University of Alberta

Behind the Mask: A Narrative Inquiry into Operating Room Nurses' Experiences of Patient Safety

by

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To mom and all my family

~ For your support and encouragement throughout life ~

To Dad - mors nos non disiungit

~ In this world, you were one person to many. To me, you were the world ~

To Kent - for your unconditional love and faith in me

~ I don't think I've said I love you near enough ~

ABSTRACT

The delivery of safe care is an expectation and a central concern of individuals using the healthcare system, particularly for those who find themselves as patients in hospitals. Healthcare researchers' reports and discussions of harm while receiving hospital services speak to the global importance of improving patient safety. The occurrence and prevention of adverse safety events has been identified as a key area of interest in the patient safety movement, especially in relation to strengthening and improving operating room patient safety. I conducted a research project in British Columbia in 2010, responding to critical questions about patient safety specific to the operating room. The purpose of the study was to understand the significance and meaning of operating room nurses' personal narratives of patient safety. Narrative inquiry (Clandinin & Connelly, 2000) was the methodology chosen for the research, and conversational interviews were used to retrieve a storied view of experience. I engaged with four female operating room nurses, in order to elicit their life narratives and to explore the experiences that were influencing their patient safety stories.

The dissertation has been prepared using a traditional format and includes eight chapters. The first chapter is autobiographical in situation the study within the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000). The second chapter is a descriptive review based on a critical analysis of patient safety research and highlights salient aspects of patient safety relevant to the healthcare arena. The third chapter describes the methods used in this narrative inquiry, a process undertaken with participants that resulted in them retelling their lived stories based on their operating room nursing experiences. In the four findings chapters, the operating room nurses' specific stories are retold

by the researcher, accompanied by the researcher's reflective analysis. The dissertation concludes with a synthesis and discussion chapter, whereby common narrative threads resonate across the four participants' stories and provide implications for contemplation by the professional discipline of nursing.

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CHAPTER ONE

Narrative Beginnings

This is a narrative inquiry about patient safety in the operating room. It is a deep account of how, as a narrative inquirer, I engaged with four operating room nurses with the purpose of retelling their professional and personal experiences. While each nurse's experiences comprise a portion of the research, my own patient safety experiences as an operating room nurse, too, are situated within the inquiry. My experiences lived and told as stories are the starting point in this study, leading to a focus on researching experience as one of the core notions of the inquiry described by Clandinin & Connelly (2000). My own patient safety narratives are situated within the operating room, my professional work landscape for many years. Yet, my personal life experiences also comprise my professional ones. Personal narratives are identified as being central to narrative inquiry, and within them help us to acknowledge who we are, to reveal our deepest experiences, and to make meaning of where we are as the participants and researcher move through the research process, together (Clandinin & Connelly, 2000, p. 70).

My story, presented later in this chapter, locates me as an operating room nurse working with others, and is about how I experienced a breach in safe patient care in an ordinary and taken for granted situation. In writing this story, my reconstruction gave me reason to pause and to reflect upon how I experienced this situation, specifically my relations with others and the tensions I felt and continue to feel as I live with these experiences. In revisiting this past experience, I came to understand that just as I had held particular views and impressions of my co-workers involved in the event, they also had held particular views and impressions of me. Thus, just as I had storied them, they too had storied me (Clandinin & Connelly, 2000, p. 178). I began to understand how our stories of each other, in some unspoken way, may underlie the tensions with which we struggle. By including this written story in the chapter, I removed it from the presumed security of the select privileged. It would no longer be concealed behind the closed doors and masked faces of the theatre suite, rather it was another tension for me to acknowledge as I began to share my narratives.

As a specialized care area, the operating room is a place hidden from view within the hospital itself. Entry to access is restricted and gained through the

privilege of belonging as a professional member, or through surgical necessity as in the case of a patient. As such, the lives of patients, their families, nurses and physicians are touched on a daily basis within this mysterious landscape of the operating room. It is a place of medically ethical importance and technological complexity. Care providers come together in prescribed and relational ways to respond to the needs of patients as they present in varied life crisis moments. Through the giving and receiving of care, human acts are experienced through encouragement and support to those who are in a most vulnerable life state. It is a place where each nurse and physician at some moment enters into the life of another, or feels the life of another enter into his or her life, making an ethereal connection. It is here where people entrust themselves to health professionals, like strangers to strangers, perhaps friends to friends, and in turn, a promise is kept to care for each patient, each unique person, as if he or she were our own flesh and blood. I feel privileged to work in a place where on any given day I can touch and sustain a life. In return, I use my knowledge and skill to the best of my ability in the provision of a safe surgical journey for patients, in order to make life better for them, even if only for a short period.

The operating room is a place in which attending to the human condition can be intricate, delicate, formidable, complicated, successful and futile. Regardless of the description, patient safety in the operating room is a complex process that can be straightforward, enigmatic, puzzling or unanswerable. Despite the best of intentions, the unequivocal assurance of safe care for all patients in the operating room, or other hospital departments, is unfortunately not absolute. For instance, acknowledged in The Canadian Adverse Events Study (Baker et al., 2004) was a high rate of undesirable actions that had occurred in surgical services and were primarily related to surgical procedures. Specifically, of 360 adverse events reviewed, 185 adverse events (51.4%) were surgical service related as compared to 162 events (45%) in the medicine service (p. 1683). The achievement of safer patient care is a central focus of overall patient care in the operating room; however, questions continue to abound in daily practice about realizing and maintaining patient safety.

Focus of the Inquiry

Safer patient care is a priority in any healthcare environment today. The occurrence and prevention of adverse safety events has been identified as a key

area of interest in the patient safety movement (Leape, 2002). However, there remains limited evidence in the literature that focuses on understanding nursing experiences of patient safety events as a valuable approach in strengthening or improving patient safety in the operating room. Streams of safety research interest, for example, include communication issues (Lingard et al., 2004), teamwork and nurse-physician relationships (Bognar et al., 2008), safety culture and safety climate (Waring, Harrison, & McDonald, 2007), and specific events such as technological issues (Smith, Darling, & Searles, 2011).

While this diverse research field identifies important aspects of patient safety in the operating room, there is limited attention directed toward understanding operating room nurses' experiences of patient safety. The exploration of these experiences would benefit nurses, their colleagues, and patients in addressing the complexities of safe patient care. In research focused on illuminating what nurses in general do when they go to work, Allen (2007) describes nursing work through "bundles of activity" (p. 45). Such examples include: "managing multiple agenda; moving or circulating patients through the system; managing the work of others; mediating occupational boundaries; obtaining, generating, interpreting and communicating information; maintaining a record; and prioritizing care and rationing resources" (p. 43). Allen also notes that nurses:

> …reconcile the requirements of healthcare organisations with those of patients….it is nurses who broker, interpret, translate and communicate clinical, social and organizational information in ways that are highly consequential for patient diagnoses and outcomes….it is nurses who weave together the many facets of the service and create order in a fast flowing and turbulent work environment. (p. 45)

While operating room nurses were not specifically referred to in this particular work, I realized how frequently my nurse colleagues and I engaged in the various "bundles of activity", and how these acts further composed our daily work in the operating room in addition to direct patient care. With nurses' work stretching across the workplace in so many ways I believe that nurses' experiences of patient safety also stretch across their workplace, with the potential to generate new knowledge. Thus, it was the operating room nurses who I wished to engage, inquiring into and hearing their stories of experience, so that we may begin to

understand patient safety from a nursing perspective. In reflecting deeply and at times being puzzled about my own patient safety experiences, I raised the following research question: What stories do operating room nurses construct about themselves, their patients, others, and patient safety in their daily work of operating room nursing?

The purpose of this narrative inquiry was to gain understanding and make meaning of operating room nurses' personal narratives of patient safety. It was also to gain understanding of nurses' lived experience as presented in their narratives, and being open to new ways of telling narratives through "storying and restorying experience" (Clandinin, 2007, p. 42; Clandinin & Connelly, 2000, p. 4). While the patient safety experience that I present in the next section was framed by a safety incident, it is not presumed that all nurses' patient safety experiences are characterized similarly by, or confined to, an adverse event experience. With this awareness in the forefront, understanding nurses' experiences is not restricted to exploration of patient safety through an adverse event only; rather it is expanded to encompass all past experiences of patient safety in the operating room as storied by the nurses. While nurses live and have their own significant stories to tell, I suspect our narratives will resonate with each other's, and that these commonalities will help us to understand better, operating room safety experiences.

The Beginning of My Story

The notion of working in the operating room was always an attractive one to me. I was drawn to it by the attention to detail, the preciseness of skills and knowledge required, the variety of patients, and the interdisciplinary working relationships characterized in the operating room. From the few times I had first observed surgery in the theatre suite, I was intrigued about how quickly a relationship of care could be established between the nurse and patient, given that most of the nurse's time spent with the patient was of a nonverbal nature, that is, the time spent with an awake patient was incrementally brief.

I observed how time for the patient could lose all sense of meaning in the operating room, for once in the theatre suite and anaesthetized the patient enters a drug-induced insensibility. As patients emerged from anaesthesia, I noticed that many would focus on time and place to reorient, or perhaps as an attempt to recapture what they felt had become lost to them. I could feel the relief in

patients' voices as they were reassured by the person they had entrusted themselves to; someone they had only just met but who had promised to care for them. Eventually, that person became me. I also came to feel a sense of deep satisfaction when my patient or their family member would smile back and thank me for the provision of nursing care. My satisfaction did not stem from the person's gratitude. It stemmed from a sense of feeling that I had succeeded in establishing relationships with these patients based on trust and respect, and that I had demonstrated to patients and their families a promise to look after them, professionally and safely.

Reflecting further, I realized being drawn to the operating room had to do with the fact that theatre nurses were specialty nurses, and that employment opportunities in this area were generally guaranteed. I knew that society as well as my family considered the role of a nurse to be a respectable and valued profession, but being able to say that I was a specialty nurse denoted a prestigious quality and signified an achievement not available to all. I recall the excitement and nervous tension in beginning to work in the operating room. This was a specialty entirely new to me, but a care area where I had always imagined I might one day find work. In being a new member of an existing tightly knit group of people, the experience was not easy; yet I felt I had established successful working relationships in the department. I believed that the ability to catch-on quickly to the ways of working in this particular area and to integrate my varied nursing background into the current work, contributed positively in securing my place as a conscientious and reliable nurse. After all, I was not new to nursing; I was only new to this group of people and in turn, they were new to me. I felt accepted and valued for my contributions to discussions and suggestions about patient care, even though I was often reminded about the concrete ways things were done in a particular department.

During the time of having begun work in the operating room, many things were new to me. The department also faced staffing challenges concerning anaesthesia coverage. As a result, a visiting anaesthetist was completing a locum for a block of time to support us. I remember trying to attend to each anaesthetist's preference as I worked with different ones, especially the particular preferences of Dr. G. This individual had worked in the department on previous occasions, a person considered peculiar and idiosyncratic by others. During a

specific week, I felt that the quality of interactions I had with Dr. G changed from concerning to disturbing, with some of my colleagues reporting similar experiences. On several occasions, Dr. G displayed profound difficulties in completing anaesthetic duties, which I felt created a situation of risk for the patients and me. Not only were some nurses and physicians unsure of what the anaesthetist was doing, Dr. G seemed unaware of what events had transpired at any particular time. Each surgical case with Dr. G was filled with tension as I tried to second guess and anticipate what might occur. In addition to caring for my patients safely through my nursing practice, I found myself in a position of having to direct aspects of anaesthetic care due to the erratic behavior of this anaesthetist. Despite the repeated concerns and examples verbalized to the head nurse and various surgeons, I felt that the situation had not been adequately addressed and it quickly escalated. As I described a particularly visible display of suboptimal behaviour by Dr. G to my colleagues, I was aware of a familiar tension rising within me.

This tension resulted, in part, from surgeons involved in specific instances who did not engage in direct communication with this anaesthetist, even when asked to do so by several nurses. Other nurses and I felt that some surgeons were only concerned with completing their surgeries and anaesthetic issues were not of their concern. In other words, we felt some surgeons did not want to become involved in dealing with this specific anaesthetic situation. An informal meeting by chance occurred in the staff lounge between the department manager, several nurse colleagues, an operating room physician, and me. I recounted specific scenarios that my patients, my colleagues, and I had encountered during the past few days. I continued by saying that we felt at risk, we did not feel safe working with this anaesthetist, and we felt patients were in danger under his care. “This physician appears to exhibit signs of instability and perhaps this is related to an underlying condition,” I stated. Unfortunately, not all of the department staff had worked with Dr. G during the time in question, thereby limiting the number of people who could support my concerns. The surgeon responded by strongly suggesting that I had exaggerated the scenarios as they actually happened. In this response, I also felt the other nurses were implicated in this exaggeration of events. The surgeon qualified the conversation by reminding me of this person’s eccentric personality, current credentials, and

experience as an anaesthetist. I interpreted this to mean that, because a licensing body credited this individual, my observations and comments were not credible because I was a junior nurse with minimal operating room experience. The manager further downplayed the events by trying to move the discussion to an end, and made light of the situation by attributing my perceptions to lack of experience. The manager also noted that there would always be variations in procedures and practices due to individual variance. A further caution issued was not to discuss these matters with others outside of the department, as others would not understand the unique situations of the operating room.

The tone and direction of my colleagues' communication confused me. Where did the surgical conscience that we all spoke of and prided ourselves in disappear? When were we supposed to speak up about questionable practice issues and patient safety concerns, if not now? In attempting to voice what I thought was a distinction between eccentric and erratic behaviour by providing specific examples from previous days, I looked to my colleagues for support. However, except for one nurse I felt no obvious encouragement. The general lack of acknowledgement, complete silence, and lack of eye contact only seemed to confirm the sentiments of the surgeon and manager. The manager reminded me that I was after all only a nurse with limited experience in the theatre suite. Did I really feel qualified to comment on the practice of others? Also pointed out to me was that in the end, despite some variations in practice, no real harm had come to anyone. I was certain that I was not exaggerating, but now in my mind a seed of doubt had sprouted. It was apparent that we understood these events differently and I felt an inner tension as I wondered if, perhaps, my inexperience and newness to the department had led me to interpret the events incorrectly.

As we debated the validity of my perceptions of events over the past few days, a situation transpired which ultimately ensured the departure of Dr. G from the department. Upon learning of this, I attempted to pursue a department meeting to review and discuss the various events encountered. I asked, "Didn't we have an obligation to our patients and ourselves?" As before, blank stares and silences were the response. My manager reminded me that, unless something was specifically pointed out to patients they would not know about the events in question. I felt that I was strongly encouraged to accept the notion that, because 'the surgeries went fine there really wasn't a problem'. The responses

from some operating room personnel reflected a similar attitude, that it was not necessary to discuss this as the situation had resolved. I found those discrepancies confusing. I felt honesty toward the patient was lost through rationalization of events and practice variations. I wondered why department members could not be honest with each other in addressing a safety event. My concerns, while unofficially acknowledged in private conversations, at the same time were made light of and dismissed in public conversation. I felt this was the case because the individual I was concerned about no longer physically existed in our department. I wondered why this sequence of events was reflected back to me as my problem, and why did I feel guilty about raising my concerns? I went over the conversation in my mind and as had been pointed out to me during the time in question, no one was harmed - seemingly or actually. Yet, I remained bothered by the potential "what if's" of the situation and I wondered why others did not seem as concerned about these events as me.

I found myself questioning my nursing practice, as well as how I was situated in this particular place. I realized that the very element of being an operating room nurse, which at one time appealed to me and positioned me as a particular kind of nurse, was one that filled me with tension and uncertainty. And through this tension, I began to question my personal and professional integrity and relationships, and most especially the kind of relationship I entered into with my patients. How could it be that those who earlier voiced concerns similar to mine were now silent when asked to speak? Leape (1999) provides a sense of what the nurses may have struggled with when he identified fear as a contributing factor in an individual's reluctance to address safety or adverse event issues. He states, "Fear is multi-dimensional: guilt, fear of embarrassment, fear of punishment of self, fear of punishment of others…" (p. 1). Brody (2002) and Ceci (2004) noted that a workplace setting which is hierarchal in nature, whether it is actual or presumed, can deter others from voicing their concerns by disempowering the presumed lower-status individual through the ignoring of their comments or making light of them. I felt my concerns similarly reduced and felt self-conscious and embarrassed when chided by the surgeon and manager for exaggerating my complaint. I thought I was voicing important information, but instead I felt ridiculed for speaking up. I felt as a child would feel, patronized, who had been punished for something she was not aware of doing, and I sensed how

these non-constructive and dismissive responses seemed to further encourage the silence of my fellow workmates (Evans et al., 2006; Leape, 1999).

In that moment, I understood that my position as a bona fide member of the department was not established. I did not have the work experience, nor did I hold a senior position in the department. I was still an outsider and I felt singled out as the one with a problem. Not only was my credibility challenged, it was also judged in a hierarchal manner irrelevant to my practice. Was it because I was a nurse and presumed to have lesser knowledge? Such a position would declare me as less credible in my observations. Or, was it because I attempted to bring this event into the open so it could be viewed through the eyes of the nurse and patient? Amongst ourselves, we could not come to agreement with whether this event was adverse or not or whether it necessitated further investigation, especially since there was lack of discussion about it and the credibility of examples provided was challenged.

This experience troubled me for I held the belief that there was a commitment to interdisciplinary regulation in the department; yet, the silence exhibited by fellow team members seemed to indicate their lack of comfort or interest in reporting or commenting on unusual events within the practice boundaries of other professionals (Espin, Levinson, Regehr, Baker, & Lingard, 2006). However, even if we had all agreed that this was an adverse event, this in itself would not necessarily ensure any sort of follow-up or review (Braithwaite, Westbrook, & Travaglia, 2008; Giles et al., 2005; Hobgood, Xie, Weiner, & Hooker, 2004; Vincent, Stanhope, & Crowley-Murphy, 1999). Several senior staff members in my department were comfortable in describing these events as practice variations, suboptimal outcomes, and differences in clinical judgment (Cook, Hoas, Guttmannova, & Joyner, 2004), especially since the adverse nature of this event was not overtly obvious to everyone and no obvious physical injury had been identified. Thus, the reframing of this situation thwarted acknowledgment of the events or of any potential fallout and forestalled an interdisciplinary review and follow up of events (Baker, 1997; Osborne, Blais, & Hayes, 1999).

As I looked at my fellow colleagues and attempted to make sense of their outward lack of response and their discomfort with me, I could not help but feel like a stranger in my home. It was apparent to me that the interpretation and

presentation of events disrupted the familiar landscape occupied by others and myself. An alternate point of view and my way of nursing challenged the perspective of one dominant interpretation of events in question. This new reading of events required others to shift their own perspective to consider mine, which challenged an established way of doing things in the department. I felt myself to be set apart from others because I did not follow their way of providing patient care and their way of addressing safety events. I was at a loss to understand the behaviour of others and I felt they were just as uncertain in understanding me. I sensed how we were now talking past each other and not with each other.

Carson (2002) notes that the "ability to *relate* one's story depends on there being a *relationship* in which that story can be received, recognized, and responded to" (p. 175). I found these words most relevant to the particular experience I wrote of above, for in the going about of our daily duties I recognized that we neglected our relationships with each other. We did not nurture a space for ethical encounters with each other, and as such, we lost an opportunity to connect with each other about the safety event. In my perceived desire to challenge my colleagues, the situation turned upon itself so that I, the new nurse, was now the one challenged, and I felt my position in the department had become tenuous. I felt myself become a marginalized individual in this landscape I shared with others. It was a tension that I had experienced on previous occasions when I desperately wanted to fit in with whatever situation was presented to me at the time, a tension that became familiar to me as I continued to negotiate a life path.

Learning to Fit In

Mr. S became my fifth grade teacher after Christmas as a replacement to the teacher who moved away. I do not remember the name of the departing teacher, only that she was very kind to me as I tried to find my place and make friends in a new school. At the previous school, my teachers had primarily been nuns or non-clerical females. Apart from the priests that occasionally taught me, Mr. S was the first male teacher I had. The move to a new school was far more than just attending a new school. It was a time of achievement for my family, and a time that saw us relocating from an old, multiethnic lower income section of the city to a middleclass newly developing suburb of the city. While we comfortably

settled into our new surroundings, my parents retained strong ties with the old neighborhood, the priests of the Polish parish, some nuns of the former parochial school we were attached to, and the familiar Polish community at large.

I recognized that there were some differences between my new friends and me, but as long as no one overtly pointed them out or dwelled on them, I felt I was accepted and fit into this new school and group of playmates. I still remember a boy whose sister I played with from my new neighborhood. He would snidely address my family and me as “DP” or verbalize other ethnic insults of varying degrees my way. Sometimes I would respond back in anger but most often, I was silent and stared back, blankly. “Why did he call me these names?” I wondered. I felt embarrassed, though did not know why and wished he would go away. Later when I was by myself, I was much braver as I imagined and practiced my countering responses, which at that time rarely came forward in public. When I did respond, my expressions were often perceived to be insolent by others when in reality, I was attempting to assert myself as an individual with something to say in a world of others.

Mr. S liked to have the students read aloud from their books. While students stood at the front of the class, he remained seated behind his desk, which was also at the front of the class. As students in this class, we were accustomed to reading in groups with our previous teacher, and reading to the rest of the class from the front of the room was entirely new to us. Many students struggled with various aspects of shyness, with mumbling, and with read-on sentences. Mr. S was quick to point out any deficiencies to the reader and to the rest of the class. I always felt the butterflies in my stomach during these mini-lectures, and while many of the students did not appear concerned, I recall feeling embarrassed for the reader during these episodes. At the same time, I felt brave in my silence as I imagined how I might respond to his comments.

I loved books and I was a good reader. My entire family was avid readers. My turn to read in front of the class eventually came and I confidently began to read aloud, only to hear Mr. S shout out in his clipped British voice, “Stop, stop, stop.” I looked up from my book smiling and saw Mr. S shaking his head. He took exception with my pronunciation of certain words and consonants. My hard g's were unacceptable, my r's were not correct, and my g’s and k’s were indistinguishable. Was I saying dock or dog? Or was it duck? I looked at the

class and some of the students stared at me while others averted their eyes. My accent was a problem said Mr. S and “we must speak properly”. I felt confused as various thoughts surfaced in my mind - my accent? I did not know I had an accent. At my other school, the previous year the teacher assigned me to help a Spanish-speaking girl learn English by using bilingual picture books. Why would I be chosen to help this girl if my English pronunciation was faulty? Mr. S then focused on my pronunciation. He would say a word and I would say it, repeatedly, until he was satisfied. I recall students giggling as I struggled to please my teacher and tried to pronounce g’s, k’s, and r’s to his liking. It occurred to me that he, himself, spoke with a British accent and that he could not pronounce my name correctly, but I could only challenge him in my mind and not aloud. Mr. S instructed me to practice my pronunciation, but not with my parents as they had what he called thick accents. This pronouncement brought another round of giggles from the class. I felt paralyzed and fearful. I stood silent in front of the class not as a fellow student, but as an outsider in my classroom.

I felt my silly smile disappear and the butterflies come back. Not only did my teacher identify me as different from the others, but he also implicated my family in this differentness. I did not know if this was good or bad, but I felt it might mean something in how others viewed my family and me. This did not sit well with me. I felt the resistance to this situation build in my mind, yet I was too intimidated to tell anyone else what had occurred. I thought of what the neighborhood boy had called me and again wondered about my perceived difference from others. I desperately wanted to fit in and be liked by my friends in class, but now I felt out of place and confused. Did I have to change how I was in order for my classmates and teacher to accept me? Even though I was always encouraged by my family to tell them of any life concerns, I did not tell them about this event because I was embarrassed and frightened of attracting more attention than already existed. My pronunciation lessons in front of the class continued every time I read aloud and finally ended after what seemed an eternity. I do not know if Mr. S was satisfied with the result or just finally gave up on me, but he did succeed in bringing to everyone’s attention a difference he had identified. Where I once felt accepted by others and comfortable in their presence, I later felt my position shift. I was part of the class and yet I was not. I now recognize the butterflies as tensions, and within the tensions of that

childhood occurrence I experienced a liminal space of “ambiguity and anxiety, of no longer and not-yet” (Carson, 2002, p. 180). Thus, I verged on the threshold of feeling and being like any one of the students in class to being an outsider positioned on the periphery looking in.

I recognized that certain differences, little as they might be, affected what others thought of me, how others viewed me, and how I might need to be in order to have a relationship with them. I tried to disguise myself, to mask the little differences that meant so much to others, by being one way at school, and then another away from school. In my “betwixt and between settled states of self” (Carson, 2002, p. 180) I was not one kind of child but neither was I another. As Carson reveals, entering into such a space “is to slip one’s moorings and be carried by currents toward one knows not where, to be in limbo” (p. 180). I understand now as I could not have then that my desire to have my difference or “otherness” acknowledged and still be accepted as belonging (p. 180) required living on the threshold, a space that is necessarily ambiguous and eludes “the network of classifications that normally locate states and position in cultural space” (Heilbrun, 1999, p. 36).

Threshold, as applied by Heilbrun (1999) in her work *Women’s Lives: The View from the Threshold*, refers to a state of transition or a threshold experience that involves the condition of liminality. She explains:

> The word limen means threshold, and to be in a state of liminality is to be poised upon uncertain ground, to be leaving one condition or self and entering upon another. But the most salient sign of liminality is its unsteadiness, its lack of clarity about exactly where one belongs and what one should be doing, or wants to be doing. (p. 3)

My desire for acceptance as a grade school classmate positioned me to act in one way for the benefit of others while also struggling to remain true to my inner feelings and tensions of how I wanted to be.

The Middle of My Story

As a nurse new to the operating room department I discussed earlier, I wanted to fit in and be accepted. I had worked in a variety of other practice settings but the operating room was unlike any other area. The contact I now had with patients was different. A pre-surgical encounter shortly before surgery was the only moment I had to speak with patients, for the remainder of my contact

with them was when they were in an anaesthetized state. This aspect of operating room nursing was a departure from the prolonged patient and family contact I was accustomed to, but I was determined to make this limited contact both important and individualized for the patients in my care. Frequently, I was reminded that I talked too long with a patient in the holding area, I took too long to review the patient's chart and answer their questions, or I did not have to ask so many questions of the patient because they were not nursing questions per se.

In wanting to be a better operating room nurse, I began to emulate the behaviour and thinking of my mentors (Ebright, Urden, Patterson, & Chalko, 2004) as I thought this was the best way to fit in and gain their approval. While there were always subtle or not-so-obvious ways of contributing my own thoughts and techniques into my nursing practice, past experiences reminded me that it was generally easier to be like everyone else when establishing myself in a particular place. However, in wanting to nurse like some of my fellow colleagues, I lost sight of my uniqueness and individuality as a nurse and sensed how I had lost sight of my patients during this time. It took a specific safety incident that threatened my patients and me to awaken, and cause me to question what kind of operating room nurse I wanted to be, and to question what kind of relationship would serve and protect my patients the best.

Despite the interdisciplinary nature of work in the operating room, at the time of my experience a dominant management style existed that did not seem to encourage interdisciplinary resolution of certain issues, nor were alternate approaches encouraged. Working together as a team is crucial in any theatre suite (Bleakley, Boyden, Hobbs, Walsh, & Allard, 2006; Fewster-Thuente & Velsor-Friedrich, 2008; Sterchi, 2007). Yet I felt that individual differences needed to be acknowledged and considered as alternate points of view rather than suppressed to ensure conformity. My requests to discuss the specific anaesthetic safety issues were dismissed, and I sensed that I was now viewed as a troublesome nurse. Where I once felt comfortable in my work landscape, I soon felt a sense of unease and displacement as I found myself situated on the periphery looking in. I felt I was being pushed into thinking and responding in a specific way, which did not sit well with me. The desire for conformity or homogeneity through dominance of others has led to many people becoming

outsiders in their own landscape, and many suffering in various ways because of their differentness. *Strange Fruit,* a disturbing poem by Lewis Allan (1938) hauntingly depicts how extreme and violent dominance exhibited by a particular group over another was disguised as a logical dialogue to maintain inequality, conformity, and silence in others, whereby strange fruit refers to the silenced individuals.

In retrospect, I sense how subtly the operating room staff was managed at that time, in order to ensure that department issues remained internal and were not discussed elsewhere. To feel accepted, it was important to follow the rules and not question too loudly or too often. Answers to questions regarding policy, established procedure, or routine were framed around managing behaviour and singular thinking in order to respond in a specific way. I wonder now if those nurses who did not seem willing to support me or speak up had become the strange fruit of that time. Had they previously been unsuccessful in their challenge of a concerning event and paid their price for speaking up? Were they themselves in a place of ambiguity as I challenged how we each practiced as ethical operating room nurses in the same landscape? I was disheartened with the management of this event and knew that I did not want to risk my patients or myself becoming the next strange fruit of this department.

As I inquired into this troublesome event, I understood that the tension I felt then was my resistance to a department specific narrative of operating room nursing. I felt the narrative wanted to script me as an unquestioning nurse, one who accepted deviations in practice by way of rationalization, and one who was comfortable to overlook relational responsibilities to others. I realized now as I did not entirely then that I was ill equipped to deal with a situation of this magnitude. As a junior operating room nurse, I lacked the necessary skills and confidence to approach this situation in a methodical way. My naivety added to my confusion. I found myself nursing as others wanted me to, and yet I felt the need to nurse in a way that was ethically true to my colleagues, my patients, and me. I felt myself situated on the threshold in a betwixt and between state, for I was not one kind of nurse but neither was I another. I felt my school experience come forward when the tensions of life challenged me as a young person to figure out who I was, and to figure out how to continue being this person while responding to a specific situation. As previously stated I did not discuss this event with others outside of

my workplace, for now maintaining confidentiality about patient encounters was a responsibility and expectation as a nurse. I did not want to draw more attention to an event that I was sure I had not misunderstood, but at the same time, was an event initially dismissed as a practice variation.

Eventually the safety event, which initiated my turmoil, faded and was absorbed as an everyday nuance of life in the theatre suite. There was no further discussion other than stolen moments between individual nurses and our daily work carried on. I struggled internally with what my nursing practice should actually be like, my ideal, and what it actually was like. Over time, I was able to redefine my practice and assume responsibility for who I was as a nurse. I challenged myself and I learned that I was not and did not want to be an acquiescent nurse, but neither did I see myself as an activist nurse. Rather I wanted to meet the ethical commitment situated in the relationship that I entered into with patients, which was my responsibility as an operating room nurse to patients as much as it was about the kind of relationship I had with myself.

Located on the threshold of figuring out who I could be as a nurse was the agency I eventually sought in determining self-direction in a story that I was not physically part of, yet felt connected to in some meaningful way. During 1994, twelve children died following cardiac surgery by Dr. Odim at Winnipeg Health Sciences Centre. When operating room nurses raised their serious concerns based on their experiences, those concerns had been dismissed. At the provincial inquest concerning this event, Carol Youngson, an operating room charge nurse with 23 years of operating room experience recalled that Dr. Wiseman, head of paediatric surgery, refused to watch Dr. Odim work. Youngson stated:

> I asked him several times throughout the year. I pleaded with him to just come in and see what was going on. I needed reassurance I wasn't going crazy. [At inquest, Youngson testified Wiseman later told her he refused to watch Odim because he didn't "take orders from nurses"]. (Sibbald, 1997, p. 26)

As I thought about my own nursing work in the operating room, I felt something open up in me as I took in this story of others. The opening enabled me to reflect

creatively on how I lived within my nursing landscape. It was a view by which to negotiate my story to live by[1].

Reflecting on My Story

Charon (2002) reminds me that "We learn who we are backwards and forwards, early memories taking on a sense only in the light of far later occurrences and contemporary situations interpretable only in the web of time" (p. 61). My story to live by as an operating room nurse became framed around meeting a responsibility to patients and myself by ensuring patient safety at various levels in the operating room department. I could not place a name on this at the time, but through a reflective process, I identified this commitment as attending to the relational ethic[2] within human encounters. Thus over the years I have discovered that enacting a relational ethic is not always an easily attained goal.

Thinking back, I understand how I learned from these experiences, but it seemed to be at the expense of a patient or family. My relational ethic, a way of being with patients, became my work strength and over the years, many challenges have left deep impressions on my mind. During those moments I would again find myself in a betwixt and between place, on a threshold of not yet and no more. I felt troubled as I tried to resolve the right thing to do and wondered how to do it. How could I promote and provide safe patient care in a meaningful and not perfunctory way? Peering at my inner self from the outside brought me to see how I engaged with my patients and others, and deepened my focus on patient safety within the context of a relational ethic. I recognized how I had repositioned myself in a professional landscape as I moved from being a nurse behind the mask to one without the mask.

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[1] 'Story to live by' is a term introduced by Connelly and Clandinin (1999) to help us "understand how knowledge, context and identity are linked and can be understood narratively" (Whelan, Huber, Rose, Davies, & Clandinin, 2001, p. 144).

[2] 'Relational ethic' is from the philosophical work of Bergum and Dossetor (2005) in which they assert that "human flourishing is enhanced by healthy and ethical relationships" (p.xii). The fundamental nature of a relation ethic lies in ethical commitment and responsible agency, with the space between moral agents as the "relational space for discovering knowledge about others…" (p.xii). The four layered components of relational ethics are engagement, mutual respect, embodiment and environment.

As I look back on my nursing practice in the operating room, it seems barely perceptible to me how my resolve for safer patient care was actualized through embracing a relational ethic while connecting with patients and colleagues. Over the years, I have become more comfortable in working in such a relationship, one that now seems natural to me and is not an abstract concept without a name. The semidetached betwixt and between places that I still encounter are both haunting and yet a sanctuary for me, a space where I revisit how I have storied others and how they have storied me in our encounters, and a space where I question if I acted in my patient's interest or my own. This is a space where I can map where I have been and where I may go in my next patient safety event, and is my place of constant becoming. And at these times, I am reminded that the landscape I work and live in alongside my colleagues is a difficult landscape to negotiate.

I appreciate how others have challenged my assumptions about patient safety and I sense how my approach has challenged assumptions held by others. This reflection helped me to understand how the multiplicity of my experiences have become my story to live by; the story that I reach for to guide me; and a story composed across time, place, and relationships (Clandinin & Connelly, 2000). I have come to understand that sometimes I must leave my relational landscape and engage with my inner self in a liminal space, so I may find a sense of self again. Despite any tension I may feel in the moment, I sense how this space does provide solace for me, and a place where I am able to acquire a richer sense of myself as a moral being (Carson, 2002).

As I began my research into operating room nurses' experiences of patient safety, I did so with my own and the experiences of some of my colleagues simmering in my mind. Every so often, I felt one of the simmering moments bubble and stir up my thoughts as I contemplated what a colleague or I had experienced in terms of patient safety. To say I was curious in making sense of these situations does not seem sufficient. I needed to know how people saw their lives at work, how they understood an event, how they related to others, and how they made sense of what had occurred. I wanted to understand their individual experiences through professional and personal knowledge. And I wanted to know how they told their stories in response to an event, for I felt that

much of what we did at work as operating room nurses depended on our many layered experiences that could enable us to explain it.

In revisiting my experiences as an operating room nurse, I opened a narrative space of inquiry and understanding about patient safety through story. Research literature has highlighted important aspects in understanding patient safety, especially communication, interdisciplinary relationships, and learning from experience. However, what was not overtly captured or explicated in the literature was the notion that understanding personal and human elements of past experiences could deepen our understanding of patient safety. By laying my experiences alongside current literature, it enabled me to lift the silence off my past experiences and offer a new perspective for generating patient safety knowledge. The viewing of past experiences as a new way of advancing, creating, and thinking about patient safety in the operating room is difficult, for it requires the telling, reflecting upon, inquiring into, reliving of tensions, and retelling of one's own experiences. Yet it is thinking in this way that brings me to ask: What stories do operating room nurses have to tell about their experiences of patient safety and what can we learn from them?

In answering this question, I presented in *Chapter One: Narrative Beginnings* an autobiographical account that situated the study within the three-dimensional narrative inquiry space of person, place and time (Clandinin & Connelly, 2000). I now turn to *Chapter Two: Discovering the Literature* which focuses on a descriptive review based on a critical analysis of selected patient safety theory and research articles, and which highlights salient aspects of patient safety relevant to the healthcare arena.

CHAPTER TWO

Discovering the Literature

The delivery of safe care is an expectation and a central concern of individuals utilizing the healthcare system, especially those who find themselves as patients in hospitals. According to the World Health Organization, patient safety is a serious public health issue (World Health Organization, 2012). With estimates of 1 in 10 persons experiencing some sort of harm while receiving hospital care, the global importance of improving patient safety has been recognized (World Health Organization, 2012). Health Canada (2012) holds that providing safe, quality healthcare to Canadians is a priority, for a focus on patient safety ensures a fundamental element of high quality healthcare.

The Canadian Patient Safety Dictionary (Davies, Hébert, & Hoffman, 2003) has defined patient safety as the "reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes" (p. 12). As the largest single group of healthcare providers in Canada, nurses contribute to the safety and quality of a healthcare system. They do this by using their "in-depth knowledge base and cognitive, critical thinking and decision-making skills…to recognize complications before they become more serious and to intervene to reduce risk to the client and costs to the health-care system" (Canadian Nurses Association, 2007). The delivery of safe, competent patient care is an expectation and a standard of nursing in Canada. With this in mind, the Canadian Nurses Association further identified the necessity of organizational and human support resources in professional practice environments to ensure nurses' goal of providing safe, competent, and ethical nursing care (p. 21).

Continually evolving perspectives about healthcare and the benefits of safe patient care have led to the realization that hospital acquired infections, disability due to healthcare related harm, and lost wages are not only a significant financial burden within the public domain, but are also a physical and social burden in the private lives of Canadians. Globally, patient safety as a healthcare concern has quickly developed into a scientific field of study, with research results developed into practice interventions. Specific interventions adopted by patient safety organizations, professional practice associations, healthcare authorities, and educational institutions have translated into practice

recommendations, many of them carried out in nursing environments to diminish specific elements that may negatively influence patient safety. Research on patient safety has proliferated through numerous disciplines, for example in nursing, medicine, sociology, ergonomics, ethics, economics, and biomedical technology. This breadth of interest signifies patient safety as a multidimensional concept, which may be better understood through a multidisciplinary research approach. It also emphasizes the importance of understanding patient safety from diverse perspectives, viewpoints that may offer alternate insight into, and understanding about, patient safety.

Focusing the Review

During my doctoral course work, I reflected on patient safety as presented and discussed in the literature, and as a theoretical underpinning to my developing inquiry of patient safety in the operating room. Early in my program, I had the opportunity to complete an independent study course at the Canadian Patient Safety Institute in Edmonton that focused on adverse events in modern health systems. Through an extensive search of the literature on patient safety, which was by no means a definitive or exhaustive review of all available literature, I recognized and read comprehensively about the recurring and dominant themes represented. I initially identified three specific documents that were fundamental for me in understanding the complexity and nuances of patient safety in healthcare and in the operating room. I also felt they were seminal contributions in bringing the issue of patient safety forward from being a hidden, and at times neglected, component of patient care within hospitals to a more visible national concern within the public domain.

The American report issued by the Institute of Medicine *To Err is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000) emphasized that the majority of patient safety issues stemmed from poor system processes or conditions that led to mistakes or failure to prevent them. Various studies referred to in this document reported adverse events occurring in 2.9% - 5.4% of all hospitalized patients, an incidence rate considered to be on the conservative side due to underreporting of error. Patient safety was identified as a fundamental component of overall patient care and an ethical and professional imperative of healthcare workers. The reporting of adverse events was identified as especially important to improving patient safety. A prominent point highlighted

in the report was that individual irresponsibility was not a primary factor in healthcare error; however, individual vigilance and attention to each patient care situation was required to promote safety at all levels of care. A four-tiered approach to addressing patient safety was outlined. This included setting national goals for patient safety supported by leadership, tools, protocols, and research to develop and apply safety knowledge; learning from error through supporting mandatory and voluntary reporting; setting and enforcing explicit performance standards and safety expectations; and creating and implementing effective safety systems inside healthcare organizations.

In 2004, a study to determine the incidence of adverse events across 20 Canadian hospitals was the first of its kind to estimate the range, frequency, and type of adverse events (Baker et al., 2004). The authors concluded that the overall incidence rate of adverse events for hospitalized patients in Canada was 7.5%. Of significance was the determination that of those patients, 36.9% experienced a highly preventable adverse event. Situations considered to be adverse events in this study included: unplanned readmission after discharge from hospital, adverse drug reaction, hospital-acquired infection or sepsis, hospital-incurred patient injury, unexpected death, unplanned transfer to intensive care from general care, unplanned removal, injury or repair of organ during surgery, unplanned return to the operating room, and development of a neurological deficit not present on admission. While a large percentage (64.4%) of these adverse events resulted in no physical impairment or disability, or in minimal to moderate impairment with recovery within six months, it was disconcerting that 15 (5.2%) of the adverse events resulted in permanent disability, and 46 adverse events (15.9%) occurring in 40 patients resulted in death (p. 1681). Not surprisingly, length of hospitalization in patients who experienced adverse events was longer than in those with uneventful admissions. In 255 patients experiencing an adverse event, it was estimated that 1521 additional days in hospital were directly related to their event; it was further calculated that in those patients who experienced an adverse event, 41.6% were found to have one or more adverse events with a high preventability rating (p. 1683).

In determining the frequency of adverse events in the service most responsible for care delivery, 51.4% occurred in surgical services, 45% occurred

in medicine, and 3.6% occurred elsewhere (p. 1683). The most commonly occurring adverse events related to surgical procedures, drug or fluid-related events, or an act of omission; that is, the failure to carry out a necessary task. While there was no difference between female and male patients in terms of their risk of an adverse event, the age of patients was higher among those experiencing an adverse event.

Baker et al. (2004) noted that even with adjustments made for age, sex, and co-morbidities the trend for adverse events to occur in teaching hospitals was greater than in nonteaching institutions. The authors offer several possibilities that may account for this apparent trend. These include: 1) true differences in the acuity of patient populations were not fully accounted for in the risk adjustment model, and 2) patients in teaching hospitals receive care from a variety of care providers that may lead to increased miscommunication and uncoordinated care. In addition, 3) regardless of co-morbidities, some patients arrived at teaching hospitals at a point in their care that may have placed them at risk for an adverse event; and 4) the depth and focus of chart documentation may differ across hospital types (p. 1684).

Baker et al. (2004) identified several limitations in this research. They included: 1) budgetary constraints limited the number of hospitals reviewed, 2) patient chart review was limited to only adult patients in acute care hospitals, 3) some hospitals were teaching facilities and others were not, and 4) a variation in charting practices between the hospitals included in this research. However, I did not consider these as negative limitations, for hospitals are different across the country and as intended, this research provided preliminary insight and understanding into the burden of suboptimal patient care in Canada. It also established a solid starting point from which to address patient safety in Canadian hospitals, most specifically through improving medication and surgical safety. Finally, the authors noted that the adverse event rate of 7.5% found in their study was lower than that reported in other large studies elsewhere, for example in New Zealand at 12.9% and in Australia at 16.6% (p. 1685), acknowledging that the criteria used to calculate the rate of adverse events differed from the Canadian study. Regardless of whether an adverse event is an unavoidable consequence of healthcare, for example an unanticipated drug allergy or a preventable event, it is clear that significantly more effort is required

to improve the safety of patients in hospitals, especially in the area of surgical services.

The *Report of the Manitoba Pediatric Cardiac Surgery Inquest* (Sinclair, 1998) is a review of a Canadian patient safety event of extreme magnitude, focusing on the paediatric cardiac surgery deaths at the Winnipeg Health Sciences Centre during 1993 -1994. What was startling for me as I read Sinclair's report was to discover a similar public inquiry report into the failings of a paediatric cardiac surgery service during 1984 -1995 in Britain. Issued in 2001, *Learning from Bristol* (Kennedy, 2001) brought to public attention the tragic consequences that can occur when organizations and people fail, not intentionally, but through a combination of circumstances. The examples cited included: 1) lack of leadership, 2) failure to communicate, 3) lack of teamwork, 4) poorly organized hospital care, and 4) efficiency-focused changes in the National Health System, which ultimately led to flawed patient care. I was surprised to learn about this significant safety event, and was equally puzzled as to why I did not remember hearing of the Bristol events, which occurred before the Winnipeg events. In addition to several issues similar to those identified in the Bristol inquiry, relational behaviour amongst surgical team members was determined to be a significant factor in unsafe patient care in the Canadian event. Sinclair specifically focused on the role of nurses in safe patient care when he wrote:

> …nurses were never treated as full and equal members of the surgical program...the concerns expressed by some of the cardiac surgical nurses were dismissed as stemming from an inability to deal emotionally with the deaths of some of the patients....any concerns over medical issues that the nurses expressed were rejected as not having any proper basis, clearly stemming from the view that the nurses did not have the proper training and experience to hold or express such a view. (pp. 477-478)

What struck me was that through the information contained in these public reports, *Learning from Bristol* and the *Report of the Manitoba Pediatric Cardiac Surgery Inquest,* healthcare and society was hopeful in preventing a similar situation in the future; yet, it seemed that the unfolding events of Bristol had not been able to deter another occurrence. What was of further significance to me was that the experiences of the parents and healthcare providers in both of these events were introduced in a broader attempt to understand the complexity of safe

patient care. While the experiences of parents and healthcare providers may have differed, it was the information in the specific experiences that provided clues to a deficiency or sufficiency of care, which enabled judgments to be made about the standard of surgical care we should expect in our hospitals. Finally, these reports addressed the notion of family and patient's rights, suggesting that the patient care situation be approached not only as a professionally determined one, but also as an ethically derived one. In other words, rather than allowing organizational processes, for example professional hierarchies or available resources to be the sole focal factor in determining the delivery of patient care, a focus on a patient-centered approach is viewed as an ethical and necessary path toward patient safety.

These documents contributed to existing knowledge about patient safety in diverse ways. Not only were elements of a structural or organizational nature concerning safety identified and examined, but also articulated was a shift to understand and pursue ethical and relational care as a vital component of safe patient care. While these reports focused on safety events related to paediatric surgery, the knowledge learned from the tragic events is relevant and applicable for all types of surgery programs in all hospitals everywhere.

These three documents, *To Err is Human, The Canadian Adverse Events Study, and The Report of the Manitoba Pediatric Cardiac Surgery Inquest* were not only seminal writings in the literature, but they were also important to me in terms of an initial discovery of the literature on patient safety. As I reflected on these documents later, I realized how as preliminary readings they connected strongly to my area of interest of patient safety in the operating room. In coming back to these writings and re-reading them, they kept me grounded as I figured out a process of how I could focus my search for select literature specific to the operating room.

Review of Selected Literature

With an awareness of the key role that nurses hold in safe patient care, I focused on examining dominant and recurring ideas about patient safety in the literature. During the initial phase of my inquiry, I retrieved and reviewed over 100 English research articles published in peer-reviewed journals between 1995 and 2008 that addressed patient safety in the hospital and the operating room. I did not review literature published in languages other than English as I only read and

write fluently in English. I initially met with a librarian from the Canadian Patient Safety Institute in Edmonton for assistance in determining search terms that would generate relevant literature. I also met with a liaison librarian for the Faculty of Nursing at the University of Alberta located in the John W. Scott Health Sciences Library for further assistance with generating and combining search terms. The search terms used included: patient safety, adverse event, nurse error, physician error, medical error, patient care, healthcare, organization culture, safety culture, safety climate, hospitals, surgery, operating room, operating room personnel, and healthcare workers.

I used the following databases to search for literature: CINAHL (a nursing and allied health database focused on areas such as patient care, health promotion, professional issues for health care workers, and patient education); MEDLINE (focused on biomedical and health sciences literature, such as health promotion, medical education, legal aspects of medical practice, and the nature of health science professions, and contains a nursing subset); HealthSTAR (focused on areas of health planning, administration, health services, health policy, and patient outcomes); and Embase (medical database focused on biomedical sciences). I reviewed reference lists for additional articles related to patient safety, the hospital, and the operating room. I also did a manual search of several journals for the years 1995 to 2009, including *AORN, CORNJ, CMAJ, The Canadian Journal of Surgery, The American Journal of Surgery,* and *The Canadian Journal of Nursing Research.* I did not limit my search to Canadian only research, for I felt that discovering patient safety from a universal perspective would provide greater understanding overall.

Further into the inquiry I selected for review articles that reported on research primarily in the operating room, included two theoretical articles, which I considered valuable to my work, were primarily Canadian or American in context, and addressed aspects of patient safety. I included four international articles based on the rationale that after reviewing much of the patient safety literature, healthcare procedures and safety concerns were similar between our nations. Specifically, I selected for review articles that addressed a particular element of patient safety that resonated with me, for example, an article that discussed an aspect of safety that I had not previously considered in terms of patient safety in the operating room or an article that addressed the role of operating room

personnel, especially nurses in the overall topic of patient safety. In order for patient safety knowledge to be considered relevant, it needed to focus on understanding, preventing, or managing safety in an everyday, work related context. While I focused primarily on writings related to the operating room, I also reviewed literature that was not operating room located where I felt it addressed patient safety issues that could conceivably be present in this area.

In selecting only English language publications, I excluded studies in which the primary focus was, for example, an evaluation of a specific device, the efficacy or merits of a particular surgical technique or intervention, randomized drug trials, clinical versus surgical approach for any particular condition, follow-up studies evaluating the effectiveness of implants, or management of patient co-morbidities. I also excluded chapters of books or literature not accessible through computerized databases. My review resulted in 21 articles that met the criteria. The intent was to consider how patient safety was conceptualized and addressed from different viewpoints, and what knowledge had implications for my inquiry and for advancing nursing research generally. I recognized concepts or themes in reviewed literature about patient safety in the operating room as reflective of similar concepts apparent in patient safety literature overall. These concepts included disclosure and disclosure practices, professional identity formation, communication practices, collaborative work, and distractions and interruptions in work. In addition, since the initial literature review I have discovered further literature relevant to patient safety in the operating room, and this is indicated where it has been included.

Narrative inquiry is a research process that begins with experiences as lived and told in stories (Clandinin & Connelly, 2000, p. 40). Reflective of this approach, the literature review is not a theoretical structuring framework that outlines theoretical principles about patient safety in the operating room to generate potential research possibilities (p. 41). Rather, this descriptive literature review was approached as a discovery of the patient safety literature that would inform a "kind of conversation between theory and the stories of life contained in the inquiry" (p. 41). Thus in an effort to reflect the above perspective, a broad scope of patient safety research in the operating room was initially undertaken, followed by a descriptive review of selected literature representative of a discussion of five patient safety foci among researchers. They include disclosure

and disclosure practices, professional identity formation, communication practices, collaborative work, and distractions and interruptions.

Descriptive Analysis of Selected Literature

Disclosure and Disclosure Practices

Disclosure of safety events and reporting of these events are identified as essential in the overall reduction and management of error in healthcare provision. Leape (2006) in a theoretical paper addresses the disclosure of error as both an ethical and therapeutic necessity. It is situated as an ethical response in the sense that full disclosure of error is not an option, it is a right of patients to know what has happened to them; and it is therapeutic in the sense that it enables emotional healing for both patients and healthcare professionals to occur. Patients are emotionally injured when they discover personal harm has occurred through someone they placed their trust in, and healthcare providers can be emotionally harmed through their involvement in an adverse event situation, especially if the event is not discussed in any way. Transparency through open and compassionate communication when adverse events occur can restore patients' trust in healthcare providers and the healthcare system.

Leape (2002) described disclosure, in the form of reporting adverse incidents, in an earlier theoretical paper as the primary method of learning from mistakes. Reporting can lead to improved safety through learning about new hazards, dissemination about methods to prevent error, discovering trends and hazards that require attention, and the identification of 'best practices' to minimize healthcare error. Minimizing potential risks and preventing harm to patients are ethical obligations common to all healthcare providers and the organizations that provide healthcare. Safety incidents, or things that go wrong, provide us with valuable learning opportunities in the realm of patient safety. Despite this acknowledgement, however, Leap (2002) suggests that disclosure and under-reporting of safety incidents are often the norm in our healthcare system.

Research by Cook et al. (2004) using surveys, questionnaires, interviews, and case studies brought to light how limited disclosure practices surrounding error stem from disparate ways that healthcare practitioners frame or interpret similar situations, and, how varying interpretations of similar types of safety events can lead to lack of clarity over what actually constitutes the occurrence of

a safety incident. Cook et al. also described nurses' perceived lack of authority as preventing them from questioning non-nursing clinical decisions, as they had often been rebuffed for their queries. For example, one nurse in this study was quoted as saying, "I have caused trouble because I have questioned some physicians. We can't do that here" (p. 36).

The authors also identified administrators' role in patient safety as limited. Administrators felt they lacked the clinical knowledge to determine whether an event was an error, and therefore relied on physicians to determine if error had occurred or not. What I found significant in this study was that despite nurses' hesitancy to question or report deviance in practice, and although administrators and physicians (who took part in the study) did not generally recognize nurses as members of any decision-making team, those same participants felt that patient safety was primarily the nurses' responsibility. The authors describe a systems approach to achieving patient safety in which all team members share responsibility for patient safety. This approach incorporates a vision of safety as a priority. It is a commitment to replacing systems that do not work by strengthening the healthcare team through interdisciplinary training, and providing accessible resources that support critical thinking. The authors also suggest that a lack of a mutual vision for patient safety has created a "climate in which errors are seen as an unfortunate but inevitable consequence of the practice of medicine" (p. 42). They conclude that effective approaches to patient safety must require a continual evaluation of individual attitudes, a willingness to accept other points of view, and the sharing of information among all healthcare practitioners.

Healthcare has been identified as a risk-prone activity (Amalberti, Auroy, Berwick, & Barach, 2005) which is extensively populated with students, interns, and junior staff who are particularly vulnerable to experiencing difficulty in either recognizing or reporting safety incidents. In this theoretical paper, the authors contend that the following considerations are necessary to address specific system barriers to healthcare becoming ultra-safe. The discretion of workers and level of acceptable risk must be limited, and individual worker autonomy needs to be limited through encouraging more teamwork. Focusing less on individual professional status and adopting equivalency amongst professionals are necessary for effective interprofessional work. Senior leadership needs to create

and ensure supports to optimize safety strategies, and in general, simplification in work is required. The wide range of risk amongst medical specialties, various structural and system constraints within which healthcare is provided, and difficulties in defining and managing medical error are issues specific to healthcare that must also be addressed, in order to ensure healthcare is ultra-safe.

In a descriptive Australian study describing nurses' perception of error in medication administration, Baker (1997) discovered there was not always a deliberate attempt to keep hidden what had occurred. Nurses used a set of criteria to re-define, potentially, an error as a non-error, which would not require official reporting. The authors identified the following criteria used by nurses in the study to decide whether an error had occurred:

> If it's not my fault, it is not an error. If everyone knows, it is not an error. If you can put it right, it is not an error. If a patient has needs which are more urgent than the accurate administration of medication it is not an error. A clerical error is not a medication error; and, if an irregularity is carried out to prevent something worse it is not an error. (pp. 156-157)

The authors suggest that reframing of error is a tactic used by nurses to gain order in their complex, and at times, constrained work environment. Conversely, if an error occurred which could not be re-defined in any way, it was considered a 'real' error and managed accordingly, with concern for the patient's safety foremost. Considering the discrepancies surrounding interpretation of error as discussed by the authors, it is understandable how safety incidents are easily reframed as a characteristic of everyday practice.

In their research using a mixed method of interview and statistical analysis, Espin, Levinson, Regehr, Baker, and Lingard (2006) found that operating room team members and patients agreed on what constituted an error; however, they noted there was a tendency for professional groups to discount safety incidents that were considered the responsibility of another health profession. This culture of individualism can be a detriment to patient safety, and the authors offer that a collective error identification and disclosure process is required to address safety concerns in the operating room.

An ethnographic study by Waring, Harrison, and McDonald (2007) revealed that normalizing risk in the operating room as a ritualistic or cultural

behaviour via tolerating and enduring risk, accommodating risk, and implementing practices to control for risk may adversely influence patient safety. When risk becomes normalized clinical practice, there is limited formal communication and limited opportunity for individual learning to occur from safety incidents. A concern is the potential for risk to remain underestimated, overlooked, or spread to other clinical areas and allowed to persist within the general work environment. The authors suggest that risk is generally an accepted feature of healthcare practice, and normalizing risk in the operating room may demonstrate a capacity to manage and work within uncertainty. They indicate that the steps necessary in creating a safety culture in the operating room, in order to expose underlying sources of peril, include: 1) communication with leaders, 2) incident reporting, and 3) joint efforts in finding solutions to risky practices and behaviors.

Literature reviewed in this theme consisted of three theoretical articles, two qualitative research studies, and two mixed method research studies, that is, studies that used both qualitative and quantitative methods. One qualitative study spanned over a period of 18 weeks and included nurses from three separate wards in a large acute care hospital; however, no information was provided to determine the actual number of participants or the size of hospital (Baker, 1997). Another qualitative study in an operating room of a large teaching hospital spanned over 2 years in length, and consisted of 80 operating room personnel. The participants were purposively selected on the basis of their contribution to the work and safety of the operating department (Waring et al., 2007).

Findings from one multimethod study conducted over a 3-year period were thought to be critically significant in providing information on what may be a fundamental difference in the recognition and conceptualization of error by nurses and physicians (Cook, et al., 2004). In another mixed method study, the researchers felt that the generalizability of results may be limited overall. Participant responses may have been influenced by use of the term 'error', and the use of hypothetical scenarios may have made identification of error easier than in an actual clinical environment. Researchers indicated the potential for sampling bias existed because a convenience sample was used (Espin, Levinson et al., 2006). The theoretical writings explored options for improving patient safety in healthcare overall, for example, recognizing barriers to improving delivery of

healthcare, and developing better work and error reporting systems (Amalberti et al., 2005; Leape, 1999; 2006).

Literature on workarounds in nursing practice was not part of my initial literature review; however, I found it to be quite relevant to patient safety in the operating room in terms of normalizing risk and managing safety events. An understanding of workarounds in the following literature denotes a deviation in accepted practice in order to prevent harm, or a way to accomplish work within a situational constraint.

Amalberti, Vincent, Auroy and de Saint Maurice (2006) discuss violations in healthcare as "deliberate deviations from standard procedures" (p. i66). Amalberti et al. (2006) propose that deviations, or workarounds, become a worker's response to competing demands in a complex environment, and may actually be more common than errors. What is especially concerning is that as workers continually adapt and respond to the demands of their complex environment, violations can become "more frequent and severe over time so that the whole system migrates to the boundaries of safety until an accident or recalibration occurs" (p. i68). While the authors acknowledge that workarounds are often a valid response for individual practitioners in a specific context, they note how this practice also becomes tolerated and sanctioned when repeated over time.

In a non-nursing personal ethnographic account spanning 30 years, Kirke (2010) discusses rule bending and rule breaking processes in the British Army in terms of being "legitimate or otherwise" after those with authority considered the circumstances and consequences of the specific action (p. 370). In a qualitative research study, Hutchinson (1990) described rule bending among nurses as "responsible subversion"; in other words, bending the rules for the sake of the patient (p. 3). In this research, Hutchinson found that nurses, acting as a patient advocate, based their decisions about responsible subversion in terms of what was professionally right or wrong in the context of an ambiguous and conflicting work environment. The nurses were often fully aware of the legal, professional, and ethical implications of their actions.

In an exploratory descriptive study, Collins (2012) also found that rule bending occurred when a system-nurse conflict impeded the intended goals of nursing care. Nurses' acknowledged rule bending involved violating or exceeding

the standard scope of practice, which could lead to professional consequences (p. 15). It was thought that experienced nurses practiced rule bending more frequently, as a higher level of expertise was necessary to successfully evaluate and manage deviations in practice. Similar to Hutchinson's research, nurses in Collins study felt they were caring and responsible professionals.

In a qualitative research study focused on technology implementation and nursing workarounds in a nursing home, Vogelsmeier, Halbeslaben, & Scott-Cawiezell (2008) discovered how nursing home staff turned to workarounds to address blocks in workflow during the implementation of a medication delivery system, and to bypass organizational processes that were not compatible with new technology (p. 114). I felt this to be especially relevant to safety in the operating room, for the introduction of any new technology, no matter what healthcare setting, must mesh smoothly with existing organizational processes to support safety in care. Based on a literature review and analysis of healthcare practices, Lalley and Malloch (2010) provide an alternate understanding and definition of workarounds as something other than overcoming barriers in work. They propose that workarounds are a "creative, redesigned process that facilitates care to patients by providing opportunities for nurses, designers, regulators, and administrators to interact and produce novel patterns or knowledge" (p. 31).

Professional Identity Formation

Researchers have discussed how both effective and poor communication patterns may have implications for novices in the operating room, as attitudes of others may be mimicked or adopted during the shaping of their professional and interprofessional identity, as well as internalization of professional values (Lingard, Reznick, DeVito, & Espin, 2002; Lingard, Reznick, Espin, Regehr, & DeVito, 2002). Based on results from grounded theory and direct observation research, the authors suggest that in particular situations, individuals learn as members of groups and communication patterns may influence the adoption of professional values and attitudes in the operating room setting. They also suggest that if one is searching for reasons why there is limited improvement amongst teams in their working relationships, it is worth paying attention to and understanding how teams communicate.

Through analyzing the written experiences of medical error witnessed by fourth year medical students during their surgery and medicine clerkship, Martinez and Lo (2008) discovered that some faculty members and mentors responded to error in ways that may have been inconsistent with professional standards and expectations. Examples included silencing any discussion about an event, non-disclosure of an event, or misrepresentation of an event. Responses inconsistent with professional expectations were emotionally and physically distressing to the medical students, and some students questioned their own professional practice and professional development. However, students did observe that senior staff also accepted responsibility for suboptimal care events, and recognized this behaviour as a professional and moral standard to follow. This literature would suggest that increasing the exposure of medical students or other surgical novices to exemplary management practices of error resolution is beneficial in professional development and personal well-being, as leaders and mentors can morally influence safety practices of lesser experienced others through modeling integrity and lifelong learning. Without adequate mentoring, novices cannot develop ethically sound safety practices. In order to gain confidence and competence through reflective practice, a supportive environment is necessary for individuals, as learning from safety incidents is paramount in patient safety.

