environments. *Journal of Workplace Learning, 16*(6), 312-314.

Billett, S., & Henderson, A. (Eds.). (2011a). *Developing learning professionals.* New York, NY: Springer.

Billett, S., & Henderson, A. (2011b). Promoting professional learning: Integrating experiences in university and practice settings. In S. Billett & A. Henderson (Eds.), *Developing learning professionals* (pp. 1-19). New York, NY: Springer.

Bishop, A. H., & Scudder, J. R. Jr. (1997). Nursing as a practice rather than an art or science. *Nursing Outlook, 45*, 82-85.

Bjorklund, P. (2004). Invisibility, moral knowledge and nursing work in the writings of Joan Liaschenko and Patricia Rodney. *Nursing Ethics, 11*(2), 110-121.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Berkeley, CA: University of California Press.

Blumer, H. (1978). Society as symbolic interaction. In J. G. Manis & B. N. Meltzer (Eds.), *Symbolic interaction: A reader in social psychology* (pp. 97-103). Boston, MA: Allyn and Bacon, Inc.

Bondi, L., Carr, D., Clark, C., & Clegg, C. (Eds.). (2011). *Towards professional wisdom: Practice deliberation in the people professions*. Surrey, UK: Ashgate.

Bonner, A. (2003). Recognition of expertise: An important concept in the acquisition of nephrology nursing expertise. *Nursing & Health Sciences, 5*(2), 123-131.

Bonner, A. (2006). Uncovering the evidence of non-expert nephrology nursing practice. *International Journal of Nursing Practice, 12*(2), 51-56.

Bonner, A. (2007a). Focusing on patients: Differences between the practice of expert and non-expert nephrology nurses. *Renal Society of Australasia Journal, 3*(1), 5.

Bonner, A. (2007b). Understanding the role of knowledge in the practice of expert nephrology nurses in Australia. *Nursing & Health Sciences, 9*(3), 161-167.

Bonner, A., & Greenwood, J. (2005). Producing the magnum opus: A metaphor for nephrology nursing expertise acquisition. *Journal of Advanced Nursing, 51*(1), 64-72.

Bonner, A., & Walker, A. (2004). Nephrology nursing: Blurring the boundaries: the reality of expert practice. *Journal of Clinical Nursing, 13*(2), 210-218.

Boud, D., Cressey, P., & Docherty, P. (Eds.). (2006). *Productive reflection at work: Learning for changing organizations*. London, UK: Routledge.

Boud, D., & Garrick, J. (Eds.). (1999). *Understanding learning at work*. London, UK: Routledge.

Boud, D., & Miller, N. (Eds.). (1996). *Working with experience: Animating learning*. London, UK: Routledge.

Boud, D., & Walker, D. (1990). Making the most of experience. *Studies in Continuing Education, 12*(2), 61-80.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research, 8*(1), 137-152.

Bradley, C., Erice, M., Halfer, D., Jordan, K., Lebaugh, D., Opperman, C.,...Stephen, J. (2007). The impact of a blended learning approach on instructor and learner satisfaction with preceptor education. *Journal for Nurses in Staff Development, 23*(4), 164-172.

Bradshaw, A. (2000). Editorial. *Journal of Clinical Nursing, 9*(3), 319-320.

Browne, A. J. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research, 32*(2), 35-55.

Browne, A. J. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry, 8*(2), 118-129.

Burton. A. J. (2000). Reflection: Nursing's practice and education panacea? *Journal of Advanced Nursing, 31*(5), 1009-1017.

Butler, M. R., & Felts, J. (2006). Tool kit for the staff mentor: Strategies for improving retention. *Journal of Continuing Education in Nursing, 37*(5), 210-213.

Butterworth, T., & Bishop, V. (1995). Identifying the characteristics of optimum practice: Findings from a survey of practice experts in nursing, midwifery and health visiting. *Journal of Advanced Nursing, 22*(1), 24-32.

Byrne, M. M. (1987, January). *From layperson to novice nurse: Professional socialization in nursing*. Paper presented at the Annual Conference on Research in Nursing Education, Milwaukee, WI.

Calman, L. (2006). Patients' views of nurses' competence. *Nurse Education Today, 26*, 719-725.

Cameron, B. (1998). *Understanding nursing and its practices* (Unpublished doctoral dissertation). University of Alberta, Edmonton.

Cameron, B. (2004). Nursing and the unpresentable. *Nursing Philosophy, 5*, 1-3.

Cameron, B. (2006). Towards understanding the unpresentable in nursing: Some nursing philosophical considerations. *Nursing Philosophy, 7*, 23-35.

Cameron, J., Roxburgh, M., Taylor, J., & Lauder, W. (2011). Why students leave in the UK: An integrative review of the international research literature. *Journal of Clinical Nursing, 20*(7/8), 1086-1096.

Campbell, A., Nilsson, K., & Andersson, E. P. (2008). Night duty as an opportunity for learning. *Journal of Advanced Nursing, 62*(3), 346-353.

Campbell, B., & Mackay, G. (2001). Continuing competence: An Ontario nursing regulatory program that supports nurses and employers. *Nursing Administration Quarterly*, *25*(2), 22-30.

Canam, C. J. (2008). The link between nursing discourses and nurses' silence: Implications for a knowledge-based discourse for nursing practice. *Advances in Nursing Science*, *31*(4), 296-307.

Canadian Nurses Association. (2000). *A national framework for continuing competence programs for registered nurses.* Ottawa, ON: Canadian Nurses Association.

Canadian Nurses Association. (2005). *Chronic disease and nursing: A summary of the issues*. Ottawa, ON: Canadian Nurses Association

Canadian Nurses Association. (2007). Improving practice environments: Keeping up the momentum. *Nursing Now*, (22), 1-6.

Canadian Nurses Association. (2009a) *The value of Registered Nurses*. Retrieved from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/ROI_Value_Of_Nurses_FS_e.pdf. Ottawa, ON: Canadian Nurses Association.

Canadian Nurses Association. (2009b). *Position Statement 102: Patient Safety*. Retrieved from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS102_Patient_Safety_e.pdf. Ottawa, ON: Canadian Nurses Association.

Canadian Nurses Association. (2010). *2008 Workforce profiles of registered nurses in Canada,* Ottawa, ON: Canadian Nurses Association.

Canam, C. J. (2008). The link between nursing discourses and nurses' silence: Implications for a knowledge-based discourse for nursing practice. *Advances in Nursing Science, 31*(4), 296-307.

Candela, L., & Bowles, C. (2008). Recent RN graduate perceptions of educational preparation. *Nursing Education Perspectives, 29*(5), 266-271.

Carnevale, F. A. (1997). "Decision-making in context": A proposal for a comprehensive methodology. *Canadian Journal of Nursing Research, 29*(3), 65-68.

Carolan, M., Andrews, G. J., & Hodnett, E. (2006). Writing place: A comparison of nursing research and health geography. *Nursing Inquiry, 13*(3), 203-219.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23.

Cartier, C. (2003). From home to hospital and back again: Economic restructuring, end of life, and the gendered problems of place-switching health services. *Social Science & Medicine, 56*(11), 2289-2301.

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303-311.

Ceci, C. (2000). Not innocent: Relationships between knowers and knowledge. *Canadian Journal of Nursing Research, 32*(2), 57-73.

Ceci, C. (2003). Midnight reckonings: On a question of knowledge and nursing. *Nursing Philosophy, 4*(1), 61-76.

Ceci, C. (2004). Gender, power, nursing: A Case Analysis. *Nursing Inquiry, 11*(2), 72-81.

Ceci, C., & Purkis, M. E. (2009). Bridging gaps in risk discourse: Home care case management and client choices. *Sociology of Health & Illness, 31*(2), 201-214.

Chambliss, D. F. (1996). *Beyond caring: Hospitals, nurses and the social organization of ethics*. Chicago, IL: University of Chicago Press.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 509-535). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory*. Los Angeles, CA: Sage.

Chinn, P. L. (1989). Feminist pedagogy in nursing education. In *Curriculum revolution: Reconceptualizing nursing education.* (pp. 9-24). New York, NY: National League for Nursing.

Chinn, P. L., & Kramer, M. K. (2011). *Integrated theory and knowledge development in nursing* (8th ed.). St. Louis, MO: Elsevier Mosby.

Cho, J., Laschinger, H. K. S., & Wong, C. (2006). Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Canadian Journal of Nursing Leadership, 19*(3), 43-60.

Cioffi, J. (2001). A study of the use of past experience in clinical decision making in emergency situations. *International Journal of Nursing Studies, 38*, 591-599.

Clare, J. (1993). Change the curriculum -- or transform the conditions of practice? *Nurse Education Today, 13*(4), 282-286.

Clark, C. L. (2004). The professional socialization of graduating students in generic and two-plus-two baccalaureate completion nursing programs. *Journal of Nursing Education, 43*(8), 346-351.

Clarke, H. (2010). Health and nursing policy: A matter of politics, power, and professionalism. In M. McIntyre & C. Macdonald (Eds.), *Realities of Canadian nursing: Professional, practice, and power issues* (3 ed., pp. 68-90). Philadelphia, PA: Wolters Kluwer Lippincott Williams & Wilkins.

Clarke, S. P., & Aiken, L. H. (2003). Failure to rescue. *The American Journal Of Nursing, 103*(1), 42-47.

Clarke, S. P., & Aiken, L. H. (2008). An international hospital outcomes research agenda focused on nursing: Lessons from a decade of collaboration. *Journal of Clinical Nursing, 17*(24), 3317-3323.

Clauson, M., Wejr, P., Frost, L., McRae, C., & Straight, H. (2011). Legacy mentors: Translating the wisdom of our senior nurses. *Nurse Education in Practice, 11*(2), 153-158.

Clinton, M., Murrells, T., & Robinson, S. (2005). Assessing competency in nursing: A comparison of nurses prepared through degree and diploma programmes. *Journal of Clinical Nursing, 14*(1), 82-94.

College of Registered Nurses of British Columbia [CRNBC]. (2006). A short guide to meeting continuing competence requirements for registered nurses [Electronic Version], 1-19. Retrieved from https://www.crnbc.ca/QA/Documents/364ShortGuideContinuingCompetence.pdf

Collins, M. (1998). Critical reforms: From andragogy to lifelong education. In S. M. Scott, B. Spencer & A. M. Thomas (Eds.), *Learning for life: Canadian*

readings in adult education (pp. 46-58). Toronto, ON: Thompson Education Publishing.

Colyer, H. M. (2004). The construction and development of health professions: Where will it end? *Journal of Advanced Nursing, 48*(4), 406-412.

Cooper, S. S. (1972). This I believe ... about continuing education in nursing. *Nursing Outlook, 20*(9), 579-583.

Cooper, S. S. (1973). A brief history of continuing education in nursing in the United States. *Journal of Continuing Education in Nursing, 4*(3), 5-14.

Cooper, S. S. (1975). Trends in continuing education in the United States. *International Nursing Review, 22*(4), 117-120.

Corbin, J. M., & Strauss, A. L. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*(1), 3-21.

Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics, 12*(4), 381-390.

Corley, M. C., & Raines, D. (1993). An ethical practice environment as a caring environment. *Nursing Administration Quarterly, 17*(2), 68-74.

Cowan, D. T., Norman, I., & Coopamah, V. P. (2005). Competence in nursing practice: A controversial concept - a focused review of literature. *Nursing Education Today, 25*, 355-362.

Cowan, D. T., Wilson-Barnett, J., Norman, I. J., & Murrells, T. (2008). Measuring nursing competence: Development of a self-assessment tool for general

nurses across Europe. *International Journal of Nursing Studies, 45*(6), 902-913.

Cowin, L. (2002). The effects of nurses' job satisfaction on retention: An Australian perspective. *Journal of Nursing Administration, 32*(5), 283-291.

Cowin, L., & Jacobsson, D. (2003). The nursing shortage: Part way down the slippery slope. *Collegian, 10*(3), 31-35.

Cranton, P. (1996). *Professional development and transformational learning*. San Francisco, CA: Jossey-Bass.

Cross, R. L., & Israelit, S. B. (Eds.). (2000). *Strategic learning in a knowledge economy: Individual, collective and organizational learning process*. Boston, MA: Butterworth Heinemann.

Currie, K. (2008). Linking learning and confidence in developing expert practice. *International Journal of Nursing Education Scholarship, 5*(1), 1-13.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476-1484.

Cutcliffe, J., McKenna, H., & Hyrkas, K. (2010). *Nursing models: Application to practice.* London, UK: Quay Books Division.

Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing, 48*(1), 43-50.

Daley, B. (1997a). Creating mosaics: The interrelationships of knowledge and context. *The Journal of Continuing Education in Nursing, 28*(3), 102-114.

Daley, B. (1997b, October). *Transformative learning: Theory to practice links*. Paper presented at the Midwest Research-to-Practice Conference in Adult, Continuing and Community Education Conference. East Lansing, MI.

Daley, B. (1998, May). *From novice to experts: How do professionals learn?* Paper presented at the Adult Education Research Conference, San Antonio, Texas.

Daley, B. (2000). Learning in professional practice. *New Directions for Adult and Continuing Education, 86*, 33-42.

Daley, B. (2001a). Learning and professional practice: A study of four professions. *Adult Education Quarterly, 52*(1), 39-54.

Daley, B. (2001b). Learning in clinical nursing practice. *Holistic Nursing Practice, 16*(1), 43-54.

Daley, B., & Mott, V. (2000). Continuing professional education: From vision to reality. *New Directions for Adult and Continuing Education, 86*, 80-85.

DeSilets, L. D. (1998). Accreditation of continuing education: The critical elements. *Journal of Continuing Education in Nursing, 29*(5), 204.

DeSilets, L. D., & Pinkerton, S. E. (2004). Looking back on 25 years of continuing education. *Journal of Continuing Education in Nursing, 35*(1), 12-13.

Dewey, J. (1938). *Experience and education*. New York, NY: Collier Books.

DiCenso, A., Guyatt, G., & Ciliska, D. (2005). *Evidence-based nursing: A guide to clinical practice*. St. Louis: Elsevier Mosby.

Dingwall, R., & Allen, D. (2001). The implications of healthcare reforms for the profession of nursing. *Nursing Inquiry, 8*(2), 64-74.

Dingwall, R., Rafferty, A. M., & Webster, C. (1988). The search for unity. In R. Dingwall, A. M. Rafferty, & C. Webster (Eds.), *An introduction to the social history of nursing* (pp. 77-97; (230-231). London, UK: Routledge.

Donaldson, S. K., & Crowley, D. M. (1978). The discipline of nursing. *Nursing Outlook, 26*(2), 113-120.

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher, 13*(3), 7-21.

Drummond, J. S. (2004). Nursing and the avant-garde. *International Journal for Nursing Studies, 41*, 525-533.

Duchscher, J. B. (2001). Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration, 31*(9), 426-439.

Duchscher, J. B. (2003). Critical thinking: Perceptions of newly graduated female baccalaureate nurses. *Journal of Nursing Education, 42*(1), 14-27.

Duchscher, J. B. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *Journal of Continuing Education in Nursing, 39*(10), 441-450.

Duchscher, J. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing, 65*(5), 1103-1113.

Duchscher, J. B., & Cowin, L. (2004). Multigenerational nurses in the workplace. *Journal of Nursing Administration, 34*(11), 493-501.

Duchscher, J. B., & Cowin, L. (2006). The new graduates' professional inheritance. *Nursing Outlook, 54*(3), 152-158.

Duchscher, J. B., & Myrick, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum, 43*(4), 191-206.

Dunne, J. (1996). *Back to the rough ground*. Notre Dame, IN: University of Notre Dame Press.

Dunne, J. (2011). Professional wisdom in practice. In L. Bondi, D. Carr, C. Clark, & C. Clegg (Eds.), *Towards professional wisdom* (pp. 13-16). Surrey, England: Ashgate.

Earvolino-Ramirez, M. (2007). Resilience: A concept analysis. *Nursing Forum, 42*(2), 73-82.

Edwards, S. D. (2009). Three versions of an ethics of care. *Nursing Philosophy, 10*(4), 231-240.

Effken, J. A. (2007). The informational basis for nursing intuition: Philosophical underpinnings. *Nursing Philosophy*, *8*(3), 187-200.

Eggertson, L. (2011). Targeted: The impact of bullying and what needs to be done to eliminate it. *Canadian Nurse, 107*(6), 16-20.

Eggertson, L. (2012). On the same team? Nurse-physician communication. *Canadian Nurse, 108*(5), 28-32.

Elias, J. L., & Merriam, S. B. (1995). *Philosophical foundations of adult education* (2nd ed.). Malabar, FL: Kreiger Publishing Co.

Ellerton, M., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3 months. *Journal of Continuing Education in Nursing, 34*(3), 103.

Emden, C., & Sandelowski, M. (1998). The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice, 4*, 206-212.

Emden, C., & Sandelowski, M. (1999). The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research. *International Journal of Nursing Practice, 5*, 2-7.

Engestrom, Y. (2001). Expansive learning at work: Toward an activity theoretical reconceptualization. *Journal of Education & Work, 14*(1), 133-156.

English, I. (1993). Intuition as a function of the expert nurse: A critique of Benner's novice to expert model. *Journal of Advanced Nursing, 18*, 387-393.

Eraut, M. (1985). Knowledge creation and knowledge use in professional contexts. *Studies in Higher Education, 10*(2), 117-133.

Eraut, M. (1994). *Developing professional knowledge and competence*. Oxon, UK: Routledge.

Eraut, M. (2000). Non-formal learning and tacit knowledge in professional work. *British Journal of Educational Psychology,* pp. 113-136.

Eraut, M. (2003). The many meanings of theory and practice. *Learning in Health & Social Care,* pp. 61-65.

Eraut, M. (2004a). Informal learning in the workplace. *Studies in Continuing Education, 26*(2), 247-273.

Eraut, M. (2004b). Transfer of knowledge between education and workplace settings. In H. Rainbird, A. Fuller, & A. Munro (Eds.), *Workplace learning in context* (pp. 201- 221). London, UK: Routledge.

Eraut, M. (2004c). The practice of reflection. *Learning in Health & Social Care, 3*(2), 47-52.

Eraut, M. (2004d). Sharing practice: Problems and possibilities. *Learning in Health & Social Care, 3*(4), 171-178.doi:10.1111/j.1473-6861.2004.00079.x

Eraut, M. (2005). Expert and expertise: Meanings and perspectives. *Learning in Health & Social Care, 4*(4), 173-179.

Eraut, M. (2007). Learning from other people in the workplace. *Oxford Review of Education, 33*(4), 403.

Eraut, M., Maillardet, F., Miller, C., Steadman, S., Ali, A. Blackman, C., & Furner, J. (2003, April). *Learning in the first professional job: The first year of full time employment after college for accountants, engineers and nurses*. Paper presented at the AERA, Chicago, IL.

Erickson, J. I., Duffy, M. E., Ditomassi, M., & Jones, D. (2009). Psychometric evaluation of the Revised Professional Practice Environment (RPPE) scale. *Journal of Nursing Administration, 39*(5), 236-243.

Eustace, L. W. (2001). Mandatory continuing education: Past, present, and future trends and issues. *Journal of Continuing Education in Nursing, 32*(3), 133-137.

Eva, K. W., & Regehr, G. (2008). "I'll never play professional football" and other fallacies of self-assessment. *Journal of Continuing Education in the Health Professions, 28*(1), 14-19.

Fawcett, J. (1978). The relationship between theory and research: A double helix. *Advances in Nursing Science, 1*(1), 49-62.

Fawcett, J. (1984). The metaparadigm of nursing: Present status and future requirements. *Image: The Journal of Nursing Scholarship, 16*(3), 84-87.

Fawcett, J. (1989). *Analysis and evaluation of conceptual models of nursing* (2nd ed.). Philadelphia, PA: F. A. Davis company.

Fawcett, J. (1992). Conceptual models and nursing practice: The reciprocal relationship. *Journal of Advanced Nursing, 17*(2), 224-228.

Fawcett, J. (1993). From a plethora of paradigms to parsimony in worldviews. *Nursing Science Quarterly, 6*(2), 56-58.

Fawcett, J. (1999). *The relationship of theory and research*. Philadelphia, PA: F. A. Davis.

Fawcett, J. (2003). On bed baths and conceptual models of nursing [Invited guest editorial]. *Journal of Advanced Nursing, 44*(3), 229-230.

Fawcett, J. (2005). *Contemporary nursing knowledge: Analysis and evaluation of nursing models* (2nd ed.). Philadelphia, PA: F. A. Davis Company.

Fenwick, T. (2000). Expanding conceptions of experiential learning: A review of the five contemporary perspectives on cognition. *Adult Education Quarterly, 50*(4).

Fenwick, T. (2006). Tidying the territory: Questioning terms and purposes in work-learning research. *Journal of Workplace Learning, 18*(5), 265-278.

Fenwick, T., Butterwick, S., & Mojab, S. (2003). Canadian adult education research in the 1990s: Tracing liberatory trends. (2), 1-19. *The Canadian Journal for the Study of Adult Education, 17*(2), 1-19.