In research that utilized interviews and qualitative content analysis to study operating room teamwork, Silén-Lipponen, Tossavainen, Turunen, and Smith (2005) contend that safe practice needs to be recognized as a team responsibility, not an individual effort, when addressing patient safety. The authors suggest that even though errors cannot absolutely be eliminated from the operating room department, systematic learning from these events should be a focus for future safety initiatives. Management could support this learning by focusing less on the error and more on circumstances surrounding the event, as a way to encourage shared responsibility. The authors address the benefit this systematic learning holds in gaining confidence and competence through reflective practice, especially for novice team members in nurturing positive safety practices. The authors further noted that once nurses have graduated, they are expected to work as accountable team members, “even though expert nursing skills are not always apparent during routine OR patient care and

expertise is crucial when the unexpected occurs" (p. 30). It was suggested that safety could be improved by assigning enough experienced staff to each team in order to support competency development in others.

In an action research study utilizing semi-structured interviews and interpretive content analysis by Alfredsdottir and Bjornsdottir (2008) to determine what operating room nurses believed influenced patient safety, operating room nurses felt that patient safety overall was strengthened by a culture of prevention and protection. An essential component of this culture was the delivery of care through specialty teams. By specializing into teams, operating room nurses felt they developed advanced knowledge specific to their specialty, and demonstrated a high level of performance, which enhanced patient safety. Developing mutual trust, cooperation, and a sense of belonging was enhanced through working in specialized teams. The nurses also felt working in specialized teams positively influenced morale through establishing supportive team relationships, which the nurses also felt led to enhanced patient safety. However, the nurses also noted that teams were not always adequately staffed, which was a potential detriment to patient safety.

Literature reviewed in this theme was qualitative in form. In one study spanning over 2 months and comprised of 52 operating room personnel, three researchers individually analyzed transcripts followed by group discussions to resolve coding discrepancies. Further data analysis was performed with the NVivo qualitative data analysis programme (Lingard, Reznick, DeVito et al., 2002). In another study, a large sample population was employed to collect data on a range of communication patterns. Researchers felt that any observer effect could be lessened by limiting the length of observation of participants. Observers were also instructed to record evidence of a possible Hawthorne effect in their field notes when observing participants. Based on the measures employed, the researchers concluded the study findings were representative of communication activities specific to the hospital studied during the research period (Lingard, Reznick, Espin et al., 2002).

Several limitations were considered in one study using thematic analysis and QSR NVivo qualitative analysis. The actual writing assignment that was analyzed was not designed for research purposes. Therefore, information in the written papers may have contained incomplete information, or incorrect

conclusions may have been drawn, and presented in writing by the participants (Martinez & Lo, 2008). In an international qualitative research study, a convenience sampling design was used to recruit 30 operating room nurses from three countries. Some limitations to the generalizability of findings were identified. While the quality of data was considered rich in context, the researcher met only once with participants, thereby limiting an opportunity to obtain even deeper information. The data was also collected in the three countries by the same researcher, which may have influenced the understanding of specific verbal information. However, the researcher was familiar with nursing cultures and languages of different countries, and research team discussions about specific language nuances in the data was felt to maintain research credibility (Silén-Lipponen et al., 2005).

A smaller research study spanning over 2 years began with eight nurses engaged in semi-structured interviews, followed by two focus groups of four nurses each. The findings based on interpretive content analysis reflected those of an international study by Silén-Lipponen et al. (2005). However, because this research came from only one university hospital, which does not reflect other operating rooms in other hospitals, the findings were not thought to be generalizable to all operating room nursing universally (Alfredsdottir & Bjornsdottir, 2008).

Communication Practices

In research based on observation and communication analysis, communication failures in the operating room were found to be frequent, with invisible effects that can later surface or become compounding factors leading to diminished patient safety (Lingard, Espin et al., 2004). The authors discuss how a false sense of safety is produced when there are no visible effects from communication failures. They further suggest that the invisibility of communication failure likely explains how the operating team has come to the status quo, in which it is highly irregular for a surgeon, an anesthesiologist, and a nurse to meet and discuss a procedure before it commences. Compared with the expectations of other high-risk organizations around team communication, this status quo is alarming (p. 334).

Examples of communication failures included conversations that happened too late to be maximally useful and conversations that were

incomplete because relevant information was missing. These failures were seen to have immediate effects, such as team inefficiency and a rise in tension. The authors note that identifying communication failures is important, as they can indicate problems with system processes or those originating in care providers' attitudes. Significantly, the authors also recognized that ethical considerations arise in research employing observational methods, for example, about making judgments whether one should intervene based on an observation. This reflected the careful balance required of the researchers between methodological and ethical goals.

In research based on observation and communication analysis, Lingard et al. (2005) described implementing a communication checklist to determine if interprofessional communication improved through discussing key procedural issues prior to surgery, with input from each member of the surgical team. The checklist was comprehensive in item content, yet practical in length, pertinent for all surgeries, and represented nurses, anaesthetists, and surgeons in content. The authors determined that there was compelling evidence that effective team based communication via use of the checklist supported or enhanced safety in the operating room. The authors identified specific functions of the checklist, with the most common functions being the provision of detailed case-related information, confirmation of details, articulation of concerns, and team building. To a lesser extent, the communication process also allowed for educational opportunities and decision-making. Finally, operating room team members underscored information provision and team building "as the most valuable functions of the checklist discussions" (p. 343).

Also discussed in the literature is the notion that communication practices in the operating room have a material influence upon practitioners and patient safety practices. Acknowledging the need to recognize and support the human side of safety incidents, van Pelt (2008) described a personal experience surrounding a safety event in the operating room. This author suggested that the establishment of a peer support service for care providers serves as a foundation for open communication and renews compassion in the workplace. Also identified as enhancing patient safety and overall quality of care is the creation of a safe institutional environment that supports transparency, accountability, and opens

communication, and calls attention to silences surrounding adverse events as a hindrance to patient safety.

The literature reviewed in this theme consisted of two qualitative studies and an original research paper. In a qualitative study that spanned over 3 months observing 90 members of an operating room, researchers raised the possibility of sampling bias influencing the findings, because no team members of the operating room declined to participate in the study. This may have indicated unusual interest or personal confidence in the specific research focus of communication abilities. The generalizability of study findings to other operating room teams was considered to be limited (Lingard, Garwood, & Poenaru, 2004). In another qualitative study, the researchers observed and participated in a checklist document intervention along with study participants. The generalizability of findings to other operating rooms was felt to be limited due to researchers' active participation and the participants' familiarity with the researchers (Lingard et al., 2005). In an original research paper, a personal safety experience was reflected upon and analyzed in comparison to an established way of coping with uncertainty, contradiction, and ambiguity in professional practice. This approach identified tensions of living a professional life that are not always known to those outside of a profession (van Pelt, 2008).

In an article that I discovered later, another author also employed confessional writing to discuss and offer an understanding of the personal impact of committing an error within the realm of daily practice in healthcare. Hilfiker (2000) discussed how the usual approach in medicine of analysing an error, followed by corrective measures, does not adequately address one's emotional and spiritual experiences of the event. In his account, Hilfiker described how he felt the guilt and anger over his own error to be devastating upon his emotional health, and how he carried this burden by himself. He felt that the inherent uncertainty of medical practice, and the complex decisions required in practice, could create situations in which errors are always possible (p. 91). Hilfiker offered that physicians are less prepared to deal with their mistakes than the average person, because perfection is expected of the physician in all that he or she does. Given this perspective, physicians do not feel they have permission to discuss openly an error or their emotional responses, creating a boundary between the physician and patient (p. 93). However, Hilfiker is adamant in saying

that mistakes need to be discussed in the open, and physicians need to find healthy ways of dealing with their emotional responses to their errors. In the article, Hilfiker's writing also includes an account of the ethical issues of his medical error. As he recounts his story, it is apparent how he is also thinking with his story as a way of understanding and improving the ethics of healthcare.

Collaborative Work

Despite the apparent recognition that a collaborative relationship is necessary for effective team functioning and patient safety, research combining qualitative and quantitative information revealed that attitudes toward nurse-physician collaboration can vary between the two professions (Sterchi, 2007). The author defines collaboration as a process of joint decision-making among independent parties, joint ownership of decisions, and collective responsibility for outcomes. To address the complex and competing demands of an operating room department, a collaborative approach among all team members is vital to ensure safe, quality surgical care and an approach that should become an institutional goal. The author suggests that the traditional emphasis on expertise, autonomy and responsibility by the medical profession is in opposition to nursing's approach, which encourages interdependence and dialogue. The different approaches that nurses and physicians have toward patient care may lead to strained relationships and compromise patient safety.

In examining relations of power and knowledge, Cecci (2004) discusses how surgical nurses' concerns were not taken seriously during safety incidents at the Winnipeg Health Sciences Centre in 1994, which gravely compromised patient care. In this theoretical paper, Cecci pointed to the relationship between power and knowledge as influential in determining who was seen as a privileged knower, based on a presumed hierarchy of position within the hospital. As elaborated by the author, in this tragic course of events a nurse was not capable of evaluating a surgeon's practice because she was a nurse; however, a surgeon could determine what any nurse could know because she was a nurse. In short, nurses' concerns were dismissed based not on what they were, but on who raised it, for example being told, "you are just a nurse, what do you know?" (p. 183). The author contends that surgical nurses in this institution were confined within existing structures of power and knowledge that located these same nurses in a diminished role, whose concerns did not need to be taken seriously

and their credibility allowed to be dismissed. Finally, Cecci suggests this extreme event is an example of how institutions make boundary protection possible through practices that ascribe and withhold credibility. It is these practices based on a presumption of credibility, rather than on determining how legitimate knowledge is constructed, that can lead us to unsafe situations.

A mixed method interview study revealed that when teams fail to establish a clear understanding of interprofessional responsibilities, or where professional disagreements are not resolved, unsafe practices and similar repeated mistakes may persist as a functional response to psychological factors, professional values, and organizational pressures (Espin, Lingard, Baker, & Regehr, 2006). In their research utilizing survey and interview methods, Bognar et al. (2008) set out to assess the perceptions and attitudes of paediatric cardiac surgery teams at three hospitals concerned with committing errors, impact of errors, and safety culture. The authors determined that the work climate influenced safety attitudes, as many team members had difficulty raising safety concerns and felt unable to express disagreement. The authors also described team members as influenced by the recognition of error, with these errors resulting in significant personal burden, especially if repeated; however, there remained a reluctance to share these safety events with others. Team members identified improving team communication and increasing education as leading to improvements in overall patient safety. The authors concluded that the overall teamwork culture requires attention in order to improve safe patient care.

In research utilizing questionnaires to assess attitudes toward teamwork and patient safety through decision-making and communication care in one Canadian cardiac surgery group, Fleming, Smith, Slaunwhite, and Sullivan (2006), concluded that interpersonal competencies, especially effective communication, were vital to ensuring safe patient care. The authors suggested that improvements to patient safety could be achieved through communication skills training and the introduction of a surgical checklist. Finally, it was suggested that patient safety improvements could also be achieved through senior surgical team members modeling behaviour of reporting and discussing errors. As suggested in the literature reviewed, often overlooked in our collaborative relationships is that good communication is ethical communication, whereby self-centeredness is set aside in favour of patient-centeredness, and the adoption of

good or ethical communication is sensitive to the promotion of a patient-centered atmosphere of safety and care.

The literature reviewed in this theme consisted of two mixed method studies, two quantitative studies, and one theoretical paper. In one mixed method study, a convenience sample of nurses and physicians was used, and descriptive and inferential statistics were used to analyze the data. A disproportionate male-female participant sample size led to the limited generalizability of some research findings. In addition, data was collected from only one hospital and the researcher was a known colleague to nurses and physicians, which may have led to participant bias (Sterchi, 2007). In another mixed method study, researchers analyzed participants' approaches to unsafe practice using three theoretical models. However, based on their findings the researchers felt that the particular theories used were weak in eliciting relational components of teamwork in order to facilitate a measured exploration of unsafe practice in group work (Espin, Lingard et al., 2006).

Generalizability of findings from two quantitative studies was felt to be limited due to sampling size. Researchers in one study noted that there is no ideal safety culture profile which to compare their findings against (Bognar et al., 2008). In another pilot study, researchers used a previously modified questionnaire from the aviation industry, but they could not be confident that their participant responses were related to patient outcomes (Fleming et al., 2006). Reflecting upon events that led to an inquest following the deaths of 12 children who died while undergoing cardiac surgery, a scholar's theoretical discussion provided an understanding of how knowledge practices in healthcare can have serious effects on patient care (Ceci, 2004).

Distractions and Interruptions

Distractions and interruptions in one’s work are common in healthcare settings, especially in the operating room. In a recent British study, Campbell, Arfanis, and Smith (2012) concluded that distractions are common in anaesthetic practice, which can threaten patient safety. In this study, 28 anaesthetists were observed and interviewed to gain information about observable and non-observable distractions in their anaesthetic practice.

Events described as common distracters were conversations unrelated to surgery by any individual; difficulty in work due to space limitations or required

equipment not being present; interruptions from music, noises outside of the theater, or multiple alarms; broken or temperamental equipment; teaching of student trainees; and managing mobile phones and pagers. The authors noted that events that occurred at an inappropriate time were regarded as distracting, than if they had occurred at a different moment. For example, casual conversation would be distracting during a tense anaesthetic moment, but acceptable when no immediate patient demands were present. Actions performed simultaneously were also regarded as distracting, for example, the patient being positioned when the anaesthetist had not yet secured the patient's airway. While this research focused on distraction from the perspective of the anaesthetist, these behaviors could also be distracters to other members of the surgical team.

In another research study that I recently discovered, Smith, Darling, and Searles (2011) considered the potential for emerging technology to distract from patient safety when they inquired through survey method about the appropriateness of cell phone use by perfusionists during cardiopulmonary bypass [CPB]. Smith also identified a generational difference in opinion when it came to using specific features of a cell phone. Perfusionists admitted to texting, surfing the internet, posting on social network sites, checking e-mail or talking on the cell phone during CPB. While many perfusionists agreed this posed a significant risk to the patient, a majority also felt that they had never been distracted, or been negatively affected, by the use of cell phones while managing patients on CPB; yet, they had witnessed another perfusionist distracted due to the use of a cell phone. I reflected on my own experiences with colleagues' use of digital devices throughout the workday, and I had often thought how distracting that action could be for everyone in the immediate environment. However, it is now becoming a common practice for professionals in the hospital to communicate with each other via cell phone and texting or to use specific applications on the cell phone to locate clinical information.

In examining distractions and interruptions in urological surgery, Healy, Primus, and Koutantji (2007) noted in their observational research that frequency of disrupting events was high, which interfered with the work of the surgical team and which could ultimately pose a risk to patient safety. A trained observer was used to document data during surgery. Examples of distraction or interruption

included telephone calls, conversations, equipment problems, nurses teaching trainees, noise from music or equipment, and waiting for assistance from other personnel. The authors noted that concurrent tasks are inherent to a professional's daily activity, and aspects of distraction and work interruption are sometimes essential to work. They also emphasized that "it should not follow that we expect operating theatre personnel to deal with whatever variable work conditions they encounter; there is a limit to what individuals and teams may adapt to" (p. 138). The authors also emphasized that rules existed for safe work in the operating theatre, but these were primarily focused on nursing protocols and sterility protocols. They found while "implicit localised or individualised rules regarding operational working practices" existed, "these will vary according to preferences from one surgeon, team or unit to another. There are no explicit rules for controlling work interference in surgery" (p. 138). The sample size of this study was felt to be sufficient and representative of the specific operating room observed. However, generalizability of results is limited as study findings may not be indicative of other specialities or of surgery in other operating rooms.

Reflecting on the Literature

In this last part of the chapter, I reflect on extending the literature through introducing the potential for research using a narrative inquiry approach as a way of understanding patient safety in the OR. The literature reviewed revealed how researchers envisaged and discussed patient safety from different perspectives by utilizing a range of methods in their desire to determine, and bring forth, an understanding of factors that influence patient safety in healthcare, and more specifically, in the operating room.

Methods used were described by researchers as ethnographic (participant observation with varying degrees of participant interview), focus group interview utilizing grounded theory, semi-structured interviews using hypothetical scenarios or focused on action research, analysis of written experience, observation without interview, survey, questionnaire, or chart review with subsequent statistical analyses, and case study. Some literature was of a confessional nature, meaning that the author wrote of a personal experience of patient safety. It is evident that no single approach to patient safety will provide a complete understanding of safety, reduce the occurrence of safety events, or improve upon the management of patient safety. What is evident is that

healthcare is a healing endeavour dependent upon collaborative, multidisciplinary efforts, and good, safe, healthcare depends on a shared commitment of all involved in order to be responsible and ethical care providers.

The scope and diversity of literature suggests that social, cultural, and political contexts determine how patient safety is defined, understood, and is approached by individuals. I believe the desire to understand patient safety in the operating room is strong, as is the necessity to examine patient safety from a perspective of reflection and re-evaluation. I suggest that this is a perspective that encourages us to reflect upon and rethink events we believe we understand. It is a perspective that values the incorporation of experience into the research process as contributing to the theoretical and scholarly realm of patient safety.

Literature that considers how patient safety is understood and enhanced through effective communication, risk management, creating a culture of safety, team-based work, identifying interruptions, and appropriate management of adverse events in the operating room is not lacking. However, even more diversity is required of us as we continue to discover and uncover the many layers of patient safety. We must also consider understanding patient safety in the operating room through reflection on nurses' experiences. This approach provides a broader context in which to consider patient safety as an experience of being, that is, as grounded in the everyday work life of the operating room nurse. In considering the diversity of the reviewed literature relating to patient safety in the operating room, I was reminded how the literature exploring nursing experiences and perspectives, and those of other care providers, on their own was somewhat limited. For example, much of the research reviewed was inclusive of operating room nurses in the research process, who also happen to comprise the largest group of care providers in the operating room, but did not focus exclusively on operating room nurses' experiences as the phenomena of research interest. In addition, the necessity for individuals to work together in promoting patient safety was addressed comprehensively; however, the aspect of relationship-centered care, though alluded to, was not considered as thoroughly. This aspect reminds us of our ethical obligations to patients and to each other in ensuring patient safety, and it is a perspective that recognizes ethical and relational care as contributing to safe patient care. While some researchers did consider nurses' experiences of patient safety to some extent,

frequently these experiences were collected through responses to a questionnaire, through field observation, or through limited interviews. What I found missing in the literature was an exploration of the patient safety dimension through the detailed expression of nurses' experiences, that is, through the voice and story of the operating room nurse.

The literature has only begun to touch the surface of knowledge that reflects operating room nurses' interpretation and understanding of their safety experiences in their life worlds. There is more work to be done on considering nurses' experiential knowledge as a fluid way of understanding patient safety from a perspective without preset expectations, and allows for experiences that are one's own to enter into the inquiry (Clandinin & Connelly, 2000, p. 39). I suggest these select gaps and silences in the literature are openings or invitational spaces in which to reflect and place our growing questions about patient safety in the operating room. The inclusion of more narrative focused research may offer a unique and alternate perspective into the complexities of patient safety. Evident in the literature is that healthcare is complex work, and one way of understanding this complex endeavour is reaching out to the people in these contexts and engaging with them. In asking them to tell us, to teach us, we are reminded that we are in relation with them; and that we need them to assist us to understand how social, political and cultural elements permeate all aspects of patient safety.

If operating room nurses are to participate in research, they must be recognized as credible knower's, especially if their perspectives are to be incorporated into the research. The engagement in dialogue through asking nurses about their particular experiences demonstrates they are valued as knowledgeable individuals, who through their experiences and voices, offer additional perspectives on patient safety in the operating room, able to share phenomena not captured and understood through questionnaires or surveys. A research approach, such as narrative inquiry, allows us to understand how nurses' patient safety knowledge is 'narratively composed, embodied, and expressed in practice' (Clandinin & Connelly, 2000). I do not suggest that other safety research is irrelevant to operating room nurses or dismiss other research methods, as they all address a particular perspective different from the one proposed in this study. All research in the field of patient safety has been

invaluable in furthering an understanding of, and advancing, safety in healthcare. What I do offer is the consideration of another perspective and understanding of patient safety in the operating room through the exploration of a research approach based on narrative inquiry. This approach through mutual dialogue, an orientation familiar to nurses, purposefully seeks out the nurses' perspectives, knowledge, insight, explanation, and experience, and asks that this information be reflected upon in order to encourage multiple ways of knowing. A narrative inquiry approach recognizes the participant-researcher relationship as an ethical relationship that develops through mutual respect and trust. Researchers relate to participants in their complexity and accept them in their entirety. In this complexity, we are opened to their beliefs, their knowledge, and their values as possibilities for new ways of understanding patient safety through the operating room-specific knowledge generated by operating room nurses themselves.

Approaching the narrative inquiry as an ethical inquiry addresses the research requirement that participant involvement necessitates specific ethical considerations, and further reflects the careful balance required of the researchers between methodological and ethical goals. The values upholding an ethical research relationship are similar values that uphold the nurse-patient and nurse-other relationships, for example in the concepts of trust, respect, empathy, relational engagement, confidentiality, and acceptance. A research process based on narrative inquiry also reflects the notion that healthcare, and specifically patient safety, is an ethical endeavour, a shared undertaking whereby patients are valued in their entirety and kept safe in the present as well as into the future. Thus, a narrative inquiry approach to research incorporates the perspectives and experiences of nurses into the research process, and values the decisions made by nurses in deciding what knowledge is necessary for patient safety, in order to effect ethical change in the operating room. Nurses hold within themselves experiences and understandings that greatly influence patient safety and safety practices in the operating room. These experiences draw from their relational work with others, and from their contextual and interconnected milieu. A narrative inquiry can better generate nursing specific knowledge and provide direction for continuing safety research with operating room nurses. This form of narrative inquiry, as a methodology, has guided my research about operating room nurses' experiences of patient safety.

I now turn to *Chapter Three: Methodology and Process of Study*, a description of the choice of method involved in the process of understanding experience within operating room nurses' stories of patient safety.

CHAPTER THREE

Methodology and Process of Study

What is Narrative Inquiry?

Narrative inquiry is a way of understanding experience. Our lives are filled with "narrative fragments, enacted in storied moments of time and space, and reflected upon and understood in terms of narrative unities and discontinuities" (Clandinin & Connelly, 2000, p.17). Narrative inquiry creates a space for engaging with human experience and exploring it, for it offers a means for others to tell their story in a way that is meaningful to them. Understandings are embedded in "stories to live by", a term introduced by Connelly and Clandinin (1999) to help us "understand how knowledge, context, and identity are linked to and can be understood narratively" (as cited in Whelan, Huber, Rose, Davies, & Clandinin, 2001, p. 144). Termed a "storied landscape", as introduced by Clandinin and Connelly (2000), it also offers a way of understanding how the varied landscapes, or places we live in, shape our experiences and understanding. Landscape as a metaphor offers a sense of the expansiveness of one's lived life and the diversity of relational experiences leading to one living a storied life on a storied landscape (Connelly & Clandinin, 1999). Stories are how people explain and interpret their world, and through stories, we learn how their experiences are connected across place, time, and others.

As a relational research methodology, narrative inquiry aims to understand experience through conversation or story. The focus of narrative inquiry "is not only on individuals' experiences but also on the social, cultural, and institutional narratives within which individuals' experiences are constituted shaped, expressed, and enacted" (Clandinin, 2007, pp. 42-43). Clandinin and Connelly (2000) identified a framework for defining an inquiry through a three-dimensional space composed of temporality, sociality, and place (p. 189). Along one dimension, temporality reflects the notion of continuity in experience, that is, the taking up of something from the past and present, and carrying it into the future experience. People and events "under study are in temporal transition" and they are described with "a past, a present, and a future" (Clandinin, 2007, p. 69). The second dimension, sociality, reflects that people are always interacting with their situation in any experience and refers to what is occurring in the social and personal context, for example, their feelings, hopes, desires, the environment,

and surrounding factors and forces that form the person's context (p. 69). The third dimension, place, reflects the "specific concrete physical and topological boundaries on inquiry landscapes" (Clandinin & Connelly, 2000, p.51). All events occur in some place, and the impact of places on lived and told experiences are crucial (Clandinin, 2007, p. 70). Within this framework of conversations moving backward and forward across time, and inward and outward across personal and existential conditions, experiences from the past are brought into the present, and are considered in an anticipated future. By adopting a backwards and forwards perspective in storytelling rather than a linear one, an opportunity for self-awareness and reflection opens up, leading to possibilities of change in our lives and the world we live in. It is through mutual reflective analysis of our experiences that narrative inquiry opens us to new forms of knowledge, offers new insights about our phenomenon, and fills us with the potential for personal and social growth (Clandinin & Connelly, 2000, p. 85).

Coming to the Inquiry

In thinking about this narrative inquiry, I recognized I would meet my nurse participants in the midst of living their storied lives, and they would continue to live their storied lives after this research concluded. I also recognized that the interaction between my nurse-participants and me in this narrative inquiry would bring us both together in thinking about and understanding experience, and establish the relational nature of this methodology. It was important for me to establish a research relationship that was sensitive to, and respectful of, each nurse's storied life as told, for I felt this would support an inquiry space in which patient safety experiences could be explored deeply and candidly. I also thought it could be a bit daunting to establish this relationship, for asking a person to share, openly, their private moments with an unfamiliar person, was not a space easily entered into.

Yet, as Cameron (2004) describes, in asking someone to 'tell me about yourself' and responding to the ensuing disclosure, an ethical moment is created which opens up a space that is sensitive to the participant's storied life. It is a space that recognizes all of our "I's", and it is a space that moves us from the vagueness, disinterest, and mundane aspects of everyday relations to an ethical space for inquiry into the "particulars" of an individual (Cameron, 2004). It is in this space we come to know a person's experience of living a phenomenon from

the inside and in this same space the question is turned back upon ourselves. As we consider who we are in this inquiry, this space offers us an ethical way of being in relation with each other (Cameron, 2004).

I thought about my researcher-participant relationships as ethical moments of being in-relation, and I sensed how an ethical relation infused narrative inquiry. As a way of further enhancing my being in-relation with others during this research, I observed a relational ethic to deepen my understanding of my nurse participants as individual beings in this world, and to guide me in respecting their life stories as I heard them, and later retold by them. The notion of 'relational ethic' is a concept from the philosophical work of Bergum and Dossetor (2005) in which they assert that "human flourishing is enhanced by healthy and ethical relationships" (p. xii). The fundamental nature of a relational ethic lies in moral commitment and responsible agency, with the space between moral agents as the "relational space for discovering knowledge about others…" (p. xii).

Relational ethics is described in terms of four elements or relation-spaces: environment, embodiment, mutual respect, and engagement, and are described as follows by Bergum (2004), and Bergum and Dosseter (2005). The relation-space of environment is more than the place that surrounds us. It is also created through our everyday relational actions and the everyday occurrences we live. The small moments in our relationships with patients, their families, colleagues, and others, layer and weave together to create the relational and physical environment we are in at any moment. Environment in this sense is in all of us, and our relational actions and ethical reflections locate us in the midst of this constantly changing relation-space. The space of embodiment brings "knowledge back to life" via stories that describe experiences of life. Story is a primary way of learning about embodied knowledge, for story opens us to the things that are not easily known to us. Relational respect provides the ethical space to empathically explore our differences with others, and affirm that we are in some way connected to each other. It reminds us that we are each important, but not more important than the other. The space of engagement is where we move toward the other, to stand close to them, in an attempt to understand their perspective or their experience in a shared moment.

Bergum (2004) writes that relational ethics is about:

> …understanding and knowing ourselves as we engage with others. In nursing and in healthcare, the particular environment of health and illness is a profound and important means by which we confront ourselves in a community of other people within a focus on relationships…it reminds us to consider how important it is to continue to know more about ourselves as nurses and as human beings. In that self-knowledge and openness, we can care for and know others. (p. 502)

Relational ethics as presented by Bergum and Bergum and Dossetor is focused on the quality of relationships in nursing practice, that is, relationships with other nurses, other healthcare professionals, administrators, politicians, patients, and their families. However, the research relationship between my participants and me is also a moral space, where I as a nurse researcher must act responsibly and responsively. Narrative inquiry encourages asking questions, and searching for deeper understandings of life's particulars, facilitated by establishing a close bond with my participants. I believe a relational ethic supports the quality of my research relationships as I focus on understanding and re-presenting each participant's patient safety experiences. As you the reader discover and respond to the nurses' stories, as you engage with them and are perhaps challenged by them, I sense that a relational ethic might also guide your understanding of these nurses' experiences.

Why Narrative Inquiry?

"Simply stated...narrative inquiry is stories lived and told"
(Clandinin & Connelly, 2000, p. 20).

I have often been surprised in hearing a story to find myself following its threads and to discover myself drawn deeper into the story, for after all, it was just a story. Yet, each time this happened, I came to understand more deeply the power of story. I remember my parents always telling a story about someone or something. My mother still tells me stories that I have not heard before. My father was a consummate storyteller and he often was teased for his digressions to a story within his story, his nested stories. Story surrounded me and I felt very much a part of those stories, even though I was not in many of them. What I remember clearly is sitting quietly, listening to the stories my parents, relatives, and their friends told, over and over to each other. I sensed at a young age that

those stories were somehow important, but it was later when I understood those stories were their life moments that wove and connected them across place, time, and each other. I began to understand how those spoken words revealed their stories to live by, and I began to understand how I also was connected to those stories in another time and another place. A bedtime delight as a child was listening to my father's stories, especially the ones about Baba Yaga, a witch that lived and travelled through the Polish countryside. His stories always varied but they were exciting, and I learned much about the country and the people of my ancestry. I learned about living in a world of others through those cultural and familial narratives, and how people were affected by actions of others and events of life.

Late in life when illness took his voice, I sensed how my father's connection to his world seemed to slip away. I sensed that in losing his ability to story tell, he felt his connections to places and people had begun to dwindle, and I wondered if he felt he was losing himself amongst us. I have often felt it is a tragic thing to feel silenced when there is so much to be expressed. Yet, as I recalled and began to share my father's and mother's stories, I realized just how connected we are and remain through story, and how we are not lost to others. Recently while looking through some randomly written quotes on scraps of paper, I discovered a few lines I had once jotted down: "Our ancestors are still with us, undefeated by time. In every breath, they are still with us" (Our ancestors, n.d.). I do not recall where I first read those words or why I felt inspired to write them down. Yet, as I wondered about those words, I came to understand how connections were sustained between people across multiple contexts through story. I sensed how, in every breath I took to tell or retell a story, the voice of another came forward alongside my own.

There are many ways to tell a story, but it needs to be known in some way for others to be able to interpret and understand the knowledge embedded in it and to learn from it. Operating room nurses have many stories that need to be told and narrative inquiry holds great potential in eliciting nurses' patient safety experiences, for narrative inquiry is a means of accessing the everyday safety experiences of operating room nurses through their own voices. As operating room nurses tell, wonder about, and retell their experiences of patient safety

through a professional and personal context, we begin to understand how their life stories are composed across time, place, and relationships.

Reflecting on my stories in the first chapter, I wondered why they had remained so strongly with me over the years. At times, the reflection was a difficult process as I peered into the soul of those stories, for I felt as I had in the past about a reality of living in the world with others and how in my experiences I had felt that others had storied me. Specific images, sounds, and emotions seemed as real to me now as they did then. Why did these particular stories remain so vivid when others did not? Even though I held them close to me, I wondered as I put them in writing, if I had provided an accurate accounting of the events as they occurred. Did I detail the events correctly? What did my memory leave out and did it matter? Did the tension I felt in asking these questions mean that I did not tell the story right?

As I thought about those stories and experiences, I felt how their threads stretched forward across time and place and I sensed how they were still unfolding in my present context and shaping current patient safety stories. In choosing and telling my stories, I understood how I began to inquire into them and retell them, and in so doing, I inquired into my lived experiences. As I reflected on myself in the past, I thought about who I was in the present and wondered who I was becoming in the future. I realized how the stories I told were ongoing ones, and that they were only some of the many stories that composed my life across place, time and relationship. In retrieving the meaning from my own experiences, I appreciated deeply the significance of making meaning of operating room nurses' lived patient safety experiences across multiple contexts, and the effect that could have on my research.

I have always felt that nurses were storytellers and story listeners. In this regard, nursing practice is not only theory and technique, but it is also composed by narrative. Narrative stretches and weaves across all aspects of nursing, for it is how nurses interpret information and communicate with each other and their patients that create practice stories. Much of the daily nursing work involves the listening to, and telling of, stories that direct patient care. Whether it is a report at the time of patient 'handoff', at the moment of a patient and family encounter, or at meetings with other nurses at a conference, the listening of stories and storytelling that nurses engage in allows them to come closer to each other. It is

an opportunity to appreciate the life world of another through their professional and personal individual stories.

Nurses have always told stories about their work and nurses will continue to recount those stories as a way of understanding their experiences across multiple contexts. I know the importance that telling and hearing stories of lived experience has in nursing, and I wanted the nurse participants to tell me their everyday stories about patient safety. I wanted to hear the stories in their own words through the places they had lived and worked, through the people they have known, and through the unfolding moments of their lives. I wanted to know their stories, for I sensed the significance this kind of research could have that originated from stories of operating room nurses' lived experiences of patient safety, especially in terms of furthering our understanding of the complexity inherent in patient safety and the context of the operating room.

Bringing Narrative to the Inquiry

> Such stories, and the symbolic worlds they project, are not like monuments that men behold, but like dwelling-places. People live in them. They are moving forms…which inform people's sense of the story of which their own lives are a part, of the moving course of their own action and experience…. men's sense of self and world is created through them….these are the stories that orient the life of people through time, their life-time, their individual and corporate experience… (Crites, 1971, p. 295)

The significance of narrative knowledge emanating from stories of the past was not always immediately apparent to me, for I was distant and far removed from those events. Yet, in wondering how it was that I came to here from there by reflecting upon stories of long ago, I sensed how past experiences channeled into the present and future can become a fundamental way of learning and of knowing. There are many historical and current stories that compose the landscape of surgery and operating room nursing, and operating room nursing and patient safety benefit hugely from understanding these stories of experience through deep critical reflection. As crude as surgery and nursing was in years past, the knowledge developed in the experiences of those times eventually led to modern surgical care, as we know it. By responding to the narrative knowledge in those past stories, we engage with the experience and let it be our teacher.

We expand the discipline's knowledge and theoretical frameworks by trying to understand the significance of a particular experience in a specific way, as well as our response to it. The timeless nature of narrative knowledge becomes apparent as the story is recounted to others, who in time will also recount the story to other listeners.

Nascent Reflections

The involvement of a nurse in surgical procedures of early days, for example, in the 17th and 18th centuries was limited to that of an attendant. The role was primarily to provide domestic care or menial assistance that might have been requested by the surgeon, such as restraining the patient. Surgical procedures were routinely performed in the patient's own home and it was not until the late 18th century that surgery became better established in a hospital setting. With the evolution of formal schools of nursing in the early 19th century, it became expected practice for qualified nurses to assist in surgery by using instruments, surgical knot tying, and ensuring hemostasis (ORNAC, 2008).

In the following account, the presence of a nurse is noted; however, what is obvious is the lack of nursing as we have come to know it today. Similarly, patient safety as a component of patient care in surgery today had yet to take shape; however, it was evident in a most basic form through the presence of attendants and a nurse to restrain the patient and ensure swift completion of the surgery, as well as possibly prevent unintentional harm from patient movement during the procedure.

The following excerpts identified by italics are from a letter written by Fanny Burney to her sister, Esther, following Fanny's mastectomy without anaesthetic in 1811 France (Hemlow, 1986). As I read Fanny's letter, I was discomforted yet captivated, and in the moment of reading, I felt myself become eyewitness to the events as I tried to understand them as they unfolded for Fanny. Fanny wrote Esther that she had been given notice of her impending surgery by letter, and with her family sequestered from the house by order of the surgeon she had little time to prepare herself: *"…it had been the decision of the consultation to allow me but two hours' notice… judge, my Esther, if I read this unmoved!... I had no longer anything to do - I had only to think - TWO hours thus spent seemed never-ending*" (p. 135).

I felt myself waiting with Fanny for the surgeons and assistants to arrive, and when the necessary preparations were made, Fanny recalled:

> *…I mounted, therefore, unbidden, the bedstead - and M. Dubois placed me upon the mattress, and spread a cambric handkerchief upon my face. It was transparent, however, and I saw, through it, that the bedstead was instantly surrounded by the seven men and my nurse. I refused to be held; but when, Bright through the cambric, I saw the glitter of polished steel - I closed my eyes*. (p. 138)

And finally, Fanny's unimaginable account:

> *…yet, when the dreadful steel was plunged into the breast - cutting through veins - arteries - flesh - nerves - I needed no injunctions not to restrain my cries. I began a scream that lasted unintermittingly during the whole time of the incision - and I almost marvel that it rings not in my ears still! so excruciating was the agony… but when again I felt the instrument - describing a curve - cutting against the grain, if I may so say, while the flesh resisted in a manner so forcible as to oppose and tire the hand of the operator, who was forced to change from the right to the left - then, indeed, I thought I must have expired….My dearest Esther, not for days, not for weeks, but for months I could not speak of this terrible business without nearly again going through it! I could not think of it with impunity! I was sick, I was disordered by a single question - even now, nine months after it is over, I have a headache from going on with the account! And this miserable account, which I began three months ago, at least, I dare not revise, nor read, the recollection is still so painful*. (pp. 135 -140)

Connecting Past Stories to Our Stories

In this recounting, I learned of the terror and trauma Fanny experienced and, perhaps, you as the reader sensed it also; and we heard how the terror continued to stay with Fanny months after the surgery. I felt her impending fear and saw myself sitting with her as she waited with her maid for what was to come about and I wondered how her life would change with little warning. I sensed how Fanny felt abandoned emotionally and psychologically when her family was not allowed to be near her prior or after this ordeal. As Fanny wrote her letter over a course of several months, her words revealed that mental preparation for surgery and recovery, an aspect of patient safety today, is complex; it cannot be rushed

nor subsumed by a desire to attend to the technical aspects of a surgical procedure.

Reflecting on Fanny's experience and surgical care today, I know that as healthcare providers we have learned and have become more adept in identifying and attending to patients' and families' specific needs. It is through telling and inquiring into their stories, though, such as Fanny's, that the cambric mask that once filtered our vision is lifted. We can connect the past and present as a way of looking to the future in understanding how our storied landscape can work to enhance patient safety measures in the operating room.

People's daily lives are shaped by stories of who they are and who others are: "Story…is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful" (Connelly & Clandinin, 2006). Narrative inquiry is a methodology that informs and guides a research process, whereby a researcher can engage with and explore human experiences with participants who can then share stories in their own way. Consistent with the process of narrative inquiry, my stories and Fanny's story illustrate the conversation and tension between theory and practice. Narrative knowledge comes alive in narrative inquiry, and narrative knowledge is fundamental to understanding life as lived. Thus, narrative inquiry is stories lived and told (Clandinin & Connelly, 2000) that become gems of knowledge representative of human experience as discovered and interpreted within participants' stories.

Locating Participants

I approached the Board of the British Columbia Operating Room Nurses Group, the professional practice group for operating nurses in the province, and explained my intended research to them. I then asked for permission to allow the membership secretary to email the information letter and consent form (see Appendix A and B) to members who resided in the geographical region known as the Lower Mainland of British Columbia. I also mailed the same information material to operating room department managers in the Lower Mainland, and asked that the information be posted in their department. This would provide an opportunity for nurses who were not members of the provincial practice group to be informed about the research. I viewed this approach as heightening individual anonymity. It would allow for the recruitment of nurse-participants from a

geographical location that was distant to my location and mitigate the potential to recognize specific individuals, places, or others in my geographic location, which was sufficiently high, thus justifying recruitment elsewhere in the province.

I asked that nurses interested in being a participant be currently employed, as well as to have practiced operating room nursing for a minimum of 5 years. I concluded that after this length of time, nurses would have had extensive involvement and feel established in the operating room environment. I also determined that participants who had worked in the operating room for at least 5 years could draw on numerous experiences, resulting in stories that were rich with information. Nurses who were willing to take part in the study had the option of contacting me directly by phone or email. Initial contact by all interested nurses was by email, and at that point, we arranged a convenient time to discuss the research by telephone. During our initial phone conversation, I reviewed the focus of the inquiry, the time commitment anticipated, ethical considerations, and the voluntary nature and ability to withdraw from the research at any time. Once a nurse decided to be a participant, I asked that they consider the information for a week's time, at which point I made contact again to answer any further questions and to finalize participation in the research.

Meeting Face to Face

I selected four operating room nurses, all female, to participate in the inquiry, and at our initial face-to-face meeting, we reviewed and signed the consent form. A signed copy of the consent was also given to each participant for her personal record. Each nurse had considerable experience as an operating room nurse and all the nurses had worked in different hospitals during their career, in positions ranging from staff nurse to service manager to patient care coordinator. Two nurses had also worked in hospitals in different countries. As I would not be 'living and working alongside my participants' (Clandinin & Connelly, 2000, p. 67), we engaged in a series of conversations that were approximately two hours in length, and which were digitally recorded. While I met with my participants in a mutually agreed upon location, I felt it was important that the decision for our meeting place rest with each participant, in order to ensure personal comfort. I travelled and met the participants in the city they resided in and we convened in a variety of places, for example my borrowed apartment, my

hotel room, a library conference room, an outdoor courtyard, or the participant's home.

The purpose of our conversational interviews was for the nurses to tell me about their personal experiences of patient safety in the operating room. I did not formulate specific questions for each participant. Rather, I began by asking each nurse how she came to the nursing profession, and how she came to be an operating room nurse. I could not anticipate the direction or the content of our conversations. I only hoped that we would discuss in some aspect, patient safety in the operating room. As each nurse and I spoke, I became aware of our conversation shifting at any given moment, with this shift then leading to another story shared and told by the nurse. Sometimes this shift would circle back to the original story the nurse was recounting and sometimes our conversation would lead in a different direction. As each nurse shared her stories, I would ask her at times to "tell me more" about a specific story she recalled, in order to provide a deeper account of that particular story. Other examples of guiding questions I asked throughout our conversations included: "Can you tell me about your workplace? Are there any patient safety experiences that you would like to share? Do you think work relationships have an impact on patient safety? How did you learn about patient safety? What does patient safety mean for you?"

Throughout our conversations, I remained aware of the context, place, and relational aspects of each nurse's experiences as recounted. I listened non-judgmentally to each nurse as she spoke and told her story. I was aware of how I responded to each nurse by respecting her as she shared her experiences and by respecting her stories. I did not question why a nurse may have acted one way and not another and I did not say what I might have done in a similar instance. I did not ask for a different or better story; and I relished each story as important and meaningful in this unfolding inquiry. As we conversed, I appreciated how I engaged with each nurse as we focused on understanding her perspective in the shared moment of conversation. I was also aware of how we engaged with each other, as each nurse openly shared more stories with me, with some of them deeply personal. It was through our conversations that I felt the creation of a relational space of environment and embodiment, for through the stories I learned of life experiences previously unknown to me. I discovered how through these stories we moved forward and backward across time and

place, and inward and outward across personal and existential conditions. I realized how through this conversational movement, I was located in the midst of scholarly inquiry moments that were supported and facilitated by our responsive and reciprocal relationship, together.

Ethical Considerations

The principles of ethical practice as outlined by the Tri-Council Policy Statement: Ethical Conduct Guidelines for Human Research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010), along with my relational responsibilities to participants, guided my ethical attitude during this narrative inquiry. I recognized that the greater the degree of trust and comfort a nurse-participant had with me, the greater the potential was for revealing sensitive information. Although assuring confidentiality and privacy was central to building a relationship of trust between each nurse-participant and me, this was still not an unconditionally guaranteed assurance. The dual role that I held as a researcher in a close relationship with each participant, and as a responsible professional, could create an ethical dilemma if information that contravened professional or legal boundaries was disclosed to me.

The main considerations of this research related to disclosure of sensitive information, confidentiality and privacy of participants, and protecting participants and others from harm. While thinking about specific ethical concerns that might arise during this study, I identified the disclosure of sensitive information as a salient concern that could impact greatly on confidentiality and privacy of participants and others. It was also a concern that could pose a dilemma for me as a researcher and practicing professional nurse. To ensure that my research reflected ethical principles, that I applied ethical principles appropriately, and that I had not overlooked or omitted any ethical considerations in conducting this research, I consulted three different sources for input prior to participant conversations.

Disclosure of Sensitive Information

I recognized that the disclosure of sensitive information during my participant conversations was a reality. In knowing that the nurses would share specific safety incidents, I asked that the nurses speak about experiences from the past that had been resolved in some manner, in order to shield the nurses,

others, and me from inappropriate involvement in a current situation that had not yet reached a resolution process. I also felt that speaking about past experiences provided a safer context for conversation rather than about a presently evolving situation.

I contacted my provincial professional practice and licensing body and spoke with a practice advisor. This person reiterated my obligation to report client or patient abuse, and further noted that the participants would need to be aware of this obligation prior to engaging in the research. The practice advisor also counseled me that I most likely would not be told intimate, firsthand knowledge of past experiences of this nature. Therefore, if a participant intimated that an event might not have been resolved, my role was to advise the participant to follow-up on that event. I could also direct the nurse to a practice advisor, but I was not in a position to enforce follow-up of the event or to take action that could be seen as 'policing' these kinds of professional practice obligations. The practice advisor noted that even when an event may have been resolved, information was not always available to particular individuals, which may or may not be known to a nurse participating in the research. The advisor also noted that by focusing the conversations on experiences of the past, the researcher would be able to demonstrate ethical consideration for the participants' privacy and anonymity.

At the same time, as a researcher and a practicing registered nurse, I held an obligation to report any instances of an obvious breach of professional standard or law that was not currently in a resolution process. It was important that I discussed this ethical and legal obligation with the nurses prior to engaging in a research relationship, so they could decide if they were comfortable participating in this inquiry. If participants wanted to focus on a current patient safety experience, it was suggested that I advise them to reconsider their decision to discuss this, to consider the potential ramifications of this conversation, and to review my legal and professional obligations with the participant.

I also spoke with an advisor for the malpractice insurance carrier for my provincial nursing practice body. The spokesperson advised me to consult with my professional body regarding my role and obligations if a situation presented where I felt I was in an ethical dilemma. The spokesperson also noted that to

their knowledge, a situation of a researcher being sued for documenting an event of the past as shared by a participant had not occurred.

I sought further advice from the University of Alberta Health Research Ethics Board [HREB] – Panel B staff. In addition to verifying my legal and professional obligation to report specific information, I was advised to defer to my licensing body any specific queries about what I was told during the course of an interview, especially if I had concerns about the information I heard. Individuals from all three sources noted that my focus on past experience was a proactive step in limiting the risk of becoming entangled in an ethical dilemma situation. The professional practice advisor and HREB staff also noted that, because this would be a conversation based research process, without any hospital chart or document review the unexpected discovery of sensitive information was further limited.

Any concerns I had about my legal and professional obligations, as related to the information the nurses might share with me, were resolved when our conversational interviews were completed. At no time during this research did I hear from the nurses shared information that required my reporting to a professional or legal body. In addition, all of the nurses spoke only of past experiences, thus providing a safe context for conversation.

Anonymity and Stories of Other

Focusing on the phenomenon of interest as a research puzzle rather than a specific research question reinforces that narrative inquiry does not necessarily define and solve problems; rather the inquiry is viewed as a search, and re-search of our interest (Clandinin & Connelly, 2000, p. 125). It was important to recognize in this search that the nurse-participants could bring others into their story, often without those persons' knowledge. The relational space between researcher-participant therefore necessarily extends to include others in this inquiry. Thus, while I initially considered how a focus on past experience could shield involvement from a current situation that was not in a resolution process, I subsequently also considered how a focus on past events could increase the potential for a high level of anonymity for all those involved.

Risks and benefits of varying degrees of participant anonymity and confidentiality have been discussed in human sciences literature. For example, complete disclosure has been discussed by a scholar as a way of maintaining the

integrity of information; that is, as an honest portrayal of events that are not skewed by pseudonym, cloaked information, and does not distance participants and events from the context as described (Nespor, 2000). Alternatively, in determining how to respect privacy and confidentiality, a guiding principle of the Tri-Council Policy Statement research guidelines suggests that researchers and participants should consider the specific privacy and confidentiality issues of the research to guide their approach to confidentiality (Social Sciences and Humanities Research Ethics Special Working Committee, 2005). In considering the specific privacy and confidentiality concerns of this research, I believe I demonstrated responsibility and an ethical attitude by using pseudonyms to deter unwanted and unwarranted attention away from participants, others in their stories, and storied-places. I believe that even though I used pseudonyms for place names, locations, and individual names, the integrity of the nurses' narratives and experiences were maintained, and remained connected in context, without exposing others unnecessarily. While I could offer anonymity and confidentiality to each participant, I recognized that the nurses themselves might reveal their participation in the study to others.

Composing Stories

The numerous conversations my participants and I engaged in comprised the data collection process. All of the digitally recorded conversations were transcribed and used as field texts (Clandinin & Connelly, 2000). I also wrote notes about the conversations, and if questions arose from the field texts, I asked the participant to clarify the information. Each time I met with a participant I reviewed our previous conversation to invite feedback and to create an opportunity to add, change, or comment on their reflections in conversation as recorded. I felt the nature of our conversations was particularly relevant, for it was through our conversations and reflections that I would understand and make meaning of the nurses' experiences. The main concern was to sort out a narrative view of experience, and as I asked each nurse to 'tell me about yourself', I felt I knew where our conversations would begin, but I also knew that I had no sense of the path our conversations would take. Rather than beginning the inquiry in theory, I began my inquiry with an exploration of experience as lived and told in nurses' stories. Kept in the foreground was the "participants' and researcher's narratives of experience situated and lived out on storied

landscapes" as my "theoretical methodological frame" (Clandinin & Connelly, 2000, p. 128). Through the process of sorting out a narrative view of experience, I slowly began to make sense of what surfaced in our minds. As I wrote the field texts and positioned them within the three-dimensional space of narrative inquiry, I began a process of reflecting upon and inquiring into the nurses' stories and gaining a deeper understanding of my research puzzle.

From Field Text to Research Text

Moving from the field texts, or transcriptions, memoing and journaling, to the research text shifted my focus from "the intensity of living stories with participants to retelling stories through research texts" (Clandinin & Connelly, 2000, p. 129). I felt this to be a transition phase as I moved away from a relationship of personal contact with a participant to being with the participant through their captured story. This consideration saw me focusing more on reading and re-reading memos and journal entries, beginning to write preliminary research texts, and constructing meaning in those texts.

This was a lengthy process as I spent many hours re-reading the field texts and organizing information into manageable portions. As I reflected on those large pieces of information and reviewed the transcripts, I discovered new insights through which I compiled further field texts and interim research texts. I focused on understanding the nurses' experiences of patient safety in the operating room, and how their past experiences had shaped and were shaping their stories to live by. This helped me to think about the nurses' stories, narratively, as a collection of stories unfolding over time in different contexts and as stories without an end; eventually I composed an account of each nurse's experiences.

Creating the Research Text

I entered this research journey in the midst of my participants living their storied lives, and I concluded my research time with my nurse participants still living, telling, reliving and retelling their storied lives (Clandinin & Connelly, 2000). Writing the findings chapters was a difficult process for me, as I struggled with discovering a way of writing that would represent, sufficiently and authentically, the nurses' narratives of experience. I was mindful of, and sensitive to, the many stories each participant shared with me. I eventually selected and worked within specific stories for each nurse, and within these stories, I felt that each nurse's

voice was clearly heard, and presented, respectfully. After several attempts with writing my voice both in and out of the stories, I eventually came to retain my voice along with the nurse's voice in each chapter. Over the course of several months, Dr. Jean Clandinin guided and worked closely with me as I developed my writings into a final research text for each participant.

With the exception of a few grammatical corrections, I have retained the exact wording spoken by each nurse during our conversations. I felt it was important to do this, in order to offer an accurate portrayal of our conversations; but above all to maintain the spirit of the stories as told by each nurse, as well as to respect each nurse as a person with an individual voice. The final stories for each nurse, Carson, Morgan, Shani, and Lynsey, are presented next as separate chapters. Pseudonyms have been used for each nurse-participant, as well as for other individuals and places within each story.

I wrote each of the four findings chapters as a conversation through a series of stories between my nurse-participant and me, with my reflections interspersed throughout each chapter. As I wrote each chapter within the framework of the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000), I felt how a narrative coherence connected each individual story and provided me a way of understanding each participant's patient safety experiences through the context of a nurse living out her 'storied life on a storied landscape'. I believe that as you read the words I have put to paper, you will find yourself following the threads and discover yourself drawn deeper into the stories, and through this, I believe you will also come to know the power and importance of each nurse's story. I now turn to the next section and present *Chapter Four, Carson's Stories: Early Landscapes*.

> "Their story, yours, mine – it's what we all carry with us on this trip we take, and we owe it to each other to respect our stories and learn from them" (Coles, 1989, p. 30).

CHAPTER FOUR

Carson's Stories: Early Landscapes

The chirping of birds filtered in through an open window of the apartment, my home away from home, situated in an elegant heritage building. Carson arrived with tea in hand for both of us, and we took in the charm of our surroundings. As we settled ourselves on the sofa she eagerly asked, "So, how do we begin?" We both laughed and I replied, "Well, I'd like to know how you became interested in operating room nursing." Carson laughed and said, "You know it's funny, I knew you were going to ask me that! Well, after high school, I was in this dead end job, and I thought, 'I have to do something with my life.' There's nobody in my family who has any medical background, but one of my girlfriends, her mom was a nurse, so I thought I should talk to her, find out what it's all about. I was asking her basic questions - when I look back now, oh my, I had no clue what nursing was about! I just thought, 'You know what, I bet you could be really good at that job.' I know that one of my strengths i*s* that people feel comfortable around me; I can make people feel comfortable very quickly. Nursing paid fairly well, and it gave you many other opportunities. So, I thought that's what I'm going to do. When I applied to nursing school, I applied at Western Memorial; I wanted to go to a hospital to learn, that was really important to me at the time." "Why was that important, Carson?" I asked. She explained simply, "It made sense to me at that point to go train in a hospital rather than in a university. I felt that a hospital-based program would be good, because it would give me the hands on. Nursing has been a great choice for me; I go to work every day and I enjoy my work." "That's great Carson," I said, "Not everybody says that."

Carson excitedly told me how her early operating room experiences created a lasting impression. "When I went into the OR as a student, I just thought, 'Oh wow this is great.' That first day in the OR I thought, 'Oh man this is where I want to be!' From then on, I knew that I wanted to work in the OR. In first year, we actually did an OR follow-through with a patient. I went and saw a cataract surgery, and I remember the OR staff actually gave me the lens to hold." She made a cupping motion with her hands and demonstrated how she held the lens of an eye in her palm. "It was like 'OOHHH'. It was so good. I was fascinated. It was so good to feel that."

Carson continued, “When third year came around, all my electives were in the OR, but I didn’t have a great experience. Due to circumstances, I ended up with a replacement preceptor for my final nursing practicum, and she treated me as if I was garbage. It was such a bad experience. She would order me around, and I was thinking, ‘Well, what am I going to do?’ She was cold to me, you know, COLD to me. And she just – well it’s unbelievable, actually, when I think about it. It’s amazing I still remember this.” “It’s made such a huge impact,” I offered. “It did,” Carson replied. “But, in some ways it was good that that happened to me. Now, I make sure any student who comes to the OR gets a really good experience. I’ll go out of my way to say, ‘Come over here, put on a pair of gloves, I want you to feel this.’ I just want them to enjoy the OR so much.”

I heard in her story how a conversation with a friend’s mother about nursing made an impression upon her in some way, and in her desire ‘to do something with her life’ led her to consider nursing as a career ‘full of opportunities’. As I thought about Carson’s story, I sensed how important being an operating room nurse was to her. I sensed how she felt her work was important and that it mattered to others; Carson said how she enjoyed her work every day. I thought about how through her daily presence in the operating room and the pleasure she derived from her work, her professional and personal satisfaction went right back into her work; she was able to give her best to her patients. I sensed how in enjoying her work so much, she encouraged students also to be inspired with the work of the operating room, and I thought how her interest in them could make a motivational difference in their career. I thought how, in her sensing early on that the operating room was the right place for her, she began the process of being the nurse whose presence made a difference to others through discovering ‘what nursing was about’.

She recalled a particular experience in the operating room when she was a student, and I thought how memorable and profound that moment was for her. Carson recalled her awe in holding the lens of a patient’s eye in her hands and I wondered if in that moment her awareness of the patient, as much more than the immediate presentation of a surgical procedure, opened up. I also wondered if in that moment she was opened to the work of the operating room supporting a person’s ability to live life as best as possible, for she said she knew from her first

day that she wanted to work in the operating room, and I felt how she strongly desired to be a part of that possibility.

Carson spoke of another significant moment as a nursing student when her preceptor in the operating room treated her poorly. I heard the indignation in her voice and I thought how, in being 'treated like garbage', her days were filled with moments of added tension as the end of her formal nursing education drew near, for I imagined that the anticipation of embarking on a career also was tension producing. I sensed how she was not accustomed to being treated in that manner. I wondered if perhaps she had previously experienced a similar kind of disrespect in her life, when in trying to be a part of something, she instead was made to feel inferior and worthless. I thought how through her behaviour, Carson's preceptor did not validate her as a student nor as a person who was committed to becoming a nurse. Carson demonstrated her interest in the operating room and her specific learning needs by focusing her education on specializing as an operating room nurse; yet, her preceptor seemingly disregarded the further development of her limited operating room skills and preparation for what lay ahead. I thought how her preceptor also disregarded Carson's desire to establish herself in a meaningful way in this world, and I thought how this might have compounded the relational tension that she already felt from her preceptor. Even though Carson felt that "people were comfortable around her", she learned from her student experience that not all work relationships were congenial or supportive. I sensed how important being a nurse was to Carson, for she endured the relational tension and persisted in accomplishing her goal of operating room nursing.

As Carson spoke about her interactions with nursing students today, I heard how she pulled that past experience forward as a reminder of what she could offer to them, through a relationship that supported learning opportunities and validated them for who they were in that moment. In encouraging the students to interact with the operating room environment through touching human tissue, I sensed how Carson also subtly exposed them to an awareness of relating to the patient as much more than the immediate context, and how she encouraged them to come closer to the patient. Through fostering that awareness I sensed that what Carson did not only mattered to the students, but also to the patients that would be cared for by those students. In wanting the

students to "enjoy the OR so much", I believe the passion that Carson felt for her work extended deeply into the care of her patients.

"Can you tell me about some of your mentors?" I asked. Carson recalled, "When I think about the people who have really influenced me, oh man! I could almost get emotional - I am. I'm getting emotional." Carson continued, smiling, "So many people have influenced me. I have such fondness for those girls in Montgomery - it was my first OR job - because when I went there I could just put my gown and gloves on," Carson laughed and rolled her eyes, reminiscing about her novice stature as an OR nurse. "But they really nurtured me and made me be better than I thought I was going to be. I remember Nicole, Nicole was just a firecracker. She had a great sense of humour; she was such a good nurse. I actually owe her the thanks as she taught me to be organized. I'm still in touch with those people. They're the ones who actually made me become an OR nurse. They're the ones that shaped me and molded me. They're the ones who really taught me about standards," Carson said.

As we conversed, Carson explained her introduction to the provincial operating room nurses organization and of feeling the power of the organization. "When I was a student in the OR at Western Memorial, BCORNG was having a conference. It was fantastic and I was so impressed! I just remember being at the opening ceremony looking at all those nurses and I just thought, 'Oh my god, they know everything there is to know!' I was just in awe! I thought if I could be just like them that would be amazing," Carson laughingly recalled. "That just solidified it for me. I was going to do that," she emphasized. "You had a very fond look on your face, talking about the nurses in Montgomery, BCORNG, and perhaps thinking of other people in particular," I remarked to Carson. "I did, I did," replied Carson. "I look at everybody that I have ever worked with. I have learned from them. When I got involved with the operating room nurses associations, and I met those nurses from across Canada, that made me a better nurse. Being there and being involved with those people and connecting with those people across Canada - that just blows my mind thinking about it. I met some of the key group of individuals that wrote our standards. It's as if they saw what we needed to do. They had a vision those women. Being part of that, it makes me proud of what I do. It makes me realize that I make a difference. How many people

actually get to feel that? Actually get to feel like you make a difference in people's lives?" Carson stressed.

As Carson shared her story about her first operating room nursing job in Montgomery, I sensed there was more behind this story than her responses to the requirements of work as an operating room nurse. I felt that her feelings of what she could accomplish as an operating room nurse were encouraged and supported through her work relationships. I thought how her sense of ability and identity as a safety practitioner in the operating room also developed from her evolving sense of acceptance by those who surrounded her. I heard how strongly she respected the nurses in Montgomery, and how she still held the nurses in high regard today. I thought about Carson's words: "they really nurtured me, and made me be better than I thought I was going to be", and I felt how her story came to me through the recollection of a young nurse focused on becoming a skilled operating room practitioner. I sensed how determined she was to learn from her new colleagues as they mentored her so that she could provide the best care possible for her patients. I felt how her nurse mentors in Montgomery became her work family as they accepted her for who she was and "nurtured, shaped and molded" her. I thought that just as a family might support their child's wondering of who they could be as a person, the nurses in Montgomery supported Carson as a novice operating room nurse on her path toward becoming the capable, safety minded operating room nurse that she aspired to be. I wondered if over the years she came to view those nurses as her extended personal family, for I felt just how close she held them to herself.

I sensed how she felt validated by the nurses in Montgomery not only as a beginning operating room nurse, but also personally as someone who brought with her an enthusiasm and passion for wanting to do better for others. I sensed how this positive experience contrasted a tension she earlier felt with her preceptor, for she now felt accepted as a contributing member of the operating room team and I thought how this gave her the confidence to discover what she could further accomplish as an operating room nurse. As I thought about her earlier description of her current interactions with students in the operating room, I sensed how she carried her memories from Montgomery and the tension she felt as a preceptee into those interactions, as a reminder of what it meant and

how it felt to have one's interest in operating room nursing nurtured and encouraged.