Ferguson, L. M. (2006). *A grounded theory study of the new nurse's journey toward competence in clinical judgement* (Unpublished doctoral dissertation). University of Alberta, Canada.

Fink, R., Krugman, M., Casey, K., & Goode, C. (2008). The graduate nurse experience: Qualitative residency program outcomes. *Journal of Nursing Administration, 38*(7-8), 341-348.

Flinkman, M., Leino-Kilpi, H., & Salantera, S. (2010). Nurses' intention to leave the profession: Integrative review. *Journal of Advanced Nursing, 66*(7), 1422-1434.

Fontana, J. S. (2004). A methodology for critical science in nursing. *Advances in Nursing Science, 27*(2), 93-101.

Fox, R., Henderson, A., & Malko-Nyhan, K. (2005). 'They survive despite the organizational culture, not because of it': A longitudinal study of new staff perceptions of what constitutes support during the transition to an acute tertiary facility. *International Journal of Nursing Practice, 11*(5), 193-199.

Frank, A. (1991). *At the will of the body*. New York, NY: Mariner Books.

Freeman, A. R., McWilliam, C. L., MacKinnon, J. R., DeLuca, S., & Rappolt, S. G. (2009). Health professionals' enactment of their accountability obligations: Doing the best they can. *Social Science & Medicine, 69*(7), 1063-1071.

Frenk, J., Chen, L., Bhutta, A., Cohen, J., Crisp, N., Evans, T.,…Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet, 376*, 1923-1958.

Frost, N. (2001). Professionalism, change and the politics of lifelong learning. *Studies in Continuing Education, 23*(1), 5-17.

Fuller, A., Unwin, L., Felstead, A., Jewson, N., & Kakavelakis, K. (2007). Creating and using knowledge: An analysis of the differentiated nature of workplace learning environments. *British Educational Research Journal, 33*(5), 743-759.

Fuller, J. (1995). Challenging old notions of professionalism: How can nurses work with paraprofessional ethnic health workers? *Journal of Advanced Nursing, 22*(3), 465-472.

Funk, L. M., Stajduhar, K. I., & Purkis, M. E. (2011). An exploration of empowerment discourse within home-care nurses' accounts of practice. *Nursing Inquiry, 18*(1), 66-76.

Furze, G., & Pearcey, P. (1999). Continuing education in nursing: A review of the literature. *Journal of Advanced Nursing, 29*(2), 355-363.

Gadamer, H. G. (1996). *The enigma of health*. Stanford, CA: Stanford University Press.

Gallagher, A. (2005). Too clever to care? *Nursing Standard, 19*(18), 14-15.

Gallagher, P. (2004). How the metaphor of a gap between theory and practice has influenced nursing education. *Nurse Education Today, 24*, 263-268.

Gardner, L. (2012). From novice to expert: Benner's legacy for nurse education. *Nurse Education Today, 32*(4), 339-340.

Gaynor, L., Gallasch, T., Yorkston, E., Stewart, S., & Turner, C. (2006). Where do all the undergraduate and new graduate nurses go and why? A search for empirical research evidence. *Australian Journal of Advanced Nursing, 24*(2), 26-32.

Georges, J. M. (2005). Linking nursing theory and practice: A critical-feminist approach. *Advances in Nursing Science, 28*(1), 50-57.

Giger, J. N., & Davidhizar, R. E. (1990). Conceptual and theoretical approaches to patient care: Associate versus baccalaureate degree prepared nurses. *Journal of Advanced Nursing, 15*(9), 1009-1015.

Girot, E. A. (2000). Graduate nurses: Critical thinkers or better decision makers? *Journal of Advanced Nursing, 31*(2), 288-297.

Glaser, B. G. (1978). *Theoretical sensitivity*. San Francisco, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine de Gruyter.

Gobet, F., & Chassy, P. (2008). Towards an alternative to Benner's theory of expert intuition in nursing: A discussion paper. *International Journal of Nursing Studies, 45*(1), 129-139.

Goleman, D., Boyatzis, R., & McKee, A. (2002). *Primal leadership: Realizing the power of emotional intelligence*. Boston: Harvard Business School Press.

Gough, N. (2002, October). *Blank spots, blind spots, and methodological questions in post-graduate research.* Paper presented at the DUSA Post-graduate research conference, Melbourne, AU.

Griscti, O., & Jacono, J. (2006). Effectiveness of continuing education programmes in nursing: Literature review. *Journal of Advanced Nursing, 55*(4), 449-456.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*, 59-82.

Gunther, M., & Thomas, S. P. (2006). Nurses' narratives of unforgettable patient care events. *Journal of Nursing Scholarship, 38*(4), 370-376.

Gustafsson, C., Asp, M., & Fagerberg, I. (2007). Reflective practice in nursing care: Embedded assumptions in qualitative studies. *International Journal of Nursing Practice, 13*(3), 151-160.

Halford, S., & Leonard, P. (2003). Space and place in the construction and performance of gendered nursing identities. *Journal of Advanced Nursing, 42*(2), 201-208.

Hall, J. M. (2004). Marginalization and symbolic violence in a world of differences: War and parallels to nursing practice. *Nursing Philosophy, 5*(1), 41-53.

Hall, W. A., & Callery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research, 11*(2), 257-272. doi:10.1177/104973201129119082

Hanneman, S. K. (1996). Advancing nursing practice with a unit-based clinical expert. *Image: Journal of Nursing Scholarship, 28*(4), 331-337.

Harding, S. (1992). After the neutrality ideal: Science, politics, and "strong objectivity". *Social Research, 59*(3), 567-587.

Hardy, S., Garbett, R., Titchen, A., & Manley, K. (2002). Exploring nursing expertise: Nurses talk nursing. *Nursing Inquiry, 9*(3), 196-202.

Hardy, S., Titchen, A., & Manley, K. (2007). Patient narratives in the investigation and development of nursing practice expertise: A potential for transformation. *Nursing Inquiry, 14*(1), 80-88.

Hartigan, I., Murphy, S., Flynn, A. V., & Walshe, N. (2010). Acute nursing episodes which challenge graduate's competence: Perceptions of registered nurses. *Nurse Education in Practice, 10*(5), 291-297. doi:10.1016/j.nepr.2010.01.005

Hatcher, B. J., Bleich, M. R., Connolly, C., Davis, K., O'Neill Hewlett, P., & Stokley Hill, K. (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace.* Retrieved from Robert Wood Johnson Foundation: http://www.rwjf.org/files/publications/other/wisdomatwork.pdf

Hayes, J. H., & Scott, A. S. (2007). Mentoring partnerships as the wave of the future for new graduates. *Nursing Education Perspectives, 28*(1), 27-29.

Hegarty, J., Walsh, E., Condon, C., & Sweeney, J. (2009). The undergraduate education of nurses: Looking to the future. *International Journal of Nursing Education Scholarship, 6*(1), 1-11.

Henderson, A. (2001). Emotional labor and nursing: An underappreciated aspect of caring work. *Nursing Inquiry, 8*(2), 130-138.

Henderson, A., Briggs, J., Schoonbeek, S., & Paterson, K. (2011). A framework to develop a clinical learning culture in health facilities: Ideas from the literature. *International Nursing Review, 58*(2), 196-202.

Henderson, A., Fox, R., & Armit, L. (2008). Education in the clinical context: Establishing a strategic framework to ensure relevance. *Collegian, 15*(2), 63-68.

Herdman, E. A. (2001). The illusion of progress in nursing. *Nursing Philosophy, 2*, 4-13.

Hodges, B. (2006). Medical education and the maintenance of incompetence. *Medical Teacher, 28*(8), 690-696.

Hodges, B. (2007). Sylla or Charybdis: Navigating between excessive examination and naive reliance on self-assessment. *Nursing Inquiry, 14*(3), 177.

Hodges, H. F., Keeley, A. C., & Troyan, P. J. (2008). Professional resilience in baccalaureate-prepared acute care nurses: First steps. *Nursing Education Perspectives, 29*(2), 80-89.

Hodges, H. F., Troyan, P. J., & Keeley, A. C. (2010). Career persistence in baccalaureate-prepared acute care nurses. *Journal of Nursing Scholarship, 42*(1), 83-91.

Holland, K., Roxburgh, M., Johnson, M., Topping, K., Watson, R., Lauder, W., & Porter, M. (2010). Fitness for practice in nursing and midwifery education

in Scotland, United Kingdom. *Journal of Clinical Nursing, 19*(3/4), 461-469. doi:10.1111/j.1365-2702.2009.03056.x

Holmes, D., & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing, 38*(6), 557-565.

Hood, L. E., Olson, J., & Allen, M. N. (2007). Learning to care for spiritual needs: Connecting spiritually. *Qualitative Health Research, 17*(9), 1198-1206.

Horrocks, S. (2004). Saving Heidegger from Benner and Wrubel. *Nursing Philosophy, 5*(2), 175-181.

Hoyrup, S., & Elkjaer, B. (2006). Reflection: Taking it beyond the individual. In D. Boud, P. Cressey & P. Docherty (Eds.), *Productive reflection at work* (pp. 29-42). New York, NY: Routledge.

Hughes, C. (2004). The supervisor's influence on workplace learning. *Studies in Continuing Education, 26*(2), 275-287.

Izumi, S., Baggs, J. G., & Knafl, K. A. (2010). Quality nursing care for hospitalized patients with advanced illness: Concept development. *Research in Nursing & Health, 33*(4), 299-315.

Jantzen, D. (2004). *Learning stories: A study of positive learning experiences to create positive change* (Unpublished master's thesis). Royal Roads University, Victoria, BC.

Jantzen, D. (2008). Reframing professional development for first-line nurses. *Nursing Inquiry, 15*(1), 21-29.

Jensen, A., & Lidell, E. (2009). The influence of conscience in nursing. *Nursing Ethics, 16*(1), 31-42.

Johnson, D. E. (1966). Competence in practice: Technical and profession. *Nursing Outlook,14*(10),30-33.

Johnson, S. L. (2009). International perspectives on workplace bullying among nurses: A review. *International Nursing Review, 56*(1), 34-40.

Kalisch, B. J. (2006). Missed nursing care: A qualitative study. *Journal of Nursing Care Quality, 21*(4), 306-315.

Kalisch, B., Landstrom, G., & Williams, R. A. (2009). Missed nursing care: Errors of omission. *Nursing Outlook, 57*, 3-9.

Kazanjian, A., Green, C., Wong, J., & Reid, R. (2005). Effect of the hospital nursing environment on patient mortality: A systematic review. *Journal of Health Services Research & Policy, 10*(2), 111-117.