I reflected on Carson's words: "they're the ones who really taught me about standards", and I thought how the nurses in Montgomery opened Carson up to the notion of operating room nurses being safety practitioners. I thought again how her preceptor had missed an opportunity to foster this awareness in Carson. I thought that rather than developing her identity as a safety minded operating room nurse and learning how to support her practice and patient care through operating room nursing standards, Carson had to focus on working within a tense relationship for the duration of her preceptorship. I thought how through her experience in Montgomery, a solid foundation for safety was established by learning how to relate her actions to the operating room nursing standards, and I thought this is where she began to discover "what nursing was about". I also wondered if Carson had not gone to Montgomery when she did, whether or not her sense of awareness about what she could accomplish as an operating room nurse would have developed as strongly as it did.

I heard in her story how the determination to become an operating room nurse was motivated through attending an operating room nurses' conference as a student. I felt how inspired she was by the nurses in attendance and how she wanted to emulate them, and I thought how she may have used that desire to guide her through moments of tension as a student and junior nurse. As Carson spoke about her later involvement with operating room nurses' organizations, I sensed how her involvement in those organizations was influential in her becoming the nurse she is today. I heard how she drew her inspiration from the accomplishments of fellow nurses and how through her committee work with them, she felt her nursing practice had developed even further than she had imagined. I also sensed how she felt strongly connected to operating room nurse leaders through her own committee work ,and how she felt she could effect change for others through following the leaders' early "vision of what needed to be done" by looking to the nursing standards for direction in practice. I also imagined how she might have felt more accomplished not only as a nurse, but also as a person for she realized she had an opportunity to consider the ways in which operating room nursing could "make a difference in people's lives".

"From our conversations, I have the sense that relationships in every aspect of life are important to you," I said. "Oh, absolutely, I have strong relationships at home and at work, and it's looking after those relationships that are truly meaningful. I talk to my sister almost every day. We're very close," Carson replied. "Was that the kind of environment that you grew up in?" I asked. She thought for a moment and then replied, "I'd say that was the environment that I grew up in to a certain extent. We didn't have a very good relationship with my grandparents on my mother's side. They didn't like my father and, unfortunately, that spilled over to the kids. And I think that maybe I have taken care to develop relationships, because I didn't have some of those kinds of relationships when I was younger. I remember a number of times we went to my grandfather's and left. There was anger and harsh words...and that was throughout our whole lives." As she spoke, I sensed how poignant this memory was for Carson and I did not ask for more detail.

Carson continued in a lively voice, "But my dad's side of the family, my aunts and uncles, I definitely knew well and that was wonderful, you know, the relationships. My aunt Sandra, she has done so much. She's 83 and runs in the senior Olympics. She is not afraid of anything. And my uncle Ray - when my sister and I were young, we were just fascinated by our uncle Ray, and we just loved him so much. He was about eighteen years older than we were, and he was such a great influence on me. All through our lives, he was such a positive force for my sister and me. That feeling that we had for him, that never, ever changed. I remember when I was a little girl, now this would have been early 1960's – he took off. He was travelling. He hitchhiked around the world – and I really believed that that was one of the first sorts of 'ah-hah' moments for me, thinking, 'Wow, you could travel around the world? Go and see different things?' And that was the first time that I thought, 'You know what, I'm going to do that'; I couldn't have been more than five. The first time I ever really travelled – well, we always went on a family vacation to Disneyland or something like that - but when I was 12, I went to Japan on a school trip. And I believe that little snap for me, to think about travelling, came from my uncle Ray, when I was at such an impressionable age."

"Over the years, there was a stage in my life where I was trying to get back into life here and working, and my uncle Ray said, 'Come live with us, come

live with us until you get yourself sorted out'. That was such a wonderful experience, because you have your feelings of your relationship with him from when you were younger, and now you can be on the same level with him, you know, just wonderful. Those kinds of relationships are just...Ohh... I mean, he's gone and he still makes me laugh. He always was positive. No matter what was going on, no matter what calamity or perceived calamity, he always had a level head. He always was calm. He always had a good sense of humour, but as well, he knew the secret. He knew that it was the journey, not the destination. My sister was telling Uncle Ray about becoming stranded on a disabled train during one of her vacations and lamenting about this, and he said, 'Wait a minute, you know what? You're just looking at this the wrong way. Every experience that you have is a story. Most people get on a train. They ride for a bit, they get off the train. You had a totally different experience. You got to have a real adventure! Think of the story that's there. Think about it,'" Carson said. "Your uncle lived his whole life as a great story of experience," I suggested. "Exactly, he had amazing insight. He was a major influence in my life," Carson responded. "You know, relationships, you have to work at them, but they are so rewarding. Really, that is what life is all about".

As Carson spoke, I sensed how strongly she treasured the close relationships she had with her family and her work colleagues. I sensed how she had learned about the value of relationships through her own family life. Carson described learning a life lesson early when as a child the notion of a happy familial relationship was disrupted through the relational tensions between her parents and her maternal grandparents. She discovered that personal expectations of life were not always reflected in the reality of living, and that living the realities of life meant living within the tensions of others. Yet she saw and felt how her parents attempted to minimize and work within the relational tensions by trying to make a connection with the grandparents, and perhaps tolerating the incivility to an extent as their response in trying to come together as a family. I reflected on Carson's earlier story about her nursing preceptorship and I thought how Carson too had tolerated a tension-filled relationship as a means or a response to accomplishing her goal of working as an operating room nurse. I had a deeper sense of just how important being an operating room nurse was for her. I thought how Carson might have been further inspired by another family member

during that time, her aunt Sandra, for Carson highly regarded her as a strong woman who was "not afraid of anything" and I sensed how Carson also wanted to be strong in any life challenges she faced.

I heard how at a young age she sensed the importance of maintaining family relationships as a way to feel connected to the world around her through others. Carson fondly recalled her Uncle Ray as a person who was extremely if not the most influential person in her life. As she spoke, I sensed how through her relationship with him she became the person and nurse she is today, and the individual she is still becoming. Carson described a momentous personal revelation when, through Ray's world travels, she discovered the world was not just what was presented to her in her immediate context. Rather, she felt how it extended to what surrounded her and everybody near and far. I thought how this was a significant moment in her life, for in Carson's innocent desire to explore and understand her world and the people in it, she unknowingly created a path that she would follow over the years as her way of living.

I also heard in her story how her uncle responded to her time of feeling unsettled in life. In supporting her through that time of life interrupted, I thought how he validated Carson as a person in a time of need, and I sensed how through that action he made a difference in her life. I thought how through her relationship with her Uncle Ray, Carson felt his life experiences deeply. Through his experiences she learned to respond to the changes and tensions in her world by viewing life from the outside in and from deep within herself. Carson described her uncle living his life as an adventure, as an unfolding journey of moments that had not yet reached a destination. I was taken with her description of her uncle. I wondered how he had come to understand the notion of experiences being connected across place, time, and through others, and how those experiences became a story to live by. I thought how in making a difference in Carson's life, he set her back on her own unfolding journey to becoming the nurse and person she envisioned herself being; one that could make a difference in the lives of others. In the process her journey would be part of her story to live by.

Carson and I talked about the value of personal validation and working relationships in the operating room. Carson explained, "Maybe to some people that's not important, but it really is to me because when you validate each other,

you're working together. It's all about being focused. It's all about going to that common team goal, that whole team thing, to give your best to that patient." I commented, "Sometimes you are in one room for eight hours behind closed doors with the same people." Carson quickly replied, "Yes, so why not develop that? Life is so short you know. The other day I had a patient in my room and he had a bit of a vaso-vagal. So I just had him lying there. I turned the lights out and it was nice. We were just sitting there relaxing and yakking, and he said, 'Oh I better get moving here, you probably have somebody else to get in here.' I said, 'No, they can wait. You need to be in here right now. That's what it's all about, it's you. Think about that. When was the last time it was all about you?' And he said, 'Oh, yeah.' I said, 'Well, it is all about you, so take advantage of every minute.' I remember, you know when you're first starting out in nursing, and especially the OR, I remember being told that having an operation is one of the most stressful things that anyone will ever go through."

Carson emphasized as she spoke, "But to be privileged to be part of that, I mean, you really make a difference in people's lives. I think to make a difference in somebody's life is the best thing you can do in your entire life! Look at me, I'm just a baby," Carson laughed and cried at the same time. "But it ties into what I said earlier. The experience, those relationships that you built, those nurses around that table, what a tremendous group, the amount of work that's accomplished - it made me feel like I was part of something that was so wonderful, that was going to benefit patients, and I can't stress that strongly enough. I don't ever want to take for granted working you know, so that life is better for patients. It's all interconnected and to be at that level, and you sit around the table with those nurses and you're all working truly as a team – it's a great experience and I know that it made me a better nurse."

As I listened to Carson I felt her passion for operating room nursing punctuate her words. I saw how emotional she became as she proudly reflected on her life as a nurse. I heard in her story how important it was to her to validate colleagues and to feel validated, in order to provide the best care possible for patients. As she spoke about the importance of developing positive working relationships, I thought again about her moments as a student preceptee and her time as a junior nurse in Montgomery. I felt how she carried those experiences

with her over her career as a reminder of what she could accomplish for patients through favorable mentoring and working relationships.

As Carson shared a patient care moment with me, I sensed how a past learning became over the years a pearl of awareness that she kept close to her, and reflected upon as a reminder of the fragility of humanity. I felt how in focusing her attention on the needs of her patient only and not rushing her patient through the system of work, she validated him as a being who mattered to her and whose ordinary life had become interrupted through the stress of surgery. Through her interactions I sensed how her patient might have felt reassured and accepted for who he was, and how he felt Carson tried to support him not only in his time of vulnerability but in life as lived.

Carson recalled again how she felt her relationships with other operating room nurses across professional organizations influenced and helped to develop further her abilities as an operating room nurse. As she spoke about the interconnected nature of nurses coming together to benefit patient care, I sensed how a thread from the past wove into her story. I felt the presence of her Uncle Ray come forward in her story. And I felt how her time living with Ray pushed her to think deeply about whom she was and what she could accomplish, as a person and an operating room nurse. I sensed how she had learned from Ray how humanity was connected across place and time, and how those connections could become a path to responding authentically to the needs of others. When she said: 'the best thing you can do in your entire life is to make a difference in somebody's life', I felt how she not only spoke about what she had done for others, but about what her Uncle Ray had done for her. How over his lifetime he made differences in her life that mattered greatly to her. I sensed how through her relationship with Ray she recognized how she too could make a difference that mattered in the life of another. I felt the profound and lasting effect their connected relationship had on Carson and sensed how she valued that thread even more as she worked to "make life better for patients".

Life in a Different Country

Carson told me that she had worked in the Middle East as an operating room nurse and I was curious about her experience there. "What took you to the Middle East? Was it the adventure of working somewhere else?" I asked. She replied, "Yes, the adventure! I thought it would be so amazing to do something

like that, to just go and work somewhere that most people never get to see. Plus I've always had that thought where I don't want to look back at my life at 75 and think, 'You know, I had a chance to do that and I didn't'. I don't want to have a lot of regrets. I want to say, 'Woo, I did that!' I mean, I don't have any crazy dreams to jump out of airplanes or anything!" We both laughed as she continued her story. "When I went to the Middle East in the early 90's, I didn't really know what to expect, but it didn't take long for me to realize that no matter where you go the operating room is the operating room. In one hospital I worked the gyne theatre and it was very interesting. And as much as I enjoyed the country and learning what life was like there, it gave me such an appreciation for what we have here, such an appreciation." Carson described some behaviours that contradicted Canadian practice. "It sounds as if the nurses didn't question anything," I suggested. "Oh, you couldn't, it was just accepted," Carson replied. "That is the way they did things and they'd often ask me, 'What's it like in Canada?' and I would say, 'You would never be allowed to do this in Canada,' and they would be surprised." And she proceeded to tell me more about her time away.

As Carson spoke, I sensed how a thread from the past wove throughout her journey to the Middle East. It was through her uncle's travels that she first sensed as a child she too could find out about the greater world around her. Later as an adult, she saw an opportunity that allowed her to combine her passion for operating room nursing with her curiosity about the world of others. I thought about Carson wanting to do something with her life and not wanting to feel that she had let moments pass by her. I sensed that I would hear how taking up an opportunity that presented to her had made a difference that mattered greatly to her and to others.

She said that regardless of where one was, "the OR was the OR". I thought about the reason that operating room departments existed, that is, for the provision of surgical services with the intent to improve the life condition of another. Yet I felt that despite a common goal of operating room work, Carson felt unique challenges and tensions in how she accomplished her nursing work in the Middle East. She spoke about going there for the adventure. Yet I sensed how quickly and acutely her awareness of her patients' contextual world challenged her own taken for granted aspects of nursing and everyday living as she had come to know them. Carson said she gained an "appreciation for what

she had in Canada". I wondered if her travel adventure to a distant country might have became a journey of self-discovery, and how through her work as a nurse in a foreign country she was further opened to the reality of life as lived by others.

"Did you have interpreters to help communicate with patients, Carson?" I asked. "Well, that was interesting," Carson smiled and explained. "You picked up some of the language along the way, and I had a translation dictionary for hospitals. Even if you don't speak the same language, you can still get the message across with just motions and actions. The women were all very fascinated by me. They wanted to hear how old I was. They would ask, 'Do you have children?', and some of them thought it was fabulous that I was not married, and some of them just felt badly for me. It was terrific, but you never really got to have that relationship with the patients that you have here, and not because of the language but because of the culture. For example, the patient would come to the hospital to see a physician, and from primary care, the patient was referred to a surgeon. Sometimes the surgeon would not be allowed to examine the patient before surgery." "Is that because the patient was female?" I asked. "Because the patient was female and they wouldn't allow themselves to be examined – their husband would not allow it." Carson further explained, "Often times a female patient wouldn't have a full pelvic exam until they came into the OR under general anaesthetic, and then we'd find out that they're here because they've got primary infertility. And I would say, 'Do you think maybe the reason she's infertile is because she's just not physically there yet, maybe she's not mature enough to even conceive?' And they would say, 'Well, Carson, she's been married a year, we must make sure…' I would say to them, 'This is so wrong."

Carson continued, "There was one lady, she came in for a caesarean section. She had had six previous sections and of course she bled. I was recovering her and I said, 'You have to take this woman back to the OR because she is just bleeding to death.' They took her in for hours and hours, and they finally had to do a hysterectomy. It was the only hysterectomy I'd seen there. A few weeks later this woman is on the OR list and she's having an ECT done. Why is she having an ECT? Well, because she can't have any more children and her husband's going to take another wife. It was a very interesting place there. If you go somewhere like that, you cannot do anything to influence their standards

or ways. You just can't. It's a struggle enough for you to maintain your own – that's the real crux of it."

Carson quickly delved into another experience, "Some of the surgeons I worked with had limited surgical skill. I remember scrubbing with two plastic surgeons. They were doing a reduction mammoplasty and abdominoplasty, and I was embarrassed to be a part of that. They took methylene blue and they wrote their names on this woman's pannus and took pictures of it, and they wanted to write my name on this woman's body also. I said, 'No, please don't. Please do not write my name'." "Why did they think that was acceptable to do?" I asked. "Was it because the tissue was being removed?" "Yes," Carson replied. "I think they thought it was OK to do that because she was a woman, and the tissue was being cut off - that's the only thing I can think of. I just thought, 'I'm going to have to go home soon because I don't know how much more of this I can take'. The job they did on her – oh, it was horrible. I mean, her breasts didn't even look alike. It was horrible," Carson spoke quietly, her voice taking on a subdued tone.

"How do you reconcile that Carson, when you are literally living within the bounds of somewhere else?" I asked. "You have to live within the bounds," Carson emphasized. "OK, I couldn't do anything for that woman – who by the way was thrilled with what they had done for her. She was happy and she was alive. But again, it's all about doing the best you can with what you've got. And that case there, that stays in my mind. It was probably the worst thing there that I saw, and I saw some pretty horrifying things. But at the same time, what I brought to the table there was trying to work within standards."

As I listened to Carson's story, I was struck by how she spoke about patient care from not only her perspective as a Western OR nurse, but from the perspective of a fellow being living alongside others. I sensed how trying to reconcile her Western culture with the local culture of patients and healthcare providers was a tension strongly felt, and one that seemed to surround her daily living. She felt the depth of relationships she could establish with patients was not as significant as those she had experienced in Canada. Yet I heard in her story how many female patients were interested in her and wanted to know more about her. I thought how this connection may have come about through her self-identified ability "to make people feel comfortable". Or possibly, in their curiosity about Carson, her patients sensed her openness to them as individuals who

mattered, for despite feeling that her patient relationships were, perhaps, superficial I heard how she cared for her patients with a deep level of professionalism and compassion.

One surgical experience in particular has stayed with her over the years and I thought how that experience reinforced for her, her notion of the patient as a being in this world living alongside others. As I heard how disgusted Carson was with the behaviour of the plastic surgeons, I felt how she told this story through the context of not only an operating room nurse and being female, but also as a person who earlier in her life had felt the disrespect of another. I heard in her stories how in a society, the context of gender could specify what was acceptable toward another. And I sensed how she felt the surgeons had shifted their view away from this patient as a person, in a lived body, and how through their actions they neglected to recognize her as part of their lived world. I sensed how Carson felt personal and professional tension through the attitude that some demonstrated toward the very being of women in that society, as well as the attitude toward the body of a woman in the operating room. In the misery of that moment, I imagined how she might have felt the vulnerability of others become her own, for I heard how that experience spurred her to reconsider what it meant for her to live her life as she had come to know it.

I sensed how she questioned what it meant to be a patient in that particular moment as she became even more aware and sensitive to what was unfolding in her immediate world. I thought how that moment led her to new insights about patient safety through her own experiences of the other as having a particular place in a particular life world. While Carson felt she "could not do anything" for her patient in terms of her post-surgical appearance and the disrespect shown toward the patient, she also recognized that as an operating room nurse she could still provide care that was compassionate, professional, ethical, and safe through the operating room nursing standards. In identifying the standards as a constant in her practice and as a way of supporting her sense of who she was as a professional nurse, I felt how she came to value them even more. And I sensed they also provided her with direction for living in the moment, within different societal boundaries.

"Carson, tell me about standards and patient safety awareness at that time," I asked. "Well there wasn't any'" Carson burst out, "I tell you, you go over

there, you work in those hospitals, and you see how lucky we are here. We would use disposable trocars for the laparoscopic surgery there, and they would wash them and soak them in cidex. That just goes so against everything that I know. I said, 'You know you should not be doing that – you should not be doing that. We should be using a new one for every patient.' I said, 'You have all this re-usable equipment here, and yet you are using disposables, re-using them and you're not sterilizing them, you're disinfecting them.' Oh it was scary." I asked Carson, "Why didn't they use non-disposable instruments?" Carson explained, "They were using disposable because they were told that "this is the best, this is the latest and greatest" and so they had it. But they had no concept of "what do we do with this when we're finished with it", or "how do we make sure everyone gets the same level of care?" So I'd go in and say, 'Listen, I'm going to have a look at those trocars in there and make sure that they're all OK,' and I would just throw them out."

"Carson, what did you bring back with you from those experiences?" I asked. Carson responded enthusiastically, "What did I bring back? Oh my, such an appreciation for the standards we have and the knowledge of how important those standards are, why it is so important we need those. And why we should be so grateful that we live in a country that follows standards fairly well. OK, we have our moments but you know, people actually try here, they see how important it is to that patient. Although as I say that, I did meet a few surgeons there that did understand what the OR was all about and it was great to see that. We had many foreign-trained nurses there and they had their BSN from their country, but they could never get a job in Canada because they could not pass the exam. We were training the locals there how to circulate and there was one foreign-trained nurse who said, 'The reason you count all the sponges when you're doing a c-section is to make sure that one of the sponges didn't go with the baby.' And I said, 'Wait, step back, step back. No, no, you are not counting to make sure the sponge didn't go with the baby. You are counting to make sure the sponge isn't in the uterus. But if it isn't, maybe it did go with the baby.' You could see the thought process, but…" "It sounds like a bit of disconnect between knowledge and practice," I offered. 'Oh yes," Carson replied, "Those girls would never, ever say they didn't know how to do something even if they had no clue - oh my word!

As Carson spoke I heard how the operating room nursing standards became a central and integral component of her ongoing commitment to safe patient care. I sensed how safe patient care became a professional, ethical, and personal responsibility for her. And I sensed how her knowledge, skills, and behaviour in achieving this care, was supported through the operating room nursing standards. As she spoke of her appreciation for the nursing standards I recalled how, as a student attending her first conference, she wanted to emulate the nurses she was surrounded by for she felt "they knew everything about OR nursing". I thought of how, through her actions she moved closer to "being just like them", for she worked to make a difference for her patients by achieving a quality level of competence supported through the nursing standards.

Carson described her determination in providing a similar standard of care for all patients by ensuring certain instruments were disposed of rather than having them re-sterilized, so that they could never be used again. As I thought about this I considered how as less obvious the semblance of patient safety appeared to her, the more concentrated her efforts became to ensure a process to achieve it. For Carson I believe that process meant the operating room nursing standards became her reference point in figuring out how to live "within the bounds" of the tensions she felt.

I wondered if her sense to respond to the tensions of patient safety, through not only her perspective but through the perspective of the other, was further developed by experiencing a cultural and contextual life that was so out of balance with her own way of living. I imagined she must have wondered what it would be like for her to be a patient in that environment. I wondered if her way of responding through an acute awareness of the other made the tensions more obvious than diminished for I thought the harder she worked to live within the tension the more she felt it at various levels. Through her story I heard how the notion of safe patient care was challenged across different levels in her daily nursing practice. She felt tensions at a cultural level when she witnessed care that were not always compassionate or ethical, or when it differed from Western practice. At a clinical level, she felt the lack of consistency across patient care encounters as a tension that stemmed from instrumentation issues and sub-optimal techniques in practice, and at a functional level she felt the tension of a limited knowledge base of some nurses as detrimental to safe patient care. I

sensed how in her feelings when the nurses would not say they "didn't know how to do something', that she felt patient safety could easily be compromised at any moment. I also thought that in training the local nurses to work in the operating room, she saw this as a valuable opportunity to address patient safety through a group of healthcare providers who were medical residents, thus passing this knowledge and information on freely to other colleagues as a routine component of patient care. While she did work with surgeons who she felt "understood what the operating room was about", I sensed how the tensions of her practice worked to increase her awareness and sensitivity of how she could accomplish her work in a way that mattered to her, and ultimately to her patients.

As I thought about her story, I sensed how she grew from an impressionable, novice operating room nurse to the discovery of how to work within the standards of an operating room nurse who experienced the inherent value and relevance the standards held for her and her patients, all in its entirety. I sensed how in trying to ensure a focus on patient safety in the operating room, Carson moved past thinking about how the standards could support her practice. She began living her nursing practice through the standards. I sensed that what she brought back with her from the Middle East was far deeper than her appreciation of the standards. She also brought back the person and nurse she had become through her experience of another as having a particular place in a particular life world.

Learning about Safety

"Carson, looking back on your nursing work, what stories would you say to others about your patient safety experiences?" I asked. Carson pondered this for a moment, then replied thoughtfully, "One of the things that I do say to every group of students in the OR is, 'I think that working in the OR is the best job in the world! You know what? The OR is not for everyone. It is a privilege to work in the OR, but if you find that it is not for you, do not kid yourself about it. You will know, either you are going to do this and you are going to really enjoy it, or you will not. If you have those feelings of not enjoying your work, you need to acknowledge them, because there is no sense trying to force it on yourself.' I really think it is a privilege to work in the OR and it's not meant for everybody," she said emphatically. "So when I talk with students, I tell them about some of the experiences that I've had, and the issue of not placing blame on anybody, rather,

asking ourselves, 'What can we do to change our practice so that this never happens again?' And to always be with the patient - you see all sorts of things. For example, we cover labour and delivery in our hospital. They have two operating rooms over in labour and delivery, and we always supply the scrub nurse. It was just frightening going over there, because those nurses didn't know how to properly assist an anaesthetist, and they had patients sitting up on the side of the bed with nobody standing there with the patient. Now they've changed their practice."

"What instituted the practice change in labour and delivery? Did it come from the OR nurses?" I inquired. "Yes it did, because of the number of times that we had to break scrub." Carson elaborated, "You'd be scrubbed, you'd be setting up, and of course everything is going on behind you, right? Just the way the room is set up – and you turn around and here this patient would be sitting there alone. I'd be saying, 'Hey come on you guys, somebody has to be with the patient. Somebody needs to be standing here with the patient!' The number of times that I've had to go over and be contaminated – just to make sure that the patient didn't fall off that bed. All those changes were instituted because of nursing in the OR, because we could see it, you know. Even properly assisting the anaesthetist, especially when you're doing a crash induction, you'd have to say to them, 'Go stand with the anaesthetist, be ready – is the suction ready, did you check it?', all those things. Now they have an educator in their area that has a very good relationship with our educator, and we've been able to bring about a lot of change in that department."

I was taken with how Carson prefaced nursing students' introduction to understanding patient safety in the operating room through the honour and fulfillment she felt in being an operating room nurse rather than focusing on the technical aspects of operating room work or the status that was sometimes associated with being an operating room nurse. I sensed how she felt passion for her work, a foundational element in her being the operating room nurse that she was; and I heard how she directed the students to consider, seriously, if in a future desire to work in the operating room, they also felt passion for the work within themselves. She said working there was a privilege and I believe she referred to the personal gratitude she felt as a nurse and a person, knowing that

she provided safe and skilled care for her patients; Carson never wanted to "take her work for granted" as she worked to make "life better for patients".

I reflected on her earlier comments about becoming a better nurse through her connections with other nurses and other work experiences. It made me think that in experiencing this bounty in her life she focused her attention further on enriching the lives of others. For Carson had earlier said that making a difference in someone's life was the "best thing anyone could do" and in effecting that, she felt as if she was "part of something so wonderful"; another one of her discoveries about nursing. She had turned that experience of making a difference back upon herself and others, patients and colleagues, in order to continue meeting the challenges in patient safety, and as a way of learning from her patient safety experiences. I wondered if the time spent in the Middle East had kindled her feeling about operating room nursing being a privilege, for I sensed while she was there she deeply felt what it meant to commit to care in safe ways of another as part of the human condition.

Carson told me how she instructed students to be aware of the patient at all times. She recalled a story about how she and others took safety measures from the operating room and implemented them in another department to support safe patient care. She described the challenges in performing caesarean sections in the labour and delivery suite. I thought about her earlier comment that "the OR is the OR". I sensed how she viewed surgery in the delivery suite as an extension of surgery in the operating room and considered how she used the safety protocols of the operating room to guide the work of others there. I heard how Carson felt the labour and delivery nurses' practice was unsafe in a surgical sense, and considered how this was a patient safety tension for her. I also heard how through identifying specific safety and knowledge deficits, Carson and other operating room nurses began to bring a new layer of safety to the nurses and patients of the labour and delivery suite. For over time they brought the safety awareness and safety measures of the operating room into labour and delivery, enhancing any obstetrical safety measures already in place.

I reflected on this and thought, with the work of a department crossing into another, it was vital that nurses were knowledgeable about patient care matters that extended past their specific specialty. Carson had implied that achieving patient safety relied on identifying and addressing practice issues. I considered

how this included not only one's own practice, but also the practice of others. I heard in her story how she felt operating room nurses were instrumental in positively enhancing patient safety in the labour and delivery suite, because they recognized other nurses' practice limitations. When Carson said that nurse educators continued the work of supporting patient safety through practice between departments, I was reminded of how patient safety also depended on the presence of individuals whose focus was primarily to educate others in becoming better practitioners.

As I listened to Carson I thought of how her way of caring for others safely, and her way of responding to patients and others as persons that mattered to her became her story to live by. It was one composed over the years in different countries, in numerous operating rooms, and through relationships and realities of life as lived. Throughout our conversations Carson spoke of herself as "wanting to make a difference that mattered in peoples' lives" and as "being a better nurse" through her professional relationships. As Carson told her story I felt how she was living out a narrative of who she was. I thought of how her conversations with nursing students, about feeling passion for her work and her response to events in the delivery suite, were expressions of the ways she came to know. I considered how she encouraged, mentored, and subtly educated those she worked with in order to strive for better practices, and that took into consideration how she lived which also enhanced patient care. I learned how she came to know through her family and professional relationships, what it meant for someone to enhance her life. She appreciated this as the "best thing someone could do". I considered how Carson wanted and endeavoured to make differences in other people's lives as a way of living her life, well. I learned how her varied nursing and life experiences connected together, pushing her to think about whom she was and what she could accomplish as an operating room nurse and as a person. I sensed how her story to live by continued to evolve as she reached out to work with like-minded others for better and safer ways of delivering patient care.

Carson continued, "One day I was working in the core area and I heard this yell from the theatre. I went in. They were doing ENT surgery. And there's the patient - now they had reversed the bed. They put the foot at the head - and he was tilted, the bed was actually tilted in trendelenberg and the patient's head

was toward the floor, and his feet were up in the air. I mean they were lucky. We were lucky, so lucky because he was firmly strapped to the bed. There wasn't a chance that he could have slid off the bed, because they had the safety belt on and everything. And he went down so gradually, so slowly that the anaesthetist was just able to protect him as he went down. You know it could have been just disastrous. As it was, one of the nurses had to go home. She was physically ill. It worked out - but still, after that, we changed our practice and we stopped reversing the bed. For adults we have a specially designed headboard now, but it's only because we went through that experience that we changed. We used to do that all the time, but all it took was one incident and we stopped reversing the bed." "Many beds are not designed for that," I said. Carson agreed, saying "Exactly, but that's a common thing to do." I said, "It certainly is. There are also the instructions in print that…" "Everyone ignores or never discusses" Carson interjected. "Or, it hasn't been a problem before so we can't see how this type of event can happen," I added. "I remember one case, Carson. The ambulance folks had brought a patient into the OR on their fracture board. During surgery we placed the patient in reverse trendelburg position and the patient almost slid off the bed. Fortunately, we caught the patient before that happened! As we looked around at each other, we realized what had happened – no one had removed the fracture board. From then on we always made sure the fracture board was removed."

"Do you think that's synonymous with all mistakes in the OR?" Carson asked me. "I remember a medication error I made one time. There was a thoracic surgeon and his technique, just before he closed, was to take one million units of Penicillin and sort of spray it around the chest cavity. I ended up giving him ten million units and I didn't know I'd done it until another nurse pointed it out. I'd looked at it but it didn't register with me, you know. The surgeon said, 'Oh Carson it's fine, the patient could use the extra.' I remember talking with the supervisor and saying I did not know what happened. I looked but I saw one million." I suggested, "You saw what you expected to see." "Yes, I saw what I was going to see, not what I was actually seeing. That could have been bad. And now I always check, always check, and it probably won't happen again but you know, I still carry that with me. I've never forgotten that," she said.

As Carson shared her experiences I heard how it was easy to become complacent, though not intentionally so, about remaining alert to potential risks to patient safety. As I listened to her story about a patient position routinely used for ENT surgery, I thought how she learned in that moment that patient safety had no limits. For despite feeling a sense of security in practice from working within an established department routine without prior incident, Carson learned that focusing on a routine of care "that we did all the time" could lead to patient safety being overlooked. I also heard how Carson learned from a medication error she had made years ago, and how she carried this learning forward in her current practice. She discovered how easy it was to "see what she wanted to see" when working within a routine of practice. I considered how that awareness had stayed with her over the years and how she continues to reflect on that event as a reminder of the importance of remaining vigilant in practice, regardless of any established routine.

I later reflected on Carson's question, wondering how she and I learned from mistakes we had made in our own individual nursing practice. I further reflected on the practice of reconfiguring the operating room bed to enable surgery by allowing the surgeon to be physically closer to the patient, a practice routinely implemented in my OR. I recalled how this maneuver was performed without question or incident until one day, in reading the instruction manual about an unrelated matter, my colleagues and I discovered there were specific patient weight limits which affected the parameters of operating room bed reconfiguration. It was that discovery that led my colleagues and I to stop and re-evaluate the safety implications of bed reconfiguration as it related to each individual patient in my operating room department. I considered how Carson and her colleagues had also taken their bed reconfiguration experience forward and changed their practice, in order to strengthen safety standards for future patients.

I felt comfortable in saying that Carson and I carried the knowledge from our past experiences forward into our future patient encounters. Perhaps this was "synonymous with mistakes" for other practitioners. Perhaps other practitioners also carried their knowledge of past experiences forward to learn from their mistakes. Carson said it was important to keep asking ourselves "how practice can be changed to prevent unsafe events". I heard how she stimulated this conversation in students for in sharing her stories about her own safety

events with them, she encouraged the students to take the knowledge from her experiences and their own experiences forward as a way of improving their developing practices. Carson described a practice change in the ENT service which stemmed from a safety event and I thought how she shared the knowledge of that event to alert all department staff of "how a common thing to do" detracted from patient safety. I considered how that knowledge continued to ensure better patient care through a safer way of positioning patients. Although I could not say why, I sensed that Carson felt discussions about specific safety events and practice changes should be on a larger scale, so that practitioners everywhere could benefit from the knowledge that flowed from such events. I thought how Carson and I had never learned of our individual safety events until we met, and began our conversations about patient safety in the operating room. I wondered how it was that practitioners in all operating rooms could learn about a catastrophic event quickly; yet, as a way of preventing unsafe events, other lesser safety incidents were not often discussed or known between operating room departments.

Carson signaled a turn in our conversation. "I'm going to go off on a tangent. We had been trying to implement this checklist - the checklist for Patient Safety in the OR, for safer patient care. I see this as a big part of patient safety. I think it is fantastic! Have you implemented it?" Carson inquired. "We are trying, and it's" I started to reply, and Carson interjected, "a struggle!" I agreed, and we were both laughing despite our frustration with the process. Carson described her experience, "This has been a real bug bear of mine, because it's a couple of years now. When the checklist launched, there was a regional presentation and it was the worst thing I had ever seen in my life. They had audio-visual connecting everybody up through the network, except that things didn't actually work. We didn't receive any documents for discussion, and you couldn't hear who was presenting. Then the manager of program development, who had very, very few years of clinical experience, and no experience with the operating room, spoke. Now, the audience was operating room nurses, surgeons, and anaesthetists. She spoke about the principles of surgery and how important it was to make sure that you had the right patient, and that you were operating on the right leg, and so on. She had zero credibility, zero. Nobody knew who she was to begin with."

Carson continued, “So after it’s been out for a while, everyone’s attitude is, ‘what checklist?’ They’ve completely dropped the ball on it, because there’s been nothing to say ‘what’s happening with it? What are we doing with this?’ When I later met with the program development manager, she said, ‘It’s just not happening and I’m not quite sure why.’ I said, ‘Well, do you think maybe because we haven’t got buy-in from the stakeholders?’ And she said, ‘What do you mean?’ Carson’s frustration was evident in her voice as she continued to speak. “I said to the program manager, ‘Well to implement anything like that you have to change the culture of the operating room. You are talking about people who have been doing it the same way for 30, 40 years. It’s really hard to break that cycle. As well, you’re talking about an environment where you couldn’t imagine how many changes we’re going through. It would be different if this were the only change that we were having in the past while, but we’re going through a change in prep, we’re going through a change in scalpels. We’ve got all these new safety products we’re implementing. It’s one more thing you know. It’s not just one thing, it is one more thing. And a lot of that change is hard for people. Change is hard to begin with for people. You’re not going to get anywhere unless you have the buy-in from the people actually using it, the stakeholders.’ I said to Carson, “The program manager didn’t seem to have the insight to take this forward.” “Exactly, she had no inkling about the operating room or the safety checklist,” Carson emphatically replied.

As Carson shared her story I heard again how the structure and established daily routine of the operating room provided a level of familiarity and perhaps security in how work was accomplished in her department. She identified several concurrent practice changes that she and her colleagues were trying to implement, and I considered how disruptive this might be for them as they learned a new way of doing their work. Carson described her experience with the introduction of the Patient Safety Checklist, sensing and hearing her tension with a process that seemingly failed to establish a foundational understanding about the checklist. That is, what the checklist was, how to implement it, and the importance of this tool in overall patient safety in the operating room. Carson described how implementing several practice changes at once could be overwhelming. I heard how an absence of consistent follow up in protocol change led to her and colleagues continuing with a previously

established routine of care, rather than changing their practice to reflect the Safety Checklist protocol. I recalled her story about changes in practice in the delivery suite leading to safer patient care and how that process was supported and followed up to ensure those changes became established practice. She described how a specific safety incident led to a change in practice in the ENT service, and I reflected on how she and her colleagues felt supported in making their change through the availability of a patient positioning headboard. Though she did not say, I felt there must have been someone who followed up to ensure this practice change was successfully implemented, for Carson said "we stopped reversing the bed". As I considered her stories I sensed how important it was to approach any change in practice or routine through the establishment of a connection between the proposed change, and acts that move current practices toward better, safer patient care, all through the improved practice of healthcare providers.

I imagined how that moment of coming together with other practitioners in trying to implement a safety checklist to make care safer for patients must have stood so far away from what Carson had previously come to know. She knew what could be accomplished through a group of like minded individuals working together to benefit patients, and I understood how she wanted her current group of colleagues to also come together and work toward the improvement of patient safety. I reflected on how her story emphasized the importance of the presence of capable leaders, with a relevant knowledge base that could support the implementation of a new safety protocol. Carson said the program leader had "no inkling" about the operating room. I considered how Carson felt this unfamiliarity, or lack of knowledge, which impeded the program leader from making a genuine, working connection with the operating room staff that could support the implementation of the safety checklist. I learned that Carson felt that the program leader did not understand the value of the safety checklist or the implications for operating room practice, as there was no follow up with the operating room staff to assess the implementation process. I sensed how Carson felt this had led to her and colleagues "dropping the ball" in relation to the use of the safety checklist.

As Carson explained her follow-up conversation with the young program manager, I considered how she felt the safety checklist supported her own

practice as a safety practitioner through initiating that important conversation with the program manager. I also reflected on how she felt the checklist was beneficial in advancing patient safety in the operating room. In her wish for the use of a successful checklist I heard how, despite her feeling frustrated, she coached the inexperienced program leader to consider the implementation, follow-up, and adherence to the safety checklist from another point of view.

Carson identified tensions that she currently experienced in practice change. In sharing the significance of what that meant to her, I understood how she opened the program manager to awareness about change in protocol, not only affecting how a group of individuals felt the tension, but also how practitioners felt the tension at an individual level. I reflected on protocol changes designed to advance patient safety which I experienced in my department, too. I recalled how tensions, such as insecurity, lack of confidence, or changes in work relationship, were also felt at a personal and group level. I thought about Carson's words, "change is hard for people", and reflected about various changes that she had experienced throughout her life, for example, family relationships, discovering a career, and exposure to life in a foreign culture. I thought it was through those life moments over time and place that she had come to know how working to improve life for another often meant questioning her way of being, and at times this had led to tensions in wondering if she had to live differently. I considered how Carson felt the strain of protocol change herself and how she recognized similar tensions in her colleagues, as she questioned how the safety checklist could become part of their long-standing way of implementing care. I also thought how a proposed improvement to patient safety, no matter how simple it appeared, was a complicated, tension-filled process.

Patient Safety Stories

"Carson, during some of our conversations you made reference to specific patient safety experiences. Would you be comfortable telling me more about them?" I asked. Carson shared, "Well, I once worked with a surgeon who had some significant personal issues - well, how can that not affect you, you know? He also had physical issues that were becoming more and more pronounced. He just pushed himself so much. He told me that, one day he had a couple of big cases to do, so in between the cases while they were getting the other patient ready, he went and had a colonoscopy done and came back and

did the second surgery. I said, ‘Do you think you should have done that?’ And he said, ‘Oh yeah, there was time, I could get that done.’ I said, ‘So what would have happened if we’re putting the other patient to sleep, you’re having your colonoscopy and there’s a complication? Then what would have happened? We would have had to wake up your patient, switch places, and put you on the table. Was that really smart? Was that an intelligent choice to make?’ And he said, ‘Well obviously you don’t think it was.’ I said, ‘Well I’m just a bit surprised. Why would you do that?’ And he said, ‘If I didn’t, I’d have to take the day off – do you know how much that would cost me?” I was quite astonished as I heard Carson’s story and said, “He didn’t seem to put anyone else’s concerns forward.” She agreed, nodding her head and then continued.

“There was another surgeon. There were incident reports filled out about him for years. I don’t know how many incident reports I filled out. They all disappeared. No one knew where the reports went. There was no idea where they all went. When it came to a question of this surgeon continuing to practice, some anaesthetists stood up for him, saying, ’Well he’s not that bad, Carson.’ They couldn’t understand why nursing didn’t support him. And I said to them, ‘That makes me consider your judgment’. The hospital people met with those of us that wanted a meeting and this is what I said to administration, ‘I have no problems dealing with him myself, but how do I protect the others? How do I protect those nurses that don’t have the experience that I have? How do I do that? Do you not have some responsibility to protect? I would hope that as administration, if you feel that he is competent and safe that you will allow your family, or your wife, your children, to be operated on by him. If you cannot answer that question, there is a bit of an issue then, isn’t there?’ And they couldn’t answer my question. There was a lot going on with this situation outside the department, so with all that going on who does it fall to, to protect the patient?” she said.

As I listened to Carson’s story about a surgeon who underwent a procedure while waiting for the theatre to be prepared for his patient’s surgery, I sensed she realized in that moment how intruding personal issues of a person could potentially affect, so greatly, the safety of many others. I thought of how she felt this as more than a professional tension, for Carson had come to know caring for patients as something extending past the physical task of human

doing. I believe for Carson that caring as a professional also meant caring about the ethical and legal responsibilities she held to patients, as well as her overall accountability to patients as their care provider. I appreciated it at the level of who she was as a nurse, and as a person in this world.

I heard how baffled she was by learning of her colleague's behaviour and listened how she tried to reach out to him as an individual and professional colleague in wondering why he took such a risk. In reaching out to him, I considered her question: how she and her colleagues went about caring for their patients and themselves, safely, as humans living in busy, complex environments. I reflected as she came to understand this person in a way not previously known to her, and considered how this tension might linger with her. Carson previously said she felt "standards were followed well" in this country, and I thought how this behaviour contradicted what she had come to expect from a colleague in her current work environment. I sensed how through her discovery, Carson's sense of awareness surrounding the boundaries of patient safety had expanded even further.

Carson described another time when she felt the boundaries of patient safety had narrowed rather than expanded. When she said that incident reports concerning a particular surgeon had "disappeared" and that not all department staff opposed the continued work of this individual, I sensed how she felt her concerns and those of others were not supported. And I considered how she might have felt alone in her pursuit of patient safety. In realizing divisiveness amongst department members, I wondered if she might have renegotiated relationships with some colleagues as a part of her ability to work well. In describing her words to administration, I sensed how frustrated she felt at the possibility of an unsafe situation repeating again, and I heard how ensuring the safety of patients was not the only tension she felt in this moment. Her tensions also came from wondering how she could protect lesser experienced colleagues from any potential safety related issues that might be unfamiliar to them. I heard how she felt morally responsible for the patients in her care, and as an experienced nurse how she further felt responsible for supporting and ensuring safe practice in lesser experienced colleagues. As she alluded to the many competing demands of this situation I considered how she was disillusioned with the system's process of reporting; yet I also felt she would continue to challenge

the system she worked in to ensure the safety of patients. Carson had asked others how she could meet her professional, ethical, and moral responsibilities to her patients, colleagues, and to herself in a system that did not seemingly support what was required in meeting this obligation.

I learned how important it was for Carson to feel that she could protect her patients from unsafe situations and the unsafe practices of others. I understood how her past experiences from the Middle East came forward in her stories, and I appreciated how she was filled with a sense of urgency in wanting to protect those in her daily work life. While she indicated she often could do little for her patients in the Middle East, her knowledge of what she could accomplish as a safe professional nurse in Canada came from working with established practice standards in unison with others. I believe her understanding of what she could accomplish also came from societal expectations of care providers, for she earlier said how she was grateful for living in a country that "saw how important it was to patients" that we follow standards. I thought that unlike her experience in the Middle East, she felt she did have the ability and responsibility as a professional to effect changes that improved patient safety in her current department. Yet similar to her previous experience, she felt a situational constraint inhibit patient safety. I now better understood how she felt a familiar tension between expected practice and practice as lived, as she figured a way to work safely "within the bounds" of the system she was currently in.

'What does patient safety mean to you?" I inquired. Carson replied, "I don't know if I'm able to answer that, but I'm just going to start talking. I think patient safety is actually the foundation for everything that we do in the OR. We have a patient safety group within our OR. Every morning we talk about patient safety or staff safety. We have a little hint or a little reminder to the staff about some aspect of patient or staff safety, which I think is really good. The educator for our OR also consults for medico-legal cases, reviewing charts. It's because of learning from this kind of information that we are more proactive about things. If we are going to be so safety conscious then people should be able to learn, not point fingers at people to say, 'this was your fault', but to say, 'how can we prevent this from happening again'. That whole culture, it's changing because patient safety is now getting the acknowledgement that it always should have had. When I was beginning, it was just assumed you would know that you never

leave a patient unattended. You never leave a patient sitting up on the side of a bed when they're putting in an epidural without somebody there, never, but you know what, it's still going on. There was a case at County General where somebody fell off the bed and broke their hip. Someone undid the safety belt and then just walked away. There was no one there – how do you explain how that happened?" Carson said.

In a serious tone Carson continued, "Every action that we take, every time we touch a patient, every interaction that we have with the patient, patient safety has to be at the forefront of everything that we do. That is, really, what our ultimate responsibility is to that patient: to make sure that no matter what, no matter what the outcome of the surgery, that that patient is kept safe, that they know that we are going to make sure they are safe in our hands. I think that unless you keep that at the very forefront of everything you do, you are missing everything, everything that there is to know about being a surgeon, or an anaesthetist, or a nurse."

As I listened to Carson I heard how her commitment to care for another person safely was foundational in who she was as an operating room nurse, and how she felt this was an obligation of all care providers. I understood in her story how patient safety was often dependent on an individual or individuals who had a specific responsibility or role; yet she also spoke about critical links that supported safe patient care. Carson spoke about receiving a daily safety reminder at work and I considered how this simple action worked to frame her practice through the everyday, routine aspects of operating room work, and as a starting place for safer patient care and accountability in ensuring this care.

Carson identified learning from an event as a crucial way of opening up others to awareness of factors that may impede or enhance safe patient care; and in her viewing this awareness as a necessary conversation, I learned how it was one without end and one that held many possibilities for improving patient safety. As she spoke about learning from error, I reflected on how she felt it was important to learn not only from her own errors, but to learn from the errors of others as a way of keeping the conversation about patient safety current and transparent. I thought about how learning from the errors of others and her own led her to consider how she could re-shape practice as a safety practitioner through this new knowledge. I understood how turning the knowledge back on

herself to become a better safety practitioner in a self reflexive way further comprised her forward looking story about the many ways patient safety could be achieved.

Carson understood that the overall framework of patient care changed as aspects of patient safety became better understood and incorporated into daily work; yet, she also felt strongly that a focused sense of awareness concerning the implications of her and her colleagues' actions was necessary, in order to guide consistently safe work in the operating room. As I reflected on her story I understood how she appreciated that the patient was susceptible to the variety of consequences that could flow from every thought and action of every care provider. I sensed how strongly her ethical and moral sense of self wove into her professional self as she considered what it meant to respond fully to the fundamental needs of another. I recalled again how as a student nurse in the operating room she felt the effect of her preceptor's words and actions as a negative response to her learning needs and to her as a fellow being. It made me think again about how her experiences in the Middle East led her to understand the patient as a vulnerable being, and I thought how that awareness remained in the "forefront" of her mind as a re-minder to ensure every patient interaction she had was as safe as possible. I understood that Carson perceived herself to be a safety minded operating room nurse. Yet I also thought how, through her layered experiences over time, place and in her continued questioning and learning about patient safety, she saw herself as a safety practitioner who was still evolving. In this process, I acknowledged that she continually wondered how she could best make a difference that mattered to others.

"Carson, during one of our conversations you mentioned you had worked with a surgeon during a difficult case and you both saw each other as something different. Could you tell me more about that?" I asked. "Well, that was the day that things turned around for me with that surgeon, our relationship turned around," Carson replied, nodding her head. "It was quite a bad trauma. The patient was in a vehicle accident and that particular day I could see the surgeon's total focus, and he saw mine. He wanted the best result, the safest for his patient that he could get and that changed everything for me with him. I recognized how he worked for the patient and it was like that whole experience for him changed his mind about me. I realized that even though he would groan and sigh a lot,

and yell about something that wasn't my fault anyway, that he really only wanted the best for his patient. And I could take it because I knew what the real meaning behind that was. But that's not to say I haven't said 'I need to talk to you for a minute. Other people are concerned you are angry with them during the case, and I know you're not. You are a really good surgeon. We can learn a lot from you, so we have to nurture that'. From then on, we were on the same page." Carson snapped her fingers to emphasize her words. "You both recognized the need to understand who and what was around you," I commented.

Carson continued, "Absolutely, take the time to understand who that person really is and the meaning behind what is going on. And I think a lot of us miss that because we are so focused on the moment and not the big picture. Now I really do see the big picture because many times I'm in charge of the OR, and that aspect of it changes everything, you know. For example, if the surgeon cancels a patient's surgery it's his responsibility to go and talk to the patient. If a nurse cancels it then we have to go and talk to the patient. Often times I'll just go and talk to the patient even if the surgeon has cancelled surgery, because I know he's still scrubbed in. But I've had to go and cancel patients and I've felt so bad. I've had tears in my eyes when I talk to them and they're saying, 'It's OK, it's alright, I can come again, don't worry.' Some people, I've really pulled strings for, and I tell them, 'I want you to come back here tomorrow and I will make sure you get your surgery tomorrow!' I'll just do whatever I have to do, because people plan a lot. Surgery's not just about showing up for the day sort of thing." "It's an ordeal to come into the healthcare system, let alone the different steps one takes to come to the OR," I remarked. "Oh yes, and they mentally prepare themselves," Carson said. "And sure enough, you pull a few strings and you can sometimes find a way to get around that bureaucratic red tape and all, and I'm willing to push the envelope." "Do you work around the red tape more than you would like to?" I inquired. Carson thought for a moment and then explained, "Well I would say yes, when I'd be in charge I would have to do that. Telling patients that they're cancelled is really difficult, but I do have the ability to talk to people and that is truly one of the gifts I have." Carson continued, "I have done things to get patients through. I remember telling one person, 'I'm sorry you're not going to get your surgery today. We had an emergency and you want the doctor to be fresh' – you know, all those things, and she just fell apart. Then she told me she has one

kidney and she has a stent in there, and she's been waiting to have the stent removed and I was almost in tears when she was telling me. So I said, 'OK, I'm going to pull some strings and I want you to come in tomorrow,' and she was really hesitant. I said, 'Listen, you will get your surgery tomorrow. I will make sure it happens'. I had her come in and we squeezed her in, because I didn't feel right. I wouldn't have felt right about things - at least I could have tried, you know. I think when you do things like that, physicians also see that you really do have the patient's best interest at heart; you're not some nurse that's just trying to give opposition."

As Carson told her story, I heard how she understood she was not alone in wanting to make a difference that mattered in the life of another. She described how a work relationship between a surgeon and herself changed through a moment of awareness when they each realized their way of being a professional reflected their desire for the safest outcome possible for their patient. I learned how in that moment she respected him not as the surgeon he was, but as a person who understood the world as a much larger place than the immediate context. Through their interaction, she understood how he felt his work in the operating room extended into the reality of life as lived by others, and for others to live their life as best as possible, he wanted the best work conceivable from others in order to support that reality. Bergum (2003) wrote, "Relationships are never smooth, and the harder ones teach us even more about ourselves as well as about others" (p. 125). I reflected on how Carson had come to realize the importance of understanding who each person was in a relationship and what each individual brought to it. As I attended to her stories I appreciated how she had come to understand herself and others in new ways, and I appreciated how she discovered through her relationships what she was capable of as a safety practitioner and human being. As a child she learned the value of family relationships and through those, imagined what her future could be like. As a professional she challenged and pushed the boundaries surrounding patient safety, as she learned through relationships what it meant to respond to the needs of another. In seeing the "big picture" she learned how existing relationships could be nurtured into stronger, more beneficial ones; and she discovered how that renewed relationship could provide new possibilities in ensuring patient safety.

As I listened to Carson describe how emotional she could become when informing a patient their surgery was cancelled, I sensed how she responded to the tension of that encounter through the perspective of the patient. As she imagined the ways it unfolded for patients in the moment, I learned how she acknowledged the vulnerability of the patient as she "pushed the envelope" to ensure surgery and the wellbeing of a person in a system that did not always accommodate the humanness of being in this world. I understood how Carson viewed her workaround of an administrative boundary as a necessary measure that supported patient safety through responding to the exigent needs of others, rather than as a measure that simply disregarded the protocol of surgical booking. I thought how her effort "to pull strings" for patients did not go unnoticed, for her ability to do this required endorsement and support from other like-minded colleagues. It made me think about how she must have felt privileged and satisfied in initiating a unified response with other colleagues, who also understood the reality of life as lived by others. I thought of how she continued to reveal herself as a human being who could make a difference in someone else's life; for in figuring out how to support safe patient care in the operating room, she supported people living well in their everyday life moments, in their life world. Profoundly, I understood that Carson believed in her ability to make a difference for others; it was a life privilege and an honour she respected and deeply felt.

On Being a Patient Safety Practitioner

As Carson and I talked about her work in the operating room, I asked her how she thought she had learned about patient safety. She replied, "How did I learn about patient safety? I don't think anyone actually spoke about it when I was a student, I'm sure they didn't. How did I learn about it – well, it wasn't anything specific. I think I learned through inferred comments, such as 'We always put the safety belt on the patient to remind them the bed is narrow, because you don't want someone to fall off of it', or, 'You always put a safety strap on their arm so their arm doesn't fall off the board when they're having surgery.' But no one ever said, 'OK, the subject of today's lesson is patient safety'. We never had that, ever, and I don't know whether that actually happens today. Nowadays there are companies that do nothing but safety products for the operating room, but I don't know. I don't know how people are taught about

safety now. I think that a lot, actually, are being taught in the rooms on a day to day basis as you are doing it, but I don't think it's being taught as a course, per se. I mean, I never really thought about that part of it. I have not thought about that."

Carson continued, "But one thing that I do remember when I was in nursing school is our instructors and other nurses talking about standards, and why we have standards. For example, why you do the same thing every time and how important it was to chart. And I just remembered, when I worked in Montgomery I was called in to a discovery. A patient had come through for surgery and the patient said that during surgery their arm fell off the board, and they suffered nerve damage and needed surgery to repair the nerve, and they were going to sue the hospital for this. I was called because I was one of the nurses involved. But I had charted that the arms were placed on arm boards with foam cushions and secured. I was asked, 'Is there any doubt in your mind that this wouldn't have been?' I said, 'No, if I wrote down that I had done it, then I did it'. They asked, 'Well, how do you know you did it?' And I replied, 'Well, because I do the same thing every time. If I know the arm's going to be on the arm board, it's going to be on a foam pad and it's going to have the Velcro strap around it, and the arm won't be extended too far'. And it was only because I'd answered like that, I didn't have any problems."

I asked Carson, "What do you see as your role in patient safety?" She considered this for a moment and then spoke deliberately. "I think my role is to keep telling patients that I'm going to look after them and how I'm going do it, and allay all their fears. As well, I have to be a role model for the less experienced staff and be a really strong member of the team. I see myself as a leader, so in that I have to affect all members of the team. I think encouraging others to speak up if they see something that isn't right; or, if it's something that puts that patient at risk, they need to speak up and not be afraid to speak up. All of that, it goes right back to the things we learned when we were students, the surgical conscience, speaking up when you see a break in technique. Don't be afraid. I think all of those things and encouraging those people who you see as being able to become leaders, encouraging them to become a safety leader."

I asked Carson to tell me more about becoming a leader. She replied, "It involves the ability to organize well, to prioritize, to interact with patients, to take

the job seriously. I'm known to have a great sense of humor and I always like to have lots of fun and laughs at work, but I take it very seriously what we do. I take it really seriously, you know what I mean?" As she spoke, I sensed how serious she was through the tone of her voice. "We have a responsibility and you had better be up to the task, because if you're not, man you're out of here. You're gone as far as I'm concerned." Carson elaborated further, "I think if anything it is really important for patients to know that, even though the OR is like the dentist, nobody likes to go, we are there for them alone; without them we don't exist. And when I say to my patient, 'I'm looking after you today,' I do mean that one hundred percent."

"That person coming to the OR has to trust everybody. When you come up to them and say, 'Hi, I'm Carson and I'm going to look after you today', they have to trust you will do that," I said. She agreed and continued, "When I go to work, I mean god, I love what I do, I love it! I could never imagine doing anything else! Having been a patient, I needed to feel that the people looking after me really cared about me, that I was important enough for them to give me their best. And I don't know whether or not everybody always does that, because of the various pressure put on them from above, from below, from beside you. You have such a sense of pressure in the OR and I know that, sometimes, patient safety is overlooked. I see people trying to move patients with not enough people. I hate that. We actually have lifts in all of our rooms, but you still need to have four people to move the patient properly. While the lifts are good sometimes people take them for granted, 'Well, we can move the patient with two people' and I say, 'No we can't!' You know the more I talk the more I think about it, to really put patient safety at the forefront you need more people in the room all the way around. You need to have three nurses in the room, not just two."

"Carson, you mentioned a sense of pressure in the OR. Where do you feel the pressure comes from?" I asked. "That can be as varied as the day," Carson laughed. "Sometimes it's the anaesthetist who's pushing, sometimes it's the surgeon who is pushing you, although I'm old enough and experienced enough to say, 'Hey, listen pal, get in here and help us and that will help speed things along.' I can say that, I have the experience. They know I'm a straight shooter. I don't have any problem speaking up, but I think the younger nurses have trouble dealing with that kind of pressure. I think there is also pressure from

the person on the main desk who is running the OR, making sure that the next patient was sent for, looking at the slate and the surgical times, are we running late and all that. The person we have at the desk right now, she is really good. The person who was there before, her perspective was, 'Well as long as there are no patients in the patient receiving area then we're all good.' So often times she would get someone to bring your patient down to your room long before you were ready for them. Just because they were out of her area she didn't have to think about it. That just used to set me off, because I think that puts more pressure on you. You are more likely to make a mistake then, because you are pressured to move ahead when you're not quite ready. You're still on step number ten and not ready for step eleven, yet. You are trying to do so many things, to be prepared for that patient, and you need to be there for that patient so they don't feel like they're incidental."

As I listened to Carson wonder how she began to know about patient safety, I learned she was perhaps surprised to discover that she could not say clearly, or precisely, how she learned about patient safety, or how other care providers currently learned about patient safety. She spoke about the daily teaching that occurred in the rooms, and I thought how in her interactions with students and colleagues she moved past "inferred comments", and connected her teachings to her own safety experiences as a way of enhancing the learning of others. I thought how through her interactions, Carson's understanding of the link between practice and theory continually evolved to improve her own nursing practice and supported the practice of colleagues. She spoke again of the importance of nursing standards and I understood how as a junior nurse, after having her practice questioned in a discovery, she came to understand and appreciate what it meant to her and her patients to follow the nursing standards to ensure safe care. I acknowledged how through her various experiences over time and place she came to locate working through the standards as a foundational way of learning about patient safety.

As Carson spoke about her role in patient safety I sensed how she felt her nursing work was important, and that it would continue to matter in her drive toward safer care. When she said she saw herself as a "leader", I thought about her long ago experience of her first operating room conference, and how that moment instilled in her a vision of being "just like the nurses" and the leaders that

she had met. She had understood the value of their contributions to operating room nursing, and I reflected on how she held that close as she worked to augment patient safety through her own committee work with operating room organizations and through her own practice. I thought of how she had not only emulated those nurses, but she had become one of those nurses in her own way, for over the years her vision of patient safety and her sense of how she might effect it became her way of nursing that she once imagined. I learned how important it was for Carson to feel that patient safety was always being developed through other nurses, who were also becoming patient safety leaders, and that she could somehow support and mentor them in their unfolding vision of safer patient care.

I felt how her experience as a junior nurse came forward as she spoke about the importance of being a role model for inexperienced staff. She knew that the mentoring and encouragement of the nurses in Montgomery set her on a path of realizing what she could accomplish as a nurse, and I understood how as a strong team member and a leader she also wanted to provide the support and inspiration for newer staff, as they set out to be safety practitioners. I thought of how she viewed the quality and effectiveness of relationships as important to work in the operating room, and I reflected on how she nurtured others to be strong team members through a focus on surgical conscience, a concept that applied equally to all care providers in the operating room. I learned how Carson considered surgical conscience to extend far beyond acceptable aseptic skill or technique. It also encompassed her ethical and moral responsibility to the patient and to her colleagues, by promoting patient safety in every encounter and 'speaking up' when 'something wasn't right'. I thought about Carson encouraging her colleagues "not to be afraid' in voicing concerns and saying she was "experienced enough to speak up'. I understood through her stories how confident she had become in her practice and in her image of herself as a safety leader, and I thought how her confidence and courage to speak up further awakened as each of her experiences layered upon the next one. I reflected on how she encouraged and wanted her colleagues to be confident in their practice as well, by letting their surgical conscience guide them. While surgical conscience on the part of each individual was important, I sensed Carson felt it

was the collective surgical conscience of the team, the integrity and consistency of her colleagues doing the right thing, which led to the safest patient care.

I learned how seriously Carson felt the responsibility of being an operating room nurse, and how in looking after her patients and 'allaying their fears' she wanted her patients to feel the depth of her responsibility toward them. I heard how important it was for her as a patient to feel a similar responsibility from others when they cared for her. Yet Carson also came to know how various work tensions could distract her or a colleague from giving their best to a patient at any given moment. I reflected on how Carson earlier spoke about seeing the 'big picture" of what surrounded her, and how this led her to understand what was required of her and others to perform to the best of their abilities. She spoke about feeling pushed by various individuals in the operating room, and I realized how patient care could be fragmented if care providers focused only on their individual concerns, without acknowledging the needs of the entire team. Carson described feeling tension when a charge nurse would bring patients to the operating room theatre before preparations for the patient's surgery were complete. She revealed that action "used to set her off" and I realized how she felt hindered in her ability to perform as a competent scrub or circulator nurse. I appreciated how she felt angry that she could not give "one hundred percent" to her patient, as she divided her time between completing preparations and caring for the patient. I heard how Carson tried to work within the daily tensions to ensure that her patients remained her primary focus, and I understood how important it was to her that she did not yield to the pressures, for she did not want the patient to become "incidental" in her work. As I reflected on Carson's story I thought about how each individual member of the operating room was an important link in expanding or narrowing the boundaries of patient safety, ensuring the patient remained in the "forefront".

Carson continued emphatically, "But what I can say is that I know that if anybody comes to my OR, I'm going to give them one hundred percent every time and that I'm there for them. And I think as a patient, knowing you've got somebody in your corner is so important, somebody who you don't know, somebody who has no connection to you at all, and they're still in your corner! They are still going to look after you and make sure that you're safe!" Carson shared the following story, "We had a new nurse assigned to work in a room with

two nurses who were older and I was just helping out. Those two nurses, they were very good, they were on the ball. I would want them with me anytime. The new nurse was scrubbed and they were prompting her and saying, 'You should put this up on your instrument tray, and this and that', and she was not really focused on being prepared. She didn't even have anything on the instrument tray. And the surgeon for that case, man alive, he would eat you if you were not ready. So, they were telling the new nurse what to have ready so she would be prepared for the surgery. And she said to them, "If you think you can do this better than I can, then you go right ahead." And she walked out, she walked out. She didn't even un-scrub. She just walked away as we walked the patient into the room and didn't come back. And we were left scrambling. I couldn't believe it, talk about abandoning your patient! If I would have been the manager that nurse would have had her license to practice reviewed." In a passionate voice she continued, "I see it really as a privilege to work there. It's an environment that, well, you can't work there just because you have a desire, 'Oh, I'd like to work in the OR'. I think many people see the OR as easy work, which tells me right away they don't have a clue. It is physically demanding. It is mentally taxing, but I wouldn't want to work anywhere else! I see people who are working in our OR that, well, the OR is not their calling," Carson laughed good-naturedly, "There's nothing really I can do about it. They're not dangerous, but it's like every day is their first day. And some of those people have been there longer than I have," she laughed.

"Somewhere in the work day as we're looking after patients, the reason we are in the OR, we are also looking after our colleagues. We are somehow looking after each other," I offered. Carson replied with conviction in her voice, "Yes, we are. And perhaps that's the environment of the OR, because it's so much a team environment and looking out for all members of the team, even if it's just sitting around the coffee table talking, it's beneficial, healthy. There have been times when newer staff had come to me to talk about a surgeon, or they were having some trouble or problem, that sort of thing. My office door is always open, and we do have a mentorship program where newer nurses are teamed up with an older member of the staff, so that they have sort of a go to person. But even though they might not have been on my team, and there were other people they could have talked to, they felt comfortable to come and talk to me. And I

really liked that, because I'm lucky in that one of my gifts is that I can talk to anybody. I can go and talk to a surgeon about their behaviour, or go and talk to a staff member, and they feel safe talking to me. They know they can trust me and I think that is really wonderful. I can get really emotional when I talk about my OR family because they mean a lot to me. I have great respect for the people I work with because I know that they've got my back, and they know that I've got theirs, anytime. And sometimes things do hang on a thread, it really is life and death, and those are the times when you know you can count on somebody to back you. You can count on them. You know, it really is quite a miraculous, delicate balance. And it's a dance; it's a dance in there. It's like a circus act – you're spinning, you're throwing up plates, you're juggling bowls, you're doing all these things all at once, and you're a lion tamer too, oh man! Still, I would not trade it for anything, oh my god no!"

I learned how important it was for Carson to feel that she could give her best to every patient she cared for, and I understood how she had learned through her many patient encounters what it meant to be present for the patient. She said it was "so important' for the patient to know that somebody who had no connection to them was "in their corner'; and I felt a thread stretch forward from her experiences in the Middle East. For I believe, that was where Carson had come to know what it really meant to be present for the patient; overall as someone whose presence in this world mattered to her. I reflected on how she carried that knowing with her, and how it underlay her approach to safer patient care through her way of living.

As she told me her story about a nurse walking out of the operating room at a critical moment, I thought how that experience must have stood so far apart from what Carson had come to know and expect, as a standard of care in her own patient care moments. I sensed how a familiar tension surfaced as she considered the privilege of being there for the patient and the operating room team. I learned how she felt patient safety had been set aside when the nurse "abandoned" her patient, and I understood how Carson felt the nurse had failed to acknowledge the patient as a person in a time of need. She earlier described needing to feel that she mattered to her care providers when she was a patient and that she was their centre of focus. I appreciated how in the moment the nurse walked out of the operating room Carson felt the vulnerability of the

abandoned patient as her own. She felt the patient become "incidental" and she again considered what it meant to be a patient in a particular moment.

As she spoke of her work colleagues as her "OR family', I sensed how Carson held them close and validated who they were to her and she to them. I learned of her satisfaction in supporting newer staff and knowing that colleagues felt "safe" conversing with her. I thought about how important it was for Carson to support the work of others as a way of enabling their practice as safety practitioners, for I sensed that her own experiences of support and non-support as a junior nurse stayed with her and reminded her what it meant to have someone respond to her. I learned how she understood her colleagues not only as workmates, but also as individuals who felt and were vulnerable to the complexities of life as it unfolded both professionally and personally. Carson spoke of offering colleagues unconditional support even though she was not their "go to' person, and I reflected on an earlier time in her life when her Uncle Ray offered his support, completely, and how she felt valued for the person she was. I understood how Carson responded to her colleagues through her relationships with them by validating, accepting them for the persons they were, and who they were still becoming.

I thought deeply about Carson's narratives and realized how her stories of patient safety, of her making a difference in the life of another, were composed from multiple contexts on her professional and personal landscape. In reflecting on her stories, I sensed how through her awareness and sensitivity to what surrounded her she came to know what it meant to live in a world of others, as well as what it meant for someone to make a profound difference in the life of another. Carson described her work as a miraculously balanced dance and I thought how her experiences across time, places, and relationships composed her 'delicate dance' and that it moved her continually to wonder how as a safety minded operating room nurse she could make a "real difference" that mattered to others. When Carson said she could never imagine "not being a nurse" I believed her, because I could not imagine it either. I now turn to *Chapter Five, Morgan's Stories: Early Landscapes*, which is comprised of my second participant's life and phenomenon narrative accounts.

CHAPTER FIVE

Morgan's Stories: Early Landscapes

Riding the train following my visit with Morgan, the rhythmic sway gently lulled me as I reflected upon our conversations. The flow of passengers joining and leaving the train was continuous and slowly mesmerizing. We followed the river as we travelled deeper into the city, and as I reminisced about taking this same route many years ago, I recalled a less pronounced urban sprawl then. I thought about the rural landscape that Morgan described from her youth, and of the intrinsic bond that she felt with her surrounding environment and all others in it. I gazed out the train window at the view passing by, and wondered when modern development would overtake the few remaining parcels of agricultural land. It saddened me to see the land, and work of the land, that is so important to our sustenance as humans visibly pushed further out of sight. I thought if one were to blink, they would surely miss it. Morgan's words repeated in my head as the train picked up speed and the expansive vista blurred before my eyes.

Morgan described for me how she was raised in a rural environment and how she came to enter the nursing profession, "I grew up on a small hobby farm in Tyler, very grounded from a cycle of life, earth, sustainability, which I know now, gives me that profound environmental focus, and nursing seemed the natural ticket to many things. My mother was a nurse, and is a nurse, almost 96 years of age, even though she's no longer practicing, she is the nurse she always was. I grew up in a household very focused on caring for everything, the environment, the animals, other people, the neighbours, and the person that walked down the street, and thought, 'OK, well I'll head into nursing', because I could leave the farm and come into a three year program, into a residence which would give me that separation from my family, which as an 18 year old I craved."

As I thought about Morgan's story, I sensed how the farm as a place to live meant a great deal to her, for it was not simply a farm that she grew up on, it was where her parents also lived their lives and learned their life lessons. It was there she learned what her parents knew about living in a relational world that surrounded them all, and it was a place where Morgan learned her life lessons as she began to live her life independently. Morgan held a special relationship between herself and her landscape, the domain of her living, and her words revealed the significance of the lived relations she held with others in her

grounded environment. The words of Bachelard (1964) gave me pause for reflection as he wrote that our home places have to do with "the sites of our intimate lives; the topography of our intimate being" (p. xxxii, p. 8). It was in this sense that I understood the term landscape as capturing the environment of where and how Morgan's relations were lived in her personal and professional world. This moved me away from a traditional understanding of landscape as an artistic representation of natural scenery or background, perhaps, suggesting a sense of disconnection or separateness from one's surroundings, and I began to appreciate how intensely connected Morgan was with the sites of her intimate life.

*Growing up in a rural home as a young person, the rhythm of the changing seasons, the influence of her family and others upon the landscape, and the temporality of existence were ways in which Morgan came to know herself, her life, and others. I considered how interpreting and responding to the changes in her relationship with her surrounding environment gave shape to Morgan's way of seeing from the outside in, and from deeply within herself; then seeing inside out, a way of being that she learned through her parents experiences. Morgan reflected on her own awareness and daily reminders of her mother as a nurse and her father as a farmer, "*My father was a farmer but worked also outside the farm, and in the late '50s and 60's a lot of the feed companies as business conglomerates were taking over and sucking up the small farms. So, in order to help support the family, my mother went back to work, I guess, when I was about five or six years old. She worked primarily night shift in the Tyler General Hospital and was one of the first nurses to look at intensive care nursing. She was always doing some course, many times on the weekends; I would see the books. Then she went on in Tyler to be very active with the intensive care unit, setting it up as far as realizing that patients needed a different level of care when they came into hospital, whether they had surgery, a motor vehicle accident or whatever." Morgan laughed as she fondly recalled, "She would come home in the morning to get my sister and myself off to school, in her uniform, white stockings, white shoes, starched, pressed uniform. There always was a nurses cap in some degree of starching and pressing rolled up in the refrigerator, that was a given. But that was just who she was." *Morgan identified a societal change during the time of her youth, which influenced the*

status of the family farm and necessitated a return to outside work for her mother. However, Morgan did not describe these events as a tension in her life, and her story revealed how a probable tension was viewed in a positive manner that was supported by all those affected, primarily Morgan's family. Her mother's return to work benefitted society, for in the struggle of supporting a familial way of life laid a professional way of supporting community members through the work of nursing. Morgan was proud of her mother's successful professional and personal accomplishments and I sensed her mother's return to work was a positive influence on Morgan's life. As Morgan spoke, I appreciated this story of her mother to be a reflection of her own nursing story. As a professional role model, her mother demonstrated a pioneer spirit in her work and determination to provide the best available patient care at the time. She pushed the boundaries of being a married mother raising a young family as a practising nurse, who worked primarily night shift and spent many weekends furthering her own education. She taught Morgan that caring for others extended past the family home and the immediate environment, and that being a nurse meant taking on responsibilities to develop one's character and to ensure that hospital patients received knowledgeable care. Morgan learned that life tensions and uncertainties were not elements to be feared or denied; rather they needed to be accepted and worked at in a way that would be beneficial in one's life and the life of others.

Morgan learned about being a person and a nurse through observing her mother in specific situations. As we talked, Morgan described a few particular experiences that have stayed with her over the years, "I also saw her relationships with people that she met when we were out shopping," Morgan continued. "One that I remember very clearly was a lady who was buying something, and the lady was having trouble communicating to the clerk what she wanted. She obviously had aphasia, but my mother interpreted what the lady wanted, and said exactly what the lady wanted; and I knew then that she had a gift to relate to other people. Even though she wasn't in the hospital, she was doing that all day. The same thing with the farmers around us - if they had a problem with a family member, if the wife was sick, if the kids were sick, when the boy down the street got caught up in the auger running into the silo - the first thing was someone coming down the road to get my mother. If an animal was sick and they couldn't get the vet, the call came to my dad 'where's my mother?'

That's who she was. There wasn't a separation between my mother and the nurse. My mother was the nurse and that was just part of my upbringing. I saw it and lived it, and was part of it." *As a child, Morgan recognized how her mother was comfortable as an outsider willing to step in to attempt to resolve a situation. Rather than ignore an opening for the opportunity to respond to another, her mother willingly lived the role of a helper to others. Morgan saw how being a person and a nurse became connected in her mother's response to others, be it a stranger in a store or a troubled neighbour. As the local community reached out to her mother to act as a healer, for example as veterinarian or physician, she allowed herself to be pulled along the relational threads she had established with neighbours. Morgan recognized that her mother's gift of relating to other people, or animals in some instances, lie in establishing a relational connection at some level. In that moment, Morgan learned how the power of making a connection with another through personal and professional knowledge could be a rich personal reward, one that supported living life relationally. As Morgan spoke about her mother's experiences, I felt they were also Morgan's experiences. Through the combined experiences, she learned what could be accomplished as an individual through relationships; and perhaps more importantly, that there were many ways she could position herself as a respected person in life.*

In our conversations, I further came to appreciate how Morgan valued the development and establishment of relationships in her life. "You grew up in an environment of relationships with people. That's how you were raised. Do you think that was advantageous in your nurses training?" I inquired. Morgan replied, "I don't know if it was so much an advantage, as it maybe gave me a bit of a different way of relating with people. When I think back to whom my father was as an individual, he was also a very gifted man. One thing I remember that he taught me very, very early on, was to take the time to know the nature of the beast. So if you step back and you take a few minutes to understand, and that time he was referring to animals, but I realize he was also referring to the humans that he related with. If you take the time to really step back and assess them and get to know them, what are they like, what's their personality like, get a read on them rather than making assumptions, you have a lot better time working with them; getting them to do what you need them to do, whatever the case may be. That certainly was how I related to surgeons and my colleagues. Often times

the more difficult the surgeon was, the easier time I had with them. I actually would plan my day so that the day would go well for everybody; just by taking the time to understand what is it that sets them off, what is it that keeps them calm, how to work around them and with them to get the job done with the least amount of distress for everybody. Often, people come into situations without taking a few minutes to assess the situation. So a couple of hours later when they're having a meltdown about something that seems relatively insignificant, it's all significant. It's all part of the evolution of what was going on. And that goes right back to my dad." *Taking time to step back and understand the people she worked with in her workplace was a natural and comfortable approach for Morgan, for this was an approach taught and used by her father throughout his life and her life. As I thought about how Morgan learned to relate with others from her father, I sensed that she saw his ability to understand others as part of his gifted nature as a person. Yet I also sensed how patience and focused thinking were gifts that he gave to Morgan as an approach to living in a world with others. For her father taught her that when she understood an individual, he or she would reveal themselves to her through their personality, values, expectations and needs; and she in turn could reveal who she was as a person to them so they could appreciate who she was and what she brought to the relationship. From this understanding of each other, Morgan could develop a new relationship into a working relationship based on mutual trust and respect for each other. In viewing work experiences through the sites of her intimate life, I understood Morgan's experiences as those lived and learned in relation to the other. I learned how, as she dwelled in her landscape, so too did her landscape dwell in her. Her home landscape is where Morgan first experienced and understood relationships with others and her world. It was through understanding, appreciating, and dwelling in those relationships that she recognized an inherent ability to affect a profound difference for others; and she has carried this experience forward to all the sites of her intimate life.*

It was also in learning how to establish and work in relationships that her father and mother taught Morgan a deep sense of respect for others, and the situation they may find themselves in. Morgan and I talked about our early nursing days and I reflected, "My experience was that our focus was not on engaging with the patient. We were there 'to do', not to really engage with the

patient." Morgan replied, recalling her early experiences, "I think it was assumed that they gave up all their rights to participate in care and also that they didn't have any knowledge about what their care should be, so everything was checked at the door, their dignity, their brains, their opinion, their voice. They were coming into an environment where they would be 'done to, done for, but not done with'. That really was focusing on the idea that physicians are all mighty and all knowing. Nurses do what physicians say because physicians know what the nurse needs to do for their patient, and the patients just submit themselves to whatever the nurse is doing because the doctor ordered it. And that concept I struggled with from the very, very beginning. What was interesting, the intern program at that time, it also was in a learning process the same way that I was as a student nurse, and many of them became my colleagues, became my supports, became my, well, how I would work through them in order to achieve something for the patient. And even today, some 30 years later, those physicians are still my colleagues." *Morgan identified a tension early in her nursing career that has been a struggle for her. In learning to live a relational life with others, she was taught to acknowledge and respect persons as unique beings in an environment of many. This way of living contrasted significantly with her experience as a student nurse and left her feeling that patients were not recognized as unique persons with individual lives in a moment of need. Morgan also recognized a tension in other's recognition of whose knowledge was considered valid, the physician's or the nurse's knowledge. In addressing this, Morgan had positioned herself as a nurse willing to push boundaries as she sought alternate ways of achieving something her patients required, ways that were not always within the domain of nursing. In taking time to reflect upon and assess the tensions she felt, Morgan realized she could forge and build upon relationships with medical interns, who were also in a tension-filled learning process at the same time that Morgan was. The support they offered each other then evolved over time into strong relationships based on a mutual understanding of each other, and an appreciation of what their relationship could achieve for patient care. Morgan's willingness to position herself on the periphery, in order to address a particular situation, was learned early in life, for it was her parents that encouraged her and showed her how to move forward in different ways to achieve what was required. The person that entered nursing was one whose way*

of living was shaped by her parents, and she realized, as she became a nurse, this was the same person she wanted to remain. In doing so, Morgan accepted the tensions she felt and began to understand how to live with them by reaching back to her early life teachings of being prepared to position herself in a way to accomplish what was required of her in response to a particular situation.

Coming to Operating Room Nursing

"Morgan, after your nurses training, did you work in the OR right away or did you work elsewhere?" I inquired. Morgan laughed and explained, "I basically got drawn into it, pulled into it maybe. I was about 6 months into working in the critical care float pool when I got a message that I was to meet with the Director of Nursing. My first thought was, "Oh my, gosh, what have I done? What supervisor have I infuriated now?' And when I met with the Director of Nursing the reason was, a couple of surgeons in the OR had gone to the supervisor and they wanted me back in the OR. The department needed nurses and with my time that I was in the OR as a student, the surgeons recognized or knew my name, went to the OR supervisor, who went to the Director. So I was offered the opportunity of a position in the OR. I said I wasn't really sure if that's where I wanted to stay but that certainly, that was OK. I'll see what it's like. And that was how I started my time in the OR; into the OR I went and very quickly found my niche and never left."

Morgan continued, "I look back at that time when I came into the OR, struggling to get up to speed as fast as I could to be as best as I could. I realized there was a huge phenomenal amount of information I needed to know, in order to practice at the level I wanted to. And some of the nurses in the OR were not very endearing to this young, active, bright - supposedly - nurse, who was now being asked for by the surgeons to scrub for them. I was often dissected, spread out on the table for everyone to look at. I was set up to fail. I was told pieces of information that the surgeon did, when in fact they never did that. Case carts were inaccurate for me. Equipment wasn't set up sometimes the way I was told it was. I realized I had to find allies if I was going to survive in that environment and a number of the surgeons became those allies. One is a physician who was a vascular-thoracic surgeon. I'd be scrubbed with him on a thoracotomy, ruptured aneurysm, and he would work me through as a scrub nurse. 'Morgan, you need to get this ready and I want you to come over here and see what I'm going to do

with it…Morgan I need that retractor and I need the blade down like that because that's the side of the chest that I'm working on.' It wasn't the nurses in the room that were doing that for me, it was the surgeons, the anaesthesiologist, that were doing that for me. One of the ob-gyn surgeons came out of his residency program the same time I started in the OR, and very difficult personality, extremely bright gifted surgeon. There's that get to know the nature of the beast. I figured him out very quickly and our relationship carries on yet today. He's a physician that I email if I'm involved with another physician problem or there's something with case management; whatever it may be. So that relationship from 30 years ago still carries on today, but there's that teaching and learning because as he taught me, I taught him so that his cases went smoothly.*" At first, Morgan was uncertain if she would enjoy the work environment of the operating room; yet she viewed this as an opportunity to diversify her nursing experience and follow a path that lay open to her. Morgan took hold of and followed the pull of a thread held out to her, and she discovered that she liked where it led her. Although her potential to be an operating room nurse was recognized primarily by some surgeons in the department, she also realized that she had to work hard in order to establish her position as a competent and knowledgeable nurse, not only amongst the surgeons but also among the nursing members of the department. From an early age, Morgan learned the necessity and rewards of putting personal effort into learning one's job in order to benefit others, and this became her personal expectation of how to succeed in her role as an operating room nurse. Morgan studied at home in the evenings, reviewing surgeon's preference cards and procedures in order to prepare herself for the next workday. She also spent many hours in a surgeon's office after a workday, reading medical textbooks, asking endless questions of the surgeons, and engaging in learning opportunities with the surgeons whenever possible. Morgan had to understand the procedures and underlying medical conditions so she could understand how to become an operating room nurse who supported patient care in a way she thought would be best for each patient. However, in the excitement of learning a new nursing role, tensions surfaced that threatened to undermine her position as a valued member of the operating room, locating her as an outsider in the department. The idea of working in the operating room did not originate from the nursing staff, the suggestion came from surgeons. And this suggestion, once*

accepted, positioned Morgan as an outsider amongst many nurses in the operating room.

In recognizing and working within these tensions, Morgan positioned herself on a boundary between being an outsider and an insider. This dual role was a familiar balance to Morgan, for her parents lived similar roles long ago when they struggled with attending to the needs of raising a young family within the expectations of a rapidly developing society. Morgan recognized that she had to establish strong relationships with individuals in order to function as a competent nurse. She became comfortable in creating these relationships with many surgeons in the department, for the receptivity of nurses to form these relationships was not always apparent. In testing expectations of who she should and could form relationships with, Morgan revealed herself as a person willing to rise to a challenge and work through it. How Morgan worked through these tensions was also familiar to her from long ago, for she took the time to understand the individuals around her and understand what was required to develop a relationship that benefitted the work of the department. The relationships she created with surgeons in her early days carried on over decades, based on mutual respect for what could be offered in the support of each other and in the delivery of safe patient care.

Morgan continued to describe her positioning in the OR, “I was 21, just about turning 22, and I was encouraged to apply for an assistant head nurse position. I applied and was successful, so now I was one of the service leaders in the surgical services at the Western Civic OR. Western Civic was one of the first hospitals to recognize that there needs to be consistent expertise in order to have a continuity of excellence with very diverse practice. I look back and I think, ‘Oh my god almighty, how much I didn’t know what I didn’t know.’ That whole unknown vortex that comes with youth, with the ability to take on challenges without fretting about the challenge; you just embrace it because it’s there and you just go for it. I think back now when I’ve a chance to do some reflection, there were times when I was on nights in charge of the OR at the Western Civic, which at that time was already recognized as a trauma tertiary care center, with another nurse. Now I look at us as TweedleDee and TweedleDum. We were the night team. We were the night team and we would get head injuries, gunshot wounds,

motor vehicle accidents, fractured femurs, emergency stat sections, and we were 22 and 23."

"Did I do it well? As far as I know, no patient was compromised. Did I learn from it? Oh my, yes. Every single minute of every single day was a learning process and I took that into the opportunity to now lead a surgical service, with nurses that sometimes had been there twenty some odd years. A couple of the nurses were extremely caustic to me. They were always, and continued to be till the day that they left, challenged by my decisions, challenged my organization, challenged my knowledge; and I just had to appreciate that no matter what I did or how I did it , it never was going to be right. But did the patient get cared for with the standard of care that was up to my level? Were the surgeons able to operate without fear of errors? Yes," Morgan concluded emphatically. *Morgan spoke proudly about her work as an operating room nurse and she felt distinguished to be recommended as a service leader. Through the consistency of her work approach and active knowledge development, she was recognized as possessing abilities to develop and support excellence of care in the operating room, and to respond to situational changes she was presented with. Morgan reinforced the importance of freely passing on knowledge to, and of teaching, others as a way to shape and strengthen professional identity and surgical conscience through relationships, a broad concept that encompasses knowledge, self-awareness, and the confidence and fortitude to act ethically and morally on behalf of the patient. As she spoke about her work in the role of a practice leader, Morgan also revealed herself as a moral, ethical and compassionate leader and teacher, with a strong patient safety conviction. Despite her recognition by others as a knowledgeable nurse, relational tensions continued to surface in her daily work, some of which she had to accept as unresolved. In accepting the difference, she used the unease and tautness of those situations to reveal further her expectations of patient care and teamwork in her leadership role; expectations that she was confident supported the operating room team in their ability to deliver safe patient care. Morgan's status as a service leader may have further reinforced her position as an insider-outsider within the department, for in this position staff nurses would view her as removed from the immediate context of patient care and, instead, see her directing and enabling how patient care should take shape from a distance. Yet I sensed that Morgan found herself closer*

to patients and colleagues in her role of service leader, for this role provided her the opportunity to address and manage any potential issues in patient care, to respond to the needs of staff in their daily work environment, and to actively push for and support consistent, high quality patient care. This role provided another avenue for Morgan to expand her relationships, not just within the operating room department but within the hospital, an element she found essential in supporting safe patient care.

I wondered why Morgan chose to stay in the operating room when other colleagues treated her with disrespect. I said to Morgan, "When you first went into the OR, you didn't have a very welcome reception." "No," she replied emphatically. "You said you had to basically fight for your life there," I offered. "Yeah," she agreed. "So why didn't you run away, saying 'I'm not working here'. What kept you in the OR?" I asked Morgan. She thought for a moment, then explained, "It was the challenge. It was the challenge to get beyond what was coming at me. It was an environment where I could have control over the care of my patient, which I wasn't getting from the ICU. I would come back after not being in the unit for a couple of days to another night shift, and everything that I'd organized for the patient, the kardex, etc, was still the same. Nobody updated the patient; nobody changed their activity or whatever was going on with them. I found that really, really, infuriating. So when I got into the OR I realized I could see the cause and effect. I could see the connection and have that connection with the patient. I could be in control of the patient's care, and then I could be in control of the patient's handover to the next unit. I got a sense of the ability to make a difference in a very profound way, from the ability to make a difference with how things were organized, how things were prepared, how the patient was cared for, how the team functioned. And that was the challenge that was exciting to me, in spite of all the other things that were part of that building. And I just dug my heels in. It was difficult when I look back now, what I went through in order to survive, how I felt, the other considerations with coming home from work and being really so exhausted I couldn't do anything else. But there was that grounding with the earth again, because I would come home and I would dig up a garden," her voice tapered.

"And take all your frustrations out on the earth," I offered. And in my mind, I pictured Morgan seeking solace in the familiarity of the ground around her.

Morgan replied, “Absolutely. I’d be out there banging with a hoe, because we bought an older home with no yard work done at all. The garden had been dug, maybe, fifty years before, so I’d be out there with a pickaxe, banging at the rocks in the back yard. My husband likes to cook, so he’d be in the house making supper, looking out the window. I’d be literally banging with a pickaxe and that was how I worked it out. I’m very connected with the earth, with the garden. This morning for an hour I’m standing watching birds feed, and they’re mesmerizing. I’m outside to get the feed organized and the water’s frozen; that sort of stuff. And then I’ll often just stare and look at them, but in that process I’m moving through a lot of other stuff, very internal, but yet I’m processing in that internal phase. I look back now and I realize that was exactly how I survived, muttering away the whole time. And that was the challenge. ‘They’re not going to get the best of me. They weren’t going to get me at the level where I was going to leave.’ But it was really cutting through that concrete wall of ‘how they did what they did and why they did it, and who are you to ask?’ Who are you to question why we do it this way?’ There was that constant rebuttal to a question.” I replied, “Yes, a cohesive group and a newcomer coming in, that’s very, very difficult.” Morgan continued, “Oh yeah, and what I learned from that experience, I recognize those relationships, for lack of a better word, ‘cliques’ that have got themselves in this nice tight knot. It’s a real challenge to unravel some of the threads and it does, it takes time to get the threads unwoven to the point that you can start getting the knot loosened to then get it straightened out a bit; so you can let some other threads into it. It sometimes takes years.”

“There are a lot of different relationships in the OR at different levels,” I suggested. Morgan agreed. “Oh my yes, a lot of them are hidden behind the doorways,” she said thoughtfully. “How do you foster good working relationships with all the different personalities that you have - the physicians, the nurses, the residents, the medical students?” I asked. Morgan described, “At any level, at any time, no matter whom we are, what we’re doing, and what we hope to do, we need to have a connection with each other. Often times the connection is just the simple addressing of each other by name and taking a minute to connect, get an understanding of who we are that day - what are we bringing to the relationship, the family dynamics, the physical personal ailments?; to take a few minutes to understand ‘who is the team?, who are we?, what are our strengths?, what are

our weaknesses?, and what do we need to prepare for? In other words, what's our day presenting like from the challenges and the preparation? And then start your day knowing who your team is. What do we need to do to support one other with what is being asked of us today? That goes right back to that relationship connection, to really understand the team. It doesn't have to be a personal-private relationship. Many of our relationships and connections with individuals we work with are on a professional level. We're together in the theatre because we work together, not because we necessarily even like one another. But because we're in the work environment and we need to spend the time together to accomplish the work for the day, then we need to have a relationship based on respect for what each of us brings to that day, and check the other things at the door - they're not relevant, not necessary to what has to happen."

Morgan's early work experiences pushed her to think deeply about who she was as an individual and a nurse, as a way of envisioning a better and safer way of patient care. She realized how her presence and her vision of safe patient care, the revelation of who she was as a nurse and a person, affected the shape of the department through the dynamics, the inner workings, the relationships, and the way in which work was accomplished (Wiegmann, ElBardissi, Dearani, Daly, & Sundt, 2007). Morgan found a familiar way to respond to the challenges and tensions of working in the operating room environment, a response reflective of her past. She learned how to control her environment through understanding her surroundings, understanding what was required to support an immediate situation, and learning how to manage unexpected changes in life. She learned how she could make a difference in the life of others, and this was an exciting challenge for her in her nursing work. Morgan learned that existing relationships grew into stronger and more beneficial ones through widening them, by understanding and responding to the needs of unfolding situations, not by closing oneself from new possibilities. At times, this required her to move to the periphery of her work landscape to gain a different perspective in understanding what was required of her. At other times, Morgan brought her work tensions home, to be chipped away and reduced to a manageable state while she worked at excavating her garden. This strenuous, yet comforting, work reminded her of the connectedness between environment and people, of her connectedness to her environment, and it provided a familiar sensation of encouragement and support.

Morgan worked the relationship she had with her landscape in order to find her direction, a direction that came to her from being instructed and nurtured in her ways of living, working in relation with others, and recognizing the needs of those surrounding her.

As we conversed about team relationships and team support, Morgan described a particularly poignant experience in which a mother died following the caesarean birth of her child. Morgan reflected on the deep connection she made with the family as she supported them through a devastating situation, and in these reflections, she spoke about the significance and responsibility of supporting her colleagues. Morgan quietly shared, "Also in that part of it was the surgeon and anaesthesiologist. I called the surgeon afterwards who was in his office and had a long talk with him on the phone. A few days later, we again talked for a long time on the phone. After this settled down, I went down the hall to where the anaesthesiologist was, and he looked at me and I said, 'Come here'. We went into the office and shut the door and he cried in my arms. It had affected him that bad. Some months later when his daughter died and I went to the funeral, he was looking around. He looked for me, he came right to me, and again he started to sob in my arms. He knew that I would trust who he was, and not how he was responding to me, so I had established that relationship. But what I learned from that is how vulnerable our physicians are, and how historically we've treated them as non-feeling, non-caring, non-affected. They are affected! They have an image. They have an image, a presence. They're afraid of being criticized, of being seen as less than strong and capable if they show their vulnerability, but they hurt just like we do. And I think that's often forgotten in our teams, that relationship-personal connection with the person, rather than 'the surgeon' or 'the nurse', and we really have to focus on getting that into our teamwork." *Morgan's compassion and capacity in caring for others gently, unashamedly, and responsively within an unfolding situation was her innate response to humanity in all its complexity, and I marveled at how quietly she revealed this. In order to support the work of others in healthcare, Morgan supported her colleagues in their work and their personal lives, through understanding who they were as individuals and knowing the meaning and significance that existed between each other. As she responded to the needs of a relationship, she validated and appreciated her team members as sensitive*

beings within that relationship and within that life. Morgan understood and reached out to her colleagues, as she would to any other person, as a human affected by the joys and tragedies of existence. This was a response respectfully taught and eagerly learned long ago; and it became a response foundational for Morgan as a way to continue to understand and live her life through the power of relational threads, as she connected deeply with the sites of her intimate life.

Doreen

As Morgan and I talked about work in the operating room, she shared the following story with me. "There was one incident that sticks in my mind because of how it unfolded during the years," Morgan said, and she began to describe it. "I was involved with a lady who had a ventral suspension; her uterine ligaments had been tucked up, pelvic surgery. We were moving her from the OR table over to the stretcher and I was the circulating nurse. As a good circulating nurse, I'm extremely focused on patients. I have to know them nose to toes; I cannot release them from my care until I'm assured that they are cared for. And the physicians I worked with knew that. So I'm doing my thing with the patient, I just looked at one of her legs, and one of her legs looked a bit mottled, looked different. I couldn't tell what it was but something was a bit different. I mentioned it, 'Did you see anything different with the leg?' 'No' replied the others, and away she goes to the recovery room (PACU). And in the recovery room I looked again. I just had a feeling something's a bit different here. It didn't feel colder, but something didn't look right. And I spoke with the surgeon who said, 'There's nothing wrong with her leg'. He went home and we got going with the next case, same anaesthetist next case."

Morgan continued, "And during the course of the case I went down to PACU and looked again, something's wrong with this leg. I came back to the anaesthetist. By then he's taken the next patient down, and his name is Philip Reynolds. 'Dr Reynolds, please check this lady's leg. There's something wrong with it'. 'Oh Morgan, you said that, you know'. He looked and said, 'I don't see anything wrong with it'. I said, 'Something's not right, look at it, it's mottled, it feels colder', this bantering going on back and forth. I remember him at the time and he said, 'You're not going to stop at this, are you?' I said 'No, there's something wrong here.' So he called the surgeon who refused to come back, and Philip Reynolds who hadn't been in the department that long, went out on a limb and

called the vascular surgeon. The vascular surgeon came in, he didn't see too much, but he said, 'Oh let's stick a Doppler on it.' She had impaired circulation. So through the course of the next few hours another gynecology surgeon came in, opened her up, and when they did the uterine suspension the surgeon had actually tied off the internal iliac artery, so she had that released. I couldn't tell what was wrong, but knew something wasn't right. I had to present my case to get it listened to and respected. But the individual that could have respected it belittled it."

As Morgan reflected, she continued to tell me, "So that was back in the late '70's, and now it's in the early 90's, and I'm at a big trade show in another city with my husband, and the women could go off and have an afternoon lunch while the men did whatever. I'm at this luncheon and we're meeting each other, and this lady and I start talking, 'What do you do?' 'Oh, well I'm a nurse at Western Civic'. 'Oh, some nurse in the OR at the Western saved my leg a number of years ago,' she said. 'Oh? What happened?' I asked. She explained her story. I said, 'I'm the nurse.' She knew the surgeon, the date, the vascular surgeon that came in, she could explain something had been tied off, 'It wasn't getting blood to my leg. If the nurse hadn't said something I would have probably lost my leg'. I met her. I met Doreen. Just thinking about it does give me a little bit of a …well, there was no evidence that there was something wrong with that leg."

I did not interrupt Morgan as she continued to speak. In that moment, I too met Doreen. I felt her presence in me, and I felt the substance of all of my 'Doreens' come forth from my own work experience. Morgan quietly moved in her chair and my time shifted to the present. "So Philip Reynolds, he went off to the States, phenomenal gifted anaesthesiologist, practicing out of the States. A couple of years ago I get a phone call one evening from one of the other docs that I know very well, and it was really quite bizarre. I was in the garden working. My husband calls and says, "Morgan, Roger's on the phone'. I said, 'Philip's in town!' because they had kept in friendship over the years; and sure enough when I went to the phone I said, 'Has Philip come?' He said, "Morgan how do you know?' I said I just felt I knew. He said, 'Well come in for dinner'. I said, 'I can't, I'm in my garden but I'll be there as soon as I can.' Well sure enough, Philip remembered that story and he started to talk about it, because by now, we were some years older and he said, 'You know, I knew you were right but I didn't know

why and I knew that you knew something I didn't know.' And I said 'Well if you hadn't respected what I was saying, that lady would have lost her leg.' He said, 'I know'. So that, I think when I look back on why I do what I do right now without a lot of thought at the time about what I do, the repercussions, the discipline, the lack of job promotion, whatever the case may be, I have to do it. I just have to. I can't, not do some of the things I do. I can't hesitate, which again I know probably drives a lot of the managers quite around the bend, but so be it!"

As she told her story to me, I felt the strong passion and drive that Morgan held for patient safety. Morgan described herself as being very particular to patient details and she said the physicians she worked alongside knew her as a focused nurse. She was not appeased when the surgeon said there was nothing wrong with the patient's leg; and I sensed how her concern kept pulling her to think about, reassess, and monitor this patient who was no longer in her immediate care. I thought about the primary surgeon dismissing Morgan's observations while other colleagues acknowledged her concerns, despite any obvious sign to confirm an underlying problem to them. Her colleagues also felt the uncertainty she felt in the moment, and together they used their uncertainty to review the situation and avert a serious complication. I thought about a similar situation I had experienced in my career before I was in the operating room, when my colleagues supported me even though the primary physician did not; and I still feel my relief in the positive outcome of the situation. I understood how Morgan felt when she spoke how a particular work colleague trusted and supported her concern; for the tensions of my experience were also tempered through a few of my work relationships.

As she spoke about this specific experience, I felt that the intensity of this event multiplied over the years, as it remained and continued to surface in Morgan's life; from meeting Doreen years after the event, to maintaining a professional and personal relationship with Philip, the anaesthetist. Her chance meeting with Doreen, a later visible result of her ethical persistence, and her visit with Philip generated a re-visitation and re-affirmation of the ways in which Morgan continued to live out a story of striving for patient safety through simply advocating for, and acknowledging, the concerns of another. Yet, as I listened to Morgan's evolving story, I felt a void in knowing that potential occurrences will

always remain for anyone to disregard a concern that any care provider may have about patient safety.

I found it fascinating how Morgan challenged the distance between patients and safety through describing the ongoing connections in this story, for each connection narrowed the distance to not only make it a story of safety, but also a story of several lives, unfolding. Telling this story to others and me provided Morgan with an opportunity to stand apart from the events and to reflect on her values, beliefs and actions. This was an important reflection, for it reinforced her story of herself as someone who lives a life as a safety advocate through knowing that others were willing to stand behind her and support her. This is a process she has known all her life but also discovered within it, was how she faced the awareness that not everyone she encountered was a support to her or the collective work they did together.

Persevering for Safety in the Operating Room

"Morgan, from our conversations, I sense how some people position themselves in different spots or places at work. From how you describe yourself at work, I sense you as positioned on the edge or the periphery at times," I said. Morgan thoughtfully responded, "It may be fear. I'm sure with frequent put downs, and fear of retaliation from your manager, when they look after your rotation you may not get the holidays to go to the family wedding; whatever, you don't want to put yourself in a position where you're on the radar, keep a low profile. Some of the work I do I have to fly under the radar. I have to make phone calls to physicians that I know, to do something that needs to be done."

Morgan explained, "I'd been able to really go out there on a limb because the physicians I worked with were holding the limb up. So if the administrators were cutting, it's kind of a visual thing, but if the administrator wanted to cut the limb off so I would fall, I had physicians holding the limb up so I wouldn't fall. And that's happened with more than one scenario when I was really at risk for what I was reporting or identifying - certainly with our gas analysis in the OR here for many years. We were in high toxic environments for nitrous oxide exposure, and I was basically told by administrators, 'Don't go there, it's none of your business.' So how I got through that, I went to one of the physicians who happened to be the Chief of Surgery. He said, "Morgan, we're having a department meeting. I'm going to bring up this conversation that I'm aware of such and such, and we're

going to put it directly in our minutes that the department of surgery and anaesthesiology supports the work Morgan's doing in questioning the exposure to whatever. It was right there in the minutes – my name, my action, supported, approved by the physicians and surgeons at the hospital. So even though the administrators were trying to gag me and tell me to stop, the physicians were supporting me, even though they didn't know what the outcome might be. And what it was is we were in an unsafe gas environment for 5 years."

"How did it come about that the gas levels were too high?" I inquired. Morgan replied, "Well, it's not only patient safety. I'm very focused on staff safety." "If you're not in a safe environment, neither is the patient," I offered. She agreed, "Patients are in the room. Staff is in the room. We're all in the same boat, breathing the same air," and continued to explain. "But with that, years ago, I'm thinking maybe we should have children, and five of my colleagues had miscarriages. There's a whole core group of us now in our late 20's who should have children, miscarriage, miscarriage…I thought oh my god. And one of my girlfriends who worked in banks said, "How come you have headaches every afternoon? I don't.' 'Why do I? What's wrong with my head?' I wondered, so then I started to ask the questions. And I was told, 'There's nothing wrong with this department. This OR is basically new, state of the art. It's all in your head'. And then the supervisor, the head nurse, wouldn't have anything to do with my comments at all. Finally the supervisor said, 'Oh for gosh sakes, what's going on there?' and brought in the fellow who had actually done the planning of the healthcare centre. So this gentleman, I remember the meeting vividly, he and a couple of other suits came into one of the side OR's with the supervisor and me, in my scrubs; so right away there's the whole power thing just based on our wearing apparel. When I explained the staff don't feel well, because none of the staff would sign a document saying 'today on such and such Susi's got a headache' - 'oh, no I won't do that'. So I didn't have evidence of who was involved, just this constant discussion about not being well as a group. And this gentleman said, 'You probably have something wrong with your marriage, ever thought about marriage counseling? There's got to be something wrong with your home life'. That made me angry, because before I was perturbed, and now I'm angry!"

"You were made fun of," I suggested. Morgan continued, "That empowered me, stirred me up, unbelievable. I also had a connection with the head of the biomedical department. We met at a couple of courses, liked one another. I actually contacted him and he said, 'You know what, I've got some contacts, let's see what we can do here.' So he connected with his colleagues and brought in the only gas analyzer at that time, and ran it in the theatres and high levels for nitrous oxide is 25 ppm. We were in 2-300ppm and had been for 5 years. But before that analyzer came in, one of the plant services maintenance guys, who are also very good people to know, they can move heaven and earth for you, he came in on a weekend when I was working, he said, 'Let's just see what's going on in here.' So he took down the metal faceplate from the tower, and the scavenger unit from the anaesthetic machine hooks into the connection adapter, it's up in the tower. This pipe on the other end of where the scavenger hooked up to was about a foot long and there was nothing on the end of it. I asked, "It wasn't even scavenging?" "No," Morgan replied, "It was coming out those corrugated vents on the tower, falling right back down on the scrub team. We were getting all the gas. They were being scavenged right into our own respiratory system. So that was one incident where the physicians put it into their notes, they were aware of what I was doing, supported, in fact directed me and supported me to do it. I was caught in the hallway a couple of times by suits telling me to 'Mind your own business, this isn't your concern, this is a new hospital, there's nothing wrong with it, why are you always complaining?' So I would go home by heading to the parking lot at different hours to my car; I'd go to the library for an hour and leave so I wasn't always walking out at 3:30, because I felt at risk with what I was doing. Interesting times…as soon as the scavenger was fixed and we had zero levels of gas exposure, then I got pregnant and the miscarriages to my colleagues stopped as well. Fascinating, isn't it…"

Morgan thought, then continued, "If your staff are protected and they're safe and they have the strength to speak up when they feel at risk, so do the patients. They're safe, and the staff are advocating for them so they're not at risk. It's the same structure. It's the same reporting system. Whether I feel that there's radiation exposure in the theatre, or I feel that my patient's not being well protected because the surgeon's not doing the time out or signing a limb, it's all the same system; takes the same amount of effort and energy to get the same

result. So from those two things, staff and patient, I go forward with a vengeance".

From an early time, Morgan lived a responsive relationship with her surroundings. Just as her environment responded to her corporeal presence, she responded to her environment and everything in it. As Morgan shared her story with me, I somehow felt there was more behind this story than responding to the safety needs of patients and colleagues. I thought about this for some time, and I thought about some of Morgan's comments: "Our new healthcare center opened, and I'm thinking maybe my husband and I should have children, and five of my colleagues had miscarriages…a group of us who should have had children – miscarriage, miscarriage…"; "There's nothing wrong with this department, it's all in your head"; "Why are you always complaining?"

As I reflected on Morgan's story, I realized my perspective of Morgan was not only of her as a nurse. I felt her story come to me through the recollection of a young woman considering parenthood, and I sensed how concerned and determined she was to ensure a healthy and safe work environment, not only for her patients and colleagues, but also for herself. Thinking about her comments again, I felt a tension, perhaps what she felt as a young woman during that time in her life. I thought about how Morgan grew up, with a focus on living well in a relational world; how she had been nurtured and supported to understand, care for, and respond to her environment, as well as everyone and everything in it. The environment of the operating room had now become another site of her intimate life. I sensed it as a place where she had made strong connections with others, how colleagues she worked alongside became her work family, and a place where she spent much of her time as a nurse. Now Morgan had to consider what it meant to be in the operating room not only as a nurse responding to the needs of patients in a professional capacity, but as a young woman responding to her own needs in a personal capacity as she anticipated her future.

I learned in her safety story how she felt a disconnect between her way of living well in any particular environment, and how certain others disregarded any potential concerns about living and working well in her work environment - the operating room. Morgan learned early to appreciate the intense connection she held with her environment; she enjoyed taking in the sensations, sounds, and

sense of life her surroundings provided and she offered her respect and care in kind. I felt how she valued this thread even more now that she and some of her colleagues desired families of their own, for the physical sensations that Morgan experienced at work reflected an unwelcome intrusion of her work environment on her body. Morgan feeling unwell and management's disregard for her concerns led her to question and respond to her work environment as a potential unsafe place, through a courageous professional and personal stance.

Morgan told me how patient safety as an ideal conflicted with her physical and tangible life experience. She discussed not only her professional role and responsibility of upholding patient safety through intentional actions, but also through personal responsibility. She understood how her colleagues, her work family, felt in the same work environment, and she channelled her understanding and support of them into a pursuit to resolve an unsafe work environment. Just as Morgan learned and responded to life's relational shifts and changes, she recognized that patient safety too is provisional and yielding, and she had to respond to the demands of both in order to sustain them professionally and personally.

As Morgan explained how she was deeply satisfied with her unfolding safety work, I sensed that she still felt vulnerable to what surrounded her. The tensions from her work life appeared in her personal life, and these tensions kept her work and personal life connected. Morgan frequently felt physically unwell while at work, whereas she felt much improved when away from the operating room. While her professional and personal environments were separate and distinct from each other, I felt how they became intertwined, in that what affected Morgan physically at work had the potential to carry into her personal domain and possibly affect parenthood. Morgan also spoke of 'feeling at risk because of what she was doing' as she inquired into the safety of her work environment. She described how she changed her daily routine to minimize her visibility at work, and I sensed her inner tension as she shared these details with me. I wondered if protecting herself professionally also meant protecting herself personally, for I sensed that there was no separation between Morgan as nurse and Morgan as person. Morgan was the same individual whether she was at work or at home and this is how her personal and professional life wove together.

Morgan described the strength of a supportive network of individuals, yet there were others unwilling to listen to and consider her concerns. In positioning herself in her stories as a safety advocate, and pushing past established boundaries and institutional narratives of patient safety, Morgan described how she also had to step back and wonder who she was in this patient safety endeavour. This questioning reinforced in her the notion that environments, whether at work or at home, must be safe ones. In questioning the safety of her work environment, I sensed how Morgan remained as an insider-outsider in the department, a role already familiar to her. I wondered why her questions about the environment bristled administrators, and I wondered why they would not be concerned about an environment they also worked in. Morgan found alternate sources of support through engineering and biomed; yet, because she did not 'leave things alone', administrators attempted to ensure her role of outsider through what Morgan described as intimidation behaviour directed at her. I wondered if, at the time, Morgan felt that the only way she could be the safety advocate she wanted to be was to keep positioning herself as an outsider while pushing the boundaries, regardless of how uncomfortable a situation may become.

The Personal Risk of Being a Safety Practitioner

"Morgan, I sense there is a story behind your move to another hospital. Is that a story that you feel you can share?" I asked. She replied, "Oh sure. Well, forever, forever, and ever and ever, I've always been a patient safety advocate. I'll go out on the line no matter what; I'll do the battle no matter what. I can see examples through my career where I've done that, and you sometimes wonder what other people think about it – do they really, really want patients protected? Do they really want patients to be safe? Or, is the person speaking about the problem the problem? Is the person vocalizing the problem, and identifying it and documenting – are they in fact the problem and should they be silenced? But it didn't stop me - advocating and going over the edge in order to support the care of the vulnerable was in fact something I could do and had to do and must do, and couldn't be deterred from it without thinking about the consequences to me, personally. Years ago, there was lots of things happening at Western Civic, decisions, budget management, lots of unravelling of what was a profoundly

excellent team of nurses, physicians, etc. That was my experience for a number of years and certainly it was really coming to a head."

She continued, "At the same time, with changing of managers and directors, I was trying to function with a significant physical injury, knowing that I had an injury that potentially could become worse at some time but never thinking it would and trying never to focus on it. I became what I now understand is the crusader for the good of the country – which most crusaders, like Joan of Arc, end up being burned on the stick. And as I look back now, that was where I was going with this. I always had the feeling that I would describe as being stabbed in the back, because many times I was. Things would happen that didn't make logical sense, but you know, I liked the job, I loved the team, it was my home base, why should I ever be anyplace else. And then, I had urgent surgery, and that cost me a lot of time off work." Morgan continued with urgency in her voice, "All the while wanting to get back to work, because I had stuff I wanted to do. And now I'm in a professional association elected position. So I never, ever, ever thought I wouldn't go back to work. My distress was when, when was I getting back to work. Then the bureaucracy started to kick in. The new manager said, 'Well you can't come back to work in this OR, you've been away too long, you're not up to date with your standards'. Little did she know about my involvement with writing the standards."

"I had no job, because the job description then was changed. It was interesting," Morgan described. "I was completely and totally and profoundly devastated, because that was my identity, and nobody could say what I did wrong. Nobody could tell me how 'You screwed up, this is what you did', nothing, nothing was ever said. Because I hadn't violated my professional practice standards, I had never done anything that I could be called on, written up, disciplined, challenged - absolutely nothing! Now I have a job. I'm working with fewer nurses and surgeons. All that stuff had changed in the matter of a few months. My identity changed, who I was as an educator, the prestige I had from the job, if that's how I wanted to look at it, but I had a job, so my identity as a nurse and an educator could be maintained rather than someone who disappeared off the face of the earth."

"What I find out as time goes on, is my ability to diagnose, articulate, discover, and follow up on patient safety issues at a high level was compromising

the status of the administration. Because of previous things I'd been involved with over the years, I was a threat. I was too visible. I needed to be silenced and this was the way of doing it." I suggested, "You were a threat to people and you were abandoned." She replied, "Yeah! So I had to resolve myself to realize that there's something else happening here, something beyond Morgan. I had to accept it that there was a different path for me, and to just let it go and place myself where I am and stop trying to get back to where I thought I had to be…"

"That's what my good physician friend said to me when I was off work, and didn't have a job, and then I was offered the job at the site I'm at. He emailed and said, 'Morgan, remember what happened to Joan of Arc. You'll be OK as long as you don't try to change that entire hospital.' I found that interesting, that comparison with Joan of Arc. I had a couple of sessions with a counselor; she said, 'You really have to focus on the crusader image, because in some cases the crusaders get killed.' It may be right what they're doing, the reasons are all good, but the actual act of doing it puts you at risk, puts you very vulnerable."

Morgan spoke about supports not always in place when or where she expected them to be, and how when support was neither available nor forthcoming, those moments led to personal uncertainty. She described how others curbed her work experiences through institutional cover stories (Olson, 2005) by placing limits on what construed authorized knowledge, and how this became a regulatory restraint upon her; so much that she lost her position at Western Civic through a series of events that she could not control.

Morgan spoke of her experience through the metaphor of Joan of Arc as a perspective from which to reflect upon and as a way to make sense of her experience. She also described how the tensions of work manifested physically as she pushed harder to be successful in her patient safety goals; and, faced with a very real possibility of physical impairment, Morgan knew she had to preserve her health to continue her work. This was an unfamiliar situation for Morgan; from an early age, she saw and learned how to control unexpected circumstances in her environment to gain balance in life. When she was a child, for example, her family adjusted to economic changes in a way that continued to provide stability in their lives, and through this, her parents were role models in her personal and unfolding professional life. She sought alliances with like-minded colleagues to establish herself in the department, and they supported

each other through situations and times of need. She would often tend to her garden after a challenging workday, easing her tension through her chores. Yet I sensed this was not a feasible option because of her diminishing health. This time, she had to draw from deep within to understand who she was as a person and as an operating room nurse, and for self-guidance in order to continue functioning as a nurse.

Morgan told her life stories through several losses during a time of uncertainty - about relationships, identity, job position, a workplace and a work family that had comprised her life for many years - and then about slowly regaining within these elements, aspects of herself. I thought of her parents faced with a potential loss, a time of uncertainty for them, and making a decision that enabled them to continue farming and living as a rural family. They recognized they had to give up some life moments in order to keep other precious ones. Morgan reconciled her losses in a distantly familiar way, by temporarily leaving one site of her intimate life so that she could one day return to it. In stepping back and figuring out a way to work through the unfolding tensions, she also took time to ponder upon and understand who she was, as a nurse and person. In her renewed perspective of herself as someone who composed her life as a patient safety advocate, she also accepted that she may have to live differently in her new environment, but what shape that way of living would take for her was not yet entirely clear.

At times, her positioning in the operating room as someone who composed a life as a patient safety advocate had been difficult to maintain through challenges to her identity and sense of ability. Morgan's story drew me back to some of my own experiences, times when I found myself at odds with others while wanting to create safe, ethical and respectful spaces of safety for patients. I remember the tensions I felt when what needed to occur in a relationship did not, and how out of sync with a particular person or others I felt when what I knew as the essential did not take place. Morgan's story touched close. I wondered how we are to keep our patients safe and to feel supported and respected, when at the same time we require courage to challenge the healthcare system we work in when situations arise that necessitate it.

Locating Patient Safety

As Morgan and I spoke about patient safety she offered, "Really, right now in healthcare, there is a cult underground working the system to keep patients safe in spite of the systems around them. And that is based on relationships, and I think a lot of what I've been able to do through the years hasn't been on a system of administrators that have supported me, it's been on my relationships with physicians that trusted me." I asked Morgan, "Could you tell me more about this underground movement for patient safety?" Morgan elaborated, "I started to identify myself as working without the administrative and system support. So when you're set up with situations when you've documented, reported, identified and discussed, and particular pieces of the problems continue to repeat themselves, and you then are trying to protect patients and family from being caught in a similar situation again, you have to do something different. That meant calling on resources that were available to me, to try to work around a system that was not supporting and changing what needed to be done. And connecting with people who had like minds, to support a system that wasn't functional for a variety of reasons, to work through those barriers to serve the needs of patients when they need help, and they need surgery, and they need to be cared for. And it really meant connecting with people that I had relationships with that I trusted. These types of activities are happening constantly, because our systems are not supporting the care of the patients at the level it needs to take place."

"Do you think that the nurses who work the system are aware of this underground, or is it just something they are doing, unaware, to make the system work?" I inquired. Morgan replied, "Those of us that are working the system are very aware of it. Those that aren't sure what they can do, hope somebody's going to do something because they don't believe they have the power to do it themselves. You'll get a sense of what I'm trying to explain with this example," and she continued, "I first identified competence-decision making problems with a physician many years ago when I was at a site as a nurse consultant. I had sat beside the surgical director and verbally said, 'Please remove the privileges from this individual before any more patients are harmed'. The director wrote it down in the notes; years later, he's still practicing. I'm very aware of him, as are many people in the community; certainly patients and families talk to other patients and

families. I'm very cautious and careful that I will never be charged with slander or libel, because there but for the grace of god go I. At any moment in time someone can determine what any of us are doing as being wrong, so my comments are very much held in confidence with individuals that may be able to make a difference, otherwise I accept the individual as he walks the face of the earth."

"An acquaintance of mine took her son into a community hospital with a query of abdominal pain, not well. The surgeon comes in, and this acquaintance was already aware about comments about this individual from others in the community. I got the call from her as she's sitting in the emergency department." Morgan described the concern voiced by her acquaintance, 'Oh my god Morgan, he looks like hell; he smells like he's been drinking; he wouldn't make eye contact, mumbling under his breath. My son's had an ultrasound; he's not quite sure what it shows; he wants to take him to the OR'. She tells me she also hears comments from one of the nurses behind the door, 'Oh my, gosh, Dr. X is looking after that boy, I hope he doesn't have to have surgery.' Morgan continued, "I phoned a surgeon who happened to be leaving the OR at a different hospital. I explained to him, "This is what's happening, will you see this boy?" He said it would be all right, he would take care of it. The boy's mother drove him to the other hospital, the surgeon did his examination and the boy went pretty well stat to the OR, he was about to perforate, classic appendix. That's the underground that's working."

"When I talked to this woman afterwards she said, '...the nurses on the ward knew that this surgeon was not safe. They were concerned that this surgeon might be doing surgery yet they did nothing to say, 'You should take your son someplace else. I wouldn't have that surgeon operate on me'. I said to her, 'They can't do that because they don't have anything else to give you. They work in that hospital, they live in that community, they can't go there…whereas I'm in a different position than a nurse on that surgical ward who has to work with that surgeon, and has worked with that surgeon, and may work with that surgeon forever…I'm not in that situation.' There's your underground that's working right now in healthcare. The system is faulty but the team is working the system to support the safe caring for patients. People aren't aware it's happening until they

need it, and then resources come out of the woodwork hopefully to support their care."

Morgan spoke about her role as a support to the staff in patient safety. I offered, "It's very important to feel that there's someone that can insulate you, and support you." She continued, *"*Probably one of the only things I can do for the staff I work with, is to take the brunt of the negative things that they often get caught in. That's often what it takes in order to get some of these issues resolved. It's not easy, because the people who could resolve them just aren't going to go there. It's not something they even are remotely interested in, and that I have difficulty with. When you know a patient's going to be harmed because a surgeon's not competent, how can you not be interested in looking at that surgeon's privileges and getting them assessed? How can you not do that as a director, as a surgical director? How can you not do that? So the surgeon continues to operate, patients are put at risk. Would you have that surgeon operating on you? The other surgeons wouldn't, the OR nurses never would…so if that's the conversation, I think every patient coming into the hospital is entitled to that information. These are the lists of surgeons that the OR nurses would succumb themselves to, these are the lists of anaesthesiologists that the OR nurses would trust their airway management with—pick one, and stay away from the rest. We can't do that I'm told…but we do it with our families, we do it with our friends." "That's the inside knowledge,' I offered. Morgan replied, "I know, and inside knowledge should be transparent. If I know it, then I want you to know it, I want my friends to know it. And if they need to know that, then the individual we're aware of needs to be helped, remediation work, another course, some time off, maybe retirement, whatever it takes, so that the bar is set equal for all involved." She continued, "The caveat to a lot of our discussions in the workplace is the whole issue of confidentiality and the potential of slander and liability. So you have to err on the side of extreme caution, but in the same token protect the patients from harm, and I think that's a quandary many OR nurses are faced with every single day of their working time."

I reflected back to Morgan, "The formal sharing of any incidents about practice issues between hospitals, for example, as you said 'this is happening in our OR, is it happening in your OR?' doesn't go on." She responded, "Well that's that underground discussion that takes place. An incident came to me from a

surgeon who works at other sites, who is very aware of my focus on patient safety, and he came directly to me and said, 'Morgan, do you know about this?' He knows my work with Canadian Patient Safety and he said, 'How could this be prevented? How could this be avoided? All the various gatekeepers in place…' And I said, 'Well, when you look at how this unfolded, it can happen in any OR at any moment in time…the assumption's that you've done this, when in fact you've assumed I've done it, because there's actually no concrete stop point - the final check, the look and see, have we done what we in fact think we've done. In my OR, we have a whiteboard as a reference point to look at, the final check is important, the team is aware that they must do that for each and every case, and stop and ask 'does anyone have any questions?', so that we are aware of where we're at before we actually harm that patient.' I'd just as soon wake up from an anaesthetic and be told, 'We couldn't do it because we weren't clear on what your procedure was or we didn't have the right knee implant' than to wake up with the wrong knee operated on."

As Morgan spoke I sensed how she questioned, affirmed, and renegotiated professional relationships, not only as part of her patient safety work but as a way of responding to and living within a community of others. On her early landscapes, she saw and learned the importance of responding to others in an ethical way. She witnessed her parent's responses to the needs of others as a sincere acknowledgment of the condition of being in this world. It was a way of living that did not isolate or dismiss others because of their humanness; rather it fostered living in a community of others, and Morgan came to appreciate the substance this response could have. I learned how Morgan's unwavering conviction and courage to challenge patient safety matters through responding to the relational needs of others has had a profound impact on the lives of many others. I thought how this too had touched deeply upon her own life over many years.

Morgan renewed herself as a safety advocate after moving beyond a time of personal and professional uncertainty in her life. She did this through re-establishing old, and fostering new, supportive networks with individuals who also supported patient safety as an essential component of patient care. While she acknowledged that her actions might have contributed to her previous situation, I sensed that this had not deterred her from pushing professional, relational,

procedural, and territorial boundaries of the healthcare system. She remained willing to maintain an equivocal balance as she challenged the current boundaries surrounding patient safety, because she knew that boundaries were especially relevant to those constrained or excluded by any particular one. She had experienced the constraint of boundaries herself on previous occasions when attempting to resolve safety situations. I again saw Morgan taking a familiar position as an insider-outsider within the healthcare system, despite any potential risk, as she described how she took the burden, or tension, of a situation as her own so others could focus on their immediate work. As before, others supported and actualized her actions in alignment with the placement of patient safety as a primary concern.