Kearney, M. H. (1998). Ready-to-wear: Discovering grounded formal theory. *Research in Nursing & Health, 21*, 178-186.

Kearns, R. (1993). Place and health: Towards a reformed medical geography. *The Professional Geographer, 46*, 67-72.

Keighley, T. (2006). From sickness to health. In S. Nelson & S. Gordon (Eds.), *The complexities of care* (pp. 88-103). Ithaca, NY: Cornell University Press.

Kelly, J., & Ahern, K. (2009). Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing, 18*(6), 910-918.

Ketefian, S., & Redman, R. W. (1997). Nursing science in the global community. *Journal of Nursing Scholarship, 29*(1), 11-15.

Kikuchi, J. F. (1992). Nursing questions that science cannot answer. In J. F. Kikuchi & H. Simmons (Eds.), *Philosophic inquiry in nursing* (pp. 26-37). Newbury Park, CA: Sage.

Kikuchi, J. F. (2003). Nursing theories: Relic or stepping stone? *Canadian Journal of Nursing Research, 35*(2), 3-7.

Kinsella, E. A., & Pitman, A. (Eds.). (2012). *Phronesis as professional knowledge: Practical wisdom in the professions*. Boston, MA: Sense Publishers.

Kirkwood, R. (1994). Blending vigorous leadership and womanly virtues: Edith Kathleen Russell at the University of Toronto, 1920-52. *Canadian Bulletin of Medical History, 11*, 175-205.

Kitson, A. (2002). Recognising relationships: Reflections on evidence-based practice. *Nursing Inquiry, 9*(3), 179-186.

Klaver, K., & Baart, A. (2011). Attentiveness in care: Towards a theoretical framework. *Nursing Ethics, 18*(5), 686-693. doi:10.1177/0969733011408052

Kouzes, J. M., & Posner, B. Z. (1995). *The leadership challenge* (2nd ed.). San Francisco, CA: Jossey-Bass.

Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. St. Louis, MO: Mosby.

Kramer, M., & Schmalenberg, C. (1988a). Magnet hospitals: Institutions of excellence. Part 1. *Journal of Nursing Administration, 18*(1), 13-24.

Kramer, M., & Schmalenberg, C. (1988b). Magnet hospitals: Institutions of excellence. Part 2. *Journal of Nursing Administration, 18*(2), 11-19.

Krugman, M., Bretschneider, J., Horn, P. B., Krsek, C. A., Moutafis, R. A., & Smith, M. O. (2006). The national post-baccalaureate graduate nurse residency program: A model for excellence in transition to practice. *Journal for Nurses in Staff Development, 22*(4), 196-205.

Krugman, M., & Warren, J. P. (2011). Professional development research literature from 1996 to 2006: An integrative review. *Journal for Nurses in Staff Development, 27*(3), 104-115.

Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago, IL: University of Chicago Press.

Laschinger, H. K. S., Finegan, J., & Wilk, P. (2009a). New graduate burnout: The impact of professional practice environment, workplace civility, and empowerment. *Nursing Economic$, 27*(6), 377-383.

Laschinger, H. K. S., Finegan, J., & Wilk, P. (2009b). Context matters: The impact of unit leadership and empowerment on nurses' organizational commitment. *Journal of Nursing Administration, 39*(5), 228-235.

Laschinger, H. K. S., & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout engagement. *Journal of Nursing Administration, 36*(5), 259-267.

Laschinger, H. K. S., Wilk, P., Cho, J., & Greco, P. (2009). Empowerment, engagement and perceived effectiveness in nursing work environments: Does experience matter? *Journal of Nursing Management, 17*(5), 636-646.

Lauder, W., Watson, R., Topping, K., Holland, K., Johnson, M., Porter, M.,…Behr, A. (2008). An evaluation of fitness for practice curricula: Self-efficacy, support and self-reported competence in preregistration student nurses and midwives. *Journal of Clinical Nursing, 17*(14), 1858-1867.

Lawler, J. (Ed.). (1997). *The body in nursing*. Singapore: Churchill Livingstone.

Leach, D. C. (2008). Competencies: From deconstruction to reconstruction and back again, lessons learned. *American Journal Of Public Health, 98*(9), 1562-1564.

Leadbetter, J. (2008). Learning in and for interagency working: making links between practice development and structured reflection. *Learning in Health & Social Care, 7*(4), 198-208.

Ledgister, M. (2003a). The nursing shortage crisis: A familiar problem dressed in new clothes: Part 1. *Leadership in Health Services, 16*(1), 11-18.

Ledgister, M. (2003b). The nursing shortage crisis: A familiar problem dressed in new clothes: Part 2. *Leadership in Health Services, 16*(1), 19-24.

Lencioni, P. (2002). *The five dysfunctions of a team: A leadership fable*. San Francisco, CA: Jossey-Bass.

Lencioni, P. (2005). *Overcoming the five dysfunctions of a team: A field guide for leaders, managers, and facilitators*. San Francisco, CA: Jossey-Bass.

Liaschenko, J., & Peter, E. (2004). Nursing ethics and conceptualizations of nursing: Profession, practice and work. *Journal of Advanced Nursing, 46*(5), 488-495.

Lindh, I., Severinsson, E., & Berg, A. (2009). Nurses' moral strength: A hermeneutic inquiry in nursing practice. *Journal of Advanced Nursing, 65*(9), 1882-1890.doi: 10.1111/j.1365-2648.2009.05047.x

Little, M. A., & Milliken, P. J. (2007). Practicing what we preach: Balancing teaching and clinical practice competencies. *International Journal of Nursing Education Scholarship, 4*(1), 1-14.

Longo, J. (2009). The relationships between manager and peer caring to registered nurses' job satisfaction and intent to stay. *International Journal for Human Caring, 13*(2), 26-33.

Lundgren, B. S., & Houseman, C. A. (2002). Continuing competence in selected health care professionals. *Journal of Allied Health, 31*(4), 232-240.

Luntley, M. (2010). What do nurses know? *Nursing Philosophy, 12*(1), 22-33.

Luntley, M. (2011). Expertise - Initiation into learning, not knowing. In L. Bondi, D. Carr, C. Clark, & C. Clegg (Eds.), *Towards professional wisdom* (pp. 27-44). Surrey, England: Ashgate Publishing Ltd.

Lutes, L. (2002). *Components of interprofessional health care team functioning.* University of Alberta, Edmonton, AB.

Lyneham, J., Parkinson, C., & Denholm, C. (2008). Explicating Benner's concept of expert practice: Intuition in emergency nursing. *Journal of Advanced Nursing*, *64*(4), 380-387. doi:10.1111/j.1365-2648.2008.04799.x

MacDonald, M. (2001). Finding a critical perspective in grounded theory. In R. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 113-157). New York, NY: Springer Publishing Company.

MacIntosh, J. (2003). Reworking professional nursing identity. *Western Journal of Nursing Research, 25*(6), 725-741.

MacKay, R., Grantham, M., Ross, S., Brown, J., & Beanlands, H. (1990). Evaluating the competence of clinical nurses from beginning to advanced practitioner. *Canadian Journal of Nursing Administration, 3*(3), 25-29.

MacKinnon, K. (2010). Learning maternity: The experiences of rural nurses. *Canadian Journal of Nursing Research, 42*(1), 38-55.

Mackintosh, C. (1998). Reflection: A flawed strategy for the nursing profession. *Nurse Education Today, 18*(7), 553-557.

MacLeod, M. (1994). 'It's the little things that count': The hidden complexity of everyday clinical nursing practice. *Journal of Clinical Nursing, 3*(6), 361-368.

MacLeod, M. (1996). *Practising nursing - Becoming experienced*. Singapore: Churchill Livingstone.

Maeve, M. K. (1994). The carrier bag theory of nursing practice. *Advances in Nursing Science, 16*(4), 9-22.

Malone, R. E. (2003). Distal nursing. *Social Science & Medicine, 56*(11), 2317-2326.

Mamchur, C., & Myrick, F. (2003). Preceptorship and interpersonal conflict: A multidisciplinary study. *Journal of Advanced Nursing, 43*(2), 188-196.

Manis, J. G., & Meltzer, B. N. (1978). Intellectual antecedents and basic propositions of symbolic interactionism. In J. G. Manis & B. N. Meltzer (Eds.), *Symbolic interaction: A reader in social psychology* (3rd ed., pp. 1-10). Boston: MA: Allyn and Bacon.

Manley, K., & Garbett, R. (2000). Paying Peter and Paul: Reconciling concepts of expertise with competency for a clinical career structure. *Journal of Clinical Nursing, 9*(3), 347-359.

Manley, K., Hardy, S., Titchen, A., Garbett, R., & McCormack, B. (2005). *Changing patients' worlds through nursing practice expertise*. London, UK: Royal College of Nursing.

Manojlovich, M., & Laschinger, H. (2007). The nursing worklife model: Extending and refining a new theory. *Journal of Nursing Management, 15*(3), 256-263.

Mansell, D., & Dodd, D. (2005). Professionalism and Canadian nursing. In C. Bates, D. Dodd, & N. Rousseau (Eds.), *On all frontiers: Four centuries of Canadian nursing* (pp. 197-211). Ottawa, ON: University of Ottawa Press.

Mantesso, J., Petrucka, P., & Bassendowski, S. (2008). Continuing professional competence: Peer feedback success from determination of nurse locus of control. *Journal of Continuing Education in Nursing, 39*(5), 200-207.

Mantzoukas, S. (2004). Issues of representation within qualitative inquiry. *Qualitative Health Research, 14*(7), 994-1007. doi: 10.1177/104932304265959

Mantzoukas, S. R., & Watkinson, S. (2008). Redescribing reflective practice and evidence-based practice discourses. *International Journal of Nursing Practice, 14*(2), 129-134.

Marsick, V. J., & Watkins, K. E. (2001). Informal and incidental learning. In S. B. Merriam (Ed.), *The new update on adult learning theory* (Vol. 89, pp. 25-34). San Francisco, CA: Jossey-Bass.

May, C. (1992). Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health & Illness, 14*(4), 472-487.

McCutcheon, H. H. I., & Pincombe, J. (2001). Intuition: An important tool in the practice of nursing. *Journal of Advanced Nursing, 35*(3), 342-348.

McGhee, G., Marland, G. R., & Atkinson, J. (2007). Grounded theory research: Literature reviewing and reflexivity. *Journal of Advanced Nursing, 60*(3), 334-342. doi:10.1111.j.1365-2648.2007.044363.x

McGillis Hall, L. (2003). Nursing staff mix models and outcomes. *Journal of Advanced Nursing, 44*(2), 217-226. doi:10.1046/j.1365-2648.2003.02786.x

McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96.