As I dwelled in Morgan's story, I recognized a paradox that I also have faced when caring for patients: working within established boundaries of care is not always a sufficient response to achieve safety. How are patients cared for safely in our complex health environments? How can we meet our ethical responsibilities to others, our patients, our society, when working in a system that does not always support what is required? I too have pushed the boundaries when I thought it was a necessary way of managing conflicting patient safety demands. Vestal (2008) wrote, "nurses have turned the art of working around obstacles into a way of work life" (p. 8). Morgan described how her push against boundaries challenged established ways of doing as an absolute position, and opened a door for alternate ways of achieving safer patient care, and as a way of working in this manner she did this through people's trust and support of her over the years.

I was intrigued by Morgan's story and wondered how the limits of pushing past boundaries were determined and sanctioned by any one person. Kirke (2010) comments on this notion when he wrote, "...whether an unofficial activity is endorsed as 'OK' lies in the hands of the agents of authority in the particular context" (p. 369). Morgan and those involved acted as agents of authority in determining the extent to which they could work around the system, within their community through various relationships, and without openly attracting official reprimand. Yet, I believe that Morgan would have stood her ground had there been any administrative questions. She previously spoke of herself as "always having been a patient safety advocate" and offered examples of "going out on the

limb" throughout her career. Her response to a particular situation revealed her way of living, a way that others had nurtured throughout her professional and personal life, and a way of living that constituted her 'story to live by'. The dialogue between Morgan and her colleagues also addressed the context and resolution of a specific event, within a professional domain and as part of an ongoing process of visibly elevating patient safety. Morgan described the sustained ongoing responses required of individuals in order to circumvent potentially compromised patient care situations, but I also recognized this as her capacity to share her life story with me. I felt that as Morgan lived her daily life, responding to the fundamental needs of others she crossed paths with, was not a question of choice. It was an ethical endeavour that strengthened families, hers and others, as well as the communities they lived in, and it provided her with a richer moral life sense and deeper satisfaction as she went about her work of caring about others.

On Being a Safety Practitioner

I asked Morgan, "How do we keep from forgetting our patient?" Morgan replied, "How do you keep focused on the reason why they're there? I think they get on the wheel. They get on the treadmill and things just start to go forward, and they just keep bringing everything forward...when you're new or not so new, and you walk into the theatre with all this technology...I grew up with the bed, the patient on it, minimal drapes, you could see the patient, anaesthetic machine, cart with a couple of I.V.'s, one room had a Bovie-Bircher. There was no pulse oximetry. There was one ECG machine. That was the technology in the room; suction hose ran from the field out the door to the suction unit. We had a wire that went from the Bovie to the wall to ground it, in case we had a backfire, that's what I started with; whereas now, the room is cluttered with technology and noise and stainless steel and lights and beepers and monitors. How easy it is to forget the patient, because there's all this stuff to attract their attention. And they can't see the patient. They're draped from nose to toes, there's no patient; they can't get near them. So I can appreciate why everybody may forget that there's someone else in the room... that's the reason you're in the room…it's because there's a patient here, that's why you're in this room…and I can imagine it's a challenge."

Morgan described, "I remind nurses when they ask the questions, certainly when we talk about patient safety, the significant component is the patient verification, to attempt to know the patient. The focus is always on knowing the procedure; know your anatomy, physiology; know your case notes; look at your patient, patient's chart, the data, site marked, and consent. Then the most important thing you can do to support those is get to know your person. Take the time to know the person. When you ask their name and the procedure they're having done, and if they have any other questions, wait… because it takes time to put words to what is bothering them, what they need to know; and because they don't say anything or say 'I don't have any questions', doesn't mean they don't have any questions. If you haven't left them with the opportunity to speak and you leave them with the impression that you really aren't interested in what else they need to know or what their concerns are, no one's going to bring forward the information. So actually stand and be quiet for a minute, and give the person the chance to actually have the feeling that you do want to know; because then there's always something else that's there, you'd be surprised what they may find the words to say."

"Morgan, you've seen a lot of changes, a lot of different things, you've had a lot of patient safety experiences in different places. If you picture yourself starting out, and where you are now, how has this affected you?" I asked. Morgan thought and replied, "I think the passage of time, combined with the experience during the time passing, has given me not only the credibility to be involved in the management and follow up of situations, but also a sense of what is the best action to follow in the situation I'm in. That only comes from being in scenarios and learning from other people's management style or way of investigation or way of discussing things; to know what might work and be more clear on what doesn't work. With each event that I'm involved in, I get a sense of 'how can I prevent this from ever happening again?' but I'm not quite there yet."

She continued, "I witnessed a surgeon explain a medical error to a patient, which was unbelievable how well he did it. What had happened is that an unsterile instrument set was used for surgery. It wasn't caught as being a non-sterilized instrument set until the scrub nurse was putting the instruments in the containment system at the end of the case, and noticed that the external tag had not changed at all. She just as easily could have swept it under the rug, but she

paged me at home. I came in because she was absolutely devastated. I was present with the surgeon when he did the discussion and there was no, untoward effects with the patient at all. Because of the SPD instrument decontamination process, all the things that are so important, in fact, were there. He explained fully what had happened, he was completely transparent, and it ultimately was not his error as a surgeon, but he completely protected and validated the significance of the nurse. It was superb; there was no shame, no blame, no guilt, no responsibility to the point of what had happened, with the exception that the external check tag should have been checked before the set was presented to the scrub nurse. But that's that domino effect, you're called back, urgent caesarean section, it happens; and that's why we do what we do over here so that when you do what you do there and you do miss that one step, it hasn't been the breaking point, all the other pieces have been in place. It's tough, it's hard, it's really devastating, but to keep the person intact in that experience is what's really important; to validate the person who had the conscience to speak up is what's important in that situation."

Morgan shared with me, *"*I was asked to be involved with a national healthcare organization at board level and I thought, 'Oh my god what is this, what does it mean?' Then I'm at a board meeting and I thought, 'Oh my god, here's my destiny', because everything I was and strived for, and worked hard for all through the 70's, 80's, 90's, here I am at a national level, and why am I there? As a patient safety advocate! So all of that, all of that stuff was for a reason, so that I would learn the problems, learn the difficulties, see the dysfunction, live the dysfunction, to now have an understanding...to now be in a position to speak how things should not be done. Now I know why I had to go through that. I had to learn many things because of what was coming down the road for me. I had to learn, rather than saying, 'Why is this happening to me?', I had to spin it to say, 'Why am I part of this experience? What do I need to learn from what is greater than me to prepare me for what may be down the road?'

Morgan continued, *"*My involvement gives me access to key people in Canada that are interested in patient safety, that are passionate about it, that in some cases have stuck their neck way out. And to have the relationship with people that I can call up if I have issues that I'm concerned about, and to know who to call and to whose resources I can tap into. So it's bringing all those pieces

together. It's a phenomenal honour for me to be in the company of individuals at those meetings. And I'm able to bring forward to our national and provincial professional conferences suggestions and ideas to support perioperative nurses advocating for patient safety. I was asked to be part of the group that developed the Canadian implementation guide, to actually understand and implement the surgical safety checklist. That was with anaesthesiology and surgeon collaboration; I represented a perioperative nurse, so the ultimate team was together doing the development of the implementation of the guideline. For example, a physician would say 'Morgan, what do you think about this? I think it might be like this...' Then I would say, 'Well, no, as an OR nurse we would have this type of discussion...', and then the surgeon would say, 'yes I agree with that.' There was never a surgeon saying one thing, and an anaesthesiologist or someone else not agreeing, it was the team that was supported with the development of that guide. So that's where the perioperative nurses' voice is brought forward to a level of national work, and is respected and viewed as being an equal participant of any of the work that we're doing from a patient safety perspective, but that it is ultimately the team that will be doing all the work, it all fits."

As Morgan shared her story, I felt the strength and conviction with which she spoke, an expression of her knowing that I believe was enhanced by working alongside like-minded safety practitioners. As I listened to her reflections of her experiences as an operating room nurse advocating for safety, and her inquiries of what her future patient safety role may be, I understood how her community of relationships threaded together throughout her life and patient safety work. I also sensed how Morgan's moral, ethical, and professional responses wove throughout her personal stories to become a full life story for her. She described how through her many relationships she learned, trusted, supported, and received support, grieved, and came to experience patient safety. In reflecting on who comprised her safety community and how it developed, she acknowledged not only the people currently in her life but also those that have passed through it. As she spoke about her relational experiences with and in her communities, I understood how she viewed her own life as one that was enabled by moving with others to participate in an ethical and moral agency of patient safety.

Morgan's stories described how care practices could be and were challenged by her and others as a way of working together to sustain safe patient care. As I considered this, I realized how others at a national level recognized Morgan's vision, motivation, capacity, and experience as they asked her to join them in advancing patient safety initiatives. I heard how proud she was of her patient safety involvement at the national level, and I felt privileged to know that she spoke for me as a fellow operating room nurse. I believe that it was at this level where she could finally embrace a position as a patient safety leader, a pioneer, who with other professionals recognized that patient safety is in flux with boundaries that are infinite. I understood that it was through this national community that Morgan was able to bring her knowledge of lived patient safety experiences in the operating room together with the knowledge of others as a way to open up barriers to safe patient practice. Morgan described how this work derived from respect for an individual as a knowledgeable person, not on an assumption of knowledge based on whom the individual was. Through her stories, Morgan opened her knowledgeable self to an entire network of practitioners, and she appreciated what a group of individuals could accomplish together.

I was led to reflect on Nelson's writing about communities and counterstories (1995). Nelson suggested how a community of choice, based on voluntary association, and somewhat different from a found community of which we are born in and live in, could function as a moral space for reflection. This space allows its members to examine what they do in the wider community, for example, the reflection of Morgan and her colleagues on their profession as a whole within the realm of patient safety. Nelson points out how communities of choice are "well suited to challenging the found communities in which they are embedded" (p. 35) through counterstories, stories that undermine, undo and retell a dominant story in such a way as to invite new interpretations and understanding of the state of affairs (p. 34). As I thought about this, I learned how Morgan's experiences combined with the experiences of others became the counterstories of their work communities, and how this enabled them to reflect upon and renegotiate current practice in the operating room. I also understood through that process, how Morgan reclaimed and renewed her identity as a safety practitioner.

Morgan's stories opened me to the power of relational threads in her work. She had taken the voice of not only her life experiences, but the voices of other nurses, physicians, and patients, and brought these combined voices forward to the national level where other healthcare professionals were also heard, respected, and acknowledged, collectively. This validation of life experiences led to new safety protocols developed for the operating room, and in these developments the voices of operating room nurses, physicians and their patients returned to their origin, the environment of the operating room.

I considered how the relational connections in our stories are a way in which we can further develop our nursing knowledge and practice overall, and how Morgan turned this learning back upon herself and others to continue to understand and learn from her patient safety experiences. Her stories are the recollections of specific patient safety endeavours supported through a community of others, and I sensed their value to others who may also find themselves on an uncertain path toward patient safety. I thought deeply about Morgan's stories and about how her experience connected everyone together, and how her experiences built a patient safety community for her. As she shared her stories of different places and different times with me, I came to appreciate how Morgan's experiences were foundational to the creation of a vision of patient safety through a community of others. I now turn to *Chapter Six, Shani's Stories: Early Landscapes,* in which I narratively inquire into Shani's experiences of patient safety.

CHAPTER SIX

Shani's Stories: Early Landscapes

As I exited the train station, Shani was already waiting for me. She saw me and we both waved, smiles spreading across our faces. Shani invited me to her home on this day and in this gesture, I sensed her comfort with me; but more importantly, her comfort with where she thought our conversation might take us. We drove to her house. Shani slowed the car down as we neared a strip mall, and she proudly pointed out the business that her father owned for many years. As we slowly drove by, she waved at the store and I remembered a conversation we had on a previous day, when I asked her if she could tell me how she came to operating room nursing. She smiled and quickly described an experience that remained with her over the years. "I was born in East Africa and we moved to Canada when I was about three or four. We moved to Columbus City at that time, then moved to Westhaven, and have been here ever since. I've got three siblings, two brothers and a sister, and my parents. We're all close by. My parents live a couple of blocks away from me; they do my babysitting," Shani said with a broad smile and continued. "What brought me to nursing - actually it's quite interesting. I was about five years old in Columbus City and I went to the children's hospital for surgery. After my surgery, I remember the nurse wanted to give me a shot. She wanted me to turn over and poke me in the bum. I said I 'was scared' because I was only five years old, and I'll never forget this – she told me to 'Shut up and turn over!' She was the meanest person I had ever seen as a nurse. I thought, 'I'm going to grow up and be a nurse and I'm never going to be like that.' From then on I had it in my mind, that is what I am going to do, because that can't be right," she said, referring to the nurse's behaviour. "When I finished school I applied to university and did my nursing; I did a degree program. When I was in nursing school, we had a couple of short visits to the operating room. Once I stepped foot in the operating room I thought, 'OK, this is where I want to be.' From the moment I stepped in there, I knew this is it. That was my goal. So as soon as I finished nursing, I applied to Memorial Healthcare to do my OR nursing course. In the meantime, I worked on an acute care ward for over a year. Then I got the call to say I had the interview for the OR nursing program, was accepted, and I went to Memorial Healthcare and did my OR training and have been in the OR ever since."

As I recalled Shani's story about her childhood hospitalization experience, I sensed how frightened and alone she must have felt when the nurse dismissed her fears. I imagined how confusing it must have been for her, as a child, to have her sense of need challenged and how perhaps a sense of fear emerged from being hospitalized. I felt the tension and upset of that moment in Shani's voice as she spoke, and as I looked at Shani, I felt the eyes of a child gazing back at me. I imagined her trying to reconcile her bewilderment when her nurse did not reflect the expectations that Shani had about the nurse-patient relationship. I suspected that her childhood image of this relationship is one that continues to be an important aspect of her nursing practice, today. As I thought about how Shani's vision of the hospital as a safe place of caring was quickly disrupted by a few careless and insensitive comments and actions, I imagined the lasting effect that any comment and action can unknowingly have on others. Yet, Shani also described how she used that childhood tension as her personal drive to become a nurse; a nurse who would recognize and respond to patients' needs and care for them in the manner that she thought was "right".

Once inside her home, Shani beckoned me to feel comfortable and to 'make myself at home'. I relaxed on the couch and took in my surroundings. The tinkling of wind chimes came in through the open patio door, as did a warm breeze and sunlight, touching vegetable seedlings of assorted size growing in containers on the living room floor. With Shani's assistance, her children had planted and cared for the seedlings, and later would transplant them into the garden when the time was right. Photos, puzzles, games, and toys filled spaces on the walls and in the rooms. I imagined the various activities at any given moment in this home, as Shani spoke about her children and husband.

We relaxed with our tea as we spoke about Shani's house. "It's a loved house, it's a lived in house," I said with emphasis, for I sensed, deeply, how Shani and her family seemed to enjoy life in this house. Shani smiled, "It is. You don't have to worry about where you sit or put your stuff down. Relax and put your feet up. I don't like some houses where you go in and you feel like you can't touch anything. I remember when we first bought this house. We came to see it and the other people were living here. There was almost nothing in the house, it was very sparse. We`re thinking, 'Are they half moved out already or what?' There was nothing in this house, nothing on the walls, completely bare. It was

very, very bare. Of course when we moved in we take over," Shani was laughing, "and fill it up. My husband knows the house is a mess every once in a while. He says, 'I'll live with it. There's other stuff happening, that's fine'. There are things in life more important. You have to concentrate on those. I learned that a long time ago. There are kids, there is your family - very important, you can have all the money in the world but if you don't have those things, you're nowhere."

I felt how Shani held her family close to her, and how they were a constant presence in her daily life. She spoke proudly about her children, her husband, her parents and siblings, and I sensed how she valued the close relationships she enjoyed with each person. I thought how she and her parents maintained close family ties through daily contact by sharing child care, and how this provided an opportunity for her children to learn about values, beliefs, attitudes - about life - from not only Shani and her husband, but from their grandparents, too.

*Shani spoke about her family's move to Canada and I began to gain a sense of how important family was for her, "*My parents decided to leave East Africa because of the evolving political situation in the 1970's. Life was becoming quite difficult for people who were not African-born citizens, and my parents felt it would be a better life for the family; and that there would be more opportunities for us children, especially in education if we came to Canada. My father's family was already in Canada. They had left East Africa for the same reasons, and we were the last to arrive here. I know that my father worked as a general manager for a worldwide company in East Africa, and I know that he held a very good position; it was prestigious actually. The house was paid for, they had servants, and there was a chauffeur and maids."

Listening to Shani's story, I thought how she came to know herself, her life, and about others through her parent's and family's move to Canada. "Our family moved to Columbus City in the middle of winter, and that was a total shock for my parents – to come to harsh winter from a hot and humid climate. Along with that, they left a luxurious lifestyle." *I sensed how a change in social standing and personal financial circumstances was a tension that Shani's parents immediately worked within, for upon arrival in Canada her father had no job, and they were strangers in a new community. Her parents had to learn how to live a new life, in a new country, and as a family with few resources available to them.*

Shani had few recollections as a four-year old newcomer. "I really don't remember much about coming here, about the move to Canada at all. My mom worked hard in the house, always, raising our family, looking after us. I vaguely remember living in a small townhouse in Columbus City. We had mattresses on the floor. And I remember walking down the street with my parents to the laundromat. I know from my parents that my father's side of the family did not help us when we came to Canada – again, I really do not know the details. My dad was an independent man and a proud man. So he would not have asked for help, he did not ask for help. My parents did not really talk about the move to Canada or about any difficulties they had settling in. I know that things were hard initially, and I think my parents wanted to shelter us kids from that, so I think that's why there was little talk about it." *I wondered if, in the way that Shani spoke, any questions about coming to Canada and becoming established here may have been put off by her parents, perhaps as a way of placing the past behind them and concentrating on the future ahead. I thought how this move must have been an intense experience for her entire family, and I wondered how they learned to live in the uncertainties of life in a new country. I imagined that family closeness was an important, supportive element for Shani's family as they settled into their new surroundings, and I imagined how family values and beliefs were upheld to provide a sense of security and family belonging. I sensed how Shani enjoyed and valued her close family relationships, and I reflected on how it was through that closeness, that experiencing of a "very important' notion of family, Shani's learning about the world around her blossomed.*

I wondered if, in the uncertainty of living in a new country as a four-year old, she might have felt her home to be a safe and secure place, surrounded by those who cared about her. I also thought how she might have been sensitive to the changes unfolding around her, even though she may not have understood what was occurring at that moment. As a young person, she saw the resilience of her parents as they worked hard to create and eventually own an independent business in a new country, which not only established their sense of identity as respected and responsible workers, but also created a sense of belonging to, and within, their community.

Shani recalled that her father worked in the real estate business "for a while until the market fell", and that he then worked as a transit driver until they

moved to Westhaven, where he eventually established his own small business. She did not seem concerned about not remembering many details about her family struggles during her childhood, and I sensed how her parents had shielded her from the tensions and realities of adjusting to a new life. But I also learned in this how her parents' focus on the family unit and concern for the well-being of their children, spurred them to challenge the issues of unemployment, a change in social standing, and life in a new country and climate, to ensure stability in family life. In working within those tensions, I understood how over the years her parents became an example to Shani of what could be accomplished in life, when immediate family was the only sure constant in one's world. I heard how Shani respected her parent's persistence in working toward a way of life that would be better for the family in a new country; and I appreciated how this provided Shani with an opportunity to view life through not only her own experiences, but her parents' experiences also.

In reflecting on Shani's story, I sensed the depth of her parents' love and responsibility for their children as they tried to own the tensions of a new life and protect their children from hardships or worries about their new way of living. Yet, I wondered if as a child, Shani had felt or perhaps experienced those un-named tensions more than she thought, for it seemed that particular recollections of family remained vivid and significant to her. Reflecting on the lack of assistance from her father's relatives, Shani said, "I do remember one story that my mom told me about when we first came to Canada. There was my older brother, my younger brother who was just around a year old, and me. My sister was born here a few years later. My mom was using cloth diapers for my brother, and dealing with all that extra laundry of diapers. They had used cloth diapers in Africa, but there were also maids to help with the childcare. My aunt, on my dad's side of the family, did not tell my mom that disposable diapers were available, you know, to make life easier for her. My mom didn't know for months that disposable diapers were available, until someone at the mosque told her. I think that knowing how my dad's relatives were, and how they treated us as a family, drew us closer together as a family unit. Just spending time with each other was, and still is, very important to us. You expect family to be close and to help, but not all families are like that. My mom's family is still in South Asia, and they were

always very close. We've gone there and visited several times. Even today, they are really close; my mom talks with them almost every day."

Shani learned that life tensions and uncertainties were not to be shied away from; rather, her parents taught her that challenging life's uncertainties could be personally beneficial, as well as beneficial to many others in their lives. In her story, I heard how her parents learned a life lesson about the fragility of life, how life is lived, and the expectation of living life in a certain way could be easily disrupted at any moment. Yet, I sensed how her parents responded to the change in their family life, and moved forward to achieve what was required to best support their young family. Her father found work that was far different from his previous job, yet he still was able to provide for the family and ensure the necessities of daily living. Her mother kept the household and was always present for the children. She spoke proudly about her parents' accomplishments, and I believe that their experience also inspired her to follow her dream of becoming a nurse, and establishing herself as a respected person in life. I believe that through some of her vaguely remembered childhood experiences, through hearing some stories about her family's move to Canada, and through observing her parents, she gained a sense of their ability to work within the uncertainties of life, in order to accomplish within new expectations, their life goals. I believe Shani felt this same sense of ability, too, as she worked to discover her own expectations and to set goals in her life.

I heard in her story how she drew upon a life lesson that she learned from her parents and how this connected to the accomplishment of her personal goal of becoming a nurse. I sensed how an uncertainty of life, a childhood surgery, harshly awakened Shani to the reality of living in a world of others, a world that could be far different from the one she experienced and had come to expect within her family unit. I learned how Shani used her remembered tension as a hospitalized 5-year old in Columbus City, and her sense of ability, as motivation in becoming a nurse, and I understood how in becoming a nurse she felt she could respond to that earlier childhood experience of patient care. I imagined how beneficial that life lesson could be for the many patients and their families who would meet Shani as she cared for them.

"What do your kids think of mom being an OR nurse?" I inquired. Shani responded with a beaming smile, "Oh they think it's cool. They always want to

know what I've been doing. From a young age my husband explained to them, 'Your mom's just not a nurse, she is an OR nurse. She helps to operate on people. They cut people open and they do things to them and she's right there'. She added, "He thinks it's pretty cool, too. When there are surgery programs on TV and they show the OR's, the doctors, and the nurse, he'll actually point out, 'That nurse – that's what your mommy does!' Even my family, whenever we're out and people ask, 'What do you do?' I say, 'I'm a nurse' – and everybody corrects me. 'She's an OR nurse. She works in the operating room'. Because to them that's pretty... um..." Shani searches for a word to complete her thoughts and I offer, "Prestigious?" She agreed, "That's the way they think about it really. Back home in South Asia, our original home - we went back a few times - my aunts and uncles and people would ask, 'What do you do?' I replied, 'I'm a nurse in the operating theatre', and they take a step back – it's a big thing over there apparently. 'You work in the operating theatre – you help the surgeon?' they would ask. I am actually floored by how amazed people are; maybe to somebody else, it's the realm that nobody enters, right? It's behind closed doors, so I guess it's the mysterious world of medicine." As we talked about her homeland, Shani also shared how she and her husband were in the process of adopting her young cousins from there, as a way of providing them with more opportunities. Her children were very excited at the prospect of their cousins from far away coming to live with, and be part of, their family here.

I reflected on Shani's earlier story about lack of support from her father's family, and I thought how that contrasted so much with her attitude toward her young relatives. I recalled her words, "there are kids and there is your family, if you don't have that, you are nowhere". I thought how, in her desire to provide a better life for her cousins, she drew from her own notion of the importance of family. Through her parent's experience, Shani witnessed and understood what could be accomplished in this world when they only had each other's strengths to draw from; now, she imagined opening up greater possibilities for living well in this world by willingly reaching out to help others and be their support when needed.

As Shani spoke, I heard in her story how she continued to maintain a strong connection with her extended relations in her family's original homeland. And I sensed how this connection would eventually stretch again across the

world and bring her family even closer, as Shani now offered her young cousins a place in her immediate family's life. I thought how this conscious action of Shani and her family, making a place for others in their lives, would not only enrich the lives of the cousins but also the lives of Shani, her husband, their children, and their extended family.

I reflected on how her sense of responsibility to respond to others, and her understanding of what this meant to others, had developed from her own family experiences. She observed and learned how her parents shaped a new way of living for themselves and their family when they came to this country. Her parents left one country to search for better life opportunities in another, opportunities not only for themselves but also for their children that existed in their immediate life, and in the one that lay before them. She learned through their experiences how fulfilling life was by focusing on people living well in everyday life; and she followed this thread by adopting her young cousins from her original home country. I believe that the personal satisfaction and at times, the dissatisfaction she experienced from others' responses to her, directed her to focus attention on caring for others in a way that would support their immediate and future needs.

As she spoke, I sensed how Shani's family respected her as a nurse and as a person in this world, but even more so I appreciated Shani's humbleness as she described her family's awe with her in being an operating room nurse. I thought about this and wondered if a similar attitude toward healthcare providers had been nurtured in her when she was a child. For in her earlier story, I felt that she held a certain expectation of her nurse, perhaps one that stemmed from family expectations; and I heard in her story how a similar respect and appreciation for operating room nursing was now demonstrated to her own children and others by her husband and family. Though I could not say why, I had a sense that I would hear in Shani's stories how as an operating room nurse, she practiced a way of nursing that reflected her notion of what was "right" as a nurse, and in a manner that she felt was deserving of the respect she felt from others.

About Operating Room Nursing

As Shani and I spoke about our mutual interest in operating room nursing, she told me that she had taken her operating room nursing programme at Memorial Healthcare, a large teaching hospital in Westhaven. I shared with Shani that I had also considered Memorial Healthcare for my own operating room nursing education years earlier. “Shani, was there anything in particular about the OR that made you think, ‘This is where I want to be?” I asked. “Oh, I liked the hands on, getting in there, seeing all the anatomy, all the procedures, that kind of thing – that’s what appealed to me,” she explained excitedly.

“How was an awareness of patient safety in the OR presented to you?” I asked Shani. She thought for a moment and then responded. “Well, in my OR training at Memorial Healthcare, there was our instructor, and there were a lot of PCC’s or charge nurses, very cautious of the students, double-checking, triple-checking. So, in that aspect, you never missed anything because if you did, it was picked up by someone else. I remember there was one issue, though. One OR aide would often bring the wrong patient to the room; we were made aware of her. It had happened several times. So that heightened our awareness of patient safety, because you knew that when she was bringing your patient around, you needed to double-check, triple-check, more than you normally would. It happened with me as well. She brought the patient in – it was the wrong patient, and we had to send her back out to pre-op holding. It’s kind of unnerving, because obviously the patient loses faith in the system. So I think from day one, we had that instilled into us, that you had to have that heightened awareness of safety, because of the presence of an individual whose idea of safety, was...a little bit different. I noticed at Memorial they didn’t have the same patient checks that we had at Crawford where I worked after my course, or in Union General, where I currently work. They didn’t seem so wary about checking patients’ name bands, consents - a little bit lax I should say. I don’t know why that was, but we had it drilled into us as students. You have to do all these checks - you must make sure. I think it was maybe a time issue, too. I know surgeons would complain if they were 15 minutes behind, or a room turnover took too long. Maybe that was the reason why, I’m not sure. I was still very green at the time. At that time I didn’t realize why or what. Even looking back, it was so long ago, I’m

still trying to think why they did not do those things - because they did run quite a few OR's, so it would just make sense to take a few extra minutes."

"It's interesting, Shani," I responded, "You pointed out you were very green, noticing these things, yet not understanding why because you didn't have the history of being on that unit to understand how these things came about. It may be that one person started doing 'it', then another person picked 'it' up, and pretty soon the whole unit is doing that one 'thing', and no one really knows how they got from there to here." Shani nodded in agreement and continued, "Also, what I found thinking back to it, a lot of nurses who had been there a long time would say, 'This is the way we've always done it, so there's no need to change it, it's always worked for us'. Yet, not realizing times have changed, the place is bigger, more patients are coming through, or issues are different – things like that, you know. It's not something that you actually pick up on at that time because you're so green, you don't know, you just accept everything around that is."

Shani spoke about feeling a heightened sense of awareness of her surroundings and feeling the tension of patient safety early in her operating room nursing programme. As she spoke of the many people who watched over the nursing students as they learned, I also thought how in that large teaching hospital the education of medical students and students of other affiliated healthcare specialties was also supported. I considered how the more experienced staff could also feel moments of tension, as they remained ever vigilant over all students, especially when there would be direct contact between student and patient.

In her story, Shani described how the actions of one operating room aide became a specific tension that seemed to envelope the department. And it was a tension that Shani experienced on a personal level when the aide brought a wrong patient into the operating room for surgery. I heard how Shani sensed that the patient might have been unsettled by that experience, or perhaps questioned her trust of the people that were to care for her when she said, "obviously the patient loses faith in the system", and I learned how Shani pulled her own experience forward in those words. Just as Shani had an expectation of a nurse when she was a child, I considered how she knew that patients held certain expectations of their surgical journey, especially of the people who would care for

them throughout their hospitalization. As I thought about the many individuals who supported patient care, either directly or indirectly, I reflected on how vital it was that each person performed his or her role in a focused and accountable manner, in order to strengthen a collective approach toward patient safety. I also learned how Shani's experience with the aide further reinforced her understanding of how anyone's actions could extend past the immediate context, and be important to an individual's future well-being. For earlier as a child patient, she had been sensitized to the effects of a careless comment and action; and now as an adult nurse, I appreciated how this was a recurring tension that Shani worked to resolve emotionally.

Shani recalled that specific patient checks were "drilled" into her as a student by her instructor, such as reviewing patient name bands or reviewing the surgical consent for accuracy. I learned how as a student, Shani recognized the importance of ensuring the accuracy of information at every step of patient care, for she spoke of "double-checking and triple-checking" details in a place that was 'big', with "more patients coming through" and a reflected change of pace in the department. I also understood how those "drilled in" learnings have stayed with her as a foundational approach throughout her nursing career, for she learned early on as a student the necessity of following an established routine to ensure patient safety, no matter how large or small an operating room department was.

Shani also recalled, that when she was an operating room nursing student, many nurses did not appear to recognize how departmental changes, such as increased patient flow, might require a change in their nursing approach. She observed they were comfortable in their routine, for they would say, "that's how we've always done this; there is no need to change". I considered how Shani recognized and experienced this tension as a disconnection between what her instructor was teaching her, and what she witnessed in actual practice. I heard in her story how she worked within that tension by following a specific routine in her patient care in order to support the daily activities of the department, which reflected the current standard of practice expected by the operating room course instructor.

Shani stated she was "very green" during her time as an operating room nursing student; yet I sensed that she was most aware of a difference between the way that the experienced nurses and the students approached the patient

check-in process. In retrospect, Shani considered and questioned why patient checks were "lax" in comparison to other departments she worked in. I thought about Shani being "very green", and not realizing "what or why" the more experienced nurses did what they did. I wondered about how vulnerable and impressionable any learning practitioner could be, and how in their desire to gain acceptance as a competent practitioner, certain fundamental elements might easily be set aside. I reflected on how it was not only students who were vulnerable to the tension between classroom theory and actual practice, implementing patient safety, universally, was also vulnerable to the same disconnect. I understood how the presence of a strong mentor was important for students and patients. And I realized that Shani's course instructor was a strong mentor for her as I heard how she followed her instructor's teachings, and not just the actions of other experienced nurses. When Shani pondered in retrospect, why some nurses "were a bit lax and did not do those things" that she was taught as a student, I appreciated how her instructor's teachings had remained as core ethical knowledge in her nursing practice.

Shani recalled her early days as an operating room nurse at Crawford Hospital, "We had a nurse in the OR. She was the head of neurosurgery, a very nice nurse, and she taught me a lot. She was quite positive, quite encouraging. She was also a protective barrier against some of the not so nice surgeons there, just to make sure that everything was OK. I remember her. She was a very good teacher." I asked Shani to tell me more about this nurse, for I sensed that she was a role model for Shani in her early operating room nursing practice. Shani continued, "She had this sense. She knew when she had to be there, and she knew when to back off and to let you do your thing. She was very encouraging, encouraging with her words, very positive words. And if you goofed up somehow she would say, 'It's not a big deal, this is how we do it, this is what you can do to fix it. Just remember it for next time.' You know, never putting people down, saying, 'Oh, you should know that by now.' She was, just all around, a very positive person, very helpful; never looked down on the students as not knowing or incapable of anything. Oh, she loved to teach."

As Shani and I spoke about working with junior nurses in the operating room, she offered, "You're not only dealing with the patient and everything else, but you also make sure that the new person is doing their job correctly. A lot of

the time, during the cases, teaching is on the spot; things that the nurse has never done before. Where I work now, they try to assign a senior nurse with a rookie nurse. If there is a staffing issue and two semi-junior nurses are together, they try to make sure a senior nurse is available to go in the OR room and check-in on them, to make sure they're OK and everyone is functioning OK. For example, I've gone in a room to help and there was a rookie nurse who had put the cautery pad on the patient. But she had not realized that the patient had joint replacement surgery where she put the cautery pad. I did point it out to the nurse and I changed the pad over to the other side of the patient; she asked me why I changed it over. At the same time, the surgeon is gowning and it's right at the time when everyone's trying to get surgery going. I told her the patient has had joint surgery on this side, so you can't put a cautery pad over the implant, because it's not the ideal thing to do. She said, 'Oh, OK'. I guess she didn't realize, she's so green. She hadn't experienced joint surgery or what that incision looks like post-surgery, or anything like that. I remember at that particular time, the surgeon noticed what had happened and he looked over and said, 'Oh, thank you for noticing that, for picking it up'. So then during the case when we had a quiet time, I explained to the newer nurse that, even though you feel rushed, you can't overlook this stuff. Because in the end, it is patient safety, and regardless who the surgeon is - you may think they're not the most patient of people - they will appreciate the fact that you're taking the extra 30 seconds, or the extra minute, to make sure the pad is in the correct position; so she understood. I explained the whole of it, the why's and what for's of doing what you're doing, and why it's important to kind of take your time and look at the whole picture, and realize what's going on with the patient, aside from the actual surgery at that time."

Shani spoke about a specific nurse at Crawford Specialty Hospital who was especially supportive of students and nurses new to the department. I sensed how this nurse was a mentor and a role model for Shani as she began her career as an operating room nurse. As she spoke, I heard how the respect and the fondness that Shani held for this nurse years ago continued to remain just as strong and certain today. I learned how, as a new operating room nurse, Shani gained confidence in her abilities as she described the nurse "holding back" to let her work through a procedure; yet ,also stepping in to provide

direction and support when necessary. I wondered if this was similar to what Shani felt in her home life, as she learned about the world as a young person, and as she continued her education and dream of becoming a nurse, as well as continuing to focus her nursing education in a specialty area. I understand how the constant support and encouragement from others created a positive environment that supported Shani as a person learning about her world – the one in which she lived and worked. I realized that it was through this support that Shani continued to develop her awareness of who she could be as a person and as a competent, safety-minded operating room nurse.

I reflected on Shani's story about the junior nurse and incorrect cautery pad placement, and I thought how Shani had acted on an opportunity to turn a situation of suboptimal nursing practice into a teaching moment. As Shani spoke, I felt her mentor come forward in her story, for Shani was now the one acting as teacher, guiding and encouraging the junior nurse in her abilities when faced with an unfamiliar situation. I learned how she used her past knowledge and the inexperience of the junior nurse to encourage her to develop awareness of, and sensitivity to, the "whole picture" that was presented in order to recognize there might be other patient circumstances not connected with the immediate surgery, that could affect the outcome of surgery. I understood how Shani supported the junior nurse to "remember for the next time", by taking time during the surgery to explain and reinforce patient care as safe care, and when approached in a methodical manner. I reflected on how Shani tugged at threads from the past as she recalled being a 'green' nurse, and when senior staff would double-check her work or observe her, ready to step in when required. I learned how, from her days as a student and junior operating room nurse, she held the teachings of her instructor and nurse mentor close and carried them forward into her current encounters with other nurses. For she explained how, as a senior nurse now, she frequently double-checked practice procedures and supported other nurses to be perceptive to what surrounded them, and to use that attention in the development of their abilities as competent, safety-minded operating room nurses.

I wanted to learn more about Shani's patient safety experiences. I asked her if she could tell me about any particular experience that came to mind. She quickly replied, "Oh, goodness, at Union General we had this incident. I couldn't

believe this happened. It was just after I started there. Now, this is before we were doing initialling of the operative side at Union." Shani paused, recalling the moment and then continued. "I went to the holding area to pick up the patient, and the patient's daughter was in the bathroom. He didn't speak any English. I was trying to figure out with him, his name, the name band, and I thought, 'Oh, I'll just come back when the daughter comes back'. The daughter came back and we looked at the consent to double-check the surgery site, and I said, 'Where, which body site?'' She pointed to 'Here, down here'. Shani demonstrated by pointing to the inguinal region. "And the consent and the slate had said, 'Gallbladder – laparoscopic cholecystectomy'. And I'm thinking, and I said, 'Up here, right?" and Shani demonstrated by pointing to the right upper quadrant where the gallbladder was. 'No, down here,' the daughter said, and again she pointed to the inguinal region. I'm thinking, 'OK, back off for a minute here.'

"I took the chart out of pre-op, went to the desk so I was away from the patient, and checked the history. Lo and behold, the doctor's history said hernia, but the consent and the slate said a lap chole, because the operating slate is made from the consent. I had our nurse at the desk double-check it with me to make sure I wasn't reading wrong. I checked all the papers, matched the patient, so I knew that it wasn't the wrong chart or anything like that. Then I called the surgeon in from his lounge and I said, 'Can you just confirm, verify – clear this up for me?' I called into the OR room, told them to put a hold on opening anything. The surgeon checked it and he said, 'Oh! No, we're doing a hernia on this guy'. He looked at the consent. The consent had been done in the office and it was a lap chole consent. They had pre-typed consents and they had pulled out the wrong one and signed it – and the patient didn't know English, so the patient just went ahead and signed it and the slate was done up. So the surgeon called his office and he reamed out his office staff. He said, 'You guys did the wrong consent on this patient! We almost did the wrong surgery!' The doctor said to me, 'You know, if you hadn't picked up on that, we would have taken out his gallbladder and not fixed his hernia'. And I'm thinking, 'Ooohhh – I need to take a 5 minute breather here people!'

Shani continued, "At that time it was a very stressful situation, I remember that. To me, that is the ultimate in patient safety!" "What a good catch on your part!" I said, and I imagined the panic and relief of that moment. "Thank you,"

Shani said, her face breaking out into a huge smile. We both nodded as we silently thought about the possibilities that could have unfolded.

"Shani, at your hospital do you see many patients that either don't speak English or have English as a second language?" I asked. "Yes, we do, we do," she replied. "I think that particular issue with that one consent was an isolated incident. When I know a patient may have limited English, I am overly careful because of that experience. You know, it depends on the situation. If it's a urology case, you know it's either going to be a cystoscopy or TUPR; judging by the age you can usually figure out which one it's going to be. But yes, I'm extremely careful - the side, the actual surgery that's taking place. If there's any doubt, I'll go back to the history and find it out from there."

Shani added, "Also, this comes from when I was in the OR booking office. All the charts that would come in, it would be our responsibility as the RN in the office to double-check the consent with the chart. That is where I did catch quite a few mismatched consents - where the side did not match or the history said total knee replacement and they were booked for a total hip replacement – that kind of thing. But because it's in the OR booking office and it's possibly months before the patient's surgery, you have that time and you have the ability to go and fix it without affecting any of the patient care or delaying the OR." "That's an important part then, being that gatekeeper," I acknowledged. "Yes. It's interesting you said gatekeeper, because everybody used to call us the gatekeepers in the booking office!" Shani said delightedly. And then added, "When our new manager came in, she displaced the RN's from the booking office. She felt that clerks could do this as in other hospitals. A lot of the surgeons and anaesthetists, they were not happy at all. Quite a few of them actually approached me and said, 'You know, we're not happy that you're gone from there. With you there, we knew mistakes were going to be caught and things were going to get done in a timely fashion'."

As Shani told me her story, I thought about the serious error that was avoided because of her diligence and focus in confirming patient details. I thought again about what she had earlier said about the patient checks "drilled into them as students". I considered again how they had stayed with her over her nursing career, and had become a constant in her nursing care. I heard in her story how she involved others in addressing the situation of an incorrect surgical

consent, and how she persisted to ensure the discrepancy was resolved. For in following the trail back to where the surgical consent originated, she drew people's attention to the notion that patient safety began outside of the operating room department. Whatever was put into motion elsewhere by someone else had the potential to impact patient safety at the final destination of the operating room.

As I reflected about that event, I wondered how the patient had navigated the hospital system, for example, the admission into the hospital and the day care surgery unit without the surgical site discrepancy being discovered until Shani's encounter with the patient. I recalled my own experiences with patient information discrepancies, and realized there were many reasons why that might occur. I also reflected on the importance of "double-checking" and "triple-checking" information, even if, initially, the information did not appear to be out of the ordinary.

I heard in Shani's story how she had recognized that the patient's limited command of the English language prevented her from performing an accurate patient review, and how she waited for the patient's daughter to be in attendance before proceeding any further with patient care. I learned how she did this purposefully, in order to ensure the correct patient information, even if this action would slow down the flow of work in the department. I understood how that action also kept the patient's interest in the forefront, and provided an opportunity for Shani to engage with the patient through his daughter. I reflected on Shani living the complexities of understanding a language that was different from one's mother tongue and living as a newcomer in an unfamiliar landscape, and I wondered if this offered her another avenue from which to approach patient safety. I, too, was familiar with living through a second language, and in thinking about my nursing practice, I found that I had slowed my work pace down when engaging with patients whose English was limited, so as to provide them with an opportunity to converse without feeling rushed or unknowledgeable about their upcoming surgery and care.

I appreciated how Shani was proud to be recognized as a "gatekeeper" of safety, and she related this to her work in the operating room booking office. She said others had recognized the booking office as a specific place where 'errors could be averted'. I thought how in that office position, Shani had applied the

fundamentals she had learned there to a later moment that resulted in ensuring patient safety in the future. By following her established routine of carefully checking all patient details, she put into motion a primary element of safe patient care - ensuring that the correct surgical procedure and the correct surgical site were recorded correctly on the operative slate, which is the master daily plan of activities in the surgical department. I sensed how others in the department respected, and perhaps came to rely on, Shani's ability and skill as a gatekeeper of safety, for Shani spoke of surgeons' and anaesthetists' concerns with her removal from the booking office. I considered how she used her knowledge to draw attention to specific details, and how her ability to recognize and address any discrepancy in information was an asset to patient safety in that department. I learned about Shani being displaced from that important function, and how others could envision that role as one easily performed by an administrative clerk if the role was interpreted as only reconciling paperwork. Yet, after hearing Shani's story I wondered if it was not so much a matter of who was reviewing patient information, but in how the review was approached. Shani's earlier experience of wrong consent actually occurred prior to the operating room clerks working in the booking office. I suspected the tension that others felt in Shani's leaving the booking office rose from their wondering if the next person in the booking office might have a different "idea of safety", one that differed from what they had come to expect from Shani. I reflected again on how an expectation held by others, for example, viewing the booking office as a first line of safety in the operating room and a place where "errors could be averted", could be disrupted and leave one feeling unsettled due to tensions arising from patient safety experiences in practice.

"How important is it to involve the family in the patient's pre-op check-in?" I inquired, thinking about the patient who did not speak English. "Oh, oh my goodness, I can't stress the importance of that," Shani emphasized. "At my previous hospital we used to do a lot of open heart. Now there is a lot of check-in to do with these open-heart cases; and you can see the family and patient are scared out of their minds. If there's family there, they're more than welcome to stay," Shani replied emphatically and continued. "Especially if it's an elderly person - sometimes they don't remember. I find that when they are stressed, they forget a lot of things or don't remember their meds or they can't hear well or

there's a language barrier – or sometimes they forgot to take off their glasses or their dentures, and the family member's there. You check them in but then you have to go back to the OR room, so they are alone for 10, 15, 20 minutes in the holding room – at least they would have somebody to talk to. That makes them feel more at ease..." "And I think some patients don't want to contradict what the doctor or nurse says, so they agree to everything," I added. "Yes, that's right," Shani replied, "It's good to have the family there."

I recalled Shani's earlier words "it's good to have family", and I considered how she supported the inclusion of family throughout the patient's surgical journey. From personal experience, she understood how surgery could create stressful moments in one's life, and how important it was to have support from family or someone close. I wondered if the presence of family might have been even more important for non-English speaking patients in an English speaking hospital, for the limited communication may have compounded other stressors during the experience. I learned through the inclusion of family in the patient's pre-op surgical time, how Shani did not consider the patient and procedure as two separate entities. In connecting interpersonally with the family and encouraging them to remain with the patient as long as possible, I understood how Shani appreciated the patient as a being in a most uncertain moment, with highly specific emotional needs. Thus in her story, the presence of family was one thread that Shani pulled through her practice and used to deliver safe care.

Differences Between Work Colleagues

Shani and I talked about our work experience in different surgical specialties. I had mentioned how surgical technique and approach for the same surgery could differ between individual surgeons. I offered, "What I found is that some nurses have memorized what they're supposed to do. There seems to be no understanding of the procedure. And because they were so set in doing the procedure one way, they struggled if there was something unusual during the case, or if they had to learn a different way for another surgeon." Shani agreed and said, "I wonder if that stems from not having that higher level of education – the ability to think things through and put the reasoning behind your actions. I've noticed that a lot. I am at the point where I can tell in the OR, who has had higher education and who does not." "Is that frustrating for you, nurses not thinking things through?" I asked.

"Very frustrating!" she said and continued. "For example, we brought insertion of pacemakers into Union Hospital as a new service. I had worked with the surgeon who would be doing them when I was at Crawford Specialty. So I was very comfortable, you know, with the way he did things, why he did them, all that kind of thing. So when we had new nurses I would scrub in. I would be seconded to second scrub with them and some nurses wouldn't get it. They wouldn't understand why the wire's going this way or the steps, why you do what you do – even though you try to explain, 'Oh, this is what he's doing, this is why he's doing it, so this is what's going to come next, and think of it that way'. Except they couldn't grasp that concept - to them it was just easier to memorize it! And to me, it plays back to patient safety. Because - I don't know how to put this – you're just going through the motions. It may be OK for the patient, because the surgeon's there and he knows what he's doing, but if the nurse is not ready for what's coming up next... I mean, the patient needs the pacemaker for a reason. And there's a certain time when you're putting it in, that the patient doesn't have a very good rhythm and that's a very crucial time, and you've got to be bang on."

I recalled assisting with pacemaker insertions and said, "The rhythm has to be captured". And Shani quickly continued, "Right, and that's where everything has to be bang on from that point. And if you're fumbling because you don't know what to do next, because you've memorized it and you've forgotten the steps, or whatever, then it can have an impact on patient safety. Because obviously everyone's getting stressed, the anaesthetist is stressed, and the patient's awake. So when I'm second scrubbing, I'm always looking at the ECG thinking, 'Come on, come on...' You want to stay hands off, but you also know what's at stake. But another time, a nurse who was in the room observed us and said, 'Well, we're doing a pacemaker again next week. Can you second scrub with me because I've never done one?' And I said, 'OK, that's fine. We can do that.' I just stayed, got approval from the manager to stay overtime to help her do that. She was quite happy with that. The surgeon who was inserting the pacemaker remembered me from Crawford, and he knew that I knew what I was doing. He's a very good teacher. He loves having students. He has no problem with that at all. But he was appreciative that I was there and he actually thanked me at the end. He said, 'Thank you for second scrubbing with her. I'm glad you were there. You know, that pacemaker was a bit of a scary one to do.' He said he was glad

that I was there to help the nurse along so that he could concentrate on his part, and not have to teach at the same time."

I recalled that Shani told me she had entered a university-based nursing program to obtain her nursing degree. I realized this was a significant personal achievement for her, as she had previously described how her family highly regarded her career not only as a nurse, but also as an operating room nurse. I also recognized that this was a professional achievement for Shani. She viewed her ability to "think things through" and to "put reason behind actions" contributed to her skill and competence as an operating room nurse, whether she was in the booking office or the theatre. I also learned how she considered a "higher level of education" as beneficial for operating room nurses, in order to perform their role to the best of their ability, by being responsible for actively thinking about what they were about to do and for choosing an action that best supported safe patient care.

Shani spoke about her experience with pacemaker insertions and how she offered support and direction to nurses who were unfamiliar with the procedure by second scrubbing with them and explaining the "what" and "why" of the procedure. I heard the frustration in Shani's voice as she described her experience with nurses who relied on memorization of procedural steps, rather than on their understanding of what to do if the approach deviated from the expected way. Yet, I also heard how Shani willingly continued to teach this new procedure to nurses, just as her operating room mentor repeatedly taught procedures to new nurses, years ago. I considered how pleased Shani was when another nurse asked for assistance in learning about pacemaker insertions, and how she felt recognized for her knowledge and teaching ability. I learned how she valued the teaching-learning relationship from the perspective of both teacher and novice, and how her commitment to support any nurse`s learning, no matter when the opportunity arose, was demonstrated by her working overtime. I understood how that action supported learning and patient safety as a flexible endeavour, rather than an activity impeded by a defined work schedule.

Even though Shani voiced her frustration in our conversation, I realized that she remained "very encouraging and very positive" in her teaching approach with others. I wondered if the experience she described related to how some nurses presented themselves to others as professionals, and the manner in

which they applied and broadened their practical knowledge. I reflected on Shani`s words about some nurses not "grasping the concept", perhaps suggesting a poor understanding of anatomy and physiology as it related to the surgical context. I sensed as Shani spoke that she felt higher education led to optimal practice as a professional operating room nurse. I learned how Shani felt her own educational preparation had contributed to her competence and capacity as an operating room nurse and how subsequently, she was held in high regard as a skilled professional by many work colleagues and family members. I also heard in her story how she viewed the memorization of steps as less than ideal nursing practice, for patient safety could be adversely affected if nurses could not anticipate what was required of them at any given moment during a procedure. I understood that even if a nurse did not have higher education, Shani held an expectation that they would learn and understand surgical procedures as a reflection of professional responsibility and accountability to the patient, as well as to one's colleagues.

I reflected on how the notion of memorizing a procedure, rather than understanding a procedure, was a tension for Shani, for she viewed this approach did not support safe practice for the operating room team or for the patient. I considered how she worked within that tension to encourage and foster the learning of other nurses, and how she willingly stayed to assist nurses so they could understand the pacemaker procedure. And in a fashion similar to her mentor from her early operating room days, knew "what was at stake" and when to step in to provide necessary assistance. I learned how Shani was a mentor for inexperienced nurses, now, and how she demonstrated to them and, perhaps, expected from them, responsibility and accountability for nursing practice. This was through an approach of learning, understanding, and awareness to the unfolding moment, rather than "going through the motions" of patient care. I understood how nurses shaped their practice to best support safe patient care in specialty areas, and of the expertise that was required of nurses in these units. It made me question, further, how some nurses could feel comfortable in their practice of memorization. I also appreciated how Shani came to know safe nursing practice as one based on a combination of sound understanding of patient, procedural, and contextual knowledge - nursing practice rooted in "the whole picture".

Shani continued to talk about work in her department, noting that, “I noticed younger nurses in the department. They take their patients in and they don’t – well, they get mad at me because I take so long to check-in the patients. But it’s just one of those old school things that I’ve been taught, right? You go through the consent. You make sure the patient understands what they are having done. And the young nurses, I’ve seen them do half the checks that I do – don’t talk to the patient, don’t worry about what the consent says, ‘Yah, yah, you’re fine, let’s go’ – you know? The rush, rush, rush. What if that wrong consent that I found had been missed? Nobody would have noticed it if you just go by the consent. The younger nurses, I found, think it’s the old-fashioned way. Their attitude seems to be that you’re doing too much.” *“*Doing too much? That you’re worrying too much?” I asked. Shani replied, “Yeah, it’s like ‘the older ones are like that...”

I sensed that Shani felt a difference in nursing practice between younger and older nurses in her department. “Can you tell me more about this?” I asked. Shani explained, “I would say two-thirds of the nurses are newer, younger, under 30 years old. The older ones are starting to retire now.” I clarified with Shani that her use of newer and younger conveyed the same meaning, that is, a nurse younger in years with lesser years of experience than she. “Personally, I get along with the older staff members more, although I’m nowhere near retiring. I’m 40. But it’s the way they do things. It’s much more conducive to the way I work, how I’ve been taught. I don’t like the cutting corners, and with the younger staff I found quite a bit of that.”

As Shani spoke, I heard in her story how she felt the younger nurses were dismissive of her focused, and at times lengthy, moments spent with patients during the patient check-in process. I sensed how Shani felt they were impatient with her way of nursing, as she spoke about the “old school things” she was taught as an operating room student nurse, the same elements she used to support her practice over the years as she became a highly competent nurse. I thought about some of the experiences that Shani had earlier described. And how through her “old school ways” that focused on detail, as well as on awareness of what was unfolding at the moment, patient safety remained in the forefront of her mind, thus potentially serious incidents were avoided. I reflected on Shani’s comments that the younger staff viewed her as “old-fashioned”, and I

imagined how this might cause her to feel her clinical abilities and knowledge as underappreciated. I learned how she felt this to be a challenge to her professional identity when her expectation of competence and excellence in nursing practice, as she had come to know it, was undermined through the actions of some younger nurses. Yet, her consistent and skilled approach in meeting patient's specific needs was precisely what was required to maintain a high level of patient safety in the operating room.

Shani earlier said how stressful the moment surrounding the patient check-in could be for the patient and the family. I heard how she viewed that time spent with the patient as an opportunity to establish a relationship, one that conveyed concern for their well-being and her intent to deliver safe care. I learned that as she spent time engaging with patients, addressing concerns they might have, her childhood goal of becoming a certain type of nurse was reflected, for she acknowledged the patient as a human being who could benefit from her years of experience and skill as a safety-minded operating room nurse. Shani commented on how many younger nurses "cut corners" in their work; and I thought how she might have viewed this as irresponsible and unsafe nursing practice. I considered, as I listened to her story, that she felt the younger nurses related to the patient as a surgical case, not as a person with specific needs as they rushed about their work and seemed lackadaisical in their patient check.

Shani said she felt more comfortable working with older staff members because of the "way they did things", which reflected how she was taught as an operating room nursing student. I thought about this and I reflected on how Shani respected their nursing practice, something she perhaps did not always feel from the younger nurses. I also learned how Shani respected the older nurses as knowledgeable nurses, who she could learn a great deal from, even though she herself was an experienced and skilled nurse. I had no answer to why Shani referred to her own nursing approach as "old school" or "old-fashioned". Perhaps that perception stemmed from her comfort in associating with older nurses and viewing their learning as "old-fashioned" in comparison to today's learning methods; or perhaps it was a sense that being older was synonymous with "old-fashioned". As I thought about that, I wondered if the tension that Shani worked within was a generational difference or a difference reflecting the educational preparation of operating room nurses over the years; a difference that, through a

particular way of nursing, revealed what it meant for an individual to be a highly skilled and well educated professional.

Shani continued, “This is pretty basic, but I noticed the newer nurses that have memorized the steps in a procedure wouldn’t do a large prep in the event of having to open a lap chole. In my mind they’re thinking, ‘Well, the surgeon’s just going here, here and here – prep to here.’ Shani was describing the patient’s surgical skin preparation with antiseptic soap and the small area of placement of laparoscopic ports for this surgery. “But if they open, you’re not prepped high enough! You need to go to here.” Shani again described, by motion, a larger abdominal area, as she spoke about the possibility of having to convert from a laparoscopic procedure to an open procedure that involves a large incision in the patient’s right upper quadrant. “And then a lot of the time, I noticed new nurses would come in when I’m prepping, and they say, ‘You’re going too high,’ and I’m saying, ‘No I’m not. What if he has to open?’ Then they stand back and you can see them, the look on their faces, ‘Oh...’ It doesn’t occur to them, because they’re so ingrained in how you do it and not why you’re doing it – that is also patient safety, because of your infection rate.”

“I’m glad you raised this point, Shani. I thought I was the only one grumbling that preps weren’t done wide enough,” I commented and shared with her that many times I, too, had requested the nurse to extend the surgical prep area in the event of an unforeseen circumstance. “No, no,” she replied, indicating I wasn’t alone in my thoughts. “And it really ticks me off because the new nurses would look at you like ‘you’re nuts – you’re going way overboard with your prepping’. They don’t say anything, but you can see it in their face, or rolling their eyes. The surgeons generally appreciate me doing that, a wider prep. Maybe it’s the way they’ve been taught - that they know, because they’re new, and they’re young and they’re fresh – they know what’s best.” “Oh, and you’ve ‘been around awhile?” I suggested. Shani replied, “Yeah, so you don’t know, you’re ‘old school’. I’ve been at Union General for a few years now, but before, I was at Crawford Specialty for over 10 years, so I’ve been in the OR for quite awhile.”

I knew that Crawford Specialty was a large, tertiary care referral hospital, with a busy surgical department providing a vast array of surgical services ranging from general surgery to open heart surgery. I commented, “You’ve had a lot of experience.” “Yeah, lots of good experience,” Shani replied emphatically.

“The way I see it, I’ve had lots of good experience. The manager that was here at Union saw the experience I came with, and she put that to use. For example, helping with new nurses coming in and their orientation, or helping to scrub for surgeries I had done frequently at Crawford when they were brand new to the staff here. So, using me in that way was a big confidence booster for me. But I found it quite difficult sometimes, because you’d be standing up against two other nurses in the room – sometimes we have three in the room for the big cases – who are younger than you. They’re on one side and you’re on the other, and they don’t think you know what you’re doing because you’re old. There are more younger nurses and the older nurses are not going to be there for that much longer. They don’t find it worth their stress level to fight, so they just go with the flow, which is kind of sad. Because I can see at Union General, we’re losing a lot of standards there.”

I heard in Shani’s story how her manager recognized, respected, and drew upon her vast clinical experience and knowledge. Yet, I again sensed how she felt some younger nurses devalued the very same qualities, leading to unpleasant work situations. I thought again how Shani felt some younger nurses viewed her nursing practice as “old school”. I reflected about advances that, over recent years, significantly changed the field of surgery, for example, the laparoscopic approach to surgery as a routine approach for many procedures. I realized it was quite possible that many younger nurses might never have experienced these surgeries as anything other than laparoscopic surgery. If that was the case, I considered how Shani’s preparation of the patient, in anticipation for the possible need of an alternate surgical approach, might have been considered “old school”. Yet, I also learned how Shani’s experience with, and awareness of, the “whole picture” was reflected in her nursing care as she took consistent measures to carefully prepare for an unexpected surgical event.

I reflected on Shani’s operating room nursing education and her early operating room days and how she gained direction in her nursing practice from nurses more experienced than she was, as well as how she viewed those nurses as mentors. I wondered about the operating room nursing education which the younger nurses who Shani spoke of might have had, and how they might have been mentored in their nursing practice. I considered as I listened to her story how Shani felt the younger nurses were trying to establish themselves as good

operating room nurses, but in their rush to do so they hadn't yet learned to be sensitive to what surrounded them in its entirety, or to sufficiently understand how their actions ultimately affected patient safety in the operating room.

As Shani spoke about the differences she felt in working with younger and older nurses, I realized how she was not accustomed to this generational tension in her everyday life. Shani spoke about her parents' involvement in the care of her children and how as a family, they kept close ties here and in South Asia. I thought of the different generations in her family and how each was valued and respected, as well as included in the daily world of one another. I learned how her life experiences and expectations of relating to elders and youngsters contrasted with her current work experience, where as an older, experienced nurse she did not always feel appreciated or respected for her knowledge and nursing practice experience. I understood how her personal life intersected with her professional life for over the years she had come to know a way of living that appreciated a multi-generational presence. Yet, this same relational approach presented as a strain within her professional work, and I wondered if the more she pushed back against this tension, the more she felt its weight on her with patient safety pushed aside.

I sensed how certain others in her current workplace might have devalued Shani's focus and respect for patient safety in their critique of her practice and desire to nurse "right". Shani felt that the tension between younger and older nurses affected patient safety in the department, and that nursing standards were not being met. As I thought more about the tensions of difference that Shani worked in, I reflected on the words of Escobar (2008) "...conflicts do not arise out of the difference per se, but out of the difference the difference makes in the definition of social life" (p. 14). In this sense, the tension for Shani and her colleagues related to whose practices and knowledge would define the values and conditions that regulated safety processes in the operating room (p. 14). I also considered how Shani worked within that discord, in order to ensure nursing practice was safe and reflected nursing standards by pulling from her past learning that which guided her present work. For over the years, she had learned to see the "whole picture"; she learned how responsible and accountable nursing practice supported patient safety. I believed that the tension she experienced reinforced her way of nursing as safe nursing; and in that tension

she was determined to apply her broad knowledge and experience so as to define patient safety in that department.

The Patient is our Work Focus

Shani and I spoke about the changing technology in operating rooms. "Our actual charting is still on paper, but all of our requisitions and lab results, it's all on computer," Shani said. "Do you find it can be distracting to be on the computer in the OR, with the patient flow?" I inquired. Shani immediately replied, "I think it depends on the person that's in there. For myself, if there is a computer terminal there, it is more to look up x-rays and history, and the labs that haven't come in on paper yet, which is what I definitely use it for, and, the odd time to check my work email to see if there's anything important. I know many nurses, they have used it for surfing during the case and I do not agree with that. To me, you should be paying attention to the patient and surgeon, and making sure their needs are met; not with your back to them and on the computer shopping on E-Bay kind of thing. That's what I found with a lot of the younger nurses. With the older nurses, they're the same kind of mindset that I am, that you should only be on the computer for patient purposes. Yes, you may need to go to the internet if there's a procedure coming up that you're not sure of; you plug it in so you know what it's all about. Or there's some anatomy you're not sure of, you want to look it up and it's pertinent to that case, that's fine. But 'us' senior nurses don't think you should be using the computer for more than that. If it's on your break, fine, go ahead, do what you want. But when the patient's in the room, your focus should be on the patient, the surgeon, and anaesthetist," Shani concluded adamantly.

As our conversation turned to technological advances in the operating room, I gathered that the way in which some nurses made use of technology during their work was a tension for Shani. She felt that rather than using it to support their work, the work of others, or patient care, many younger nurses used computers for social purposes. I had noticed that Shani was most comfortable and adept with various digital devices in her daily life. Yet, I sensed how she set apart her social and professional worlds when it came to computer usage in the workplace. In her story, I heard how she separated the social elements of technology from the practical elements, and how she held clinical vigilance as primary in her patient care. Shani had earlier spoken about how she felt some nurses were unfocused in their patient care. I learned how she felt strongly that

the way in which some nurses used technology in the operating room turned their focus even further away from the patient, the surgical team, and their surroundings and could potentially lead to compromised patient care.

I thought about what it meant to Shani to be a professional and competent operating room nurse in a changing environment, and how her way of nursing contrasted with the way some other nurses approached their practice. I sensed how through their actions, she felt some nurses did not act in a professional or responsible manner when their focus was primarily on themselves, rather than on supporting safe patient care. This drew me to think again about the discrepancy Shani felt between her childhood image of a professional nurse and her personal experience, and how this contrast continued to surface as an ongoing tension in her work life.

Shani said that "senior nurses" did not agree with using the computer for social purposes during active work moments. I thought about what Shani said earlier about being "old school" in her ways, and how she aligned herself with senior nurses because their practice reflected how she was taught to nurse; thus, how she continued to nurse. I learned that despite feeling "old school", Shani was most aware of her evolving work environment and that she used her patience and perceptiveness to adjust her established nursing routine, in order to incorporate technological advances in the operating room. Rather than allowing the advances to divert or control her patient focus, I understood how Shani used these advances in a controlled way, for example, to gain information about a specific procedure or an anatomical inquiry. I marveled at how that control maintained her patient focus and reflected her way of professional nursing.

"Shani, you described many younger nurses using the computer in a different capacity than the older nurses. Do you think this is part of the technology explosion the younger people live?" I inquired. "Texting, all this texting, they're used to texting and e-mailing," Shani replied. "To me, they're not used to phone calls or face-to-face conversations. I was thinking about this last night actually. When I did my OR course, one of the specific requirements was that you had to work on an acute ward for a year before you could be accepted into the course. This is why I was on an acute ward; it was one of my stepping-stones. Now, with most new programs, you don't need to have the experience. So you can go straight into the OR program without having that acute care

experience. And I think what's happening is that the nurses aren't having that one on one patient contact, and that overall scheme of things, the holistic patient view – dealing with the family, dealing with everything that it encompasses – and having the experiences with all the little medical things that may come up with these patients. And because they don't have that experience, I think they're so in tune to getting the patient in and getting the patient to sleep, and that's it. None of this patient focus is quite there. I was thinking about it last night, thinking that maybe that has something to do with it. We don't do the high, intense OR cases here at the Union OR. I find new nurses don't get these experiences here. I think in a sense it should be mandatory for all OR nurses, not only to do a year of acute care, but also to do a year in a tertiary care hospital with all the shift work, and all the trauma cases that come in. Because I think it is a real eye opener and you get hands on. You may never have to do an arterial line again at this hospital, but at the other hospital you needed to do one in 30 seconds, no problem. I'm finding that all of those experiences help you to see the bigger picture, so you can cope in situations."

I thought about what Shani had said and realized I had forgotten that nurses were once required to have worked on an acute care ward for a specified period, prior to acceptance into a specialty-nursing program. "How valuable for you was that year on the acute care ward before you went into the OR?" I inquired. Shani earnestly replied, "Very, very extremely, at that time I was thinking, 'Oh man, I can't wait to get out of here,' she laughed. "But now looking back, all those skills I learned, the organizational skills, the patient focus skills, the background of all the medical issues and problems that patients come with, the family issues that you can deal with, you know – it all helps." She emphasized, "I find these new nurses don't have that whole picture. You do one or maybe a couple of OR follow-throughs during your program. Well, that doesn't really tell you anything. The follow-through usually just encompasses the patient transfer to the ward and that's it. You're not looking after them for two or three days post-op, so you don't see the other stuff."

As Shani spoke, I heard how she felt many younger nurses in the operating room lacked an awareness of or sensitivity to, their surroundings and the many people in it. She felt that the ability to now enter an operating room program with only minimal clinical experience, or in some instances with no

foundationally solid nursing experience, resulted in junior nurses missing a vital opportunity to appreciate and understand "that whole picture" of patient care that would support their work in the theatre suite. I also wondered if Shani felt this was a lost opportunity in their path of "stepping stones" in learning to develop professional values and accountability in practice, even before they started work in the operating room.

I reflected on Shani's thoughts about some nurses' inexperience with face-to-face patient conversations or other focused patient care moments. And I felt how she thought this specific "greenness" could be detrimental to patient care in the operating room. From my own experience, I recalled that many people viewed operating room nursing as primarily a technical function and nursing as, they envisioned, quite limited, especially when patients were anaesthetized soon after their arrival in the theatre suite. I thought how it was easy to imagine operating room nursing in that manner if a person did not have an appreciation of what it meant to be a nurse in the operating room. Shani spoke about some nurses responding to technology in their life with a sense of ease and proficiency. Yet, she also felt they were unable to respond to a patient in their care in a similar manner. I felt an underlying tension come forth as I sensed how Shani's practice as a professional operating room nurse contrasted with the practice she had observed in some junior nurses. I learned how the actions of some junior nurses kept the tension awake and unresolved for Shani, and how this discord kept her connected with her earlier days as a junior nurse. As a novice, Shani had been taught and learned what it meant to be always aware of, and focused on, her duties and the actions of others. I understood how she now experienced what this meant as a senior nurse, as she worked at encouraging junior nurses to be aware of their actions and to know what surrounded them.

Shani spoke of her time spent on an acute care ward working with patients and their families as a valuable moment in her life. I sensed how her awareness to the life moments of her patients and their families, as well as her recognition of patients as beings connected to a world away from the hospital, developed over time as a junior nurse. And I thought how she always took that understanding of the "bigger picture" with her as she learned to become an operating room nurse. I also appreciated how she kept her awareness of the

notion of life as unfolding all around her in the forefront of her mind, and in any department she worked in.

As Shani spoke, I learned how her thoughts about what the ideal minimum preparation of a novice operating room nurse might be were a reflection of her own experiences of higher education, of clinical work as a junior nurse, and of time spent working in a tertiary care operating room after the completion of her program. I understood how she felt those kinds of experiences would develop the novice nurse's focus on the patient as a person, and that it would encourage nurses to "think things through and put reasoning behind their actions" when they engaged in patient care. I appreciated how Shani viewed those moments as contributing to her own practice as an engaged, safety minded professional; and I reflected on how she wished that all operating room nurses could have a similar experience.

Shani continued, "It's ingrained in me that when the patient's falling asleep, that you're right there. You're holding their hand if they need their hand held, you're comforting, you're talking to them, you're making them feel more at ease. The young ones are just...they're standing there, but they turn around and they talk to their co-worker. They talk to the anaesthetist, socialize, whatever. They are not focused on the patient! And to me that's not right. I've always been taught that if the patient goes to sleep calmer, they wake up calmer, and to me that's patient safety." I replied, "I was taught even to be quiet when opening instruments and counting." Shani emphasized, "Yes, that's how I was taught, that it's quiet, none of this extra ruckus."

I offered, "It sounds as if you take the time to establish a relationship with your patient, even if you're only going to see them for an hour." Shani laughed as she replied, "You could say I'm very patient oriented." I continued, "I think creating that relationship indicates, 'I'm here to look after you. You're the only one that's important to me right now.'" "I've been on the other side, the receiving end in the OR," Shani replied and gloomily recalled an experience. "I had surgery. It was an emergency at 3 o'clock in the morning. I was on the operating room table. I knew everybody in the room. This really got me. Here I am. I'm falling asleep and I don't know if they assumed because I was an OR nurse, and I worked with them it was fine, no big deal, but nobody was there while I was

going to sleep. The nurses were both there at the back table talking away. And I'm thinking, 'Oh my god – thanks guys."

"You're there as a patient and you need somebody..." I began to say and Shani continued. "I fell asleep. The anaesthetist was putting the propofol through the IV and looking down at the nurses, talking to each other. And nobody was even standing at the arm board. I'm thinking, 'You've got to be kidding me!' I was not impressed," she said bluntly. "It's not like they were brand new. I guess they had just assumed, because I worked there and I knew what was going on, that it was fine. It's scarier as far as I'm concerned, because you know what can go wrong." I agreed and added, "Someone should be there with you to say, 'I'm here if you need me', and also be there to assist the anaesthetist." Shani agreed, "Yes, that's right. I was very disappointed."

As I reflected on Shani's story, I thought how revealing her first few words were, 'It's ingrained in me to be with the patient', and I felt how she remained connected with a way of nursing safely that began years ago. I thought how through her early nursing experiences, she had learned about keeping her focus on the immediate concern, especially during critical moments in patient care, and how she understood what it meant to be present for the patient. I understood the power of Shani's words as she described herself "being there" for the patient during their anaesthetic induction, ensuring a calm environment, remaining by the patient's side, and assisting the anaesthetist as required. I appreciated how she related to her patient as someone whose presence mattered overall, and I thought how her "ingrained" learning remained a strong presence in her approach to patient care. As I listened to Shani speak, I felt a familiar thread from long ago stretch forward and weave through her story. I sensed how she held her childhood hospitalization experience close to her as it accompanied her throughout her nursing education and career. And I felt how the tension of a long ago moment surfaced in Shani's surgical experience as an adult, and how it solidified her image of what it meant to nurse "right".

She described how during her emergency surgery, she felt a gap between an expected standard of care and the nursing care as she experienced it. I thought how that distance was made even greater when she recalled the operating room nurses who physically stood apart from her and the anaesthetist during her time of need. I sensed how through their indifference, they failed to

acknowledge Shani as a patient, as a colleague, and especially as a person in this world. I appreciated how she must have felt vulnerable as an invisible patient. I also recognized how patient safety was set aside as the nurses focused on themselves and neglected the patient-nurse relationship that was presented to them. Shani described the nurses as "not brand new'. And this reminded me of the responsibility of all nurses, junior and senior, to not only develop a perceptiveness to what presents to them in the moment, but also an awareness of the responses required to ensure the safety needs of all persons are met in that immediate environment. As I listened to Shani, I understood even more fully how her personal life continued to mesh with her professional one; thus her experiences knotted together to keep the connection to her past learnings fixed in the present.

Patient Safety in Different Workplaces

"Shani, you earlier said that you were also working at a private surgery clinic. Was there any discussion about patient safety there?" I inquired. Shani replied, "Well, they did tell me that it was more patient oriented because it was a private clinic. They cater, you know. The rooms where all the patients wait – you would think you're in a spa. There are big, fluffy bathrobes they get to wear on top of their gowns, and piped-in calming music, and lounge chairs. It's all very touchy-feely. They're very oriented to make the patient feel calm and comfortable. In terms of patient safety, there is a standard. They do put sequential compression devices on all of their patients, warming blankets on all of their patients. It's a standard there, whereas in the hospital you don't do that for every patient." Shani continued, "I had noticed other things in terms of patient safety. Their sterilization is up to par. It is all done in-house. The patients they see for surgery are so healthy. They're ASA 1's and 2's. Anaesthesia does go through the charts of all the patients and they do the appropriate blood work and x-rays that they might need. They have a crash cart there. They have the malignant hyperthermia stuff there – totally prepared. I know a couple of the anaesthetists there. They are from my old hospital. They're not just fresh out of school. These are very seasoned anaesthetists and the same with the surgeons, very experienced. Even the nurses are very seasoned nurses. They're the ones who just want to cut back on work hours, not have high stress, which is what I wanted - no call, no weekends. The surgeons choose and hire who works at the

clinic, and everybody seems to get along quite well. It seems to be a very close-knit family. It's nice. They are all nice. "

As Shani talked about working at a private surgery clinic, I heard how she identified readily with the "seasoned" nurses and how her image and practice as a knowledgeable, highly experienced nurse was confirmed in being hired to work there. She described the clinic environment as specifically focused on making the patient "feel calm and comfortable"; yet, she also identified the numerous safety processes in place for each patient. I heard in her story how, unlike a hospital environment where a patient may feel a sense of clinical detachment from their surroundings and care providers at times, the clinic environment fostered and supported a sense of patient inclusiveness. I reflected on how a specific, consistent approach to patient safety underlay the focused patient care, for what initially appeared as seemingly simple patient comfort measures were actually measures that controlled and supported patients throughout their entire surgical experience. For example, a "big, fluffy, bathrobe" and "warming blanket" would keep a clinic patient warm by supporting minimal body temperature fluctuations, which in turn can limit the incidence of post-operative infection. However, not all patients in a hospital operating room would routinely be warmed pre- or intra-operatively, thereby minimizing a patient safety opportunity.

I reflected further on how the purposeful selection of like-minded, experienced staff, whose professional and personal values and qualities resonated with the surgeons, was instrumental in achieving and maintaining focused patient care. I considered how the surgeons had come to know the necessity of effective working relationships, clinical expertise, and a structured way of collective practice as foundational elements of safer patient care. While patient safety can never be absolute, I also considered how the careful selection of patients was a process focused on minimizing overall care risk in the clinic. Surgery on patients with varying acuity levels and multiple co-morbidities has become a norm in the hospital setting, but only the healthiest patients presented for surgery at the clinic; and it was desire, not need that determined patient access.

Shani alluded to her clinic colleagues as enjoying good working relationships and she described them as a "close-knit family". I sensed how important this closeness was for her in her work at the clinic, for it reflected

similar values she had come to expect and live by in her daily life. I thought how her way of living had begun long ago in her personal life and had then crossed paths with her professional life, as she experienced and learned to understand the "whole picture" of being a patient and of the intricacies of patient care. I thought how in this "family" of professionals, Shani felt appreciated and respected for her focused way of nursing, similar to what she felt from her own family in her life away from work. I also sensed how her attention to the "whole picture" of patient care was validated and how she now could live it as an expectation and standard of care at the clinic, as well as not feel that her approach was at odds with that of other colleagues. I connected how Shani's "old school" ways of working meshed seamlessly with the work of the clinic, and I considered how others respected her as a skilled and competent professional, because of how she nursed. I recalled what Shani said earlier about purposely connecting with older, more experienced nurses whenever she could, because their practice reflected her own. I thought how in the clinic she no longer had to search for those alignments to support her work, because she was now part of a "close-knit family" of "very seasoned nurses". I wondered if the tensions that Shani had felt in her operating room work, elsewhere, had minimized at the clinic for while she remained ever vigilant to safety concerns, she could now attend to safe patient care as the nurse and individual she had become. And who she had become was a person who responded to the unique needs of others, because it was the "right" way of recognizing the "whole picture" of humanness in each one of us.

"You've worked in several OR departments," I said to Shani, "Can you tell me your sense of the patient safety atmosphere?" Shani pondered this for a moment and then explained, "I think at Crawford Specialty it was more obvious than at Union General. At Union General, patient safety didn't always seem to be a big issue. It was more nurse safety that was a big issue. For example, nurses arguing over smoke evacuators, pouring the formalin into the containers – which I agree, it is a safety issue, but it's not as important as immediate patient safety. The patient safety didn't seem, for some reason... well, you just see things, you know. I'm used to the fact that as soon as you get the patient back on their stretcher post-op, the side rails go up immediately. There was always - I always found a lag. There was somebody standing there, but they didn't immediately put the side rails up. Or the patient's airway wasn't always an issue. They were not

concerned about it. ‘Is the patient OK?’ When the anaesthetist was putting the patient to sleep or when the patient was waking up – you’re there, in case of laryngospasm, who knows what can happen. You need to be there to help, an extra pair of hands. Well, some nurses didn’t find it a priority, maybe, to be there when the patient was being extubated or intubated. It just seemed to me it was more ‘get this place turned over quickly, cleaned up, get out of here, when can we go on our break’ you know, ‘make sure instrument pans aren’t too heavy’, all that versus taking care of the patient.”

I replied, “It’s as if there wasn’t that awareness on the patient, completely.” Shani commented quickly, “It’s a lot to do with some of the individuals that are there. They seemed to be in it for the job, not because they wanted to help the people. I think before when a person went into nursing, it was because they cared about their patients. They enjoyed doing what came with it. I think nowadays, there are people entering the profession because it’s a job. They don’t see the emotional side of it or the psychological side of it.” Shani paused and then continued, “So it’s sad to see, because I know at Crawford there was the awareness, the patient safety, the awareness was there. There was always somebody there when being intubated, always somebody there when the patient was coming back out, always somebody there for the patient. You did not just stand back and worry about the changeover. They expected a higher calibre of practice and knowledge in that OR, because there was so much trauma and neuro and vascular. They expected it and if you didn’t have it, they expected you to speak up and say what you needed. I think because it was such a fast, fast paced OR, you didn’t have the opportunity to sit and chat and socialize, and pick on others. And when I went to Union OR, I wasn’t used to that. It was very disturbing to me. I was used to everybody getting along with everybody else, one big happy family.”

Shani continued, “Oh, I’ve seen it so many times for some reason. I don’t know if it’s the language barrier or what, when patients came in at Union having eaten breakfast or they’ve had tea, or they were chewing gum until they got to daycare. A couple of anaesthetists are very strong, firm about that. If the patient had eaten, if they were chewing gum, or if they had something to drink, we would not do their surgery. That’s it. But then the surgeon would come back and push, and say, ‘Well, I’ll do the patient under local anaesthetic instead of general’.”

Recalling my own experiences of surgeon and anaesthetist conflict concerning patients who had not remained fasting, I responded, “Or the surgeon might say, ‘We’ll do them at the end of my list’.” “Yes, do the patient at the end of the list,” Shani agreed and continued, “So then the patient safety issue kind of goes out the window. The anaesthetists are concerned but it’s like they’re mowed over by the surgeons, because the surgeons need to get their cases done, so the anaesthetists feel pressured to do it. But looking at the patient safety part of it, what is best for the patient? Yes, you might have to fast again and come in another day, but in the end, if you get a severe complication, how was patient safety considered?”

As Shani spoke, I acknowledged how over the years a rooted safety ethic had become a driving force that supported her way of nursing. I appreciated how Shani’s training and mentors had provided her with a sense of structure that she was expected to know and work within; and I heard in her stories how following that framework enabled her to become a responsible and accountable nurse. I also heard how a way of nursing that she had come to rely on, was not always evident, nor similarly demonstrated by others, in all of the operating rooms in which she had worked. I reflected on how, in feeling the rub between what she had learned and expected as standard nursing practice in the operating room, as well as what she had over the years come to experience and witness, she turned to her firmly held past practices, in order to help inform and guide ethical acts of patient safety in those in-between moments.

I reflected on Shani’s thoughts about why some people were motivated to enter the nursing profession and how those presumed reasons for becoming a nurse were quite unlike her own. I felt her passion for nursing and being a nurse weave throughout our many conversations, as well as her disapproval of those who did not seemingly embrace nursing as a genuine response to humankind. I realized how (when she spoke about some nurses’ disregard for the “emotional” or “psychological” aspect of nursing) the tensions of her past personal experiences (as a patient feeling a lack of compassion and care from care-providers) were brought forward in self-awareness. I thought again about what it meant to Shani to nurse “right”; and how her personal and professional experiences combined to develop her sensitivity to, and awareness of, the needs of others as a “priority” of nursing work. I learned how she remained extremely

vigilant of others whose idea of safety in practice was exemplified through a "lag" in response. I also learned how her early experiences as a vigilant operating room student living the tensions of patient safety continued to surface and be reflected in her practice today.

I understood how through her nursing practice, Shani connected deeply to her patients and to her workplace, and in this way supported and sustained the safe care of patients. Yet, I also heard how she felt others did not form a sincere attachment with their workplace or their patients, when social convenience rather than commitment to society seemed to be their inspiration for nursing. I reflected on Shani's earlier conversation about her time as a junior nurse, and how she felt her work on an acute care ward prior to entering the operating room had opened her to the realities of humankind, as well as the ways in which she could respond. I thought further about her experience of a past workplace as "one big happy family", and I understood how that represented a relationally connected way of living, one that she was comfortable and familiar with at work and at home. Yet, I also heard in her story how some nurses did not value that structure and how this created a recurring tension for her. I admired how Shani's deliberate connection to her patients, her workplace, and the many people in it, was essential for her in developing an awareness to what unfolded in her work environment. And I realized she believed that without those foundational connections, a genuine recognition and response to humanity at its most basic level was sadly neglected.

Shani spoke about feeling an expectation of a "higher calibre" of practice in operating nurses in a particular workplace. I learned how this expectation resonated with her earlier thoughts about higher education supporting the competent practice of operating room nurses, and ultimately, resulting in quality patient care. I understood how Shani viewed the self-assessment of clinical competency as a necessary obligation of accountable and responsible professional nurses. I realized how ensuring accountability and responsibility for her own professional practice extended into and supported the practice of her colleagues and the safer care of patients. I acknowledged that Shani viewed accountability in practice to be not only her professional and personal responsibility, but it was also a fundamental responsibility she held toward her work colleagues and patients, for if she felt no responsibility to herself in

achieving excellence in practice, how could she support others in the same endeavour?

As Shani spoke about her experiences with patients not fasting pre-operatively at a particular hospital, I heard how she felt the activities of the operating room department (in response to some non-fasting patients) did not support patient safety in the best way possible. Shani had been taught that to be effective in ensuring safety of patients, established practice standards needed to be followed and upheld in the daily activities of that department. Yet, she again experienced discord between expected and actual practices. She understood the tension acutely when, rather than meeting the standards as a response to an unfolding patient situation, she realized that they had been minimized, in order to allow for the continuation of surgery. Patient care situations present, whereby many factors cannot be controlled, such as emergency surgery. I appreciated how not controlling and not being able to ensure patient safety to the highest degree in an elective surgical procedure stood far apart from what Shani had come to expect in her practice. Thus, I understood how the tension of patient safety in practice could never entirely be absent for Shani, for I believe she used that tension to reflect upon and question her practice and the practice of others. It was an ethical response to perceived professional complacency that she had seen growing in the operating room over time.

Reflecting on Past Experiences

As Shani and I continued to talk about operating room nursing, she shared the following story with me. She recalled, “I remember when I first started my OR nursing. I was on-call. I just finished my orientation and it was my first day of work. Lo and behold, my pager goes off,” she laughed. “We’re doing a stat craniotomy. I thought, ‘OK, I guess I’m fresh off my orientation. This will be good experience.’ Well, as I found out, the charge nurse at that time wasn’t the best-organized charge nurse. The surgeon on-call was a very fast surgeon and the patient was coming straight up from ER, so it’s not like we had a lot of time. Instead of having me scrub and set up as soon as I arrived - and a craniotomy is a big set up, especially for somebody who’s new – the charge nurse sent me into the other room to relieve for coffee! I was thinking, ‘Shouldn’t I be setting up?’ But I didn’t question it, because I was so new, completely green, off orientation. And you don’t question anything the charge nurse was doing. So I thought, ‘Maybe I

have more time than I think I do'. Then I hear that the patient's on the way up! The charge nurse said, 'You should go scrub now'. Well, nothing in the room had been opened - nobody was there opening supplies - and the charge nurse goes back into the other room to help there! So, I'm opening supplies. The patient comes in the room and I'm supposed to be the scrub nurse - and I'm circulating at the same time. The surgeon comes in and asks, 'Where's the scrub nurse?' I said, 'It's me'. He said, 'Why aren't you scrubbed?' He was not impressed. So, here I am going out to scrub. He opened whatever he could, and he and I are scrubbing side by side. Then the charge nurse came and helped the anaesthetist with the patient and I'm thinking, 'What a mess!' The surgeon is gowning and gloving at the same time I am, and then I had to wait for the rest of my supplies to be opened for me, and then set up my instruments. At the same time, the surgeon is opening the patient's head and I'm thinking, 'This is not right, this is not right.' He was not happy with me at all. But, you're the new person, you're there, you're the one to blame, right? Of course the charge nurse didn't come up and say, 'My fault. I should have got her to scrub and set up'."

Shani then described another experience. "Another time, one of our other charge nurses was very in tune to new staff needing more time. We had a patient who had chest surgery and was coming back for massive bleeding. We knew time was a big issue. The charge nurse had me set up and said, 'Look, I know what's on your instrument back table. I've written everything down on the count sheet. I want you to refer to it as you set up. If there's anything different, you let me know.' This way she could be free to deal with the patient. There were two circulating nurses. It was one of those all hands on deck cases. They were opening the sponge packs for me and I was handing up five at a time for the surgeon to soak up the blood. I would just throw them into the bucket and the other two nurses would then count them. So in that case, patient safety was definitely acknowledged, because there were all hands on deck and they were there to support us."

"How did those experiences impact on how you prepared afterwards for other cases?" I asked. Shani answered, "Well, as I became the more experienced nurse and we had new nurses come in, I always made sure they had enough time to set up. Even for myself, I wanted to make sure they had enough time to set up and count, and be prepared for the surgeon - especially for

emergency cases. You know what? I am not doing that to anybody or myself again – that's not going to happen," she said, in reference to her first on-call experience. "Often, it's the patient that suffers, because it's taking you that much longer to get in and fix their problem. And then of course, the surgeon's stressed, so if he's stressed, he's more flustered and maybe not as careful as he should be, because he's trying to do three things at once like you are - not good," she said pointedly.

As I reflected on Shani's story, I thought how through her experiences as a new operating room nurse, her awareness of everything and everyone in her work environment evolved as a crucial way of achieving safe patient care. I heard how a difference in practice, one that she experienced as a "very green" nursing student, presented as a tension in her early days of operating room nursing. In describing being called for an emergency surgery, Shani explained a disorderly approach to the ensuing patient care. I considered how through her lack of preparedness, she felt hindered in her ability to perform as a competent scrub nurse. Despite her knowledge of what she should have done, she deferred to the guidance of the charge nurse. I thought how she apprehensively set aside her focus on surgical preparedness to respect the hierarchy of experience she worked within, for she did not 'question anything the charge nurse did'. I thought how, as a junior nurse who had just completed her orientation, Shani might have been inclined to view the charge nurse as her mentor; as someone who in that position should have the knowledge and ability to guide her in developing critical thinking in relation to practice, just as her instructor once did. I imagined she felt that she had let her colleagues and her patient down, professionally, through her lack of preparedness. I sensed how Shani felt that she and others were let down and abandoned by the charge nurse, and how patient safety was compromised and neglected. I also considered how she was further disillusioned, but remained professional in her role, when the charge nurse was neither accountable nor responsible in accepting the burden of the situation, by not shielding Shani from the negative impressions that others might have held of her. I remembered the other mentor Shani spoke about, a nurse who acted as a "protective barrier" between new nurses and some surgeons, and I thought how crucial that kind of support was in the encouragement of Shani as a junior nurse to gain confidence in unfamiliar situations. I also reflected on how, in deviating from a nursing

approach that she had been taught and then finding herself in a sub-optimal patient care situation, Shani experienced a profound personal let down, for her lifelong goal was to always nurse in a manner that was "right".

By contrast, however, I heard in another story how Shani felt supported as a new operating room nurse, when another charge nurse assessed and provided the required elements to ensure the best possible outcomes for the patient and for the team. Unlike the other in-charge nurse, Shani described this particular person as demonstrating perceptiveness of all that was unfolding quickly around her, and used this awareness to support Shani's professional abilities and confidence. I appreciated how Shani respected this nurse as a mentor, as someone who did not just go through the motions of acting like a charge nurse, but one who lived the responsibility. It was a mentor who had the capacity to focus on the "big picture" of a junior nurse paired with a critically ill patient and a more experienced interprofessional team, and then to translate it into an opportunity for safe patient care.

I learned how Shani held these different experiences close to her and then took them forward into her practice, as she realized what it meant to be prepared as a nurse, a responsibility not only to herself, but also to patients and colleagues of what this meant. I understood how she connected her own memories of being a junior nurse with the experiences of her mentoring other nurses, and how she supported their developing abilities and skills by ensuring they had adequate time to organize their thoughts and necessary supplies, in order to rise to the demands of the situation. I also appreciated how a chaotic practice situation could interrupt her image of what a competent and skilled nurse was, which motivated Shani to consider continually how she could improve her practice. For, as she spoke, I captured how appalled she was to imagine the recurrence of a similar "mess." In the "I'm not doing that to anybody again," I was inspired by how determined she was to ensure that patients and colleagues would not feel the tensions of an unnecessary chaotic practice setting.

"From your work in the OR over the years, what has been your experience concerning relationships with colleagues and patient safety?" I asked Shani. She explained, "I find that if you know the nurse in the room with you, then you're comfortable with each other, and it eases a lot of the tension. Because you both know where you're at, you both know what your role is, and you can

concentrate on the patient without worrying about what the other one's going to say or do. And the same with the surgeon; you know the surgeon. Not just what their preferences are, but you have a good relationship with that surgeon – they know you, you know their work, they know your work, so that when you are scrubbed in with them, that confidence is there. You are much more able to concentrate on the details and things that are important for patient safety, and pay attention to those aspects, versus worrying about, 'Ok, what does the surgeon want? Is he going to be happy? Is this what he wants? Does he know me? Doesn't know me?' Or the staff; what's their experience? What's their level of expertise? Are they looking over my shoulder? If you have a good relationship with the surgeons and nurses, and the other staff, then that can go to the side of your head. The patient can become the focus, which is why we're there in the first place. You know your task at hand is the patient and you don't have to worry about all those additional things."

Shani continued, "I think if you just come to work, do your thing, and not get to know anybody, then you don't know other peoples' experiences. You don't know where they are in their career. And in fact, you may be missing out on a whole lot of learning. And you may be missing out on the opportunity to teach somebody else. What I have found helps with nurse colleagues is to identify their personality, whether they like to be a leader, a follower – and adjust yourself to a role that complements them. They might be someone who likes to teach, who knows a lot, or has a lot of experience. So you just take the follower role and learn from them. Obviously, it's a good thing to do, to let them guide you, at the same time meeting your own standards. But if you've got a newer staff member, then you have to take the actual leadership role, and you go ahead and do that to the best of your ability. Nurses are people and they, like everybody else, have good days and bad days. You may hear that someone is having trouble in their personal life, or there's a sick family member – then you realize that you might have to take a step back and say, 'Well, they may not be 100% today'. Even though they may normally be in a leadership role in the room, today they may just want to take a mental break, and just go about their tasks and not worry about everybody else in the room. And you have to adjust your thinking and your focus to accommodate for that. I think it's very important - you have to have a good relationship with your co-workers and know that you do a good job together."

As Shani described why good working relationships were important for her work as a nurse, I thought how she used those relationships as a way of responding to the challenges and tensions of working in an environment composed of diverse personalities. Shani would try to "step into a role" as required of her at any particular moment. In accepting what she believed was required of her she validated colleagues as human beings, who also experienced moments of vulnerability in their daily lives. I reflected on how this fortitude - to answer candidly in whatever capacity was required - was a constant of Shani's life. It was a response that she had first experienced in her family life as a child, and it had become an ethos of her integrated professional and personal life.

In "being there for the patient", Shani learned that one way of supporting patient care and the work of her colleagues was to be a strong leader for some, and ensure that priorities remained in the forefront. She also understood the importance of being a capable follower, one who continued to question and learn how she could do it better the next time. Through her actions, Shani reflected a strong sense of accountability and responsibility in her nursing practice by professionally recognizing what was required of her during critical moments of work within activities orchestrated as a team.

I learned how Shani used her work relationships not only as a means of teaching others, but also as a valuable connection that sustained her own ongoing learning. She had come to recognize and appreciate the knowledge and abundant years of experience held by the nurses with whom she worked. I understood how even as an experienced nurse, Shani had never stopped learning for in feeling there was always something new to discover, she willingly assumed a learner role. As a mentor for newer nurses, Shani encouraged them to develop their own awareness of their surroundings, and in these opportunities enjoyed teaching them. She took pleasure in wanting to share her own vast knowledge and experience with them. Thus as a "leader and a follower", Shani kept the connection alive between knowledge and practice, for as she continued to develop her nursing practice, she also supported and developed the practice of others, which ultimately contributed to patient safety.

"That validation is important, to be recognized for what you bring," I offered, and Shani quickly replied, "Well, I've been on the other end of the spectrum, too. One time I was scrubbed with a neurosurgeon who could be quite

nasty to the staff - no patience for anybody and expected everything from everybody, and yelled and screamed whenever he felt like it. I mean, he's made staff cry. It was late afternoon and we were doing some sort of cystic stenosis thing," Shani recalled. "That sounds very complicated," I said. "Yes, it was. I don't really remember what the patient's problem was," Shani replied and continued, "There were two anaesthetists in the room. There were five or six nurses and there were people just for support. There's a moment during surgery where you have to irrigate saline into tubing that's attached to the telescope, and he kept yelling at me, 'It's too fast! It's too slow! It's too fast! It's too slow!' Well, I couldn't see the speed because of how it was hooked up. Then he said very loudly, 'If you can't do this, find somebody else who can,' and I was stunned. An anaesthetist stood up for me. He said to the surgeon, 'She's doing the best she can. If you want something more specific, then you have to tell her. She can't read your mind.' I was flustered but I kept it together. I finished my case and then I left. After that day, I refused to scrub for him – I don't need to be treated like that."

"It was interesting," Shani continued, "Even at the private surgery clinic, when they asked what my background was, where I've worked and they said, 'Oh, you know this surgeon, that surgeon'. And one surgeon at the clinic asked me, 'At Crawford there was a surgeon. I wonder if you've ever worked with him? His name is Dr X.' I said, 'Yes, I've worked with him'. He said, 'Did you ever find him pleasant?' and I said, 'No, to be honest with you, I did not.' He said, 'OK – you're on the same page as everybody else. Just so you know, nobody here is like that'. Well, that's good to know. I'll stay then," Shani laughed. In thinking about the neurosurgery experience she had previously described, she recalled, "My self-esteem was so low for a while after that, I was thinking, 'Can I even walk into there again?' But you have to pick yourself up and realize not everybody's like that. People are people. People have lives outside the OR. They do impact your work, you know, regardless of how much they may try to leave everything at home. They still come with those emotions and extra baggage to work. For a while it did bug me a lot and then it kind of eased off."

As I listened to Shani's story, I heard how the demands and intruding personal issues of an individual led to a tense and disrupted situation, and how all team members in some way felt this atmosphere. Yet, I sensed how she felt this particular event was more than just professional tension or situational stress

from a complex surgery. Despite the bruising of her professional ego, I believe this experience touched her on a much deeper level as an affront to her identity and capability to function as a person. I empathized with how she had felt humiliated and inadequate, and how she later questioned her ability as a knowledgeable professional. But in this time of self-doubt and wondering if she could "walk in there again", she made a choice to limit the possibility of experiencing another personal intrusion by refusing to work with that surgeon again. I acknowledged how this gave her control over her sense of who she was, and what she could accomplish as a nurse, and with this strengthened sense of self, she re-focused on "being in the OR for a specific reason" – a steward of safe patient care. Even though Shani had minimized the tension within herself, though, I realized the issue of the surgeon's specific behaviour remained unresolved and would probably continue to linger as tensions in her mind and those of others for some time to come.

As I got to know Shani, I realized how she, too, held her experiences emotionally close and how she reflected on them as a way of developing her knowledge and nursing practice. I discovered how she turned this knowledge back upon herself and others, as a continual process of learning from her patient safety experiences. Thus, I understood how the threads of her past learnings wove a path forward through various operating room departments, as she figured out what was required of her to shape her practice as a safety-minded operating room nurse, who could continue making a difference – the "right" difference. As I thought, deeply, about Shani's stories of patient safety, I was also able to understand how they were composed across time, place, and relationship, and how they were anchored by her own experiences. It made me wonder, what would that frightened child of yesterday think of the nurse she was today?

I now turn to *Chapter Seven - Lynsey's Stories: Early Landscapes*, a narrative account of the fourth and final participant.

CHAPTER SEVEN

Lynsey's Stories: Early Landscapes

Lynsey and I first met each other over the telephone when she responded to my inquiry for operating room nurses who were interested in discussing their experiences of patient safety. I sensed her passion for patient safety and operating room nursing early in our conversation, and I was very pleased that Lynsey chose to participate in this research. We greeted each other as if we were long-time friends when we met in person, and I knew that I wanted to get to know Lynsey better and hear her stories. As I asked my first question, Lynsey began to share her life events with me.

"Perhaps we could start our conversation learning about you, your work," I said to Lynsey. "Well," she replied, "currently I work at Ross Memorial Hospital in the operating room. I'm the PCC, which is the Patient Care Coordinator, so I run the day-to-day flow of the OR. That's what I thought until I started working there. They've a set of responsibilities that I didn't think were mine." Lynsey gave a warm laugh and continued, "I've learned to delegate very quickly! Prior to that I worked at Fairview General in Redmond in the operating room, and prior to that I worked in Scotland in the OR there. In Scotland you had a bank of nurses and when a department needed staff, they called the bank and said, 'I need somebody for this' and then they called you, whether you had experience or not!" Lynsey laughed.

"Oh!" I replied, intrigued by hearing about a different system. Still laughing Lynsey continued to explain, "So I walked in, going 'hi – I don't know what I'm doing here, but...' And I really liked it, and they saw my enthusiasm. I was asking a lot of questions. Then a position came up and I applied, and I got it, so then I was working in the OR full-time. Each OR there hired within itself, so for instance, one OR hired for itself and you only worked in that OR all the time. It was a general theatre I worked in initially, and then I got another job in the theatre next door, which was vascular; so then I worked only vascular for my days there. I would take extra shifts in the emergency theatre so that I got a little bit more of an idea about emergency cases. But we never had emergencies, only elective vascular unless they had a triple A or something. Prior to that though, I did a nursing diploma in Scotland."

"How did you come to do your training in Scotland?" I wondered. Lynsey recalled, "I went over to live with my cousin because...well, why not?" she chuckled, "and I worked in a place called Trinity Foundation. A man who after the war and disabled himself realized that people who have disabilities of any sort needed a home, and because there were no places for people with disabilities, he started it. He started this foundation and all sorts of buildings went up that were wheel chair accessible, just for people with disabilities. I went there and worked as a care aide and just loved it! I saw what I could do - it was wonderful actually. I loved that experience. I found that my accent was a great icebreaker - I used it a lot. Sometimes it was just to have a topic to chat about, and of course everyone would have a relative in Canada! I just loved it there. So I applied for nursing in Scotland as I had a lot of family there, and that's how I started."

I was taken with Lynsey's story about her journey of discovery. I sensed how the strength of her family ties provided a certain comfort and familiarity in her uncertainty and how these ties became a connection to discovering the world around her. Although she did not say it outright, I considered that perhaps her uncertainty of not knowing what she wanted to do with herself as a young adult took her to a different country, and her experience there quickly transformed any doubt or confusion into a specific goal of becoming a nurse. Her passion for her work with the Trinity Foundation was evident as she spoke; yet I believed Lynsey uncovered much more than her interest in nursing during her time there. I imagined the Trinity Foundation originating as a place of refuge, benevolence, and care, a place of humanity for people when there was nowhere to go. I learned that this was where Lynsey discovered the world as a much bigger place than she knew it to be. It extended past her immediate context and presence to include the realm of humankind – realities of life lived by others.

I was curious. "Lynsey, tell me about nursing education in Scotland." "Well, it had just changed," she explained. "Before, it was all hospital based. Now it had become university based and we were through a college that had affiliated with a university. You did your 18 months – all the students together. And then after that for the next 18 months, just the midwife people split and did their own stuff, and we carried on and did more adult nursing. We had a lot of time on the wards. Our first 6 or 8 months were all in lectures and then the rest was in different areas. So it covered a lot. I enjoyed thoroughly my community care,

district nursing as they called it. It was wonderful. And I must say that the training in Scotland was much less than it is here. I know that the nurses that came out of university here, for instance, they all had IV access training. They had patient assessment where they would listen to the chest through the stethoscope. We never did any of that. It was all very much - you did what the doctor told you to do. There was not a lot of nurses thinking for themselves and performing the assessment. We did a lot of assessments but not where you would then report to the doctor and say, 'this is what I found'. It was not there yet. Some of the hospitals still had the old matrons in them, and so they expected you to know everything about each patient. It was Florence Nightingale wards, so you would just do morning report and go up and down the ward, like you read in books," she laughed as she recalled. *It was at the Trinity Foundation where Lynsey learned about the uniqueness of each person through engaged care relationships and the difference she could make in their lives. From the tone and intensity in Lynsey's voice as she spoke, I sensed that as she gave of herself as a nurse to each person, thereby enriching their life, she received from them in return, a new richness of life. I learned it was in experiencing this life quality that Lynsey shifted her attention to the lives of others, and came to appreciate the moral and ethical responsibilities that societies could hold in the care of others. I thought about her experience of working at the Trinity Foundation and of choosing nursing as a career. I wondered if Lynsey would have understood the world as a place larger than she knew it - as a community of others trying to live well in everyday moments of life - had she not gone to Scotland to live with extended family when she did.*

Lynsey revealed that her parents had both held careers in healthcare. I inquired if this had influenced her career choice and she responded, "No, it didn't. My dad was a doctor and my mum was a midwife, and I knew they had met at the hospital. And dinner talk – oh dinner chat was anatomy and stuff! I found it always interesting, and any time my dad or somebody had a sliver, I was right in there. So I don't know if that was from them. But it wasn't actually until I was working in the OR that I learned that my mum was an OR nurse, and that she had worked in the same hospital I did in Scotland. To phone her and say, 'I'm actually working in the OR'. And she said, 'Hmm, did you know I was an OR nurse?' I'm thinking, 'No!' Phenomenal, I had no idea! She never mentioned it.

She always just talked about midwifery, but I had walked the same halls!" she said excitedly. "That's where they met. So I would walk the same halls my mum and dad walked, and my grampa – the same hospital! The hospital is from 1750 or something - I loved it!"

When Lynsey told me how she became an operating room nurse, I realized that she was also sharing a personal story nested within a family story. As she recalled her earlier times I sensed how her family interactions, captured and woven throughout her experiences, created a life story connected across person, place, and time. Lynsey recalled how conversations during family meals included anatomy discussions and other healthcare related talk; yet she felt that her parents' careers in healthcare were not influential in her own decision to enter the same profession. However, I think the seeds of identity as a healthcare practitioner were planted early, for Lynsey spoke about interest in her parents' occupations as "being right in there any time somebody had a sliver". I wondered if our conversation had provided an opportunity for her to reflect on and to reconsider her contrary comments.

As we spoke, Lynsey expanded on how her grandfather, father, mother, and she were all connected to healthcare through the same hospital in Scotland. I heard how vivid the discovery of her mother having been an operating nurse was for Lynsey and felt myself being pulled into that discovery, too. I learned how this familial connection became such an important part of her identity as a novice operating room nurse in Scotland and how it rose from deep within her and surfaced as connections to what had been, and continued to be, in her life. In her back and forth stories of becoming a nurse, I shared awe and excitement at the thought of her walking and touching the same hallways they had experienced many years before. For she continued to hold them close, as part of an inner self, by returning to the remnants of those thoughts – living, walking, and caring for hospitalized patients in a similar place.

Thus, their monumental human presence from the past entered the present and enveloped Lynsey as she used this discovery to celebrate a treasure in her life. It was a discovery that reminded her of a world much greater a place in many ways than just her immediate existence presented, for her connections to the past no longer remained silent as she relived them as a young student nurse. It made me wonder if feeling and celebrating these memories of family as care

providers in the same hospital provided mentorship for Lynsey, in a form that, perhaps, shaped the future nursing experiences that were to come.

My curiosity continued, "Was your OR training in Scotland on the job?" "Yes, they didn't have a course," Lynsey explained. "You circulated first for 6 or 8 weeks and then you double-scrubbed on whichever cases, and it was great. Even today, I feel that people would learn more by circulating first than scrubbing." I replied, "When we do orientation for somebody, we always get them to scrub first and I wonder why?" Lynsey offered, "I find it's just not right. When you're circulating, you learn how the flow of the room goes. You learn how to watch your scrub table. You learn where things are; then when you're scrubbed, you understand why you don't ask for something that is used at the end, or right at the beginning when they're busy setting the patient up. I find LPN's do that, because they don't circulate and they only scrub. And I remember this one fellow come running out of the OR – he's frantic and I said, 'what's wrong' and he says 'I need this'. I come in and I said to the scrub nurse, who was an LPN, 'you do not need that right now. You can see that he is busy doing other things.' 'Oh yeah, Ok' – but she was fine with letting him run. She tried that with us who were more senior and we would just say 'no', which you'd never do in Scotland because there, the scrub nurse runs the OR. So as the scrub nurse, you look around and you send people for breaks or you tell the people to be quiet. I was taught that the scrub nurse runs the room, but here it's the circulator that runs the room – just a different perspective."

"I remember my mentor at my first job in the OR in Scotland. She was a West African woman who was a stickler for rules," Lynsey passionately emphasized. "I just loved it - oh I loved it, and everything I did, always a reason why – 'now this is why I'm doing this, it's because of this.' Then she would say, 'you could probably do another thing, but at the moment you're doing it my way, then you can find your own way.' And I quite liked that because I've had other people say 'do what you want' and I say 'I can't, because I don't know what I'm doing." I murmured in agreement and Lynsey continued, speaking with laughter in her voice, "Don't let me do what I want, because I don't know how to do it. She was fantastic and she really taught you, exactly, the basics. But I must say I was always taught 'load your blade first. That's the first thing we need. Then use your scissors. That's the second thing you'll need. And have it in order,' she says,

‘because you’re going to have to scrub in for a triple A or something that’s so fast, that you don’t want to be messing with something that you need at the end when you don’t have everything ready at the beginning.’ It’s just common sense and I haven’t seen anybody who’s teaching, say that. So she was just brilliant. She was like everybody’s mum,” Lynsey fondly remembered. “That’s good to have,” I commented and Lynsey agreed.

Lynsey spoke most highly about the nurse who became her mentor in Scotland and I sensed how she still felt close to her, as she shared her story of years ago. I listened to Lynsey describe how this nurse taught and directed her, and how she watched over her as an interested parent might. I learned how important and foundational she was in Lynsey’s journey to becoming and being a skilled operating room nurse. Lynsey described how she gained a sense of ability and structure in her workflow from her mentor by being “taught exactly the basics” and using “common sense”, as well as how she was “like everyone’s mum”. I thought about what Lynsey had said and wondered if in recalling this story of mentorship, it was a reflection of her childhood and family expressions of support, acknowledgment, and direction, parallel to such an influential experience through her “mentor-mum”. Just as her family helped Lynsey to develop her awareness of who she could be as a person, her mentor nurtured her in the requirements, expectations, and confidence of being a capable and safety oriented operating room nurse.

Lynsey described her enthusiasm for the operating theatre from the moment she entered the unit and how this resulted in a permanent position for her there. Her desire to learn more and to better prepare for the unknown was encouraged and developed through her mentor, as well as through her own initiative to work additional shifts in an emergency theatre. I thought, perhaps, this mentorship led Lynsey to learn how to become a practitioner with a sense of awareness; to push herself and discover what she could accomplish in an unpredictable environment. As I reflected on this, I considered how others had made a difference in Lynsey’s life and unfolding career through genuine interpersonal connections; and I felt her identity as an operating room nurse strengthen as she shared this story with me. I could not say why, but I sensed the profoundness of how Lynsey had used this experience to make a difference in the future lives of her patients, their families, and many others in her life.

Brilliant Perfection

"Lynsey", I asked, "how was your concern for patient safety in the OR addressed or managed?" She responded, "Even back then in Scotland we had a huge amount of paperwork to do. We had straps and padding, and we had gel pads everywhere. We had the newest type of padding; it's memory foam now, but it was new there. So I think the hospital itself was very safety orientated. And we were the first to have – I don't know if you've ever used sliding sheets?" she asked me. "Yes we do use those," I said. "So they used those before I even got there," Lynsey continued, "every single patient had them. So it was patient safety, as well as staff safety, which was very, very good. And then I think it was the nurse I had as a mentor. She was brilliant! She had me look at positioning and so I looked at every single position. I looked at what you see when you put patients in a position, you know, broke it down into skeletal, muscular, circulatory, the whole thing; so this is what happens to your circulatory system when your legs are up, then you have to put them back down together, and you have to be sure you tell the anaesthetist, things like that. I loved it! It was good where I worked. Safety was huge. But there was also a musculoskeletal injury prevention program," Lynsey continued to explain. "When a nurse came on for orientation, they had two full days of training. You were taught for a full two days hands-on; how to move patients up the bed, what you're looking for in these patients. And they get you to be a patient in the bed, so if you're putting a patient's back up, they might look comfy but it's awful. And so they had a number of safety programs going on there," she emphasized.

I reflected on her experience and commented, "It sounds like the basics were really instilled as most important." Lynsey replied, "Yes, they were and I think it's because we had a matron. She was the OR-charge of that theatre and we had someone who was accountable. You know it was very much a sense of accountability. If you ignored something, she was just on you all the time, which was great! Here it's me, but I've got numerous OR's to look after. And the people in the theatres are not always accountable to each other, like pulling people up on things they missed." I remarked, "If a scrub nurse contaminates her table and she doesn't say anything, she's not being accountable to anybody at all." Lynsey replied, "Yes, and the circulating nurses should say 'hey, you did that' But no, they don't, because they're too shy or too scared. There's only a few nurses

where I am now who would be able to do that. But when I worked with that charge nurse in Scotland, in the room every day, I learned! She was always watching, always watching out – there were strong people in that theatre."

"That's what has worried me. I feel the standards have dropped from what I'm used to and it's hard. Talking about the circulating role, I remember one time we were so short staffed we had a care leader scrubbed and another care leader circulating. And the scrubbed care leader couldn't believe what she was seeing, because she had to ask continually, 'Can I have more sponges?' She couldn't believe how she had to keep asking." "That's something the circulator should be on top of," I offered. "Yes, and they were not. And the paperwork was not being done properly either; simple circulating role activities. So we as a group were trying to figure out a way to have a learning session on the basics of circulating. Patient safety for me is absolutely huge! I know there are terrible things that happen in the OR, but they're usually one-off's, sometimes. But these sorts of things are day to day stuff and I feel it compromises patient safety," Lynsey said, adamantly.

Lynsey described a strong group culture that emphasized patient and staff safety in her Scotland hospital, which she felt supported an overall focus and awareness of safety in healthcare by all health professionals. Yet, as she spoke about specific patient safety measures in that hospital, I felt the particularly strong presence of her operating room mentor come forward in her story. I think it was in following her mentor's guidance, along with a desire to gain more knowledge, that Lynsey recognized how she could continue to make a difference in the lives of others. I reflected on Lynsey's mentor, encouraging Lynsey to stretch her mind in order to understand patient safety in various ways. And I imagined how this was also a rewarding experience for her mentor, to see Lynsey move forward and develop into an expert professional. I also sensed that this mentor most likely had taught Lynsey to understand patient safety as something that extends past the immediate context of patient and nurse, and into that which is much bigger than is realized. As she spoke, I heard the profound and lasting effect this mentoring relationship had had on Lynsey; and I began to understand how Lynsey had taken this experience forward into mentoring relationships with nurses that she had created for herself.

As we discussed the importance of learning the basics of patient safety as part of mentoring, Lynsey identified a tension that was troubling her in her current work setting. She described how she had been taught to be accountable for her actions and to speak up to ensure a consistently applied safe standard of practice in the operating room. Yet, she felt that this past standard of practice contrasted with what she was currently experiencing at work, identified as a "drop in practice standards". She also recognized that others might be feeling similar tensions, in relation to their perceived inability to speak out against such practice violations. I learned that, how Lynsey began to work through these tensions was not new to her, as she had located many times before the "day to day" theatre concerns into a larger, overall context of patient safety and operating room nursing. But significantly, Lynsey's story revealed how her attention to patient safety in the present found her reaching back to recall elements of the past - experiences that had formed the fundamental structure guiding her work. Her identity as a patient safety practitioner evolved through experiencing and understanding the connections between knowledge, actions, and learning, along with reflections about the interconnectedness of her surroundings with those persons in it. I wondered if Lynsey wished for those she currently worked with to experience and feel what she had, for I was left with a sense that she felt they somehow had missed out on a key element of what operating room nursing was really about.

"When you worked in Scotland, were you encouraged to speak up or question practices you saw that you weren't sure about?" I asked Lynsey. "You said the culture was a little bit different there, the doctor's were supreme and the nurses listened." "That's correct. You never questioned the surgeons, ever," Lynsey said and clarified, "I think in respect to the surgeon, it was very hierarchical. So being junior, I felt that difference there in Scotland. I was the one who got into trouble when I laughed at a surgeon, because he stomped his foot and almost cried like a baby, and the staff allowed that to happen. And I got into trouble because I reacted like, 'You've got to be kidding me'. So it was very much like that, but I think that the senior nurses in the room told the surgeons what was on."

"But with the other nurses I worked with there, oh yes, they had their roles. I was taught the scrub nurse is the ruler of the room and if you find

someone is walking around your table too close, you tell them to back off. If they're wearing a jacket that is untied, tell them to tie it; and if they're over your table when you're counting, you tell them. This is your domain and you must keep the sterility. So I was taught at that time to be very aware of other people in the room and their distance. There were some people, because of the way our rooms were set up and there always being a corner to the table, who took that corner sharply, not missing the edge of my table. And I was told, 'It is your duty to make sure that these people do not contaminate you'. I think I was taught from an early age to just keep an eye on everybody; also making sure the surgeons kept their hands up, that things didn't drop, that you didn't pull things back up, all that kind of stuff."

"But another thing I remember was that in the theatre I would work with Dr. X every Wednesday. You always worked with the same anaesthetist. So it was always the same team and you got to know them really quickly. It wasn't like every sixth week you're in an orthopedic room for a day, no. You knew how they worked and if one was a little bit shadier than the other, then you just watched him a wee bit closer, that's all. And how I used to do it, if I couldn't speak to a surgeon, I'd say to the circulator, 'Could I have another glove please? Then I would say, 'Dr. X, I think you've contaminated your left hand'. He says, 'No, I didn't', and I said, 'Well, you know what? The glove's right here!' I would get the glove first so he wouldn't have a chance, really, to decline. I wouldn't do the blame-game. I would say, 'Let me help you,' and have it all ready.

"An interesting way of addressing patient safety," I say. Lynsey responded, "Oh, completely. The nurses were right in there. That's where I learned all that, actually. I think that I am good at my present job. I don't really acknowledge that the nurses I work with hold me in such high regard here. My manager keeps telling me this. I think, 'Well, maybe I'm doing OK with my job,' but I think it's because of how I was trained by the Scottish OR nurses. It would not have been from the OR nurses trained here." Lynsey explained, "I don't mean that in a bad way. I think that the Scottish nurses actually taught you, there. Here, you learn it yourself. I gravitate to the older nurses who are just about to retire, because that's how I learn. But the younger nurses avoid them, because they're too strict, they're too scary, or too whatever. For something as serious as the OR, you want good trained nurses. You don't want nurses to fake it as they go along,

which some tend to do. I feel sometimes that in the OR, the training is not like it is in Scotland. They taught you, “This is how we do it, but you can do it your own way later.” And here, when I’ve heard teaching going on, it’s very wishy-washy. So the students or the young ones are getting frustrated, because they don’t actually know how to do it. We’re in an environment of “just try and do it yourself”, Lynsey concluded.

As Lynsey spoke, she situated her story in two different locations through her experiences of professional accountability. I again sensed her underlying tension of trying to reconcile a discrepancy in operating room practice, as she had come to know it and currently experienced it. As Lynsey described her expectations and experiences of accountability with operating room practice, images of her mentor directing her in the specifics of being a “good OR nurse’ came to mind. She was comfortable working with older and clinically experienced nurses, and their structured way of practice was a familiar element that Lynsey found lacking with others in her current practice here; a structure reminiscent of her mentor’s method of teaching and learning. In reflecting on how, as operating room nurses, we learn and understand accountability in practice, I considered the differences in our practices, despite trying to follow similar practice standards and the tensions they cause.

“You had the same team in each theatre,” I recalled. “Yes, everyday,” Lynsey replied. “And it sounds like that was perfection,” I offered. She smiled, “Oh, brilliant, yes – perfection - you had the same seven people in that OR and you just followed your rotation. It was brilliant. And you knew your cases. Everybody knew their roles and whenever an emergency came in, for instance a Triple A, they would come into our OR instead of going to the general one. Because it’s a serious case, we did these kinds of electives all the time with the same staff,” Lynsey snapped her fingers and grinned, “we’d have those counts done and we’d just speed up as needed. But it was always just the same demeanour - it was beautiful. And the surgeons were happy. The surgeons knew who they could trust. They knew what people could do and they knew how much to say to the scrub nurse, because they knew how that scrub nurse worked. It was beautiful,” she recalled, fondly.

I asked if the reasoning behind keeping the same teams in each theatre was to ensure proficiency in each service. “I don’t know,” Lynsey replied, “the

whole OR was done like that. You worked within a group and a set of three theatres were a group. If you were short staffed you could borrow from another OR group. They had vascular, two general rooms, two cardiac rooms, and orthopaedics. I don't remember ENT being there and gynecology was in a different part of the hospital. All those elective theatres, they ran from 0800 to1800 hours and there were two theatres that ran 24 hours, which were staffed differently. There was a 24 hour orthopedic trauma and a 24 hour general emergency theatre. So the hips and knees were never bumped, or the tibial plateau fractures, by an appy or anything. It was great. The flow worked beautifully, but now that I'm working here I realize the difference." "Yes, you see the difference in systems," I offered. "Yes, I really liked it there in Scotland," Lynsey reminisced.

"Why did you come back to Canada?" I asked and Lynsey explained, "My family was here. My brother and dad were quite unwell at one point, so I thought, 'I have got to get there'. I got a job at Fairview General. I went in and said, 'I don't have any experience other than general and vascular, and a little bit of gyne – but I'm willing, give me three months'. When my three months were up they put me on night shift!" she was laughing. I joined her in laughter as she continued, "So I said, this must mean that I'm OK!" "That's the vote of confidence," I replied and I felt our laughter carry us through remembrances of early nursing days and long, unpredictable nights.

Lynsey fondly recalled the structure of operating room teams in Scotland as a "flow that worked beautifully". As she spoke, I sensed she felt the absence of dedicated teams as a lack of coherence in her daily work and perhaps in the work of others. Lynsey knew what each member brought to the team as a whole and how that unity facilitated "beautiful" work. I thought how with some exceptions, most of our operating room teams here in Canada were composed of different people with varying skill levels on any given day. How did we go about ensuring a beautiful workflow in a system so different from the one described and longed for by Lynsey?

Lynsey connected, deeply, with her work in Scotland; yet, it was her sustained family connections that pulled her back to a life in Canada. I reflected on knowing that, as much as her family needed her, her sense of urgency to be with them was overwhelming. As she alluded to the tension of family illness and

returning home, I thought how Lynsey re-established the roles that she had grown up in, came to love, and left behind in two countries, roles that she had not abandoned but now lived in a new context. I saw her returning to Canada not only as a daughter, but also as a mature professional who had embraced the legacy of her family while discovering the world around her. She quickly found work as an operating room nurse and started a new career for herself, which allowed her to balance working at what she loved with keeping close family connections an integral part of her life.

"What was your impetus for moving from Fairview General to Ross Memorial?" I asked Lynsey. She thought for a moment and then replied, "Well, two things. My husband got a job across the way and he didn't like the driving, commuting; and the other one was, well, it was time for me to go. Because I saw in my work that it was really hard to change things. Let me explain. New people come from different places with great ideas, thinking 'why do we do this here? It seems a little odd'. And I'm like, 'You know what? You're right. So let's try and change it.' Something as simple as the location of the suction, for instance, the plastic yankauer suction that can be kept in a better place - the core - as opposed to having to squeeze by the perfusionist to get to the anaesthetic machine and then grab it from there – let's just get it from the core. What a great idea. So we made a bin, a label, and put it there; and then the leadership team said, 'Nope, we don't have the space for it,' and threw it away. So you see how the people who come with some wonderful ideas get frustrated. I remember being frustrated, too, and just accepting it after a while. But after a couple of years it just becomes the way. And they do say, 'This is the way we've always done it'. That's a phrase that is used a lot and I don't know, it was just time to go." I felt these words resonate with me for I, too, had experienced what Lynsey described. But I also felt a nudge of doubt rub against me as I wondered if I had ever failed to recognize, and then dismissed someone's spirit and enthusiasm for envisioning better patient care. Lynsey reminisced, "When I first got to that OR, actually, there was a crowd that always went out every payday, just went out all the time – anaesthetists, the surgeons as well, it was great fun. By the time I was leaving there were a lot of younger people there. I did have fun at work, though, but I also worked hard."

Earlier in our conversation, Lynsey had said she was in a management position at her current workplace. I wondered about the reason for her move to a different hospital, and I felt her story said so much more that the actual words "it was time to go". Although professional and social relationships were established amongst colleagues, I sensed how Lynsey and, perhaps, others felt a stifling tension in their everyday practice at work when attempting to institute change that could make a difference, such as in supporting a smooth workflow. Lynsey was open to considering alternate suggestions from colleagues; and I believe she was concerned about becoming a nurse who over time would be comfortable in rejecting new ideas and accepting the status quo. As she spoke, I felt she did not want the person that she had become to disappear in an environment of 'this is how we do it here". I wondered if her husband's desire to be nearer his job provided Lynsey with the opportunity to act on this tension she felt in order to relocate to a different worksite where, as patient care coordinator, she could continue to be the nurse that enacted "this is how we could do it better".

On Being a Safety Practitioner

"Are there any specific patient safety issues that you would like to share?" I asked Lynsey. She quickly replied, "I think the first one that pops into mind - and maybe it's just this area where I am now – is the focus on teaching new nurses or new RN's only about scrubbing and circulating; we're missing anaesthesia. I remember once I popped into a theatre just to speak to the surgeon, but they were busy intubating. So I just stood back and waited. I could hear that things weren't going well and I heard the anaesthetist saying something about 'this is an 8. I need a 7 ET tube'. So I was the quickest to get it for him and then just waited and observed. I noticed the scrub nurse never turned around to have a look at the patient and the other circulator was just doing paperwork. There was no sense of 'something is going wrong' with the patient."