McLaughlin, S., Gorley, L., & Moseley, L. (2009). The prevalence of verbal aggression against nurses. *British Journal of Nursing, 18*(12), 735-739.

McPherson, K. (1996). *Bedside matters: The transformation of Canadian nursing, 1900-1990*. Toronto, ON: Oxford University Press.

McPherson, K. (2005). The Nightingale influence and the rise of the modern hospital. In C. Bates, D. Dodd, & N. Rousseau (Eds.), *On all frontiers: Four centuries of Canadian nursing* (pp. 73-88). Ottawa, ON: University of Ottawa Press.

McVicar, A. (2003). Workplace stress in nursing: A literature review. *Journal of Advanced Nursing, 44*(6), 633-642.

Meleis, A. I. (2007). *Theoretical nursing: Development and progress* (4th ed.). Philadelphia, PA: Lippincott, Williams & Wilkins.

Mezirow, J. (1990). *Fostering critical reflection in adulthood: A guide to transformative learning and emancipatory learning*. San Francisco, CA: Jossey-Bass Inc.

Milisen, K., Abraham, I., Siebens, K., Darras, E., & Dierckx de Casterlé, B. (2006). Work environment and workforce problems: A cross-sectional questionnaire survey of hospital nurses in Belgium. *International Journal of Nursing Studies, 43*(6), 745-754.

Miller, B. K., & Boud, D. (1996). Animating learning from experience. In D. Boud & B. K. Miller (Eds.), *Working with experience: Animating learning* (pp. 3-13). London, UK: Routledge.

Milliken, P.J., & Schreiber, R.S. (2001). Can you "do" grounded theory without symbolic interactionism? In Schreiber, R. & Stern, P. N. (Eds.), *Using grounded theory in nursing* (pp. 177-190). New York, NY: Springer Publishing Company.

Mills, J., Chapman, Y., Bonner, A., & Francis, K. (2007). Grounded theory: A methodological spiral from positivism to postmodernism. *Journal of Advanced Nursing, 58*(1), 72-79.

Mitchell, G. J. (1994). Intuitive knowing: Exposing a myth in theory development. *Nursing Science Quarterly, 7*(1), 2-3.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. New York, NY: Routledge.

Montgomery, P., & Bailey, P. H. (2007). Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research, 29*(1), 65-79.

Mooney, M. (2007). Professional socialization: The key to survival as a newly qualified nurse. *International Journal of Nursing Practice, 13*(2), 75-80.

Morrow, S. (2009). New graduate transitions: Leaving the nest, joining the flight. *Journal of Nursing Management, 17*(3), 278-287.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147-149.

Morse, J. M. (1997). Theory derived from qualitative research. In J. M. Morse (Ed.), *Completing a qualitative project* (pp. 163-188). Thousand Oaks, CA: Sage.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1-19.

Morse, J. M., Stern, P. N., Corbin, J. M., Bowers, B., Charmaz, K., & Clarke, A. (2009). *Developing grounded theory: The second generation*. Walnut Creek, CA: Left Coast Press, Inc.

Munro, K. M. (2008). Continuing professional development and the charity paradigm: Interrelated individual, collective and organisational issues about continuing professional development. *Nurse Education Today, 28*(8), 953-961.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 41*(4), 154-164.

Myrick, F. (2004). Pedagogical integrity in the knowledge economy. *Nursing Philosophy, 5*(1), 23-29.

Myrick, F., & Yonge, O. (2004). Enhancing critical thinking in the preceptorship experience in nursing education. *Journal of Advanced Nursing, 45*(4), 371-380.

n.a. (1996). Emerging licensing issues in Canada and the US. *International Nursing Review, 43*(4), 113.

National Working Group on Continuing Competence (NWGCC). (2000). *A national framework for continuing competence programs for registered nurses*. Ottawa, ON: Canadian Nurses Association.

Nelson, S. (2001a). S*ay little, do much: Nursing, nuns, and hospitals in the nineteenth century*. Philadelphia, PA: University of Pennsylvania Press.

Nelson, S. (2001b). From salvation to civics: Service to the sick in nursing discourse. *Social Science & Medicine, 53*, 1217-1225.

Nelson, S. (2004). The search for the good in nursing? The burden of ethical expertise. *Nursing Philosophy, 5*(1), 12-22.

Nelson, S. (2006). Ethical expertise and the problem of the good nurse. In S. Nelson & S. Gordon (Eds.), *The complexities of care: Nursing reconsidered* (pp. 69-87). Ithaca, NY: Cornell University Press.

Nelson, S., & Gordon, S. (Eds.). (2006). *The complexities of care: Nursing reconsidered*. Ithaca, NY: Cornell University Press.

Nelson, S., & Gordon, S. (2009). The 'core of nursing': knowledge and skill. *Nursing Inquiry, 16*(1), 1-2.

Nelson, S., & McGillion, M. (2004). Expertise or performance? Questioning the rhetoric of contemporary narrative use in nursing. *Journal of Advanced Nursing, 47*(6), 631-638.

Nelson, S., & Purkis, M. E. (2004). Mandatory reflection: The Canadian reconstitution of the competent nurse. *Nursing Inquiry, 11*(4), 247-257.

Nelson, S., & Rafferty, A. M. (Eds.). (2010). *Notes on Nightingale: the influence and legacy of a nursing icon*. New York, NY: Cornell University.

Newhouse, R. P., Hoffman, J. J., Suflita, J., & Hairston, D. P. (2007). Evaluating an innovative program to improve new nurse graduate socialization into the acute healthcare setting. *Nursing Administration Quarterly, 31*(1), 50-60.

Newman, S., & Lawler, J. (2009). Managing health care under new public management. *Journal of Sociology 45*(4), 419-432. doi:10.1177/1440783309346477

Newton, J. M. (2011). Reflective learning groups for student nurses. In S. Billett & A. Henderson (Eds.), *Developing Learning Professionals* (pp. 119-130). New York, NY: Springer.

Newton, J. M., & McKenna, L. (2007). The transitional journey through the graduate year: A focus group study. *International Journal of Nursing Studies, 44*(7), 1231-1237.

Nightingale, F. (1859/1863). *Notes on hospitals*. London, UK: Longman, Green, Longman, Roberts and Green.

Nightingale, F. (1860). *Notes on nursing: What it is, and what it is not*. London, UK: Harrison and Sons

Northrup, D. T., Tschanz, C. L., Olynyk, V., Shick Makaroff, K., Szabo, J., & Biasio, H. (2004). Nursing: Whose discipline is it anyway? *Nursing Science Quarterly*, *17*(1), 55-62.

Ohlen, J., & Segesten, K. (1998). The professional identity of the nurse: Concept analysis and development. *Journal of Advanced Nursing*, *28*(4), 720-727.

O'Leary, K. A., Estabrooks, C. A., Olson, K., & Cumming, C. (2007). Information acquisition for women facing surgical treatment for breast cancer: Influencing factors and selected outcomes. *Patient Education & Counseling*, *69*(1-3), 5-19.

Olson, K. (1993). Creating the impetus for research-based practice. *Canadian Nurse*, *89*(1), 36-39.

Olson, K. (1996). Evaluation of a weekly flushing policy for central venous catheters. *Canadian Oncology Nursing Journal*, *6*(2), 75-76.

Olson, K. (2007). A new way of thinking about fatigue: A reconceptualization. *Oncology Nursing Forum*, *34*(1), 93-99.

Olson, K., Hanson, J., Hamilton, J., Stacey, D., Eades, M., Gue, D.,…Oliver, C. (2004). Assessing the reliability and validity of the revised WCCNR stomatitis staging system for cancer therapy-induced stomatitis. *Canadian Oncology Nursing Journal, 14*(3), 168-174.

Olson, K., Hanson, J., & Michaud, M. (2003). A phase II trial of Reiki for the management of pain in advanced cancer patients. *Journal of Pain & Symptom Management, 26*(5), 990-997.

Olson, K., Hayduk, L., Cree, M., Cui, Y., Quan, H., Hanson, J.,…Strasser, F. (2008). The changing causal foundations of cancer-related symptom clustering during the final month of palliative care: A longitudinal study. *BMC Medical Research Methodology, 8*, 36-36.

Olson, K., Rogers, W. T., Cui, Y., Cree, M., Baracos, V., Rust, T.,…Bonville, N. (2011). Development and psychometric testing of the Adaptive Capacity Index, an instrument to measure adaptive capacity in individuals with advanced cancer. *International Journal of Nursing Studies, 48*(8), 986-994.

Olson, K., Tom, B., Hewitt, J., Whittingham, J., Buchanan, L., & Ganton, G. (2002). Evolving routines: Preventing fatigue associated with lung and colorectal cancer. *Qualitative Health Research, 12*(5), 655-670.

Ousey, K. (2009). Socialization of student nurses -- The role of the mentor. *Learning in Health & Social Care, 8*(3), 175-184.

Owen, S. M., & Stupans, I. (2009). Experiential placements and scaffolding for reflection. *Learning in Health & Social Care, 8*(4), 272-281.

Paley, J. (1996). Intuition and expertise: Comments on the Benner debate. *Journal of Advanced Nursing, 23*(4), 665-671.

Paley, J. (1997). Husserl, phenomenology and nursing. *Journal of Advanced Nursing, 26*(1), 187-193.

Paley, J. (1998). Misinterpretive phenomenology: Heidegger, ontology and nursing research. *Journal of Advanced Nursing, 27*(4), 817-824.

Paley, J. (2000). Heidegger and the ethics of care. *Nursing Philosophy, 1*(1), 64-75.

Paley, J. (2004). Clinical cognition and embodiment. *International Journal of Nursing Studies, 41*(1), 1-13.

Paley, J. (2006). Evidence and expertise. *Nursing Inquiry, 13*(2), 82-93.

Pask, E. (1995). Trust: An essential component of nursing practice - implications for nursing education. *Nurse Education Today, 14*, 190-195.

Pask, E. (1997). Developing Moral Imagination and the Influence of Belief. *Nursing Ethics, 4*(3), 202-210.

Pask, E. (2001). Nursing responsibility and conditions of practice: Are we justified in holding nurses responsible for their behaviour in situations of patient care? *Nursing Philosophy, 2*, 42-52.

Pask, E. J. (2003). Moral agency in nursing: Seeing value in the work and believing that I make a difference. *Nursing Ethics, 10*(2), 165-174. doi:10.1191/0969733003ne591oa

Pask, E. (2005). Self-sacrifice, self-transcendence and nurses' professional self. *Nursing Philosophy, 6*, 247-254.

Paul, P. (1994). The contribution of the Grey Nuns to the development of nursing in Canada: Historiographical issues. *Canadian Bulletin of Medical History, 11*, 201-217.