Lynsey continued, "I could see what was on the glidescope and I could see the anaesthetist's view, and it was a terrible view. So I went to the difficult airway cart and grabbed a bougie. And when I came back the anaesthetist had the airway, but I said 'would this have helped you?' He said, 'oh yes, that would have been great'. But the nurses, even the circulator nurse who was helping him, were just waiting to be told what to do. There was no anticipating of things, which I thought was very odd, because these were really quite experienced nurses in

there. I thought they were experienced. They were only great on circulating and scrubbing. And another time there was a different kind of difficult airway. My scrub nurse was just standing there and looking at her instrumentation. I immediately called to her and said, ‘Come off scrub and bring me a difficult intubation cart!’ ‘Oh!” she said. Lynsey laughed bemusedly as she recalled what she said, ‘If we can’t intubate the patient, who cares about the instrumentation.’ What you have do is come out of your gown, get the cart, and then put on another gown. It’s not a big deal to come off scrub. I found out that the only anaesthesia they teach is a day where the nurse follows the anaesthetist around and they talk to her, that’s it!”

“That’s pretty inadequate but also an interesting point” I commented and continued. “Whenever we’re doing an orientation for someone they get one day with the anaesthetist, too. Then it’s showing them, ‘This is the difficult intubation cart. This is the glidescope. Never take the ET tube away until the patient’s out of the room’. Then there are the very basics like, make sure the suction works and go over the anaesthetic machine.” Lynsey agreed and replied, “I think it’s awful! I was an anaesthetic nurse in Scotland. I took the six month course and did everything. So I was very well versed in it. I used to know the anaesthetic machine and would check it. And now I don’t see any of the nurses actually do that or anticipate anything, even when the pitch drops for the oxygen saturation monitor. Nobody looks up, nobody even pays any attention. So that’s one of the safety issues, I think.”

Lynsey continued, “And I remember even with my experience, one time the anaesthetist grabbed the suction but I didn’t hear the suction, so I said to myself, ‘The suction’s not on’. I went to the machine to look and there were three knobs, and I knew it was one of them but it didn’t say suction. So I’m looking at it and there aren’t even pictures and I’m saying to myself, ‘I’m going to write 'suction' on it.’” I said to Lynsey, “It’s a bad design.” “Yes, it was a real bad design,” she agreed. “You turn a knob, and you either turn off the whole machine or put the suction on. You’ve always got to get the right one, always know the right knob,” Lynsey laughed. “But more than that, I actually asked one of the anaesthetists if he would find it helpful to do a session and speak to the nurses, and say ‘This is what I would expect from you when I’m having problems with a difficult intubation.’ And he said, ‘Yes, that would be great! I think that would be

very, very good.' And I was thinking to myself, 'Well actually, this lack of practical knowledge was kind of scary," she recalled.

As Lynsey told me her story, her high level of awareness to events that unfolded in the operating theatre was most apparent, and her ability to identify quickly specific elements that inhibited patient safety was impressive. She had identified anaesthesia assistance as an important patient safety focus and related it directly to her own comfort level and experience of operating room nursing. Yet, I felt Lynsey's concern as she described what she had perceived as other nurses' lack of awareness or, perhaps, insensitivity to their immediate surroundings, and how it detracted from them instituting overall safe patient care during critical moments of anaesthesia. As she spoke, I sensed her desire and initiative to foster an increased sense of awareness to all operating room matters in nurses that she currently worked with. It was an aspect of nursing that began in her nursing education and had developed over the years. I learned in Lynsey's stories of how she situated herself in the background during patient care, in order to observe and understand what was going on in the immediate theatre environment, and how she came forward to actively assist her colleagues when required. Although she did not say directly, I sensed that this was an approach Lynsey frequently utilized in her current managerial role so that she could learn about the educational needs and discover mentoring opportunities relevant to specific operating room nurses, as well as other care providers. I thought how Lynsey experienced this with her mentor years ago when she was the one being observed and assisted as required; now, she was the one purposefully watching, providing direction, and intervening as required.

I thought about how nurses gained or learned a sense of awareness and I wondered why, for a function as important as anaesthesia and a critical time of patient safety, nurses seemingly received a minimal amount of preparation. Did nurses lose awareness because they thought anaesthesia was not their concern? Was a sense of awareness ever fostered? Perhaps this was the message nurses received during orientation when the anaesthesia experience received was so limited. In contrast, I understood that along with Lynsey's anaesthesia course, her mentor had further helped her to develop the attention to detail this aspect of patient safety required. As Lynsey shared her story, I was reminded of my own experience as a beginning operating room nurse and

memories of thinking I needed more time to learn about anaesthesia. I studied at home and sought extra time with anaesthetists so I could be prepared to assist the anaesthetist as required. I learned how to troubleshoot the different anaesthetic machines in our department, as at the time each theatre had a different machine. Just as individuals took time to support my learning, I try to offer support and direction for nurses in their uncertainty. I understood how Lynsey also used her knowledge to support new and experienced nurses to be more attentive to events unfolding in the operating room theatre. Thus I was left convinced that Lynsey's concern for anaesthetic attentiveness could affect a change in orientation practice in her department, for she had opened the door to an important conversation with anaesthesia that could be ongoing, which is what is required when considering new possibilities for patient care and safety.

Lynsey recalled a troubling patient safety experience. "Moving patients – when people are supposed to place a bean bag under the patient pre-op and they haven't. In this particular incidence, there wasn't one in place. The patient was already asleep and the surgeon comes in and says, 'Oh, we need a bean bag under here'. So, people just lifted up the patient and someone placed the bean bag there, and you know they're all lifting the patient to do this – now the table's up here," Lynsey points to her chest to indicate the height. A beanbag is a positioning device that is activated only when it is already in place, underneath a patient on the OR bed. "What was the thinking behind that?" I asked. She explained, "It was considered to be so much faster by doing this. But my thought was if a person hurts them self doing this and the patient falls, then they all hurt themselves. So whenever I was in the room I forbid it. I had the other stretcher in there as fast as possible and I said, 'Let's just move the patient over and put the beanbag on the table, and then move the patient back again on top of it.' They didn't like that very much. And I said 'Well, I'm leaving the room then. I'm not taking part in this whatsoever.' 'Oh, that's just being silly,' they would say. I said, 'I don't care if it's being silly. I'm trying to help you all out, because that patient will fall on the floor!"

As I thought about how Lynsey insisted that the team follow her direction in their attempt at moving a patient, and how she approached this from a "common sense" perspective, I recalled Lynsey's past experience with her mentor as part of this story. She had described her mentor as a person who was

“a stickler for rules” and I thought how, now, others possibly viewed Lynsey in the same way. Yet despite feeling belittled by their comments, she held her ground and kept her focus on ensuring the patient remained safe.

“Ultimately it’s the patient we’re worried about here,” I offered. “How does one get around that mentality of the short-cut, that ‘we’ve done it before, we’ve never had a problem?" I asked. Lynsey replied, “Usually, whoever suggests that is the person who is holding the least amount of weight. Do you know what I find? It’s the anaesthetist who will say, ‘Come on, just do this.’ Well, *you're* holding a ten pound head, we've got the rest...” Lynsey laughs, “You know what I do when it’s appropriate? I say, ‘See, nobody got hurt. It didn’t take that much longer. The patient’s actually in a better position now than they were before. The airway is fine and there was no compromise.’ I try to show how good that was, and then the staff say, ‘Yeah!’ The nurses do what they’re told, especially if there are guys in the room, and they’ll say, ‘Oh, sure. We’ll just lift’. But I don’t do that. I’ll say, “Ok, you’re wanting us to lift but you’re not the ones lifting, so it’s not up to you,’ because they’re only placing the beanbag, which is the easiest part of the job,” she chuckled.

I offered, reflecting on her experience, “Probably, if the surgeon would have come earlier, the beanbag would have been there.” Lynsey agreed and continued, “Yes, that’s what I find difficult. I had a surgeon who never spoke more than a word a day. He grunted a lot. But if I were to have a general surgery done on myself, I would have him because he’s fantastic. He comes in before the patient’s even in and he’s with the patient. He stands by the patient, helps with intubating, and then he has all the equipment ready. He helps with everything! He’s just brilliant and his cases go well because of this. Then there was a surgeon who was doing an odd case on a patient that had a tumour in the jaw. He brought in an oral surgeon to help him and he walked in scrubbed and said, ‘Oh, I need this, this, this, and that’ – things that we didn’t know because we didn’t do ENT. Then he’s getting all uppity and thank goodness the dental surgeon said, ‘Oh, you don’t need that,’ and as he’s rummaging through the supplies he said, ‘You just need this! I use this all the time’. So it was brilliant, because the other surgeon was all dive-like, ‘Oh, I can’t do it unless I have my special equipment’ and here’s another colleague saying, ‘You don’t need that, come on, you can just use this.’ It was very refreshing! If the nurses had done

that, it never would have worked. Yet, there are the two of them. They're not anywhere near the theatre room. They're not helping with positioning. They come in with their hands wet and then they're saying, 'Oh, that's not right!' and making everybody run around, instead of coming in early. If I work in a room with a surgeon I know who does that, I'll call him in a lot earlier. I'll say, 'We're ready for you', when we're not. So they'll sit in the room. Then I'll say to them, 'Is this what you want?', and then I have them involved. I'm pretty conniving." She smiled broadly, pleased with herself.

Lynsey continued, "Perhaps I haven't had major safety issues because I've not been allowing people to lift patients off the table when they're asleep, and change their position. Here's another example that comes to mind. I was thinking, 'Ok, so that's what they're intending to do' – a full four-man lift and then rotate the entire bed. I said 'How are you going to maintain the patient when you have to move your hips out of the way with the bed coming at you?' A team member says, 'Oh, don't worry about it.' I said, 'No, think about it for a second and where the bed is. What will your position be like while holding up a 250 lb patient?' Lynsey laughs as she demonstrates a most awkward motion of avoiding a rotating bed while holding an anaesthetised patient above it. "So what their answer was, 'Oh, just take the head of the bed off, that would make it shorter.' 'Well, you have to be joking'' I said. 'Come on, let's just get the stretcher.' So then I just ran and got that stretcher so they had no option. Yes, I'm a bit of a tyrant but I do smile while I'm doing it," she laughed.

In that moment I pictured Lynsey quickly bringing the stretcher into the operating room. It made me think about how her training and mentor's guidance, again, had instilled in her the confidence and responsibility to act in the best interest of the patient, as well as the operating room team. I considered how fortunate it was for the patient to have had Lynsey there; yet I wondered when the operating room team would come to appreciate her and the teaching experiences she willingly provided them.

"I've never dropped patients, but other people have," Lynsey continued. "It wasn't good. The brakes were not set, but they were actually blaming me because of the sliding sheets, which were new for people. I taught the OR staff how to use these sheets. I had a pager with me and if anybody was moving a patient, they could call me and I would come in and help them. So I was trying to

be there for everybody. So I had been with all of them; they all knew how to do it. But they blamed me and said my 'slippy sheets were too slidey', and I was brought into the office because of that. I said, 'Well, they didn't use a sliding board, which you're supposed to do. It bridges the gap and they didn't put the brake on the table. So I don't quite know how I was involved in that," she laughed as she recalled, and said, "It's kind of a blame thing." "Deflecting it," I suggested, "Perhaps it was something that they didn't like to use because it was a new way and they felt there was 'nothing wrong' with their old way."

As Lynsey spoke about her experiences with repositioning and moving anaesthetised patients I sensed her worry, and mine, in discovering how easily a tolerance for risky actions could be accepted by any operating room team. I thought how very alone she must have felt in her challenge of others' intended actions, for I too had felt that way at times. Yet I also felt her determination to minimize always any safety risks to patients and at the same time to the team. I sensed how Lynsey's insistence that the team perform tasks, consistently, and be involved in aspects of patient preparation (for example with positioning and instrument selection) reflected coherence in teamwork and an attitude that she had experienced in Scotland. It was there she learned how working together as a unified team minimized risk to the patient and team; and through this story I learned how she worked at keeping that unified team experience in the present. I reflected on my own experiences with patient positioning and preparation, and wondered why a surgeon would feel it was not necessary to be present during those preparatory moments; yet given their absence, had no reserve in informing the team that the patient's position or specific instrumentation was not correct or to their liking. I thought about how some individuals can come together as a team to create a smooth workflow and how others remain compartmentalized within specific roles. It made me reflect on how important receptiveness is in the participation of every aspect of patient care by all team members, regardless of role.

I considered how Lynsey's presence had prevented colleagues from taking certain actions and how she encouraged them to work in unity. And I wondered if they did the same when she was not present. I thought how in trivializing Lynsey's concerns for patient safety, her colleagues' interest in patient safety was pushed aside; and without realizing it the team's concern for safety

set aside, too. As Lynsey had learned earlier, the environment of patient safety extended far beyond the immediate context that it presented in. While not everyone seemed receptive to her insistence on taking time to ensure control and coordinated movement in the theatre room in the moments that she described, I believe her determination reinforced her identity and practice as a patient and staff safety advocate. I also recognized how the teachings of operating room matrons and mentors stayed with Lynsey, as she described how she was now the one who "was on people and pulling them up on things" - how she was ever watchful of others. She learned early on to be a strong person and a responsible nurse, especially when it involved professional or personal accountability; and I again felt her full strength and passion for safe care as she shared her stories with me.

Lynsey continued, "I don't like extreme patient positions, like trendelenburg. It scares me – that one scares me. There must be a better way. I have seen the shoulder braces used only once. And then what I'll notice is that the patient's legs are straight if they're in stirrups, so then the patient has moved down the table too much. I'm not sure if that's any good either." I agreed, "No, the legs are not supposed to be straight." She explains, "Yes, and when you mention it, it's 'so what?' I find it very odd. We're here for the patient. Patient safety's first – it's like the airway is first and then you spend a good ten minutes making sure that the bony prominences are all good, that they're all covered with gel pads and whatever, blankets aren't wrinkled, and you spend time doing that. And then, you go ahead and just mess it all up," Lynsey laughs as she referred to how patient positioning can sometimes alter measures taken to ensure safety. I reply, "I guess that's the space where the nurses have to speak up." Lynsey continues, "I remember a surgeon. He said 'Oh, the legs are fine.' And I said, 'I don't think they are. Could we please put her back in level and figure out how we can get the legs positioned better?' We just moved the stirrups up. She wasn't off the top of the bed at all, so that was OK. It just scares me!" she said emphatically.

As Lynsey and I discussed patient positioning considerations and dangers, I felt how she spoke with reverence for a matter that at times created a sense of fear and tension in her. Yet, rather than let the moment control her, Lynsey used her sense of alarm to focus herself and others' attention, in order to ensure safety in patient positioning. This particular act of awareness was

something that Lynsey developed in her operating room training, in response to a suggestion that she examine and understand muscular, skeletal, and circulatory implications of patient positioning. I thought how this knowledge, coupled with her confidence to speak up to other team members about positioning concerns, provided Lynsey with opportunities that encouraged and instilled similar thoughts and considerations in others.

Again I thought about Lynsey's mentors and how they possessed a quality that awakened and stimulated in others, a drive for learning and a passion for safe patient care. I did not know what that particular element was, but it resonated with Lynsey; and I understood the importance of a successful mentoring relationship not only for beginning operating room nurses, but for fellow team members and patients as well. As Lynsey told her story, I witnessed how she remained connected with a mentoring relationship narrative that began much earlier; how later she became the person to suggest and direct care approaches with colleagues when their awareness of these matters was limited or unfocused, no matter how many years of experience they had. Thus I realized that mentoring was not only an activity to be reserved for learning practitioners, but a mindset that supported continued learning for everyone as a way of achieving safe patient care. And specifically for Lynsey, it was a story to live by that developed over many years in a variety of operating room environments and in different countries - a way of nursing that responded assertively to patient safety concerns and worked to minimize their influences in the future.

Being Aware of Each Other

Thinking back to our earlier conversations, Lynsey and I began to discuss how operating room nurses and their colleagues might try to work around a protocol to accomplish their work. "Yes, OR nurses are good at that!" Lynsey said, and this comment led us to consider the importance of communication in patient safety. "Before it gets to the point of a workaround or if we're not familiar with something, someone should say 'we have to stop and figure this out', I said, "but if no one in the room feels strong enough to say 'stop', that's an issue." Lynsey agreed and added, "Well, by not saying anything it can be worse than saying things – you can't be silent. And there are a few nurses I have found who don't say a lot. Or they agree to everything - 'yes, yes, yes'. Ok, does that mean you understand or are you just saying, yes?" she said with a frustrated laugh.

"You had earlier mentioned how you felt communication was a problem with some foreign-trained nurses. How do you think that can be addressed?" I asked Lynsey. She replied with this story, "At Fairview General, there was a foreign-trained nurse who was a great, great guy. He knew his stuff. One of the surgeons said to him, 'You're always just so happy'. He said, 'yes'. The surgeon asked, 'When you're really mad at a surgeon, what do you actually say?' and he said, 'Yes, doctor.' And we all laughed. It was very funny. So of course, the next time something happened and the surgeon asked to talk with him and he said 'Yes, doctor', the surgeon just looked at him and wondered, 'Are you mad at me now?"

"But you know what, that's how things happen," Lynsey said in a reflective tone. "It was a surgeon who brought that up. She had been at a conference and she said, 'You know, you have to be very careful with the nurses. Be aware of the nurses that won't say anything and watch them closer than you would any other nurse, because she may do something like contaminate the field and won't say anything.' "That's a good point," I replied and continue. "I think also when you're in a situation and everyone's looking at everyone else, there are a lot of assumptions going on. For example, 'I'm not going to say anything because she's more senior so she'll know what to do', or, 'Well, the surgeon has done this surgery before, he or she should know what to do'. This is dangerous." "Yes, it is dangerous," Lynsey repeated.

Lynsey continued, "I think it's their training. It is ingrained. I think we have to be aware that it is ingrained. The people I'm thinking of have worked in other countries, but they just seem to be very subservient and they know that. They were taught never to even look a doctor in the eye, always agree, and always say 'Yes, I'll do anything for you'. They don't actually pipe up and say, 'Well, actually you've just touched that and it's contaminated', because they're not supposed to. But if we're aware of that, I think we need to change our method of questioning, not use a closed question but an open question. For example, 'What do you think about that? What do you think about what you're doing?' Then I know they have understood what I just said. Saying 'Yes' doesn't cut it anymore. Somebody taught me that because she realized it."

Reflecting on this later, I wondered if the colleague that Lynsey referred to had a safety experience that altered her conversational approach. Although

Lynsey did not share that story with me, I sensed how it stayed with her as she, too, adjusted her communication approach to ensure that the nurses understood necessary information.

Lynsey continued to reflect, “But how do you get nurses to talk, that don’t, that’s not in their nature? Is it a language thing? And that scares me. Then I don’t know the ability of the staff in that operating room if something goes wrong and they shut the doors, and don’t tell anybody. I remember a charge nurse was absolutely off her head one time because nobody phoned to tell her there was a huge bleeder. They called the vascular surgeon. They just ran to the theatre and got him, pulled him out. There was blood arriving for the patient, yet nobody knew because the staff didn’t ask or talk to anybody. It was odd and that scares me. And another thing, they wanted the windows covered. I said ‘Don’t cover the windows! The patient is covered. I can tell as I walk past a room how the room is doing by the feel of the room.’ I can see it in their eyes or their body movement. So if I see people are starting to run or panic, I’m in that room to help. I remember one time knocking on a door - knock, knock, knock- knock, knock - I look in and it’s empty! The windows are covered up, and they were supposed to be in there, but they switched theatres on me!” she laughed. “So I just walked in and I started uncovering the windows.” ‘Why are you doing that?’ someone asked. I said, ‘Because it’s for safety, for safety!’ Lynsey said emphatically. “Yes, if you’re in-charge you need to know what’s going on and there’s no better way to do that than looking in the theatre as you walk by,” I commented. “Yes, they’ve taken the time to put ‘Do Not Enter’ signs on the back door. Well, if you don’t want me to enter then don’t cover up the windows, because if I can see all is going well then I can walk away,” Lynsey said.

Lynsey’s concern about communication difficulties amongst operating room nurses was apparent as she spoke. While she identified a particular group of nurses that in her experience had specific communication challenges, she also spoke of remaining aware of any nurse who was silent or communicated poorly, describing how that could lead to compromised safety situations. This was an important recognition that extended past the domain of nursing to anyone, in that nurse, surgeon, anaesthetist, or patient could remain silent at any time, no matter what their background. I thought how silence loudly drew attention to patient

safety; how silence and not the silent person was the primary safety focus in the moment.

As Lynsey shared her story, I thought how she, too, was a foreign-trained nurse; however she had been mentored and expected to speak to any concerns as a nurse, especially patient care concerns. While this may not always have been an easy conversation for her to have, I believe this became a part of nursing that Lynsey has lived daily and come to expect over the years from herself and other nurses – an integral approach to safer patient care. Yet, as Lynsey explained, it was a part of operating room nursing that was not always encouraged or even determined as familiar in nurses. From my personal experience, I believe this is evident no matter where nurses may have received their education. Some nurses have asked me if it was acceptable to speak up about patient care concerns that were both nursing and non-nursing generated, and how to go about doing this, for they felt that they had not received any direction about "speaking up". In reflecting on this important aspect of patient safety, I thought about the implications of remaining silent, and how this needed more attention throughout nurses' operating room education and department orientations. I wondered if, just as Lynsey was perplexed with some nurses for their limited communication, other nurses were puzzled or uncomfortable with her assured approach.

Lynsey shared how she and some surgeons felt the tension and implications of poor communication; and I thought how this also extended to the patient. She revealed how she used this awareness to address communication difficulties through attention to the use of specific word patterns, and I learned how she, and possibly some surgeons, experienced the necessity of remaining "ever watchful" of others. When she described how she observed activities in the theatre rooms as she made her rounds, I was again reminded of how she positioned herself in the background as a way of learning and responding to what was occurring in each room. I considered how the knowledge and experience of some nurses' limited communication kept the tension alive and unresolved for Lynsey, and how this tension kept her connected with her earlier days of operating room nursing. Thus she had learned what it meant to be aware and vigilant, and how to speak up as a staff nurse even within an established

professional hierarchy, and this extended into experiences of what it meant to be a manager in the operating room, as she worked at getting "nurses to talk".

Lynsey shared another story about communication and awareness in the operating room. "There was an anaesthetist that had certain issues from the past. He was back at work but his behaviour was so erratic. He would stand there." Lynsey recalled, demonstrating a far away gaze as she explained, "And then he would be asking what the patient's name was after the patient was on the stretcher to be extubated, in order to fill in the paperwork. What was he doing for the last hour? Then the patient started trying to extubate himself and he had his back to the patient. So that's where you have a nurse who is quiet, who doesn't say anything and another one who's saying, 'Hey, your patient's extubating. You want to help him with it?' As well, you could never find him in between cases, couldn't find him in the middle of cases. I ended up talking to the head of anaesthesia about that. But that's another story. What do you do when a surgeon or anaesthetist is not acting appropriately? That's a hard one. Maybe he is a nice guy, but there are safety issues," her voice drifted.

I offered, "Some people as you said, stay quiet because they don't feel comfortable commenting on another profession. And maybe they don't want to experience being challenged when having to confront that person. It's a very uncomfortable situation but to let it slide is worse." "Yes, yes!" Lynsey remarked. "I was mentioning this, no names, I was being very general when I was talking to my manager, and another nurse had just popped into the room for a second, she said, 'Are you talking about Dr. X?' We all looked and I said 'Why?' 'Oh, well a while ago he was feeding a patient in the OR.' Lynsey continued, "We're like, 'what?' The nurse said, 'Yeah, when I went to talk to the patient, the patient had food particles around his mouth. So I said, 'Are you eating? I knew he was having a spinal anaesthetic for surgery.' Lynsey stopped then continued, "I said to her, 'Are you positive that he fed the patient?' And she said 'Yes, because I asked the patient. And the patient said, 'I was just commenting on how I hadn't had any breakfast so he gave me some food.' "So, did you tell that to anybody?' I asked the nurse. She said, 'No.' And I am thinking that this had occurred awhile ago. Time had gone by and she didn't bother telling anybody. I think she might have mentioned it to the nurses but she didn't actually mention it to anyone as a concern," Lynsey said, perplexed. I asked, "Did she not recognize it as a

concern?" Lynsey answered, "Well, not the way she was telling us. She recognized it was wrong but didn't bother telling anyone. When I asked her, I thought maybe she didn't want to get involved. I said, 'Would you mind writing that up just so that we have documentation?' She said 'No, no problem,' and handed it to me about 10 minutes later. Well, that was easy but why had she done nothing about it, earlier, with those involved?" Lynsey puzzled.

Perplexed as well, I asked, "Lynsey, is there a list of events that should be reported in your OR? If I were starting in your OR, how would I know what I should even consider reporting?" "No," she replied, sounding surprised, "It's interesting but what's very interesting is when you're learning, you don't know what's wrong. I guess you have to rely on experience." "Which takes us back to the basics," I commented. "Exactly," Lynsey replied. I continued, "How do you figure out as a starting nurse what you should think about or how to figure out 'is this right?', or 'Should I be doing something different? Is this something I should be doing?" "I think those are good questions," Lynsey says. "Actually, quite a few people have come up to me and asked me that. They tell me what has happened." "Well, that's good they're doing that," I replied. "I do find," Lynsey continued, "that it's the same people asking me and it's the same people going into a room to relieve for a break. They catch what's going on but the permanent people in the room where it's happening didn't mention it."

I reflected on how Lynsey had come to understand and appreciate the importance of using a situational tension as a response to patient safety concerns. As she recalled the story about the patient eating in the operating room, I sensed the horror of her discovery of this event creep into our conversation. I learned how Lynsey felt the lapse in protocol create a tension in that moment; yet the involved nurse seemingly did not have a similar response. I also heard how she used her tension of that moment to gain control and to follow up on the situation by requesting a written report of the event, rather than reprimanding the nurse and letting the situation end without resolution. In a particular way, Lynsey demonstrated how she used her knowledge and concern to act in response to a potentially tragic situation, rather than react negatively to someone relaying information, thereby possibly deterring any one from voicing a concern in the future.

She learned much earlier in her care relationships how she had the ability to make a difference in the lives of others, not because she had to but because of the moral and ethical responsibility she felt toward others in her care. She learned to question and point out breaches in practice to nurses and physicians alike, derived from an acute awareness and high expectations of patient care. And I understood how over time this became a grounding element in Lynsey's work. I thought how her strength to address patient safety outside of her profession could have boundless effects on others, for in bringing practice concerns forward she also brought patient safety forward as a fundamental aspect of care in the operating room, no matter who provided that care. I thought how patient safety was not the only concern addressed by Lynsey, for I also understood she was concerned for the personal safety and health of professional colleagues as fellow human beings. I felt the concern and care in her voice when Lynsey pondered what a person should do when a colleague was acting inappropriately. I sensed how conflicted she could have been in her conversation with a department head about an anaesthetist who was "a nice guy", yet displayed practice concerns, for while receiving the necessary professional and personal support depended on people voicing their concerns, the risk of a colleague being removed from their position laid bare the uncertainties hidden in that conversation. And I wondered if in speaking to her superiors in a "general" way about a particular colleague, Lynsey encouraged others to view their colleagues as more than just a professional image; that is, as team members who needed professional and personal support stemming from emotional issues generated from work or from home. As I reflected on the stories that she shared with me, I sensed how Lynsey recognized and responded to the needs of co-workers that surrounded her by trying to understand who they were as complex people living in a busy, high paced world.

As Lynsey spoke, I sensed how the notion of professional accountability wove throughout her story, and how she used her professional responsibility to enhance her daily work and respond to safety concerns. As a manager reflecting on the action of nurses covering windows in the theatre to prevent others from observing what was occurring, Lynsey felt obligated to answer to the professional and ethical behaviour of nurses in that theater. She felt that covering the windows was an unsafe practice, for this limited her awareness of events

unfolding in the theatre; and as an operating room manager she knew she also had to answer for the actions of those that she supervised. As Lynsey explained why the windows must remain open to view, she also had the nurses accept accountability and responsibility for their actions by adhering to expectations she set out. As Lynsey had learned much earlier as a staff nurse, caring for people extended past the physical task of doing; nursing also involved accepting and addressing the ethical, professional, and legal responsibilities of one's activities, and it was this accountability that Lynsey held close as she watched over the actions of others.

I shared the tension Lynsey felt in responding to a professional practice concern of a colleague, for I recalled how difficult that conversation could be, especially if the colleague belonged to a different profession. I thought how for some nurses, the idea of addressing practice concerns inside or outside of their profession was a fearful and intimidating prospect, a tension they would rather avoid for numerous reasons. Perhaps they thought or hoped that someone else might speak up. I thought about the nurse in Lynsey's story who discovered that a colleague had fed her patient, and I wondered why she refrained from speaking up. The nurse recognized the potential danger of the situation; yet, what was it that kept her silent?

I also thought it curious that a guideline or an example of concerns that should be communicated by nurses or others was not available in Lynsey's operating room or mine. I recalled asking other nurses over the years if they had a list of what to report in their theatres, but they said they had no such list, either. Specific situations required to be reported by law and professional codes of ethics are assumed to be known amongst professionals, but how do nurses learn what other practices should be brought to attention as well, especially if some nurses are reluctant to communicate or question them. I wondered, if I became a patient in an operating room, would my nurses speak freely about safety issues that might affect me? Alternatively, would the tensions they might feel in those actions lock in their silence? I knew what I would expect the nurses I worked with to do, but how could I be certain that they would? Thus, as I thought about Lynsey's and my experiences, I realized the importance of asking questions about how it was that we came to know and decide which practices, actions, and

communications should be brought forward and responded to as safety concerns in the operating room.

Work Relationships and Patient Safety

I asked Lynsey about her thoughts concerning working relationships in the operating room and patient safety. She responded quickly, “Ohhh, it has to be good! It has to be. It's important! You can’t be having a tiff with somebody in the room because the patient is going to suffer. First of all, the patient is not even asleep yet, and you can hear things like, ‘Well I asked for this’ or ‘I didn’t hear you’ or ‘you have to speak more, please enunciate better’ and ‘Well, I did’. You can hear it in the background and you’re saying ‘sshhh – what’s going on here!’ Also, if the surgeon has annoyed the scrub nurse, the scrub nurse can be quite vicious – make him wait – you can’t have that. We’re here for the patient. We need to put things aside and just focus on the patient. You can see where it can happen. Actually, I have seen it with nurses who despised each other. I was scrubbed and ready and the patient was barely going to sleep, and these two nurses were really quite at each other. ‘You’re supposed to do it this way. No you’re not. You’re supposed to do it this way’. So I came off scrub, touched the two of them and I said, ‘You both need to get out. Just get out and I’ll be here with the anaesthetist, and we’ll be fine’. And I just helped because it was too disruptive. And the anaesthetist is saying, ‘What’s going on?’ and then he’s worried because fewer people are paying attention to what’s happening with the patient. No, you can’t have that.”

“I can’t imagine the poor patient,” I responded and continued, “They’re just so hypersensitive to everything.” “And they’re just about to go under and they’re looked after by these people who were at each other’s throats,” Lynsey said, with a frustrated laugh. “Now, this next story is about language in the OR. The patient is scared. This man is getting his toe amputated and I’m with him. As I am just about to hand supplies to the scrub nurse, the anaesthetist and I are watching the patient. I said to him, ‘I’m just going to move for a moment and be back’ and I took the saw blade to the scrub nurse and shook it, making a pointing motion. And she says, ‘Oh Dr. X, what saw blade are you needing?’ And I’m making this ‘what are you thinking of?’ motion with my hands, and she says, ‘Ooooops’. I’m thinking, ‘Come on now, the patient is awake for surgery.’ And the anaesthetist is rolling his eyes. I don’t even like counting blades out loud. People

don't need to hear the word blade. They don't need to hear the word saw blade at all. So watching the language in the OR with patients, especially when they are being intubated, that to me is patient safety. Little things like that I think are huge!" she declared.

As Lynsey described her story, I thought about work in the operating room as not occurring in isolation. It is work done in unity with others, in order to meet the needs of the patient. Yet, in her narrative I heard how personal interests and issues could be poorly aligned with the immediate interests of others in the same room, and how this could lead to a disrupted and tense atmosphere. I wondered how it was that someone could so easily forget the presence of the patient so much that the nurse would speak words without thought or compassion, and without awareness of the present moment of patient care. I wondered how the patient felt, to know that he was at the mercy of professional care providers who set the patients' immediate needs aside, and allowed their personal issues to become their focus of concern. For many patients, coming to the operating room and having surgery is a life changing experience. As Lynsey spoke, I understood how through our working relationships in the operating room, we have the ability to either detract from, or enhance, the patient's experience, as well as future health interests.

I thought back to Lynsey's description of how she observed interactions without speaking, how she anticipated and recognized what was required, and how she took steps to provide that assistance. I reflected about her earlier reflections on operating room education, how she learned to be observant and sensitive to what surrounded her through the continued awareness of others. I considered the strict professional hierarchy she had experienced in Scotland not to be a constraint upon her; but rather a way of learning how to communicate and use language in the operating room in an appropriate, professional, and effective manner. It was within this hierarchy that Lynsey learned how to work effectively in relationship with others, for that was the expected way of operating room work in Scotland. Lynsey told me how, as the scrub nurse, she took control of disruptive situations involving circulating nurses in the theatre by instructing them to leave the room, even though these same nurses were supposed to be in charge of the theatre. I understood how natural it seemed for Lynsey to take this control. As she explained earlier, "in Scotland the scrub nurse was in charge of the theatre,"

and I appreciated how this was a role she easily slipped back into. I believe that Lynsey used her gift of awareness to know her surroundings as a way of enabling relevant and efficient communication, which in turn established her credibility as a competent and knowledgeable nurse who could respond to situational demands as they unfolded. It was this quality of awareness that guided Lynsey in her daily work with others, and I realized how relentless she was in the encouragement of her colleagues to do the same.

Lynsey settled into her chair to share another story with me. “One time I popped by the room and looked in. The patient was lying on the OR bed,” she began, and then continued, “So this woman was lying with her arms out and I thought, ‘Oh, she’s not intubated’. There’s no anaesthetist. I’m looking and don’t see anyone. Then the patient looks up like this,” and Lynsey imitates the patient making eye contact with her and lifting her head off of the pillow. “So, she’s awake and her arms are out like this,” Lynsey demonstrated, her arms stretched out, “The patient has no safety belt on and she’s looking around. She sees me through the window. So I walk in and there’s a surgeon at the computer with his back to the patient, and there’s a care leader, too. A care leader is someone who’s supposed to be leading and she’s got her back to the patient. She’s looking at the case cart and thumbing through paperwork. So, I said to the care leader, ‘Are you OK?’ She said, ‘Yes’, and I said, ‘Are you missing some staff in here?’ She said, ‘Yes.’ I said to her, ‘Where’s your anaesthetist? Where are the people who need to be with the patient?’ ‘Oh, we’re fine,’ she said. ‘Well, I’ll come in and help you,’ I responded. ‘No, we’re OK’. She didn’t want me in there. I came in anyways. So, I walked up to the patient and I said, ‘Hi, my name’s Lynsey. How are you doing?’ She seemed fine, she was smiling, she said, ‘I’m just looking at what’s going on – interesting.’ But I thought that was absolutely horrendous, absolutely horrendous. What’s that in patient safety?” she asked.

“That troubles me,” I replied. “And this is somebody who’s supposed to be a leader in the OR, which bothered me even more,” Lynsey asserted. “But nobody was around the patient, not even the anaesthetist. I’ll judge whether I can leave the patient, depending on where the anaesthetist is and what he’s doing, and then determine if it’s safe to walk away. Or I’ll say to the scrub nurse, ‘Can you just stand here for a bit?’ and I’ll go and get blankets or whatever. I’m always

cognizant about that, but I couldn't believe what I saw. And the care leader didn't see any problem with it!"

Lynsey continued, "So, one of the things I've always wanted to do is have the team work through a scenario, one at a time. I've always wanted the nurse to come in and lie on a table, just how we would normally have a patient do, with her arms completely spread out and no one talking to her. People would be in conversation about their Friday night over in one area of the room and somebody over in another area would be on the computer. Then I would ask her, 'How do you feel as a patient?' Then I'd have the anaesthetist talking from above following no introductions. More people would be just standing and waiting around her, waiting for her to fall asleep so they can begin. And there would be no opportunity for eye contact with anybody. I would want the nurse to feel what that was like and be more aware of such an experience. I would then hope she'd change how she treated patients," she concluded.

I could sense Lynsey's disgust in discovering the situation she described in her story and her deep disappointment in the behaviour of members of the team. I heard and felt the ugliness of that moment come forward and learned how the intensity of that experience has remained with her. I tried to imagine how the patient might have felt and how as a person her presence was made inconsequential. I reflected on how she waited, distanced from care providers simply by the turning of their backs from her. Lynsey described how the nurse and surgeon chose to use their brief time as they waited, the patient forgotten in the present moment. I could not stop thinking that, even though they were with the patient in the same room, they were not there "for the patient", which Lynsey alluded to earlier. I thought about how we care for others and develop our attitudes about care, and reflected on work by Zerubavel (1979). He wrote that, in addition to being formal and complex institutions, hospitals were also organizations whose "social significance is to a large extent moral" (p. xvii). Zerubavel further explained that, most cultures symbolically located health and illness in the sacred domain which would imply, the hospital continues to be governed by moral principles as well as the practical. Continuous patient care is the "moral raison d'être" (p. xix); yet, I wondered about how easy it was for us to forget the reason for our presence in the operating room.

I learned about what it meant for Lynsey to be "there for the patient" and how the event she experienced unsettled her. She described how the nurse and surgeon focused on practical activities in the operating room; yet the patient, the reason they were there, was excluded from their attention. I understood how Lynsey quickly moved from watching as a bystander in the background to making a connection with the patient whose presence mattered overall, not just merely in that moment. I felt her attitude toward the patient was a thread that stretched from her early career at Trinity Foundation right through to her most recent emotionally intense patient experiences, such as the one she spoke about in relation to drawing attention to the meaning of personal accountability in team member's daily work. As I listened to Lynsey tell her story, I thought how these experiences wove together to ensure that the connection to her past learnings remained strong in the present.

"I remember another time," Lynsey said. "There was an issue where a surgeon wanted to do a gastroscopy for an active bleed. So, they were just about to call for his patient when they heard word from the emergency department of a three year old with an obstructed airway. They held the gastroscopy patient at bay. Now, we don't do a lot of paediatrics, so a nurse from recovery came in to the OR because she had worked at a children's hospital. She was in there and they were having a heck of a time getting an airway in this poor child. It was awful. They had a terrible time. Well, the surgeon who wanted to do his gastroscopy was walking in the room and asking, 'How long are you guys going to be – how long are you going to be?' And at one point the anaesthetist, who is the quietest person you ever heard, swore at him and said 'Get out of my OR! Get out!' And the surgeon's response was to go over to the nurses asking, 'How come it takes three of you here? I only need one of you.' And here they're trying desperately to keep this three year old alive and he's in there bothering the nurses." Lynsey continued, "Then the nurse who was in charge said, 'Well, I might be able to bring a nurse back from dayshift', and when the surgeon heard that he said to the unit clerk at the front desk, 'Get my patient!' 'Oh', she said, 'Well, I don't think they're done with the child'.

"They had to helicopter that child out and I think they kept him in the OR for three hours. And the surgeon was just freaking out and ranted on, telling them how useless the clerk was, saying the charge nurse just couldn't do her job, and

swearing at everybody. I said, 'None of you thought of calling the manager? Call the manager if you're bullied!' In the meantime, here's a gastroscopy patient who's supposed to be actively bleeding, sitting in the holding area. The night anaesthetist was called in early and you know what, that patient was not bleeding at all. It turned out later that someone discovered that he was the last patient on the day slate and the surgeon had some event to go to that night. So, where's the patient safety there? It was a three year old child," Lynsey said. "That sounded terrible," I replied. "It was awful," she said, continuing. "His behaviour was awful but none of the staff actually said to him, 'Stop what you're doing. This behaviour is unacceptable."

I reflected on Lynsey's description of work in the operating room in Scotland and about the sense of awareness and attention instilled and fostered in her by colleagues, as well as the adherence to professional courtesy that enhanced everybody coming together to work as a team. Her words – "we're here for the patient" – came to me again; and I thought how the event with the child that she spoke of must have stood so far away from what she had been taught and come to expect in her work. Lynsey's story emphasized the importance of the presence of a strong and capable in-charge person, someone who could effectively take control of an unfolding situation and ensure priorities remained in the forefront. I was reminded of Lynsey's description of the role held by matrons in Scotland, and thought that the behaviour described in Lynsey's story would certainly have been quashed by those matrons. I thought about different socialization experiences we embody as we learn to function in our roles, and how diverse those approaches could be. I wondered if the surgeon may have been mentored to believe that, as a surgeon, he was in charge of directing nurses' activities or other activities in the operating room department; for it appeared as if through behaving badly toward coworkers, he could perhaps intimidate them into doing what he wanted at the time. Yet, Lynsey's mentoring experience instilled in her the expectation of working together in a team, with a clear chain of command supporting that team, in order to ensure they came together in unified form for the patient.

Thus I thought again about working relationships in the operating room and patient safety, and Lynsey's initial response, "It has to be good. It has to be. It's important. You can't be having a tiff with somebody in the room because the

patient is going to suffer". I somberly reflected on how a seemingly simple concept of professional working relationships and teamwork could remain as elusive as it did.

Continuing the Patient Safety Conversation

"Lynsey, in one of our conversations you mentioned that student nurses come to the OR," I said to her. She replied, "Yes, lots. I love students. I find out which level they're at and that depends how much I bring them in and talk to them. As I'm opening supplies, I have them stand behind and I say, "Ok, this is what I'm opening. Can you see that?' And I just chat while I do my thing. If somebody's prepping the patient, I say, 'See how the nurse is looking at the bony prominences, the bed's made of this, so you don't want to have bedsores,' and they're like 'Oh!', because they just see a patient lying on the bed. So as I'm chatting work is being done." "You're telling them what and why," I suggested. Lynsey replied, "Yes, but then I'll walk in a theatre and see the students sitting there doing nothing. The nurses haven't even bothered putting it on the video screen." I responded, "That's how the students get their fundamentals, from having someone talk to them and tell them." "Yes," Lynsey added, "because the OR is such a mystery. Hospital people usually say, 'Oh, OR nurses are scary. Don't ever go to the OR.' But it's because they don't know about the OR. So, if you have a student that's had a great time in the OR, they tend to want to come back," she emphasized.

"We also get employed student nurses," Lynsey continued, "They come in the summertime. However, they are not allowed to be taught anything new." "So they can only use the skills they know?" I clarified. Lynsey replied, "Yes, you can't teach them how to open anything to give to the scrub nurse. They're not allowed. If they've done a Foley catheter insertion on the ward, they can do it. So, I get them to go in with the aides so they can pick things to practice; and to look how SPD - the sterile processing department - works. A student actually said to us, 'Oh, this SPD isn't my job. I'll never need to know how to do this.' So, we're all like, 'Oh, keep an eye on this one'. But another student was so eager to go there. I said, 'Why don't you take her downstairs to SPD. She'll really enjoy that.' And she was just great. She knew what she was doing. Now, I wouldn't have said that if I hadn't seen her enthusiasm." "She would get the idea of the system's flow and how it all connects together," I offered. Lynsey added, "Yes, that's how OR

nurses start. We pick cases. So it was interesting how our little flags went up with the student who didn't want to go to SPD. 'I don't think *you're* going to be cut out for this area," Lynsey said, continuing her story.

"But that other student was very astute, a very quick, quick learner. She watched the operation. That was the other thing. She would watch not just what was happening, but how they were doing it. You can tell the difference, so instead of being entertained by television, she's curious and asking, 'So, you use that instrument for this procedure, is that right?' and 'This machine gets plugged in here, doesn't it?' You could see her working it all out. It was fantastic. She actually was more astute than a couple of the nurses we had already. We had one laparoscopic case that we had to open, surgically. I had gone away before this because everything was fine. But then I was called back 10 minutes later and it was the student nurse that came and got me. She said, 'They're opening.' I said, 'Oh, OK.' I looked at her and she was kind of fidgeting, and I said, 'Do they want me in the room?' She said, 'They might. I think it would be good if you went in the room'. So, it turns out that they hadn't asked for me. She had come in to get me. She could see the chaos that was occurring." I could tell how impressed Lynsey was with this student's awareness.

As I listened to Lynsey's story, I heard how her passion for patient safety and her interest in teaching nursing students came together in the operating room, and provided an opportunity for her to mentor students in aspects of patient care and safety. She recognized the value of a positive learning experience, and how it could stimulate enough interest in students so that they would want to come back to the OR, perhaps to eventually work as a qualified OR nurse there. She described how she included the students in the activities she performed, how she had them observe and watch, and how she pointed out important aspects of OR nursing and patient care that outwardly appeared simple and basic, but were actually important elements of safe care. I felt how Lynsey included the students as members of the OR team and I sensed her disappointment when others made little attempt to interact with them as she did. Some of my most memorable student nurse experiences were those in which a nurse or physician took time to explain, or point out, a specific aspect to me, something that I would not have known to inquire about because I simply did not know. I thought how nurses were students at one time in their careers and

wondered why some nurses just did not want to interact with them. Why would they not pass on a learning opportunity to the student and, perhaps, learn something themselves?

I thought about the student nurse that Lynsey described as being "very astute". Although the student was only in the OR for a short time and not always under Lynsey's direct supervision, I wondered if her mentoring experience was similar to the one Lynsey enjoyed with her mentor. Lynsey shared how she had provided extra guidance and mentoring to this student because she was interested in OR work and displayed an ability to understand the significance of events unfolding around her. I pictured Lynsey as a beginning OR nurse working alongside her mentor, someone who took an interest and provided her with extra guidance, because she recognized in Lynsey the ability and desire to become a very skilled and capable OR nurse. I wondered if Lynsey saw herself in this student nurse. I sensed how Lynsey felt her time spent with her was rewarding, both professionally and personally, for she spoke proudly about the student's sense of awareness and her ability to judge a potentially compromised situation. I recalled Lynsey saying her mentor was "everyone's mum" and I pictured Lynsey as a "mentor-mum" too, as she spoke about her time spent with students.

"What kind of stories do you tell nursing students to understand what patient safety means to you?" I asked Lynsey. She thought about this and replied, "Well, the first thing that pops into my head is an image I have whenever a student comes into our operating room and they watch what we do to get the patient ready. Afterwards I always go up to them and say, 'Did you see how much time we spent on making sure that each aspect of their bony prominences are covered?' That kind of thing and I would go through it with them and you can see them say, 'Oh!' And I say, 'We do it quickly because we're used to doing it.' But I also emphasize that we are looking out for patient safety as in tissue viability and most of them don't actually realize that. I feel sometimes that people working in the OR forget that, too. So I tell the students that this is why we are here, because of the patients and to keep them safe. We're not just keeping them on the table, but we're always thinking is it padded enough? Is the blanket wrinkled? Are the arms above 90 degrees? Also, when they put patients on their sides are the IV's padded? And the blue clamps, are they right against the skin or are they padded?"

"It sounds like a lot of those taken for granted things that you spend so much time learning to identify when you're new to the OR, become difficult to bring back down to an individual level again," I said. Lynsey replied, "Yes, and when I have a student in the room that's the first thing I say to them, 'Watch how I do this.' So for me, preserving tissue viability is one of the most important parts to understand as a new circulating nurse. I would also say that remembering the simple things like putting the brakes on the beds is crucial because patients fall in-between the cracks and fall on the floor. There are many of those kinds of stories and the students will say, 'What, that really happens?' And keeping a safety strap on, they may think it's silly because the patient is anaesthetised and they're not going anywhere, but it happens. A surgeon had put his foot on the lateral button on the foot control and didn't actually realize what he had done, but it kept everybody from moving the table. Then he moved his foot and the table went into a severe lateral position, and because the patient was actually strapped on it he didn't fall off." So I tell them, "Just don't take anything for granted. Don't ever forget the safety straps because you never know when you're going to need them. Even coming out of anaesthesia, I remember three times when I was in a room with the same anaesthetist and all three patients when they woke up, flew their legs up, suddenly sat up, and then flopped back like this," and she demonstrated a sudden sitting up straight motion with legs in the air, arms hanging down, and a body limp and skewed. So I always say to students, 'You can never be too careful! " she concluded.

As Lynsey described the various patient safety details that she pointed out to student nurses in the OR, I also heard how she introduced continuity of care as a safety measure repeated over time, so it would be a constant element of care. I also thought how this might have served as a reminder and a reinforcement of information for anyone else in the theatre who may have listened to the conversation between Lynsey and the students. She described the importance of approaching care in a certain way, for whatever action was taken in the present moment was important for the patient's well being into the future. I also sensed how Lynsey emphasized that these safety actions were not for the convenience of the OR team, but rather they were meant to ensure patients' safety throughout their operating room encounter and recovery in hospital.

When Lynsey took the opportunity to share her knowledge with students, she also created an opportunity for students to take their new found knowledge into future patient encounters. I thought how in developing the students' awareness of patient safety related matters, Lynsey indirectly supported safe care in any patient the students might care for in the future. Yet, Lynsey's story also reminded me how easy it was to forget the "simple things" in the routine of care. With tasks performed quickly and simultaneously, the reason for specific actions and attention to detail may be lost in the efficiency of care.

"Where do you place the importance of patient safety tools like standards and the pre-op check in overall patient safety?" I asked Lynsey. She thought and then replied, "I think they're up there. We have to remember that it's important because it's almost taken for granted. Some of the questions are routine, especially if it's the third or fourth patient of the day; like 'Yes, the anaesthetic machine is checked. Yes, we know who's in this room already'. So you can become quite lazy with it, but it's going to help everyone create safe work. So I think it is very important." I continued and asked Lynsey, "I sensed in some of our other conversations about patient safety, and some of the experiences that you have had, that you approach safety from a common sense perspective. For example, do you consider it common sense to complete these checklist steps?" "Yes, but it can also be dangerous," Lynsey replied, "because, we're not all at the same level." "Can you tell me a bit more about that? We bring in the checklist and the standards, but are those common sense things or are they above the basics?" I asked. "I think those things actually dumb down the system. They are a way of covering everybody," Lynsey responded. "Because I think there are some nurses like you and me," she laughed, "who would just walk in and be able to work it out. And if anything were to pop up that looked odd, you'd immediately say, 'Right, hold on a second everybody. What's odd about this?' So it's that kind of thing that's important and I think having these different systems in place makes sure that everybody's on the same playing field, so to speak, and there are no assumptions being made.

Lynsey continues, "Our education nurse is very good. Every week she puts on every scrub sink a new professional standard on the wall. And then she'll test people during morning report, saying, 'Right, what's on the wall this week?' And if anybody questions the standards or brings it to our attention that we're not

up to them, she's immediately there. So at our place we do try to adhere to them all and we're huge on certification. Several nurses just wrote the certification exam so now they are saying, 'You know what? We could be doing that better' and then we implement a change." I replied, "I like that idea of having a different standard posted every so often, because it reminds you, 'Ok, let's focus on this today." "Yes," Lynsey said, "because you're just standing there washing your hands. It's a good place for it. You can only read the eyewash bottle so many times," she laughed.

As Lynsey spoke about how some OR work could become a repetitive routine, she also emphasized that it was the "day to day stuff", the mundane activities of operating room routines and processes, where patient safety must be consistently addressed. I thought how repeated work over time became routine work, and while routines were helpful to ensure efficient functioning of an operating room department, people and safety could become lost in the routines of function. Davies (1990) wrote that routines themselves were not primarily a problem, but it was "...in the manner in which the routine is applied" (p. 113). As I reflected on this, I recalled the story Lynsey shared about the surgeon who inadvertently pressed the bed tilt pedal with his foot. I thought how in that moment the patient remained safe and did not fall off of the operating room bed, because healthcare providers had anchored themselves so firmly in their routine by consistently monitoring patient safety. The simple application of a lap belt ensured that the anaesthetised patient remained on the bed. Yet, I also thought about the story Lynsey shared previously, whereby a nurse and surgeon seemingly ignored a patient in the theatre, their backs turned to her as she lay on a narrow OR bed without a lap belt, and without anyone paying attention to her. I thought how in the familiarity of their routine to get surgery done they forgot they were there "because of the patients" and there "to keep them safe".

Lynsey also described how some nurses in her department had obtained their perioperative nursing certification. This is an exam-based credential issued by the Canadian Nurses Association, which denotes a designated level of proficiency in operating room nursing practice founded on parameters that include the application of knowledge to advance the current and ongoing care of patients in the operating room. I also heard in Lynsey's story how she saw these nurses using their knowledge from the exam process by paying more attention to

nursing standards and suggesting how certain things could be improved upon in the department. I thought about an earlier experience Lynsey shared, when suggestions for improvement were dismissed and instead were met with the response "this is the way we've always done it". I thought how that attitude was one reason Lynsey identified for leaving her previous work site, and how in her current work site she felt a new found enthusiasm amongst the nurses for wanting to do things better.

I learned how Lynsey welcomed opportunities for improvement as a way of attending to safer patient care. She focused on operating room nurses "being there for the patient" and I thought how through this focus, she had learned and recognized the importance and necessity of responding to others' suggestions to improve patient care and safety. I felt how her openness to change was so much a part of her identity as a safety practitioner; and I reflected on how her identity had developed over the years in different places and surrounded by different people. I could not help but think of Lynsey's mentor who encouraged her to use her awareness to shape, continually, her nursing practice and ultimately her identity as a safety practitioner. I thought how Lynsey's willingness to listen to others and make improvements also reflected a strong sense of accountability and responsibility in her nursing practice. By responding to suggestions in a positive rather than defensive manner, Lynsey actualized her desire to improve her practice, constantly, as well as the practice of others that ultimately all resulted in safety for patients.

Although she did not say it, I sensed how Lynsey was pleased that the nurses in her department were using their new found awareness to guide them in their daily work and in future patient encounters. Now she saw other nurses acting in a similar fashion and open to improving their practice. I wondered if a tension that she had earlier felt, which stemmed from feeling a "drop in practice standards" in her department, would begin to ease as she saw how some nurses realized that the "day to day stuff" of operating room nursing was where accountability for one's practice and safe patient care began. Thus, I have often wondered if we could ever say that we have accomplished patient safety; and I would have to say that based on our conversations, Lynsey and I are even more aware that there is no finite answer to that wonder.

CHAPTER EIGHT

Narrative Threads

As described in the first chapter of writing, the primary focus of this narrative inquiry was to gain an understanding and make meaning of operating room nurses' experiences of patient safety. It was about inquiring into the nurses' stories of their patient safety experiences and learning from them. The stories of the operating room nurses in this study take us across their personal and professional life narratives, moments that are seemingly separate but also somehow connected together. Narrative inquiry supported a process for engaging with the nurses and exploring their experiences in a manner that allowed them to tell their stories in a way meaningful to them. The nurses and I conversed within a three-dimensional inquiry space as a way of eliciting their experiences and new insights about patient safety in the operating room.

These stories revealed how the operating room nurses have experienced patient safety in ways that are rarely known or witnessed, except by virtue of working in the operating room department or being a patient. Patient safety in the operating room is rarely a solo effort because so many others are involved in every patient's care; however, an individual can influence how patient safety is viewed and achieved. The nurses' stories make visible how they have experienced patient safety through relational moments of tension and unity, through identifying and pushing boundaries, and through liminal moments. I always had a sense of this in my own practice when hearing other nurses speak of patient safety in a similar manner, which resonated deep within and validated my experiences.

An underlying desire of mine as a narrative inquirer and practicing nurse is for patient safety to be always in the moment, and for all care providers and organizational leaders to actualize this as conventional patient care. My understanding of patient safety in the operating room continues to stretch past the professional context and extend into the personal and social context. For the nurses in this research, their life moments across place, time, and relationship influenced their way of nursing and provided me with a context for understanding their patient safety experiences. As a way to gain a deeper understanding of the nurses' stories to live by, I looked for "patterns, narrative threads, tensions, and themes within or across an individual's experience" (Clandinin & Connelly, 2000,

p. 132). I read and re-read texts and preliminary writings as a way of discovering threads and unity between and across the nurses' experiences.

While the nurses' stories each on their own resonated with me I recognized when writing the research texts how each nurse's story also resonated across the other nurses' stories, and I identified certain threads that ran across their stories. Clandinin (2007) writes that accounts, read singly, would offer thoughtful insights into important issues of particular phenomena. However, "read together as a set, they offer even more exciting possibilities" (p. 323). I realized how reading across the nurses' stories made "visible the patterns and complexities" of what I was inquiring into (p. 325). Reflecting further on the stories, I sensed how those threads also knotted and interwove across social, cultural, and institutional contexts. I sensed how they moved backward and forward across time, and inward and outward across personal and social expanses, to bring forth a narrative understanding of the nurses' patient safety experiences in the operating room.

As I lay their stories alongside each other, I felt how the nurses' lives and stories bumped together, and I felt a certain resonance across their stories (Clandinin, 2007). It was in laying these stories alongside each other that these resonances and threads offered new ways to think of the nurses' experiences, and offered new stories to live by. I was reminded again how "narrative inquiry carries more of a sense of continual reformulation of an inquiry than it does a sense of problem definition and solution" (Clandinin & Connelly, 2000, p. 124). What follows, with links to the nurses' accounts, is a discussion of the connective runs of resonating narrative threads, which surfaced and wove across their stories.

Resonating narrative thread one: Resistance

A narrative thread that I felt ran strongly through and across each nurse's story was one of resistance. Similar in each nurse's account was a sense of coming to know about resistance by standing against or withstanding an action at some moment in her life. Resistance in this sense was not in terms of being a rioter or dissident; rather I sensed how resistance was a part of their living alongside others as a response to vulnerabilities and tensions of life.

Shani learned about resistance early in her life. Shani's family moved to Canada when she was a child and I sensed how this was a journey of re-

establishment in all aspects of life, for example, in work, education, and community involvement. Shani spoke of tensions when her family arrived in Canada and her parent's response to this was to resist tensions directed toward them, and to create their own stories to live by as a family renewed. I believe that Shani learned about resistance, that is, resisting what was not supportive of living well through her early family experiences.

Shani described an unforgettable hospitalization experience from childhood in which a nurse caring for her resisted Shani's story of who she was; a frightened five-year old child patient who had undergone surgery and who was an outsider in an environment new to her. As Shani spoke of this experience, I sensed her resistance to how the nurse had scripted her and to the behaviour of the nurse in her words, "She was the meanest person I had ever seen as a nurse...that can't be right". Shani's response, her resistance to what she felt had been directed toward her, was the driving force that drew her to a career in nursing and, ultimately, operating room nursing, which enabled her to care for patients safely while acknowledging them as unique individuals. Shani learned through her family how resistance could be a positive force in attaining one's life goals, and her work stories hold in them the thread of resistance as a positive support in patient safety.

Shani spoke of resisting being scripted as "old fashioned" by younger nurses at one work site. "Because they're young and they're fresh, they think they know what's best; they don't think you know what you're doing because you're old" she said. Shani resisted the younger nurses' practices and their behaviour toward her by ensuring her own practice remained consistent, safe, and methodical. She refused to be drawn into a system of work where "quicker is better" by continuing to take the time to connect with her patients, and to take the time to perform care, both necessary components of safe patient care. As Shani pushed for behaviour from the nurses that was more attentive to the patient, she continued to role model ways of providing patient care that was safe.

Shani knew how her nursing practice supported patient safety because she had "lots of good experience" in the operating room; she had over 10 years of experience in a tertiary care operating room. I thought how her knowledge and conviction to resist what was not supportive of safe patient care was so strong and a necessary component of her nursing practice, for she spoke of some older

nurses “going with the flow” because it was too stressful for them to resist the younger nurses' practices. Shani also commented that the older nurses would soon be retiring and ‘they would not be in the OR that much longer’. With these nurses leaving the operating room, I wondered who else would have the knowledge and experience to resist practices that did not support patient safety.

Carson also came to know about resistance early in her life. A particularly poignant story that she recalled was about recognizing a relational resistance in the family that spread past her parents toward her and her siblings. She learned through her experience how resistance to others could become a supportive force in her own story to live by. In enjoying inclusive, mentoring relationships with other members of her family, she was able to feel that her life was important and significant in the life of others. Through her family, she came to know what it meant to live life in a way that was inclusive of others through the resistance of opposing behaviours.

As a student nurse in the operating room, Carson strongly felt resistance from her nursing preceptor to whom she was a young, enthusiastic nurse, who wanted to develop her skills and become an operating room nurse. Yet, she took a tension familiar to her, the resistance to her story of who she was and could be, and used the drive from the resistance she felt to become an operating room nurse who did make a difference in the lives of others. Carson also spoke of her opposition to practices that did not support a uniform standard of care and patient safety when she worked in the Middle East. Despite the accepted way of practice in that environment, she continued to comment upon and challenge what was not supportive of safe patient care. One way in which she accomplished this was to “inspect” certain instruments in the supply area and “just throw them out”. To support the process of halting suboptimal care and striving for a safe and similar standard of care for all patients in that operating room, Carson turned to the Canadian operating room nursing standards. In interpreting the standards and applying the knowledge found in them, Carson discovered professional agency to resist practices that did not support safe and competent patient care.

Carson also spoke about her resistance to the reality of life as lived by others in an environment far different from the one familiar to her. She said her comments, for example “You would never be allowed to do this in Canada”, about certain practices and behaviours she witnessed, were met with surprise

from the local care providers. I sensed how she challenged the deficiencies in the work environment she was currently in, as a specific focus on patient safety did not seem to be a component of the healthcare system she described. I wonder if she resisted the established way of work even more, because she felt there was no interest in attending to patient safety or using standards to guide work in the operating room.

Carson spoke of another moment in which she opposed the return to work of a colleague who had been on leave due to clinical competency concerns. Her challenge to this individual's return to work extended past her own concerns, for she "had no problems dealing with the person" herself. She resisted this colleague's return to work not out of concern for herself, but primarily to shield her patients and fellow colleagues from potentially unsafe situations. In all of this, Carson felt this resistance pushed back on her, for some colleagues did support a return to work for this individual.