Paul, P. (2000). The history of the relationship between nursing and faith traditions. In M. Clark & J. Olson (Eds.), *Nursing within a faith community: Promoting health in times of transition* (pp. 59-74). Thousand Oaks, CA: Sage Publications Inc.

Paul, P., & Ross-Kerr, J. C. (1995). A philosophy of care: The Grey Nuns of Montreal. In B. Hesketh & F. Swyripa (Eds.), *Edmonton: The life of a city* (pp. 126-134). Edmonton, AB: Newest Publishers Ltd.

Penz, K., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D., & Smith, B. (2007). Barriers to participation in continuing education activities among rural and remote nurses. *Journal of Continuing Education in Nursing, 38*(2), 58-68.

Picheral, H. E. (1994). Place, space and health. *Social Science & Medicine, 39*(12), 1589-1590.

Pillow, W. S. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education, 16*(2), 175-196. doi:10.1080/0951839032000060635

Pine, R., & Tart, K. (2007). Return on investment: Benefits and challenges of a baccalaureate nurse residency program. *Nursing Economic$, 25*(1), 13.

Poghosyan, L., Clarke, S. P., Finlayson, M., & Aiken, L. H. (2010). Nurse burnout and quality of care: Cross-national investigation in six countries. *Research in Nursing & Health, 33*(4), 288-298.

Polifroni, E. C., & Welch, M. (Eds.). (1999). *Perspectives on philosophy of science in nursing: An historical and contemporary anthology*. Philadelphia, PA: Lippincott, Williams & Wilkins.

Polit, D. F., & Hungler, B. P. (Eds.). (1999). *Nursing research: Principles and methods* (6th ed.). Philadelphia, PA: Lippincott.

Porter, S. (1992). The poverty of professionalization: A critical analysis of strategies for the occupational advancement of nursing. *Journal of Advanced Nursing, 17*(6), 720-726.

Porter, S. (1998). *Social theory and nursing practice.* New York, NY: Palgrave Macmillan.

Purkis, M. E. (1994). Entering the field: Intrusions of the social and its exclusion from studies of nursing practice. *International Journal of Nursing Studies, 31*(4), 315-336.

Purkis, M. E. (2001). Managing home nursing care: Visibility, accountability and exclusion. *Nursing Inquiry*, *8*(3), 141-150.

Purkis, M. E. (2002). Governing the health of populations: Conversations in the clinic. In L. E. Young & V. Hayes (Eds.), *Transforming health promotion practice* (pp. 190-206). Philadelphia, PA: FA Davis.

Purkis, M. E. (2007). Aftermath of the curriculum revolution: What did we overthrow? In L. E. Young & B. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (pp. 364-382). Philadelphia, PA: Lippincott Williams & Wilkins.

Purkis, M. E., & Bjornsdottir, K. (2006). Intelligent nursing: Accounting for knowledge as action in practice. *Nursing Philosophy, 7*, 247-256.

Pyles, S. H., & Stern, P. N. (1983). Discovery of nursing gestalt in critical care nursing: The importance of the gray gorilla syndrome. *Image: The Journal of Nursing Scholarship, 15*(2), 51-57.

Rafferty, A. M., & Clarke, S. P. (2009). Nursing workforce: A special issue. *International Journal of Nursing Studies, 46*(7), 875-878.

Rankin, J. M. (2003). 'Patient satisfaction': Knowledge for ruling hospital reform -- An institutional ethnography. *Nursing Inquiry*, *10*(1), 57-65.

Rankin, J. M., & Campbell, M. L. (2006). *Managing to nurse: Inside Canada's health care reform*. Toronto, ON: University of Toronto Press.

Rashotte, J. (2005). Knowing the nurse practitioner: Dominant discourses shaping our horizons. *Nursing Philosophy*, *6*(1), 51-62.

Rechel, B., Buchan, J., & McKee, M. (2009). The impact of health facilities on healthcare workers' well-being and performance. *International Journal of Nursing Studies, 46*(7), 1025-1034.

Reed, P. G., & Lawrence, L. A. (2008). A paradigm for the production of practice-based knowledge. *Journal of Nursing Management,* 16, 422-432.

Reed, P. G., & Runquist, J. J. (2007). Reformulation of a methodological concept in grounded theory. *Nursing Science Quarterly, 20*(2), 118-122.

Reed, P. G., & Shearer, N. C. (Eds.). (2011). *Nursing knowledge and theory innovation*. New York, NY: Springer Publishing Ltd.

Reed, P. G., Shearer, N. C., & Nicoll, L. H. (2004). *Perspectives on nursing theory* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Richards, L., & Morse, J. M. (2007). *User's guide to qualitative methods* (2nd ed.). Thousand Oaks, CA: Sage.

Richards, L., & Potgieter, E. (2010). Perceptions of registered nurses in four state health institutions on continuing formal education. *Curationis, 33*(2), 41-50.

Risjord, M. (2009). Rethinking concept analysis. *Journal of Advanced Nursing, 65*(3), 684-691. doi: 10.1111/j.1365-2648.2008.04903.x

Risjord, M. (2010). *Nursing knowledge: Science, practice, and philosophy*. West Sussex, UK: Wiley-Blackwell.

Rolfe, G. (1997). Science, abduction and the fuzzy nurse: An exploration of expertise. *Journal of Advanced Nursing, 25*, 1070-1075.

Rolfe, G., & Gardner, L. (2006). Education, philosophy and academic practice: Nursing studies in the posthistorical university. *Nurse Education Today, 26*(8), 634-639.

Romanow, R. (2002). Building on values: The future of health care in Canada. Retrieved from http://www.hc-sc.gc.ca/english/pdf/care/romanow.

Romyn, D. M., Linton, N., Giblin, C., Hendrickson, B., Limacher, L. H., Murray, C.,…Zimmel, C. M. (2009). Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship, 6*(1), 1-17.

Roxburgh, M., Watson, R., Holland, K., Johnson, M., Lauder, W., & Topping, K. (2008). A review of curriculum evaluation in United Kingdom nursing education. *Nurse Education Today, 28*(7), 881-889.

Royal College of Nursing (RCN). (2005). *The RCN expertise in practice project*. London, UK: Royal College of Nursing

Ruth-Sahd, L. A., & Hendy, H. M. (2005). Predictors of novice nurses' use of intuition to guide patient care decisions. *Journal of Nursing Education, 44*(10), 450-458.

Ruth-Sahd, L. A., & Tisdell, E. J. (2007). The meaning and use of intuition in novice nurses: A phenomenological study. *Adult Education Quarterly, 57*(2), 115-140.

Rutty, J. E. (1998). The nature of philosophy of science, theory and knowledge relating to nursing and professionalism. *Journal of Advanced Nursing, 28*(2), 243-250.

Ryan, A., Goldberg, L., & Evans, J. (2010). Wise women: Mentoring as relational learning in perinatal nursing practice. *Journal of Clinical Nursing, 19*, 183-191.

Salt, J., Cummings, G. G., & Profetto-McGrath, J. (2008). Increasing retention of new graduate nurses: A systematic review of interventions by healthcare organizations. *Journal of Nursing Administration, 38*(6), 287-296.

Salvage, J. (1988). Professionalization—or struggle for survival? A consideration of current proposals for the reform of nursing in the United Kingdom. *Journal of Advanced Nursing, 13*(4), 515-519.

Sandelowski, M. (2002). Visible humans, vanishing bodies, and virtual nursing: Complications of life, presence, place and identity. *Advances in Nursing Science, 24*(3), 58-70.

Sargeant, J. (2008). Toward a common understanding of self-assessment. *Journal of Continuing Education in the Health Professions, 28*(1), 1-4.

Sawyer, A., Green, D., Moran, A., & Brett, J. (2009). Should the nurse change the light globe?: Human service professionals managing risk on the frontline. *Journal of Sociology, 45*(4), 361-381. doi:10.1177/1440783309346478

Schluter, J., Winch, S., Holzhauser, K., & Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: A literature review. *Nursing Ethics, 15*(3), 304-321.

Schoessler, M., & Waldo, M. (2006a). The first 18 months in practice: A developmental transition model for the newly graduated nurse. *Journal for Nurses in Staff Development, 22*(2), 47-54.

Schoessler, M., & Waldo, M. (2006b). Organizational infrastructure to support development of newly graduated nurses. *Journal for Nurses in Staff Development, 22*(6), 286-295.

Scholes, J. (2008). Coping with the professional identity crisis: Is building resilience the answer? *International Journal of Nursing Studies, 45*(7), 975-978.

Schon, D. (1983). *The reflective practitioner*. New York, NY: HarperCollins Publishers.

Schreiber, R. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. Schreiber & P. N. Stern (Eds.), *Using grounded theory*. New York, NY: Springer Publishing Company.

Schreiber, R., & Stern, P. N. (Eds.). (2001). *Using grounded theory in nursing*. New York, NY: Springer Publishing Company.

Schweitzer, D. J., & Krassa, T. J. (2010). Deterrents to nurses' participation in continuing professional development: An integrative literature review. *Journal of Continuing Education in Nursing, 41*(10), 441-447.

Scott, J. G., Sochalski, J., & Aiken, L. (1999). Review of magnet hospital research: Findings and implications for professional nursing practice. *Journal of Nursing Administration, 29*(1), 9-19.

Scott, S. M., Spencer, B., & Thomas, A. M. (Eds.). (1998). *Learning for life: Canadian readings in adult education*. Toronto, ON: Thompson Educational Publishing Inc.

Secretan, L. H. K. (1997). *Reclaiming higher ground: Creating organizations that inspire the soul*. Toronto, ON: Macmillan Canada.

Sellman, D. (2000). Alasdair MacIntyre and the professional practice of nursing. *Nursing Philosophy*, *1*(1), 26-33.

Sellman, D. (2011). *What makes a good nurse*. London, UK: Jessica Kingsley Publisher.

Sellman, D. (2012). Reclaiming competence for professional phronesis. In E. A. Kinsella & A. Pitman (Eds.), *Phronesis as professional knowledge: Practical wisdom in the professions* (pp. 115-130). Rotterdam, NL: Sense.

Shaha, S. H. (2010). Nursing makes a significant difference: A multihospital correlational study. *Nurse Leader*, *8*(3), 36-39.

Sherratt, Y. (2006). *Continental philosophy of social science*. New York, NY: Cambridge University Press.

Shulman, L. (2010). Forward. In P. Benner, M. Sutphen, P. Leonard, & L. Day (Eds.), *Educating nurses: A call for radical transformation* (pp. ix-xvii). San Francisco, CA: Jossey-Bass.

Siebens, K., Casterlé, B. D. D., Abraham, I., Dierckx, K., Braes, T., Darras, E.,…Milisen, K. (2006). The professional self-image of nurses in Belgian

hospitals: A cross-sectional questionnaire survey. *International Journal of Nursing Studies, 43*(1), 71-82.

Silver, I., Campbell, C., Marlow, B., & Sargeant, J. (2008). Self-assessment and continuing professional development: The Canadian perspective. *Journal of Continuing Education in the Health Professions, 28*(1), 25-31.

Simon, M., Muller, B. H., & Hasselhorn, H. M. (2010). Leaving the organization or the profession - A multilevel analysis of nurses' intentions. *Journal of Advanced Nursing, 66*(3), 616-626.

Simons, S. R., & Mawn, B. (2010). Bullying in the workplace -- A qualitative study of newly licensed registered nurses. *AAOHN Journal, 58*(7), 305-311.

Skar, R. (2009). The meaning of autonomy in nursing practice. *Journal of Clinical Nursing, 19*(15-16), 2226-2234.

Slaikeu, K. N. (2011). Addressing the preparation/practice gap: A new era, new approach. *Nurse Leader, 9*(2), 46-49.

Slusher, I. L., Logsdon, C., Johnson, E., Parker, B., Rice, J., & Hawkins, B. (2000). Continuing education in nursing: A 10-year retrospective study of CE offerings presented by the Kentucky Nurses Association. *Journal of Continuing Education in Nursing, 31*(5), 219-223.

Smith, L. M., Andrusyszyn, M. A., & Laschinger, H. K. S. (2010). Effects of workplace incivility and empowerment on newly-graduated nurses'

organizational commitment. *Journal of Nursing Management, 18*(8), 1004-1015.

Soanes, C. & Stevenson, A. (2008). *Concise oxford English dictionary* (OED) (11th ed.). New York, NY: Oxford University Press.

Sochalski, J. (2002). Nursing shortage redux: Turning the corner on an enduring problem. *Health Affairs, 21*(5), 157-164.

Spouse, J. (2001). Bridging theory and practice in the supervisory relationship: A sociocultural perspective. *Journal of Advanced Nursing, 33*(4), 512.

Steadman, S. (2005, December). *Practically perfect? Excellence in practice-based educational research*. Paper presented at the ESRC TLRP Seminar Series: Quality in Educational Research, Oxford, UK.

Stein, A. M. (1998). History of continuing nursing education in the United States. *Journal of Continuing Education in Nursing, 29*(6), 245-252.

Stein, L. I. (1968). The doctor-nurse game. *American Journal of Nursing, 68*(1), 101-105.

Stein, L. I., Watts, D. T., & Howell, T. (1990). The doctor-nurse game revisited. *Nursing Outlook, 38*(6), 264-268.

Street, A. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Albany, NY: State University of New York Press.

Stern, P. N. (2009). In the beginning Glaser and Strauss created grounded theory. In J. M. Morse, P. N. Stern, J. M. Corbin, B. Bowers, K. Charmaz, & A.

Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 24-29). Walnut Creek, CA: Left Coast Press.

Suddaby, R. (2006). From the editors: What grounded theory is not. *Academy of Management Journal, 49*(4), 633-642.

Svensson, R. (1996). The interplay between doctors and nurses: A negotiated order perspective. *Sociology of Health & Illness, 18*(3), 379-398. doi:10.1111/1467-9566.ep10934735

Sweet, S. J., & Norman, I. (1995). The nurse-doctor relationship: A selective literature review. *Journal of Advanced Nursing, 22*, 165-170.

Tabari-Khomeiran, R., Kiger, A., Parsa-Yekta, Z., & Ahmadi, F. (2007). Competence development among nurses: The process of constant interaction. *Journal of Continuing Education in Nursing, 38*(5), 211-218.

Tanner, C. (1990). Reflections on the curriculum revolution. *Journal of Nursing Education, 29*(7), 295-299.

Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education, 45*(6), 204-211.

Tanner, C. A. (2007). The curriculum revolution revisited. *Journal of Nursing Education, 46*(2), 51-52.

Tanner, C. A. (2010). Transforming prelicensure nursing education: Preparing the new nurse to meet emerging health care needs. *Nursing Education Perspectives, 31*(6), 347-353.

Taylor, B. J. (2010). *Reflective practice: A Guide for nurses and midwives* (3rd ed). Buckingham, UK: Open University Press.

Taylor, C. (1991). *The ethics of authenticity*. Cambridge, MA: Harvard University Press.

Teekman, B. (2000). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing, 31*(5), 1125-1135.

Teel, P. (2011). *The metaphysics of dappledness: Charles S. Peirce and Nancy Cartwright on the philosophy of science* (Unpublished doctoral dissertation). University of Victoria, Victoria, BC.

Tellis-Nayak, M., & Tellis-Nayak, V. (1984). Games that professionals play: The social psychology of physician-nurse interaction. *Social Science & Medicine, 18*(12), 1063-1069.

Thorne, S. (1997). The art (and science) of critiquing qualitative research. In J. M. Morse (Ed.), *Completing a qualitative project: Details and dialogue* (pp. p. 117-132.). Thousand Oaks, CA: Sage.

Thorne, S. (2006). Nursing education: Key issues for the 21st century. *Nurse Education Today, 26*, 614-621.

Thorne, S., Canam, C., Dahinten, S., Hall, W., Henderson, A., & Kirkham, S. R. (1998). Nursing's metaparadigm concepts: Disempacting the debates. *Journal of Advanced Nursing, 27*, 1257-1268.

Thorne, S., Henderson, A., McPherson, G., & Pesut, B. (2004). The problematic allure of the binary in nursing theoretical discourse. *Nursing Philosophy, 5*, 208-215.

Thomas, M., & Fothergill-Bourbonnais, F. (2005). Clinical judgments about endotracheal suctioning: What cues do expert pediatric critical care nurses consider? *Critical Care Nursing Clinics of North America, 17*(4), 329-340.

Tornyay, R. (1990). The curriculum revolution. *Journal of Nursing Education, 29*(7), 292-294.

Tourangeau, A. E., Doran, D. M., McGillis Hall, L., Pallas, L. O. B., Pringle, D., Tu, J. V., & Cranley, L.A. (2007). Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing, 57*(1), 32-44.

Tsang, K. L., Carlson, L. E., & Olson, K. (2007). Pilot crossover trial of Reiki versus rest for treating cancer-related fatigue. *Integrative Cancer Therapies, 6*(1), 25-35.

Turkoski, B. B. (1995). Professionalism as ideology: A socio-historical analysis of the discourse of professionalism in nursing. *Nursing Inquiry, 2*(2), 83-89.

Unwin, L., Felstead, A., Fuller, A., Bishop, D., Lee, T., Jewson, N., Butler, P. (2007). Looking inside the Russian doll: The interconnections between context, learning and pedagogy in the workplace. *Pedagogy, Culture & Society, 15*(3), 333-348.

Van den Heede, K., Clarke, S. P., Sermeus, W., Vleugels, A., & Aiken, L. H. (2007). International experts' perspectives on the state of the nurse staffing and patient outcomes literature. *Journal of Nursing Scholarship, 39*(4), 290-297.

Violette, B. (2005). Healing the body and saving the soul: Nursing sisters and the first Catholic hospitals in Quebec (1639-1880). In C. Bates, D. Dodd & N. Rousseau (Eds.), *On all frontiers: Four centuries of Canadian nursing* (pp. 57-72). Ottawa, ON: University of Ottawa Press.

Vujicic, M. (2003). *Recent trends in the nursing labour market in Canada.* (Unpublished doctoral dissertation). University of British Columbia, Victoria, BC.

Waddell, D. L. (1991). The effects of continuing education on nursing practice: A meta-analysis. *Journal of Continuing Education in Nursing, 22*(3), 113-118.

Wall, S. (2010). Critical perspectives in the study of nursing work. *Journal of Health Organization and Management, 24*(2), 145-166.

Wall, S., & Austin, W. (2008). The influence of teams, supervisors and organizations on healthcare practitioners' abilities to practise ethically. *Nursing Research, 21*(4), 69-83.

Watkins, M. J. (2000). Competency for nursing practice. *Journal of Clinical Nursing, 9*(3), 338-346.

Welton, M. R. (1998). The struggle of memory against forgetting. In S. M. Scott, B. Spencer & A. M. Thomas (Eds.), *Learning for life: Canadian readings in adult education* (pp. 35-45). Toronto, ON: Thompson Education Publishing.

Wheatley, M. J. (1999). *Leadership and the new science* (2nd ed.). San Francisco, CA: Berret-Koehler.

Wheeler, H. H., Cross, V., & Anthony, D. (2000). Limitations, frustrations and opportunities: A follow-up study of nursing graduates from the University of Birmingham, England. *Journal of Advanced Nursing, 32*(4), 842-856.

Winfield, C., Melo, K., & Myrick, F. (2009). Meeting the challenge of new graduate role transition: Clinical nurse educators leading the change. *Journal for Nurses in Staff Development, 25*(2), E7-13.

Wolf, Z. R. (1988). Nursing rituals. *Canadian Journal of Nursing Research, 20*(3), 59-69.

Wolf, Z. R., & Zuzelo, P. R. (2006). "Never again" stories of nurses: Dilemmas in nursing Practice. *Qualitative Health Research, 16*, 1191-1206.

Wolff, A., & The coalition for entry-level registered nurse education. (2007). *The meaning of readiness as it pertains to newly graduated registered nurses in British Columbia*. Vancouver, BC: Coalition on Entry-level Registered Nurse Education (Nursing Education Council of British Columbia, Health Care Leaders Association of British Columbia, and the College of Registered Nurses of British Columbia.)

Wolff, A. C., Pesut, B., & Regan, S. (2009). New graduate nurse practice readiness: Perspectives on the context shaping our understanding and expectations. *Nurse Education Today, 30*(2), 187-191. doi:10.1016/j.nedt.2009.07.011

Wolff, A., Regan, S., Pesut, B., & Black, J. (2010). Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Education Scholarship, 7*(1), Article 7.

Wray, J., Aspland, J., Gibson, H., Stimpson, A., & Watson, R. (2009). "A wealth of knowledge": A survey of the employment experiences of older nurses and midwives in the NHS. *International Journal of Nursing Studies, 46*(7), 977-985. doi.org/10.1016/j.ijnurstu.2008.07.008

Wuest, J. (2007). Grounded theory: The method. In P. Munhall (Ed.), *Nursing research: A qualitative perspective* (4th ed., pp. 239-271). Sudbury, MA: Jones and Bartlett Publishers.

Yoder-Wise, P. S. (1984a). Jo Eleanor Elliott. *Journal of Continuing Education in Nursing, 15*(1), 22-25.

Yoder-Wise, P. S. (1984b). Evelyn K. Tomes. *The Journal of Continuing Education in Nursing, 15*(4), 136-138.

Yoder-Wise, P. S. (1984c). Dorothy H. Coye. *The Journal of Continuing Education in Nursing, 15*(5), 180-183.

Yoder-Wise, P. S. (2003). A contemporary interview with Signe Skott Cooper. *Journal of Continuing Education in Nursing, 34*(5), 202-203.

Young, M. E., Stuenkel, D. L., & Bawel-Brinkley, K. (2008). Strategies for easing the role transformation of graduate nurses. *Journal for Nurses in Staff Development, 24*(3), 105-112. doi:10.1097/01.NND.0000300878.95436.98

Zurmehly, J., Martin, P. A., & Fitzpatrick, J. J. (2009). Registered nurse empowerment and intent to leave current position and/or profession. *Journal of Nursing Management, 17*(3), 383-391. doi:10.1111/j.1365-2834.2008.00940.x

Appendix A: Study Timeline

Timeline for Study (How do nurses learn to nurse well in the current health care milieu?)

Data Collection Activity	Data Analysis	Date
Meet with manager		March 31, 2010
Ethics Approval VIHA		April 15, 2010
Reflexivity Interview		April 29, 2010
Ethics Approval (Final - HERO)		May 20, 2010
Schedule Observation Shifts		May 21, 2010
Observation Shift (set) B1		May 27, 28, 30 (June 1st)
Recruitment Information Emailed and Posted		June 4 - forward
Observation Shift A1		June 6
Observation Shift A2		June 10 (day)
Interview C1 (not in Victoria)		June 12, 2010
Interview C2 (Victoria)		June 15, 2010
Observation Shift (set) B2		June 16, 17, 18, 2010
Interview (C3)		June 17, 2010
Research Decision Point: based on volume of data and observation that final shift did not reveal "new" notes and reflections		June 19, 2010

(memos) to begin analysis		
	Begin analysis with printed data, pen and highlighter	
Contact with manager re further scheduling and feedback from staff		
Interview C4		June 24, 2010
Interview (Skype) C5		June 25, 2010
Interview C6		June 26, 2010
Observation Shift (set) (A3 & A4)		June 28, 30
	Line by line coding complete on NVivo for 4 shifts (field notes)	July 6, 2010
Interview CNE from observation site (brief)		July 7, 2010
Interview (not in Victoria) C7		July 9, 2010
Interview (community nurse) C8		July 12, 2010
	Diagrams developing; met with supervisor	July 13, 2010
Interview re Palliative Care Course		July 14, 2010
Observation (B3)		July 15, 2010
Interview C9, C10		July ?17, 2010
Observation Shift: Clinical Education (IV		July 19, 2010

therapy)		
Pause	Diagramming	
Observation Shift: Clinical Education (Hand Hygiene Workshops)		August 11, 2010
	Second level coding (tree nodes) developing (NVivo)	August 15, 2010
Interview C11		August 19, 2010
	800+ codes, 50 second level codes/concepts, developing categories	August 20, 2010
Interview C12		August 21, 2010
Interview C13		August 30, 2010
Interview C14		August 30, 2010
Interview C15		October 21, 2010
Presentation of early grounded theory to 2 groups of nurses (focus group-style transcribed conversation)		Nov. 18, 2010
	42 categories (13 of which "stuck" as higher level codes or categories	
Interview C16		Dec. 2, 2010
	Multiple diagrams; deduction and induction for BSP	January 12-Feb 10, 2011
	Compilation and synthesis	January 15, 2011

	of interview question: What sustains you?	
Interview C 17		May 9, 2011
	Data Analysis shifted from NVivo to (multiple) diagrams, written memos, written synthesis	March 2011-June 2011
	A Day in the Life: Synthesis of Data (writing for analysis)	March 24, 2011
	Table of "emerging" categories, with relationships, and BSP	May 16, 2011
Summary of study data collection and analysis to methodologist		June 23, 2011
	Diagram of Crucible and Refining Nursing Practice Re-affirmed through constant comparison and higher level coding	Dec. 2011
	Summary of Findings sent to 12 participants	Feb 23, 2012

Appendix B: Participant Table

Participant[30]	Role	Estimated Years' Experience	Hours of Contact
C1	Direct patient care	35	2
C2	Direct patient care	25	1.5
C3	Direct patient care	3	0.5
C4	Direct patient care	20	1
C5	Direct patient care	20	1
C6	Direct patient care	20	1
CNE	Direct patient care	N/A	0.5
C8	Direct patient care (community)	30	2
C9	Physician	30	2
C10	Area experts	20-35	1.5
C11	Direct patient care	8	1.5
C12	Direct patient care	40	2
C13	Direct patient care and education	25	1.5
C14	Direct patient care (Pediatric)	25	1.5
C15	Physician	25	1
C16	Direct patient care/liaison	8-10	1.0
C17	Public Health	25	2.0

[30] Participants are listed in order to contact to match with Appendix A.

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Appendix C: Recruitment Information

How do nurses learn to nurse well in the current health care milieu?

If you fit the criteria for this study, or know someone who does, please contact the researcher for more information using the information below.

I am looking for nurses who:

- have worked in direct patient care for more than 10 years;
- are still involved in direct patient care;
- are recognized for their ability to nurse well, based on the following descriptions.

Nursing well, for the purposes of this study, involves:

- being knowledgeable (knows what to do) and using this knowledge;
- having technical skills and adeptness;
- being able to identify patients needs and intervene for healing in an individualized way;
- being able to “be with” patients to alleviate suffering.

Contact Darlaine Jantzen at nurseslearning@gmail.com or at (250) 475-0406

Appendix D: Interview Questions

Tell me about your career and feel free to include both the highlights and challenges, or the everyday aspects as well.

Please tell me about your experiences of learning to nurse in your nursing career.

Can you talk about any aspects of the workplace that hindered or helped you learn in your nursing career?

Tell me about your current workplace. How long have you worked there? Describe other workplaces.

How do you understand the continuing competency requirements for RNs?
- How have you worked to fulfill these requirements?

Can you describe a typical nursing practice situation for me?
- Additional exploratory questions if necessary:
- Where did this interaction happen?
- Can you describe the place you are talking about in this situation?
- What was your workplace like there?
- What did you "know" in that situation?
- When you said you … for the patient, what made you decide to that?

What has sustained your ability to nurse well over the years?

Appendix E: A Day in the Life of Nursing Well

In the following section I present the refining nursing practice process as it occurs in everyday practice. I created a composite day during analysis of the data. The strength of this presentation of everyday practice (the data) is that it incorporates the temporal aspects of refining nursing practice.

The shift begins, often just before the actual start time, with nurturing or establishing a sense of camaraderie on the team. Following the pre-shift exchange the nurse negotiates space, gets organized (including collecting information and organizing tools and space) and begins to puzzle and inquire. She[31] then does medication checking, patient checking, and prepares for ward report, all the while working with what I came to call "custom notes." During ward report an enormous amount of teaching and learning occurred. This occurred between seasoned nurses and new graduates, between two or more seasoned nurses, and between those who had worked on the unit for years and those who had just been hired. It also occurred between the nurses and individuals from the leadership team, including the manager on some occasions. In the case of the leadership team the questions or interjections were often around system issues that potentially would pose a barrier to excellent patient care. During report the nurses would use questions to seek clarification, fill in knowledge gaps from the previous shift, and to develop plans for the patients. "Why this, why that?" It is difficult to convey the frequency of this questioning. It was constant.

[31] Note that all of the observation participants were female and therefore I use the pronoun she when referring to data from the field notes.

Throughout the shifts I observed that various triggers would prompt learning. While providing patient care the nurses' learning was initiated by both patient related and system related triggers. The participants would respond to this trigger for learning by engaging in the process of puzzling over the information or the problem and then recognizing that they did not have enough information or knowledge to respond to the patient related need. The nurses would then inquire into the chart, policy manuals and electronic information. I coded these actions or descriptions of the actions by interview participants as "figuring it out." If the result of this figuring was not satisfactory the nurse would begin by asking her partner, and then move in an increasingly broad circle, from the partner, to the team, to the CNE or CNL, to the physicians and, when necessary, to individuals who I have called "area experts" Asking around. Care is interspersed with conversations between members of the team regarding patient care and problem solving.

The nurses would often consult about how to respond to the puzzle in the best way. This process seemed like an endless back and forth between patients, chart information, policies, and team. I observed learning that altered practice for the specific situation and learning that was added to the accumulation of nursing practice knowledge the nurses use to inform their decision making. "That is why we are tired at the end of the day. Always thinking and trying to figure things out."

Break time is also an important part of always learning. Between the seasoned nurses on the unit, break time was used for strengthening camaraderie and storytelling. The stories were most often very entertaining and educational. A quick question about something in the story evolved into learning. I did not include the myriad of stories in my field notes although I did make note of a few. One break time the nurses started off discussing a current patient problem, which led to a series of related stories around parallel situations. Within each of the stories there was a moral or teaching point, which was either developed by the next person's story or countered with a contrasting case.

Finishing well was one of the unit standards, which was talked about and also posted on the bulletin board. There are clear guidelines about what needs to be done at the end of a shift. As the nurse hands off to the next shift the interaction, the storytelling, often included the tips that have been learned about a specific patient, or about more general points of concern. This face to face interaction, while actively discouraged by many managers and other administrators and considered unnecessary and redundant, is an important step in the process of always learning in the day to day routine of nursing[32].

This narrative presentation of the data represents a typical day for the participants and is intended to create a picture of everyday practice, the context of much workplace learning for nurses in direct patient care.

[32] While I was collecting data the organization was handing down strict guidelines about when, where, and how nurses would be "reporting" to each other.

Appendix F: Knowledge Translation

Nursing Education: I have become actively engaged in curriculum reform in the collaborative UVic/Camosun College undergraduate program.

Publications: Three key publications include one of the refining nursing practice theory for the *International Journal of Nursing Studies* as a response to Rafferty and Clarke's (2009) call for an examination of this cohort. A second publication for *Nursing Education Today* on the sub-process of getting grounded. A third publication on becoming relatively impervious, journal yet to be determined.

Implementation: Seek collaboration with Marion Clauson and colleagues (Legacy Mentor Project).

Local Health Authority: I have contacted the Research Coordinator and will be presenting the findings in the fall of 2012. I will also be contacting the Directors for Quality and Patient Safety, the Professional Practice Office, and the Medical Rounds coordinator to share the findings.