The first time that the notion of resistance came up in conversations between Lynsey and me was when she described how she came to be a nurse. Prior to nursing, she worked in a care home for disabled people and learned that a disabled individual out of necessity originally formed this Foundation of care homes many decades ago. I thought how this was an act of opposition to a society that was absent in supporting disabled individuals, and I believe that through her work at Trinity Foundation, Lynsey discovered how a long ago resistance to attitudes and thoughts was a positive force in living life well. In coming to understand the reality of life as lived by others, Lynsey learned that she could make a difference in the life of another by resisting that which did not need to exist.

As Lynsey told her story, I heard how she was aware of and felt resistance toward herself from others at her workplace. She spoke of implementing slider sheets as a safer way of moving unconscious patients at one site, and of relocating specific anaesthetic supplies for quicker access at another site; yet, the opposition she felt from others in these actions was significant. Lynsey and I both wondered why there was resistance to a simple measure that worked to improve patient safety in the operating room.

Lynsey spoke of another time where her direct actions resisted the disinterest of care exhibited toward a patient by members of a surgical team.

Lynsey said she knew “the nurse didn’t want me in there; I came in anyway and said to the patient, ‘‘Hi, my name’s Lynsey. How are you doing?" In purposefully resisting the behaviour of the surgical team, Lynsey conveyed to the patient and the team that comfort and safety were not all that mattered; acknowledging the patient’s presence as a person also mattered greatly in overall safe care. As strongly as Lynsey encouraged all nurses in her workplace to become more comfortable in recognizing and challenging unsafe practices, the resistance of some nurses to adopt this way of nursing practice was as strong. In turn, Lynsey positioned herself in the team structure in a way that supported safer care and limited resistive behaviours.

When Morgan shared her stories with me, I sensed how she expressed resistance as a personal responsibility. As a young person, Morgan experienced and lived alongside her parents as they challenged societal changes, in order to maintain a way of living that was important to them. Morgan’s mother returned to work as a nurse primarily on night shift while raising a young family, which enabled the family to continue farming and living on their rural landscape. I believe that in witnessing and understanding how resistance to a particular in life could support living well in her own world, Morgan came to incorporate resistance in her nursing practice as a way of supporting patients and safer patient care. Morgan resisted strongly how others storied her patients when she was a nurse in training. She recalled, “We were there ‘to do’, not to really engage with the patient...it was assumed that they gave up all their rights to participate in care and also that they didn’t have any knowledge about what their care should be. So everything was checked at the door, their dignity, their brains, their opinion, and their voice. And that concept I struggled with from the very, very beginning”. She also discovered that some interns experienced similar struggles, and together they formed supportive professional and collegial relationships that have remained strong for decades. Through those relationships, Morgan has been able to find strength and assistance in resisting what has not supported safe patient care in the operating room.

In knowing that she could accomplish something good for her patients, she worked through the resistance shown toward her very being in the operating room as a junior nurse. In wanting to ensure that others lived well in their surgical environment, Morgan had also experienced how resistance was not without risk

in her own nursing practice. Morgan assertively resisted a work environment that was unsafe to both patients and care providers. She recognized that her superiors opposed her actions, for she said 'I felt at risk for what I was reporting or identifying. The administrators were trying to gag me and tell me to stop.' This period of resistance to an unsafe environment was a life-altering time for Morgan and, subsequently, her family. Yet, despite any personal or professional consequences she endured, Morgan continued to resist that which did not support patient safety in the operating room by continuing to question and challenge unsafe practices across all professions. Morgan's resistance to what was unsafe had not gone unnoticed. She was invited to be a member of several national patient safety committees, and through this committee work she joined with others to evaluate and formulate further strategies that addressed patient safety in the operating room.

Resistance, as an action to speak against, enhance, or support what is necessary, is discussed in the literature. Resistance in nursing has been described as an ethically motivated response to morally challenging actions of health professionals, and primarily in terms of relational power (Peter, Lunardi, & Macfarlane, 2004). With the belief that nursing is "still too often characterized by passivity and silence to its ethical detriment" (p. 414), Peter et al. drew from a feminist ethic perspective to consider how acts of resistance reveal information about power relationships that can weaken or oppose the actions of others. If nurses resist when they are in moral disagreement, they exercise power as ethical action, and uphold their values and knowledge to protect their patients in situations of concern or conflict.

Garon (2006) studied resistance in nursing as a way of addressing workplace concerns. Resistance referred to standing up for one's beliefs through taking action about an abuse of power, an unjust situation, or an ethical situation, and was exampled by speaking up or filing a complaint. Garon identified resistance as a new area of study within nursing that generally focused on "successful or dominant" nurses, and suggested that a different perspective may surface by studying resistance experiences of nurses who did not hold positions of power within a workplace.

Using an ecological framework to discuss ethical issues that nurses faced in their practice environments, Marck (2004) wrote of resistance in nursing as a

form of integrity and ethical behaviour when nurses questioned inappropriate treatment decisions applied to patients, or when they questioned the integrity of their practice environment in terms of safety (p. 235). Marck identified a link between nurses' resistance and the integrity of patient care, and noted that nurses' resistance "required a commitment to speak up regardless of who is in charge" (p. 237). Marck further noted that working in damaged or systemically toxic practice environments threatened nurses' ability to ensure good, safe nursing care. The experiences of the operating room nurses in the Winnipeg Health Sciences pediatric cardiac surgery program, their fellow colleagues, the children and their families, speak to the necessity of steadfast resistance to move closer to safe, good nursing care (p. 237).

In their work on ecosystems, Gunderson, Holling, and Light (1995) identified the resistance of "loyal heretics" (p. 505) as vital in pushing boundaries to change unsatisfactory conditions that impede achievement of ecological goals. Even if people do question too loudly or resist too strongly, loyal heretics play a key role in sustaining safe and healthy systems because they are knowledgeable and committed individuals (Gunderson et al., 1995; Marck, 2004). The operating room nurses in this study may be thought of as loyal heretics, for they frequently resisted conditions that did not support patient safety and frequently were challenged for their stance.

Heresy, viewed as a challenge to the orthodoxy or internalized ideology of an institution, has typically been associated with religious conflict (Kurtz, 1983). However, heresies as an action and heretic as an identity have also been discussed in the context of healthcare. Wolpe (1990) discussed a holistic movement in medicine as an ideological challenge to medicine and Stambolovic (1996) discussed alternative medicine as medical heresy. In both of these articles, heresy or acting as a heretic, was offered as hope for others as a possibility for alleviating human suffering through alternate ways. Stambolovic so strongly favoured heresy as a way of confronting entrenched beliefs and practices in medicine that he called it the "sledgehammer for change" (p. 604). Marck (2004) offered examples of necessary heresy through nurses speaking up to ensure patient safety or to challenge an unhealthy work culture (p. 237). In this sense, heresy is a nursing response that sheds light on what is required in achieving safe patient care. Heresy or resistance in healthcare is not without

controversy and at times has persisted even when a specific professional practice was deemed highly unorthodox and even dangerous (Bullough & Groeger, 1982).

Garon (2006) and Peter et al. (2004) valued the act of resistance in nursing for its positive effects in enhancing individual change, clinical practice, and addressing workplace injustice. In a similar fashion, the nurses' stories in my study helped me appreciate how resistance to specific events or actions positively supported patient safety and resisted that which did not. Their narratives of resistance take us further, however, and fill a void in understanding how patient safety in the operating room through resistance is not a solitary action or moment for the nurses in this study. As I reflected on each nurse's story, I was reminded how each nurse had come to know about resisting life's vulnerabilities across place, time, and relationships, and I understood how this composed her story to live by. I understood the actions of everyday resistance in Morgan's, Carson's, Shani's, and Lynsey's life and work stories as much more than singular acts of defiance or acts that simply challenged power structures. The everyday resistance in their nursing practice was a continuation of an individual story of wanting to live well through resistance; it was a way of being that nurses in this study had come to know and live. This allowed me to understand how everyday resistance to the vulnerability of the patient was an essential component of patient safety that expressed and further composed each nurse's story to live by. These narratives offered resistance as a continuous motion in the nurses' practice and their life world, and further revealed how, in working to ensure patient safety, the nurses 'are still becoming in the midst of their storied landscape' (Clandinin, 2000).

Resonating narrative thread two: Work-arounds

The topic of work-arounds also wove throughout the nurses' narratives, but figured in different ways in the nurses' practices. While there is no one solitary definition of work-around in the literature, it generally is regarded as a way of achieving a task or goal when the prescribed way does not work. Work-arounds have been defined as "informal temporary practices for handling exceptions to normal workflow" (Kobayashi, Fussel, Xiao, & Seagull, 2005, p. 1561) and as processes used to "bypass hospital protocol or procedures to accommodate patient's immediate needs" (Eisenhauer, Hurley, & Dolan, 2007, p.

85). Healthcare work-arounds have been addressed in the literature through several perspectives. For example, as a response to managing technology issues (bypassing monitor alarms or limitations in computer charting or medication dispensing), as a response to poorly designed or inefficient work processes, or as a way of bypassing time spent waiting for others to respond (waiting for an order or other communications). Based on the amount of patient safety literature that addresses work-arounds, rule bending, violating established rules, or implementing shortcuts, these practices are a familiar and prevalent concept in healthcare (Amalberti, Vincent et al., 2006; Collins, 2012; Diconsiglio, 2008; Eisenhauer et al., 2007; Halbeslaben, Wakefield, & Wakefield, 2008; Lalley & Malloch, 2010; Vogelsmeier, Halbeslaben, & Scott-Cawiezell, 2008).

Yet, as I reflected on the stories the nurses shared, I thought how work-arounds were anything but 'informal and temporary' in their practice. Vestal (2008) noted how work-arounds were often more creative than an actual solution because implementing a work-around required ingenious thinking; however, putting additional pressure on a work-around could also create further system failures (p. 8). I thought how the nurses in this study described moments of thinking and acting in resourceful ways, in order to accomplish their work in a complex environment. The resourcefulness of the nurses did not lead to their being irresponsible, rather their 'ingenious' thinking offered a divergent way of arriving at their goal. In acknowledging a customary turn to work-arounds by nurses, Vestal emphasized that work-arounds could become a standard way of achieving work even though it may not be the optimal way (p. 8).

Lynsey and Shani spoke about work-arounds from their perspective of trying to prevent colleagues from bypassing processes that supported patient safety in the operating room. Recently coming to a position of supervisor, Lynsey noted that operating nurses "are good" at working around a protocol to accomplish their work. She offered an example of preventing a work-around to a procedure designed to move unconscious patients safely from the operating room table to a stretcher. She recognized how a safety process familiar to her was a new and unfamiliar process to others, and one that others did not immediately accept as a safer one. To limit the extent of the work-around by others, Lynsey understood that she needed to participate actively in assisting the surgical team to move patients in a specified manner. She said she also

explained the procedure each time to reinforce the inherent safety in the method and demonstrate her belief in the procedure. Lynsey said, “I try to show how that was good. I say ‘See, nobody got hurt. It didn’t take that much longer’ and then the staff are ‘Yeah!’ I thought how Lynsey’s efforts encouraged the operating room staff to be more receptive to a new way of moving patients, and how the receptiveness of a few staff could generate a similar attitude amongst other staff, while decreasing a work-around to a particular process.

Shani spoke of some nurses at her worksite routinely “cutting corners” in their practice and patient encounters, and she felt this was a detriment to patient safety in the operating room. Describing how some nurses minimized the amount of information they would review from the patient’s chart, Shani said, “I’ve seen them do half the checks that I do”. She also noted that some nurses did not verify the surgical consent and they did not speak with their patients: ‘They rush, rush, rush’. Working around a protocol to increase efficiency is familiar to Shani, for she recalled this as a practice that operating room nurses engaged in when she was a student operating room nurse. She said as a student, it was “drilled” into her to take time in the patient pre-operative check-in process; yet she sensed how surgeons pressured nurses to work faster and “they didn’t seem so wary about checking patients’ name bands and consents”. The practice of short cuts to the patient check-in process can have a significant effect on a patient’s safety, and Shani’s refusal to work around a specific protocol actually prevented a wrong-site surgery. Yet, Shani felt she was frequently at odds with other nurses because she adhered to safety processes. Despite the awareness generated from Shani’s experience, which reinforced how adhering to a protocol diminished risk and elevated patient safety in the operating room, she felt many nurses' attitudes were that following specific processes in patient care was ‘doing or worrying too much’. Even though she consistently role modelled an expected standard of nursing practice in the operating room, Shani was saddened to witness short cuts as commonplace at a worksite and noted, “we’re losing a lot of standards there”. Lynsey and Shani both spoke about trying to limit work-arounds by their colleagues, and while the literature described how and why care providers accomplished work-arounds, the notion of a nurse preventing another colleague from engaging in a work-around was not represented.

Unlike Lynsey and Shani, Carson and Morgan spoke about bypassing the established work system as a way of ensuring safe patient care. Carson spoke of her role in rescheduling patients whose surgery had been cancelled at the last moment; however, she also spoke of not following the established protocol for rescheduling surgery. Carson described how in conjunction with the surgeon and other colleagues, she would independently reschedule a patient's surgery with the least amount of disruption to the patient as possible, often for the following day. Carson said, "I have done things to get patients through. I remember telling one person, 'I'm sorry, you're not going to get your surgery today and she just fell apart". Carson said she 'pulled some strings and squeezed her in' for surgery the following day. She explained that if she had not bypassed the existing system, she "wouldn't have felt right about things - at least I could have tried, you know". For Carson, her responsibility to ensure safe patient care did not end with the cancellation of a patient's surgery; rather, she felt it was her responsibility to work around the system to provide what was necessary for the patient. She said that, "When I'd be in charge, I would have to do that".

Morgan identified an "underground cult working to keep patients safe in spite of the systems around them". Morgan said "these types of activities are happening constantly, because our systems are not supporting the care of the patients at the level it needs to take place". She described when the current system does not support the safety needs of patients or does not support healthcare workers in providing safe care, a different approach is required, "You have to do something different". For Morgan in a particular event she spoke of, this meant connecting with like-minded colleagues to ensure that patient safety was achieved in ways that the established system could not provide. Morgan and her colleagues activated a safety system that was set apart from the system of healthcare provision that was in place.

Hutchinson (1990) described responsible subversion in terms of rule bending, as behaviour nurses engaged in for the sake of the patient by consciously planning what was best for the patient. The behaviour was described as responsible, for nurses used their best professional knowledge in deciding when and how to bend rules; yet, it was subversive in that, hospital rules or practice regulations were violated. Hutchinson also noted that nurses decided the extent of their own responsible subversion, and that responsible subversion was

“a complex process that required energy and effort; following rules was inevitably easier” (p. 7). I thought how Carson and Morgan both spoke of working around the current system not as isolated incidents or options, but rather as a professional responsibility they held in protecting patients. This practice relied on expert operating room nursing knowledge and the ability to assess accurately the risk in proceeding with a specific action. It was not enough for Carson and Morgan to believe they were competent, credible, and knowledgeable; their ability to intervene in patient safety matters relied on their colleagues also perceiving them as an expert knower. Because of their past work experiences and current work role, Carson and Morgan were both in a position to engage in this type of work-around through their many connections and relationships they maintained in healthcare. Both nurses had vast clinical experience and knowledge, and both had worked in a supervisory position that provided them the opportunity to make decisions not always available to a staff nurse.

In thinking about their actions as responsible subversion, Carson and Morgan engaged in more than rule bending, for they described deliberately working in, and supporting, a parallel system, in order to accomplish what the current one could not in terms of patient safety. The work they engaged in was certainly complex and required effort from many individuals; it was also work that was supported by others and actualized in a way that did not draw official attention from superiors or administrators. I believe this was a key consideration in Carson and Morgan’s ability to bypass what did not support patient safety, and activate an entirely different system that did. As I thought about this, I wondered: Was there a lack of awareness from their supervisors concerning an ‘underground’ system, or were their supervisors aware of their actions but did not interfere because the current system could not provide what was required? I think supporting patient safety in the operating room through an independently structured work system is a new concept not addressed in the literature, and perhaps a concept that currently remains largely ‘underground’.

I heard how closely the threads of resistance and work-arounds wound around and through each other in the nurses' patient safety stories. Resisting what did not support patient safety found Carson and Morgan engaged in work-arounds to ensure patient safety; while Lynsey and Shani resisted the work-arounds and short cuts they witnessed amongst work colleagues. While the

nurses' experiences of work-arounds differed, they each knew what was required of them to ensure patient safety. The more frequently the nurses resisted a vulnerable situation, the more confident they became in using resistance to support or halt a work-around in their practice, in order to achieve patient safety in the operating room.

Resonating narrative thread three: Counter stories

Also woven tightly around the elements of resistance and work-arounds were the counter stories that nurses told about advocating for and supporting patient safety in the operating room. Their stories differed from the standard or unquestioned story offered by others as the dominant story about patient safety in the operating room. The notion of counter narratives in healthcare is represented in the literature through several perspectives. For example, Campesino, Ruiz, Glover, and Koitham (2009) brought forward counter narratives of discrimination and social inequality in healthcare in her work examining immigrant women's experiences of seeking healthcare following a breast cancer diagnosis; and Clark (2008) discussed immigrant counter stories of access to healthcare from a legal perspective. Refuting a particular healthcare narrative about disabled babies, parents of disabled infants offered their counter narratives to reject interpretations of 'disability and abnormality', which allowed them to 'enjoy their children as they were' (Fisher & Goodley, 2007). What I did not locate in the literature was how counter stories challenged a standard or dominant story about patient safety in the operating room.

As Morgan lived her patient safety counter story, she challenged a prevailing narrative supported by hospital administrators at a particular site. She also challenged the wisdom and complacency of superiors in their views about patient safety in the operating room. Morgan knew that her conversations and help-seeking actions bumped up against a dominant story that upheld care as safe in the operating room; for she was told by administration, 'Don't go there, it's none of your business'. Despite the intimidation from those who tried to discredit Morgan, she persisted and supported by other colleagues, her counter story was eventually accepted as a just story – the operating room environment was highly toxic from extreme gas exposure and unsafe.

Carson spoke of challenging a dominant story presented by administration concerning the competency of a colleague. Her counter story also

challenged the wisdom of her superiors and her counter story was strong, in that many of her colleagues felt unified through her story. Carson responded to a story of professional safety as presented by administration by counter storying with her experiences and the experiences of others, and by working alongside this particular colleague. She asked how she could protect those nurses that did not have the experience that she had. She said to administrators, “How do I do that? Who does it fall to, in order to protect the patient? Do you not have some responsibility to protect?” Carson challenged the administration by turning their dominant story back upon them. She asked, ‘would you allow your wife or children to be operated on by this surgeon? If you cannot answer that question, there is a bit of an issue’. Carson said they could not answer her question and I thought how her counter story offered an alternate position through which administration could consider patient safety.

Shani’s patient safety counter story developed from her experiences in one operating room. There is an assumption and expectation that in all surgical centres, operating room nurses perform their work in a manner that supports and enhances safe patient care, but Shani’s story did not support this position in its entirety. She discovered how amongst a certain group of nurses in a particular operating room, it became routine to deviate from practices that supported safety. Although like-minded nurse colleagues supported Shani’s counter story, she felt her story was neither legitimized nor heard by supervisors or the manager. She said that lack of consistency in nursing practice was not addressed, because supervisors were so busy they didn’t have time for patient-nurse interactions, and the manager seemed more worried about ‘getting everything done on time rather than the patient safety end of it’.

In her new position as an operating room supervisor, Lynsey’s counter story challenged a department narrative about safe patient care. Many care providers did not view some long-standing practices as suboptimal or detrimental to patient safety, for example, the way patients were moved in the operating room. However, Lynsey offered a different view and a different story about patient safety in that operating room, and she found herself repeating this story frequently as care providers tried to adhere to the established practices they knew.

Counter narratives have been defined as the telling of stories of and by people whose experiences are often not told in relation to a privileged story, for example, persons on the margins of society or low-income individuals (Calabrese Barton & O'Neill, 2008; Delgado, 1989; Solórzano & Yosso, 2002). In a similar fashion, the nurses in this research had counter stories that either, were not told, or they were heard but suppressed by others in favour of a dominant story. In addressing environmental safety, Morgan recalled being confronted at her worksite and being told to "mind her own business", and "this isn't your concern, this is a new hospital, there's nothing wrong with it, why are you always complaining"? By persisting with her counter story, Morgan also challenged notions of 'who is privileged and authorized to tell a story and who is not'. Carson's counter story regarding an individual's competency to practice exposed and challenged the one endorsed by administration, the very individuals with the power to decide hospital matters when they themselves could not equivocally support the dominant story they presented.

Nelson (1995) noted that anyone can tell a story and a counter story, however, the privileged or dominant story cannot be told by just anyone. What we know about ourselves, our world, and our relationships to others, and how others understand who we are, depends on our social standing in a community of those who have cognitive authority (Nelson, 1996). Only an individual with perceived or actual authority can tell a dominant story, and the counter story attends to the difference in the story. Told from the standpoint of the 'other', a counter story resists, undermines, and invites new interpretations of the dominant story by shedding light on underplayed or ignored details (Nelson, 1996).

Lynsey and Shani's counter stories challenged and untangled stories upheld as dominant by some individuals who felt they had the authority to tell this kind of story. Lynsey and Shani both experienced how some nurses justified their position as privileged through the repeated enacting of their stories and repeated behaviour in practice. But by responding to the differences in the story, Shani and Lynsey destabilized the notion that any one individual or group, in their respective operating rooms, held the exclusive authority and knowledge to tell a story as the dominant and only story. In some instances, individuals came together to work within and support a counter story, as in Morgan's experience described previously, and her counter story about the 'underground system supporting

patient safety'. Nelson (1996) cautioned there was no certain guarantee or assurance that a responsible counter story had been told. However, instead of telling the counter story within a community that does not deny the cognitive authority of its members, it rather takes their collective and individual judgments seriously and increases the prospect of a responsible telling (p. 102).

Nelson (1996) viewed counter stories as stories of self-expression and self-definition, and as stories of repair and restitution (p. 98). Nelson explained that a dominant story became understood over time when enough of the "particulars are captured and arranged so the story's moral gist can be seen" (p. 98). In understanding the particulars of a dominant story, the inconsistencies become apparent to the other; however, the specific placement of others and their knowledge in a dominant story is necessary for a structure or organization to maintain its status quo. Nelson held that dominant stories "masquerade as descriptions…when in fact they are prescriptive" (p. 99), leading to gaps between the requirements of the story and requirements of individuals. When one must function in a "system of knowing others but never being known in return", the counter story comes forth to elicit recognition from knowing others (p. 101). Similar in all of the nurses' stories, their counter stories were told with a specific purpose of weakening a dominant narrative that did not support patient safety and put forth an alternate story that did. Their counter stories directly challenged an institutional or departmental belief about who was a privileged knower, and who had the authority to interpret, analyze, and speak about patient safety in the operating room. However, the separate and distinct nature of counter stories and dominant stories was even more apparent to me when Nelson (1996) wrote the following about the teller of a counter story:

> …her story becomes, as it were, a pair of spectacles that she extends to the inhabitants of the normal moral context who can't see her without them. The trouble is [they] don't know how to look through them. They can't make sense of what they see. (p. 101)

Resonating narrative thread four: "World"-travelling

Elevating patient safety by authentically seeing and understanding the patient through "world"-travelling was a strong thread that held the nurses narratives close to each other. "World"-travelling, as described by Lugones (1987), is a way of identifying with someone. Lugones believes that when we

travel to someone's "world" "…we can understand what it is to be them and what it is to be ourselves in their eyes" (p. 17); we become fully present to each other only when we have travelled to each other's worlds. Lugones wrote about "world"-travelling as a way of understanding and affirming the plurality of women in a cross-racial context, but this way of understanding others translates well into the nursing environment because patients' diverse needs benefit from plurality in care; that is, care that also takes into consideration the patient's world context. "World" as introduced by Lugones is not a specific place; rather it refers to a context of life as lived, a social structure or perhaps a society inhabited by 'flesh and blood' people. Rather than listening to the patient's story from their (nurse) world, the nurses in this research learned to hear their patients by travelling to the world of their patients. As I listened to the nurses' patient safety stories, I too learned to hear their stories from their world rather than through my experiences in my world.

Morgan's first experience with world-travelling was as a child, when she observed her mother's response to a mute woman in a department store. She described her awe at witnessing the event from her own child world, and she recognized how the ability to travel into the world of another could be a significant moment for many people. Morgan came to know that world-travelling was essential in her nursing practice as a way of supporting patient safety in the operating room. She not only entered the world of her patients, but also the world of her colleagues. She spoke of supporting colleagues after tragic outcomes in the operating room, and she spoke of how this carried across into her and their personal worlds. On occasion individuals openly invited Morgan to enter their worlds when they asked for her assistance, and she did without hesitation. Her ability to view a situation from the perspective of a patient, mother, or child from the perspective of 'the other', was a defining element in her conviction to ensure that patients and her colleagues were safe. Morgan said, "forever and ever, I've always been a patient safety advocate. I'll do the battle no matter what…and you sometimes wonder what other people think about it – do they really, really want patients protected? Do they really want patients to be safe? But it didn't stop me - advocating and going over the edge in order to support the care of the vulnerable was in fact something I could do and had to do and must do." Morgan came to live world-travelling as a foundational and necessary way of advocating for safety

in the operating room; yet, she also spoke about the detachment of others when addressing patient safety concerns. Lugones (1987) cautioned that being at ease in one's own world could be dangerous, because "it tends to produce people who have no inclination to travel across worlds" (p. 12). Morgan's story described how other individuals resisted entering into the world of the patient as a viable way of further understanding patient safety concerns; they remained firmly in their own world, with the patient and safety concerns outside of their vision.

Shani's first world-travelling experience was in a literal sense when her family moved across the world when she was a child. During a hospitalization as a youngster, Shani felt how a nurse avoided an opportunity to travel to her world. In that moment as a young child, she had an intuition that travelling to the world of another was significant and this sense has remained with her throughout life. Later, as an adult patient, she again felt how nurses did not travel to her world. Even though Shani had to go to their world to be a patient, the nurses did not reciprocate in an attempt to understand her as a patient, with genuine patient concerns and fears in that moment. Shani also told of caring for many patients whose first language was not English, and she would always take her time in establishing the nurse-patient relationship to "make sure the patient understands what they are having done". She explained how she was "overly careful, extremely careful", perhaps more so since she discovered an incorrect surgical consent when caring for a non-English speaking patient. Not only did she travel to their world, but it was a familiar and comfortable world, for Shani lived largely in a non-English world with her own family. Her comfort and ability to travel between worlds, and her experiential knowledge of living in different worlds, further structured her focus on patient safety in the operating room. For Shani, patient safety was not carrying out an action; it centered on the ability to understand, genuinely, from the perspective of 'the other', what it meant to feel safe in the care of another.

Carson first came to know world-travelling figuratively through her uncle, a person who opened her to seeing how life unfolded around her. Later, when Carson went to work as an operating room nurse in the Mideast, she came to know about travelling to the world of another as a component of safe patient care. As she travelled between the world of her patients and her own world, she constantly questioned the disparities in care she witnessed between the two

worlds. This experience of world-travelling was influential in her nursing practice, and it became part of her safety process in the operating room. Carson entered her patient's world and kept learning about life from the patient's perspective. She came to appreciate how an action or decision by anyone could affect any patient in their world. She said she remembers learning that surgery was one of the most stressful events anyone could experience; yet she emphasized how she was "privileged to be part of that. I think to make a difference in somebody's life is the best thing you can do in your entire life!" The ability to make a difference for someone else further inspired and guided her world-travelling as a way of figuring out how to provide the best and safest care for her patients. Carson said, "if anybody comes to my OR, I'm going to give them one hundred percent every time. I think as a patient, knowing you've got somebody in your corner - somebody who you don't know, somebody who has no connection to you at all - is so important!" The way that Carson gave her one hundred percent to each patient, and felt privileged in doing this, was to continue travelling to witness life from their world.

Lynsey also world-travelled to another place, one that was culturally familiar to her. However, while living and working in her familiar world, Lynsey came to know how people struggled to situate themselves in a world of others, and this encouraged her to become a nurse. She discovered how understanding an event from a patient's perspective supported nursing care that was safety focused. She said several times when referring to specific troubling events, "I found it very odd; we're here for the patient– patient safety is first", and I thought how through world-travelling Lynsey held the patient as a person close to her in her nursing practice. Lynsey described how a patient, having had to leave her familiar world and enter the unfamiliar operating room world, was left at the periphery waiting to be acknowledged and accepted for who she was in the operating room world. She said this of the moment, "Where are the people with the patient? Nobody is around the patient. That was absolutely horrendous. What's that in patient safety? I'm always cognizant about that, but I couldn't believe it when I saw it. And the care leader didn't see any problem with it - a care leader is someone who's supposed to be leading". Lynsey intervened upon recognizing how each person in that theatre was alone in the presence of the other because the care providers made no effort to know the patient. By

welcoming the patient into her operating room world, Lynsey travelled to the patient's world to live the situation from the patient's perspective, to attempt to illuminate themselves to each other. Lugones (1987) wrote: "Without knowing the other's "world", one does not know the other, and without knowing the other one is really alone in the other's presence because the other is only dimly present to one" (p. 18). In her nursing practice, Lynsey came to know how being receptive to world-travelling supported patient safety through 'knowing the other'.

The notion of world-travelling, or entering into the patient's world as a way of facilitating safety through discovering and knowing the patient's world, is not distinctly represented in the literature. However, seeking patient input or active patient participation in care, as a way to reduce harm and improve safety in healthcare, is described abundantly in patient safety literature (for example Davis, Jacklin, Sevdalis, & Vincent, 2007; Donaldson, 2008; Hovey et al., 2010; Howe, 2006; Millman, Pronovost, Makary, & Wu, 2011; Stevens, 2010; Vincent & Davis, 2012; Waterman et al., 2006; Weingart et al., 2011). While encouraging patients to speak up and ask questions about their care is a way of recognizing the patient and promoting active patient participation, Entwistle et al. (2010) noted that patients and their family's willingness to speak up about safety concerns was influenced by the way care providers behaved and related with the patient. Patients spoke of uncaring attitudes and feeling forgotten by care providers when they felt they were not taken seriously or when there was a lack of responsiveness toward the patient.

Similarly, Davis, Sevdalis, Jacklin and Vincent (2012) found that patients were willing to speak up about safety concerns, but only when they felt able to, and when they thought care providers would be receptive to hearing those concerns. The authors identified the unwillingness of healthcare providers to move away from the notion that they know best for the patient, as a detriment in facilitating patient involvement to ensure safer care. The notion of the patient travelling outside of his or her world, and entering actively into the world of healthcare, may be disruptive and incompatible in the world of some care providers. Perhaps some believe that patient safety is achieved when nurses and patients remain fixed in set roles within their worlds, for exploring the world of another might cloud or compound the matter. Morgan, Lynsey, Shani, and Carson all spoke of instances where others held patients in a specific role, and

by keeping them at the periphery of the healthcare world, they also kept them at the border of safety in the operating room.

In describing patients' experiences following spinal surgery, Davis, Vincent, Henley, and McGregor (2011) found that patients wanted and needed better information about their overall surgical journey, because patients felt they could not always speak up. Specifically, patients said they wanted to feel safe and to be treated with dignity and respect; they needed ongoing support, continuity of care, and human contact. Davis et al. (2011) did suggest that, rather than a standardized approach to surgical care as is generally the norm, an individually tailored approach could go further in providing the specificities of care relevant to patient context.

There is a growing body of literature on the importance of understanding patient safety from the patient's world, and we are advised to seek the patient's input as a component of safe patient care. However, we are not fundamentally compelled to consider in practice what it is to be a patient in a patient-world, and we frequently fix our safety gaze on the perspective of a care provider's world. We expect the patient to enter our "world" of care, but as the nurses' narratives revealed, patients remain at the periphery and invisible, and at risk for harm if care providers make no effort to reciprocate. Davis et al. (2012; 2011) touch on the notion of travelling to the patient's world, when they identify individualized care and awareness of interpersonal and cultural factors as important to overall patient safety in surgery. While the safety literature supports including the patient in care, and encouraging the patient to participate in care, patient recognition remains addressed, largely, from the context or world of the healthcare provider. What was evident was how the quality of patient-professional interactions weighed heavily on patients' ability to communicate about safety concerns. There is a strong emphasis on encouraging and developing good communication between patients and care providers as a way of being active in their own care and thus supporting safety. However, I sense that not all practitioners might know how to accomplish this in practice. That is, other than encouraging the patient to ask questions, how could a nurse develop a relationship with the patient that supported safety; and whose perspective is considered in developing that relationship? As varied as Morgan, Carson, Shani, and Lynsey's stories were, they all shared the idea of travelling to the patient's world as a genuine and

concrete activity that supported patient safety in the operating room; through understanding the patient as a multi-dimensional being, regardless of whose world the patient or nurse inhabited.

Resonating narrative thread five: Living-in-relation

The aspect of living-in-relation with another also wove throughout the nurses' stories. Morgan began her narrative by saying how she grew up immersed in “the cycle of life”. She learned how her family’s well-being depended on the relationships they all held with their environment, the animals in it, and the people who came into their life. This relational living provided Morgan “a different way of relating with people”, for she learned how to acknowledge and respect an individual for whom he or she was in a world of others. Carson and Shani also spoke about a relational way of living. Shani spoke of relational living as being fundamental to living life well. She noted that even if you had all the money in the world, you were nowhere if you “don’t have those things (relationships)”. Carson spoke more than once about living relationally, and how this was important in her home and work life. She noted that you have to work at relationships, but that was rewarding in itself because “that is what life is all about”.

Genuinely responding to another individual through living-in-relation was a familiar thread in the stories. Morgan mentioned several times how the relationships she lived with colleagues were a way of responding to specific safety needs of patients. She noted how those relationships were driven by respect for what each individual brought forward, and how through this type of relationship, the vulnerability of others was witnessed and acknowledged. Shani lived relationally with others, an example being the continued maintenance of family ties across distance and generation. This wasn’t an individual action decided upon by Shani; it was a relational response in coming to know how to live well. She also spoke of being “very patient focused” and working to establish effective nurse-patient relationships at work. Her way of living was one that included others, and she continued to show others how living this way was a genuine response to humanity.

Carson noted how a focused response toward the patient was created when team members responded to each other through mutual validation in their work relationship. She recognized that a relational way of living was not important to some people, but it “really is important to me”. Lynsey understood how living

relationally benefitted her personally and professionally early in her nursing career. She recalled a mentoring relationship that made a significant difference to her life, and she carried this into her nursing practice. By trying to focus on what it meant to “be there for the patient” and creating a relationship with the patient, she recognized their humanness in any particular moment.

The nurses first spoke about living-in-relation as an aspect of their personal life, but it was clear how relational living was their way of living and responding to others. Relational living was not something reserved only for their private domain and it was neither tentative nor provisional; there was no separation between their different worlds because their personal and professional remained connected through relational living. Living-in-relation with others, as presented here, is not in an intimate or sensual context. It is put forward as a way of understanding and being open to the humanness of being in this world; it is a way of engaging with others and understanding who each individual is in the relationship. Bergum and Dossetor (2005) note that relational engagement exists in the “shared moment in which people have found a way to look at something together” (p. 103). Relational engagement is a way of living-in-relation with others, and is viewed as a necessary component of ethical care (Austin, 2006). Taking this further, relational engagement as the source of action is also a necessary component of patient safety, for “without engagement, patients are alone even when surrounded by professionals” (p. 136). Disengagement, “the lack of involvement of person-to-person” movement is an ethical concern (Bergum, 2004, p. 495) and a safety concern. If there is no movement to come close and be present to the patient as person, there similarly is no movement to bring safety closer and present to the patient.

Relational engagement was at the heart of the nurses' operating room practice, and living-in-relation was the texture of their lives. The strands of living-in-relation and relational engagement became plaited closely together in the nurses’ life stories. Morgan talked of how she achieved patient safety through her relationships not by exploiting the people in her relationships, but by connecting deeply with them to understand and address a particular issue together. She also said nurses had to remember the reason they were there – the patient – because the work environment was distracting with so many other matters competing for the nurses attention. Considering the introduction of various checklists in

operating room work as a safety measure, it is understandable how nurses might become more list-oriented and distracted from patient engagement. Shani noted how effective work relationships felt like being in a “close-knit family" and how these relationships “let you focus on patient safety”. Lynsey also noted how effective work relationships were necessary for ensuring patient safety, because “the patient was going to suffer” if care providers could not come together, relationally. Carson said how building relationships and coming together is not something that should be taken for granted, because it was through a relational approach that “life is better for patients”. Patient safety in the operating room was not viewed in terms of implications for one individual only; it was viewed as affecting everyone, because every person lived in-relation with another. Patient safety was always in a relational context for the nurses.

The idea of living-in-relation and relational engagement as a way of understanding something together brings forward an idea that Lugones (1987) discussed as a pitfall of living in a world of others, arrogant perception. Arrogant perception is the failure to identify with others while continuing to perceive them ‘arrogantly’; for example, in a stereotypical manner or as a non-dimensional entity. When we perceive someone arrogantly, we use our preconceived notions to view someone in a way that makes sense to us, and it is a way of viewing that keeps individuals positioned apart from each other rather than in-relation. Arrogant perception was described by the nurses as something they witnessed from others in their attitude toward patients. Lynsey spoke of theatre staff willfully ignoring a patient, and of a surgeon who felt his priorities should supersede the priorities of a child patient; and Shani spoke of some nurses failing to take into account language difficulties when caring for patients. Carson spoke of seeing patients perceived arrogantly when she worked in the Mideast. She described this in her current work environment, an example being a surgeon focused on personal needs and undergoing a procedure, while preparations for the next patient’s surgery were in progress, disregarding the potential risk of that personal behaviour and positioning the patient as an object of care. Morgan described how managers had ignored the complexity of a safety situation because they would not, or could not, identify with the people affected.

To move away from perceiving the other arrogantly, one must learn to understand and respect the other in their differentness, no matter how different

from us they are. It is to engage in the humanness of another. The nurses' familiarity with living-in-relation and relational engagement, as a way of life, had a significant effect in their approach to patient safety in the operating room. For these nurses living-in-relation was not specific to the nurse-patient relationship only. Relational living was a condition of life, no matter where and how that life unfolded. Relational living was also a necessary condition of patient safety, no matter how safety unfolded. While the safety literature speaks abundantly about types of relationships that support patient safety (for example, relationships between organizational leadership and safety or relationships between safety culture and patient safety or effective nurse-physician relationships as a support to patient safety), I believe that addressing patient safety through attributes of relational living and relational engagement is a new matter.

Resonating narrative thread six: Image of self as safety-practitioner

Another thread that appeared in all of the nurses' stories was one of their self-image, not simply as an operating room nurse, but an image of themselves being a safety-practitioner. Rather than viewing nursing and patient safety as separate disciplines or components of healthcare, they each spoke of nursing work in terms of safety practice and patient safety composing their practice. Their ability as capable operating room nurses was evident in their stories. What was a new idea was how over the course of their careers, their great passion for operating room nursing, their vast knowledge, and their awareness and understanding of nursing and safety as a unified practice, developed their self-image and ability as safety practitioners. At the same time, a tension was felt between engaging in their practice as safety practitioners with like-minded colleagues, and their working alongside others who did not always view the nurses as safety practitioners. The Code of Ethics for Registered Nurses directs nurses to "question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care...and they support those who do the same" (Canadian Nurses Association, 2008, p. 9). The nurses shared many stories about questioning and intervening to address safety; yet, a thread in their stories was that working as a safety practitioner often meant working within tension. I wondered why this was. How do the attitudes or values of others impact on nurses' images and work as safety practitioners?

Shani found herself in tension with co-workers at a particular work site, as she frequently felt disregarded as a safety practitioner. She said the younger nurses often did not say anything directly to her, but she could see a certain look on their face or they would roll their eyes in response to her actions and instructions. She said because she was older, her approach to patient care was viewed as 'old-school', and that it was not relevant in the eyes of the younger nurses because she was 'doing too much'. Despite the attitude and behaviour she felt from some others, Shani firmly held onto her image as a safety practitioner. Yet, to accomplish this it meant she had to reveal more of her 'old-school' self in each of her work encounters. She did this by connecting her many years of experience to the current surgical environment, in order to provide a context for safe patient care.

Morgan described herself as being a patient safety advocate "forever and ever"; and she said she could not hesitate in doing some of the things she did to ensure safety in her practice. Speaking about a specific departmental safety event, she described how colleagues supported her image as a safety practitioner but administrative personnel dismissed it. Rather than her concern being acknowledged and investigated as a safety risk, she was ridiculed and told that marriage counseling could resolve her concern. Yet, her firm image of herself, and an understanding of the responsibilities as a safety practitioner, drove her to persist in finding a resolution to the safety concern. She said that what she did was right and the reasons were good, but the actual act of addressing that safety concern put her at risk, and she felt vulnerable during that time; she said she 'became the crusader for the good of the country and was burned on the stick'. What does this say about the value of nurses as safety practitioners if their work is sufficiently derided or trivialized? How are nurses to enact safe patient care and keep safety awareness in the forefront if colleagues, leaders, and administrators do not always support transparency in patient safety?

Shani's and Carson's images as safety practitioners came forward when they spoke about 'seeing the whole picture' in their patient care. In general, the nurses all spoke about their nursing practice and patient safety as a singular act, rather than safety being a separate or additional element of patient care. I captured a sense of this when Carson said that some of her nurse colleagues had worked in the operating room far longer than her; yet, "every day is like their

first day". Shani said newer nurses did not understand the whole picture of care, and they did not incorporate safety into their work when they focused on shortcuts as a way of care. Lynsey said that sometimes people working in the operating room forget why they are there when they focus only on their own concerns. "We are here because of the patients, to keep them safe", she said. Lynsey also said that some nurses could walk into a theatre and 'just immediately work it out', but not all nurses were at the same level and needed support and direction in practice. These were examples of a nurse as a safety practitioner and a nurse in the operating room, who had to be reminded about the fundamentals of practice, and how to bring them together for patient safety.

When the nurses spoke about their work in the operating room, it was not in terms of responding to the duties of their job or their job description. They described their work as a response to their image of themselves as safety practitioners. As safety practitioners, the nurses viewed safety as an always event, yet many others approached safety as a sometimes event or a good enough event. The nurses did not seem to need reminding about patient safety composing patient care; however, they frequently reminded, mentored, educated, and challenged others in that regard. The nurses each have many years of operating room experience. The fact that they have chosen to remain in the operating room, despite the tensions they have encountered in their work as safety practitioners, is profound in terms of patient safety. I cannot in all certainty say why the nurses stayed in the operating room, other than each nurse 'knew' she wanted to work there. What each nurse did was to bring patient safety to the forefront in her workplace, and influence how patient safety could be accomplished. Hearing their stories revealed how they came to envision themselves as safety practitioners. And as safety practitioners, these nurses came to know and model for others, patient care in the operating room as the fusing together of patient safety and therapeutic regimens.

Resonating narrative thread seven: Tacit knowledge

The explicit or formalized knowledge required to ensure patient safety and to practice safely as a professional in the operating room is documented in the safety literature. A different form of knowledge that may not always be recognized as having a role in supporting and advancing patient safety is that of

tacit knowledge, specifically the tacit knowledge of care providers in the operating room setting.

The notion of tacit knowledge as a recognized form of knowledge was introduced by Polanyi in a time when the "declared aim of modern science was to establish a strictly detached, objective knowledge" (Polanyi, 1966, p. 20). He felt that tacit knowledge formed an "indispensible part of all knowledge" and the "elimination of all personal elements of knowledge would aim at the destruction of all knowledge" (p. 20). Polanyi felt that explicit integration and formalization of knowledge could not replace tacit knowledge and illustrated this through an example. He described how the skill of a driver could not be replaced by a thorough education in automotive theory, that is, that one's personal knowledge differed significantly from one's formalized knowledge (p. 20).

The difficulty in understanding tacit knowledge is that it is neither easily articulated in words, nor is it easily apprehended when observed. Polanyi (1966) held that it was "impossible to account for the nature and justification of knowledge by a series of strictly explicit operations" (pg. x), and proposed "we should start from the fact that we can know more than we can tell" (p. 4). Polanyi felt that the basis for tacit knowledge was the ability to bring together sensory and conceptual information, in order to gain knowledge of a particular kind (p. 13). Polanyi's example of how we can know a person's face, recognize this face in a crowd, yet cannot articulate how we recognize this face we know, is knowledge that cannot be put into words or stated in formal or propositional terms (p. 4). This is tacit knowledge and this is what it means to say we know more than we can tell.

Schön, a philosopher who studied professional knowledge, education, and practice, drew from Polanyi's work to make sense of how professionals think in practice and in different situations. Schön opposed the notion of Technical Rationality as a dominant view of professional knowledge through the application of only scientific theory and technique. He proposed that the model of Technical Rationality be set aside to recognize craft or professional artistry as valid and critical sources of knowledge (Schön, 1983, p. 50). Schön referred to professional artistry as the "high-powered, esoteric, variant of the more familiar competence exhibited in everyday acts of recognition, judgement, and skilled

performance... [which does] not depend on our being able to describe what we know how to do..." (1987, p. 22).

Schön (1983) offered that in the "spontaneous, intuitive performance of everyday life we show ourselves to be knowledgeable in a special way" (p. 49); this knowledge was our tacit knowledge. He referred to this as "knowing-in-action" or the kind of knowledge revealed in our intelligent action, for example, riding a bicycle or instantly analysing a document (1987, p. 25). Schön felt that the knowing was in the action and it was revealed in "our spontaneous skilled execution of the performance; and we are characteristically unable to make it verbally explicit" (1987, p. 25).

Schön also felt that the everyday work of professionals depended on tacit knowing-in-action. Despite consciously applying research-based theories and techniques in daily work, professionals still depend on tacit recognitions, judgments, and skilled performance to achieve their work (1983, p. 50). Along with knowing-in-action, Schön held reflection-in-action as a central concept by which practitioners manage situations of "uncertainty, instability, uniqueness, and value conflict" (1983 p. 50). It is through this reflection-in-action that professionals refine one's artistry or craft and develop professional excellence within their discipline, and this cannot be achieved outside of the professional's context. Schön further noted that practitioners deemed to be outstanding in their practice were not thought to have more professional knowledge than others, rather they had "more wisdom, talent, intuition, or artistry" (1987, p. 13).

It is not surprising that nursing, as are other professions, is thought of as an art and a science. In their stories, the nurses in this research described the use of their formalized knowledge; yet, they also described using tacit knowledge, their professional artistry, to support patient safety in the operating room. While tacit knowledge has not been singularly defined in literature, a comprehensive definition used by Kothari, Bickford, Edwards, Dobbins, and Meye (2011) to examine health practitioners application of tacit knowledge in public health program planning and implementation, seems equally applicable to the operating room setting. This definition, which reflects the concepts of Polanyi and Schön, views tacit knowledge as “knowledge-in-practice developed from direct experience and action; highly pragmatic and situation specific;

subconsciously understood and applied; difficult to articulate; usually shared through interactive conversation and shared experience" (p. 3).

Morgan spoke of being extremely focused on the patient when she was in the role of circulating nurse. She said she had to know her patients "nose to toes", and shared a story about knowing a patient had compromised circulation in one leg, even though this had not been confirmed and was dismissed by others. She said a physician colleague knew that she was right; he said, "I knew you were right but I didn't know why and I knew that you knew something I didn't know." It was only through her persistence that, a surgeon confirmed Morgan's knowledge, and the patient was spared from irreversible harm. Morgan said that when she looks back on what she does and why she does certain things, she knows she 'just has to do it'. It was difficult for her to explain why she did certain things or how she knew of something that may affect patient safety. In examining ways that patient-related, intraoperative nursing care was accomplished by operating room nurses, Kelvered, Öhlén, and Gustafsson (2012) offered that it was difficult for operating room nurses to describe their work in a way people could understand. Kelvered et al. (2012) also noted that a core function of operating room nurses was to, "continue developing patient safety by exercising control over the working situation through good planning, being one step ahead" (p. 450). Referring to her many safety experiences, Morgan also spoke of gaining an understanding of problems and difficulties, "the stuff", as a way of learning many things to "prepare for what may be down the road". Morgan's knowledge did not entirely arise from textbooks or policy manuals; a portion of her knowledge came from her experiences and was unknown (tacit knowledge), until called upon at a particular moment.

Lynsey made a connection between tacit knowledge and supporting patient safety through work as a team. She described her operating room nursing practice and attention to patient safety details during her time in Scotland as 'brilliant perfection'. She described how the same team members always worked with each other in the same operating room theatre. She said her theatre always received the emergency abdominal aneurysm cases, and it was a 'flow that worked beautifully' because the same staff were always present in theatre. She said, "The surgeons were happy, they knew who they could trust, what people could do, how much to say to the scrub nurse because they knew who the scrub

nurse was". Lynsey also spoke of knowing, as an operating room supervisor, how an operating room was functioning just by looking in a window. She said, "I can tell as I walk past a room, how the room is doing by the feel of the room". She also spoke of instructing nurses not to cover the windows to the operating rooms, because she could "see that all is good and I can walk away". This way of knowing what others might do in a certain moment was difficult for Lynsey to explain, even though this unspoken knowledge was something that composed her nursing practice every day. In research to determine how tacit knowledge influenced the performance of cardiothoracic surgery teams, Friedman and Bernell (2006) found "the unscripted and unspoken knowledge and understanding of what it is that the other team member will do in a given set of circumstances" (p. 228) is a significant feature of successful team performance. Friedman and Bernell also noted that tacit knowledge required all team members to be "in the moment", a connection that Lynsey also made in her work when she spoke about the feel of a room and the individuals working in it.

In studying the types of knowledge used by surgical teams to achieve safe work practices, Høyland, Aase, and Hollund (2011) discovered that teams and individual members used a combination of tacit and explicit knowledge to ensure safety. They also suggested that tacit knowledge supported a continuous focus on injury prevention through an awareness or anticipation of future events; it was a way of being prepared for what might come. Carson also spoke of planning for safe patient care and being one step ahead, when she described performing caesarean sections in a labour and delivery unit outside of the operating room setting. She was surprised at having to break scrub so many times for safety reasons, because she knew something was about to happen and she was equally surprised that the staff nurses did not recognize this. She spoke of patient safety changes that were eventually instituted in the unit, "because of nursing in the operating room – because we could see it". She took this knowledge to another level when she suggested 'they could see' patient safety in their practice and others could not; I believe this was Carson describing her tacit knowledge. She talked about patient safety in her practice in terms of explicit knowledge as well as tacit knowledge. She likened it to a "miraculous, delicate, balance. It's a dance in there. It's like a circus act – you're spinning, you're throwing up plates, you're juggling bowls, you're doing all these things all at once,

and you're a lion tamer too". Carson knew far more than she could tell me or anyone else, or even explain, yet it was something that composed her safety practice.

Shani spoke of tacit knowledge in both an individual and team perspective. She described working with junior nurses at one site and explaining to them why it was important to take their time, and "look at the whole picture, what's going on with the patient aside from the surgery". She felt the junior or new nurses did not have that understanding or knowledge in terms of the "whole picture". She described the introduction of a pacemaker service in one hospital, a service that she was knowledgeable and proficient in. Shani said how this new service was difficult for many nurses and how this tied directly to patient safety. She and the surgeon knew each other from their previous work and she was comfortable "with the way he did things, why he did them, all that kind of thing; he knew that I knew what I was doing". Shani said she was 'always looking and thinking' during pacemaker insertions and the surgeon was appreciative of her presence. In trying to explain her discomfort with what she felt was an inattention to patient safety at another site, she stated, "well, you just see things, you know", and, like Carson and the other nurses, Shani knew more than she could tell.

Each of the nurses had many years of operating room experience, and each had a great amount of diversity in their individual experiences. Yet each nurse struggled to explain how she knew certain nuances of patient safety. Carson said she learned from everyone she ever worked with, but she still could not clearly explain how she learned about patient safety. She was puzzled and said, "it wasn't anything specific – I never really thought about that part of it". She also thought that a lot about patient safety "is being taught in the rooms on a day-to-day basis, as you are doing it". Lynsey said she learned from 'always watching', and Shani learned from understanding 'who the other person was', and having a heightened sense of awareness to what surrounded her. Morgan said, "Every single minute of every single day was a learning process". She also described a professional relationship that became a time of learning; she said, "As he taught me I taught him".

As these nurses struggled to explain their 'knowing how', I thought how they also described an element of expert nursing practice as described by Benner, Tanner, and Chesla (1992). Benner et al. (1992) identified four levels of

practice - advanced beginner, competence, proficient practice, expert practice – and described how practitioners at different practice levels "lived in different clinical worlds" (p. 14). Unlike less experienced practitioners, expert practitioners are guided by direct apprehension of the requirements of a current situation, while keeping established rules or expectations in the background of their response to a situation (p. 25). For the expert nurse, the application of clinical knowledge provides a more fully developed, whole, reading of a situation. Benner et al. (1992) identified three specific aspects of expert nursing practice as follows. First, a nurse's sense of what lay ahead shaped an understanding of and response to a particular situation. Second, an expert nurse could attend to many other aspects of care simultaneously that would go unnoticed by others, for example, basing actions on an understanding of other clinicians' interpretation of the situation (p. 28). Finally, a nurse's sense of responsibility for the patient's well-being was more realistic in terms of actual possibilities inherent in the situation and in the nurse's capabilities (p. 26).

In discussing clinical knowledge as the knowledge embedded in the practice of nursing, Benner and Wrubel (1982) offered that clinical knowledge was relevant "to the extent to which its manifestation in nursing skills makes a difference in patient care and patient outcomes" (p. 11). This knowledge relied on the "development of a perceptual awareness that singles out relevant information from irrelevant, grasps a situation as a whole rather than a series of tasks, and accomplishes this rapidly without deliberative analysis of isolated information" (p. 13). The crucial element in developing this clinical knowledge was experience. Experience in this sense was not in terms of longevity or work seniority. Experience referred to "living through actual situations in such a way that it informs the practitioner's perception and understanding of all subsequent situations" (Benner & Wrubel, 1982, p. 14).

There is no doubt that explicit knowledge has informed the nursing practice of these four nurses over the course of their careers, and that explicit knowledge continues to inform their practice. Of great interest is that the nurses used their tacit knowledge and their experience in their everyday operating room work as a way of supporting patient safety and, frequently, could not express how they knew what was necessary in a moment. Reflecting on the nurses' stories, I sensed how their 'knowing how' to attend to patient safety came through their

many experiences which led to the development of their "perceptual grasp of an expert clinician" (Benner & Wrubel, 1982, p. 13).

Informing Nursing Practice, Education, and Research

A limitation to this study is that it is comprised of only four operating room nurses. Despite this limitation, there is a depth and soundness to their experiences and stories. Just as their experiences resonated across each other's stories and with me, I sense they will resonate with the experiences of other operating room nurses and perhaps other care providers in the operating room, as well as other nurses in other care environments. This research has provided an opening to understand, narratively, the patient safety experiences of operating room nurses and it has created an opportunity to view patient safety as always being in the midst, as always unfolding. Largely absent in the safety literature, especially literature focused on the operating room, are nurses' storied accounts of their patient safety experiences. It is these accounts and their resonating threads that can inform and advance nursing practice and safety research in ways that support patient safety across place, time, and relationship – across lives as lived.

The Canadian Nurses Association (CNA) Position Statement on Patient Safety (2009) states patient safety is the "reduction and mitigation of unsafe acts within the health-care system", but also is clear to state that for the nursing profession, it "must mean more than that" (p. 1). The CNA directs nurses to ensure:

> …all necessary actions are taken to prevent or minimize harm [because] … Patient safety is fundamental to nursing care and to health care more generally…It is not merely a mandate; it is a moral and ethical imperative in caring for others. Ensuring the provision of safe, compassionate, competent and ethical care to patients within the health-care system is a responsibility shared by all health-care professionals, health-care organizations… (p. 1)

Based on the findings of my study, certain matters are relevant to how operating room nurses experience patient safety and their safety responsibilities as upheld by the CNA. The following section addresses the implications for nursing, education, and research.

This study informs nursing practice, research, and education through its narrative form in understanding how working-in-relational ways is an ethical and morally responsible way of addressing patient safety. Working-in-relational ways extends the conceptualization of relational work as something more than a team of people working well together during a specific moment. The findings provide information on how relationships between nurses and others have developed into long-time professional, and at times personal, relationships. These relationships are based on mutual respect, trust, and recognition of who each person is in this world and what each person brings to the relationship. The findings assist us to understand how this kind of relationship is not confined to the work domain of the operating room, but that it is also an ethical and moral way of relating to others in the world as lived.

This research provides information on how working-in-relational ways is about the ways in which an individual thinks about another and how an individual behaves toward another. The findings encourage us to consider how working-in-relational ways becomes a vehicle for patient safety in the operating room, based on authentic engagement with each other and the patient. This study also revealed how the burden of safety and safe care is shifted onto patients when care providers fail to work-in-relational ways, and how patients are distanced from the care relationship rather than being included in it. Nurses, and others, need to inquire into 'world'-travel as a way of further understanding what it means to enact patient safety in a relational capacity

This study offers knowledge about how working in-relational ways may benefit patient safety within and across institutions. The findings reveal how relationships are neither determined nor bounded by work location; rather, they are sustained through what can be accomplished when working-in-relational ways, no matter where one is. The findings provide information on how nurses working-in-relational ways developed a sense of identity as safety practitioners and how this was recognized as significant in achieving patient safety in the operating room, for some nurses were presented with an opportunity to work-in-relational ways with others at a national level and bring this experience back to practice at a local level.

This study informs nursing practice, research, and education by revealing the daily challenges four operating room nurses experienced in making their

safety concerns acknowledged and validated both by colleagues and those in positions of authority. Evident in the findings was that, despite being responsible for the majority of patient care in the operating room, and having the most contact time with patients, nurses' knowledge was not consistently recognized as valid knowledge. This research offered insight into how unwarranted questioning or disputing of nurses' knowledge led to a compromised safety situation, and how some nurses experienced the disregard of their knowledge as a personal risk. It is prudent to address this for patient safety depends on the identification of safety concerns and those concerns acted on, regardless of who has identified the concerns. In addition, I wonder, when others still devalue senior operating room nurses' concerns, how a propensity for identifying and questioning safety concerns can be cultivated in the practice of junior nurses. This study further revealed how nurses' counter stories of patient safety became their dominant stories and provided a way of legitimizing their nursing actions as safety actions, and how the knowledge in the nurses' counter stories was not derived from preference or opinion, but from their safety experiences. The findings also provided information on operating room nurses' use of tacit and explicit knowledge in order to achieve safety, and establish a basis for inquiring into the knowledge and education required for a professional to not only support, but also advance patient safety in the operating room.

This study also revealed how patient safety was such a constant in the practice of these four senior nurses that they often could not clearly describe how they had learned about patient safety. The full-time, on-site operating room education of these nurses differed from the education offered today. Operating room nursing is no longer included as a clinical rotation in general nursing education because it is deemed a specialty practice. Many post graduate operating room programs now offer on-line computer theory components with clinical placements to integrate theory into practice. Ways of providing education do need to reflect the reality of fiscal and employment challenges for the individual and for the healthcare system, but learning about operating room nursing is not the equivalent of becoming a safety practitioner. That the senior nurses could not clearly articulate a specific process for learning about patient safety, given their structured education, opens an inquiry into wondering how

beginning practitioners learn about patient safety in education programs largely designed for independent learning.

This study offers knowledge about how four operating room nurses experienced a system process of regulating practitioner behaviour as a constraint to patient safety, and how their experience of and engagement in work-arounds in nursing practice differ from ways we previously knew. This study provided insight into the lived tensions of achieving patient safety in the operating room, when the administrative and regulatory process of managing care providers (who exhibited persistently unsafe actions or profound deficiencies in their abilities) was ineffective or when no further action could be taken. The description of senior staff working around a certain department policy at times was not surprising; but brought to light in this study is that some novice or junior operating room nurses engaged in work-arounds or shortcuts in work as a routine early in their practice, rather than as a short-term solution to safety concerns. That is, the practice behaviour occurred for personal reasons rather than safety reasons.

This finding of personally driven work-arounds is significant in terms of developing and establishing safe and competent practice in beginning practitioners in the operating room. A hospital by itself is neither safe nor unsafe; safety as a state arises in the relationships and actions between practitioners, patients, and the hospital system. When performance problems or professional competency remains unresolved or inadequately managed by leaders, practitioners will continue to repeat their actions. As a relational property, where safety is absent or diminished, organizational competency is also diminished, which further impedes nurses' overall ability to achieve patient safety as directed by the Canadian Nurses Association. If the mission statements of care facilities (such as providing the highest quality and safest care to each patient by employing excellent professionals for example) are to be reflected in practice, then facility leaders must also consider their contributions to ensuring the highest quality and safest care for patients. The notion of practicing safely or unsafely has long been viewed as an individual or personal aspect of safety. This perspective needs to broaden so that the role of the institution and health system leadership in patient safety is better articulated and operationalized. This expanded concept is not to discount the individual practitioner's role in patient

safety, but rather to illuminate the collective role and importance of all healthcare associated personnel in patient safety.

Nurses in this study spoke of tensions in practice when other practitioners used work-arounds in practice that did not support safety; however, these nurses also looked to work-arounds as a way of supporting patient safety in their own practice. Organizational and departmental policies generally are written from a detached stance and aim to regulate, direct, and control actions of others. Yet, in following some policies as written, the nurses in this study at times felt detached from the patient and the context of care, thus rendering the patient an object of care, which also isolated safety from the context. This research revealed that when nurses in this study experienced the system, or policy, as a constraint to patient safety, they would seek alternate ways to ensure patient safety in the operating room, for example ‘fitting the patient in’ for surgery and avoiding the lengthy wait-list process. This practice was possible by these nurses when in a supervisory or management type position, for they could implement an action without question or attention.

This study informs nursing practice by revealing the extent to which these senior nurses were willing to engage in activities that extended past the boundaries of established work parameters, in order to ensure patient safety. The further revelation and description by a nurse of a functional ‘underground’ system establishes a basis for understanding how patient safety is achieved through like-minded individuals working relationally in a system they experience as deficient. I believe this nurse viewed the underground as a safety borderland, a space to re-imagine patient safety outside of the constraints of the established system. I imagined the 'underground' as a liminal space where practitioners came together on the fringe, in unknown shifting spaces without pre-defined boundaries and where they discovered openings that enabled them to actualize patient safety in the current system. The movement back and forth between structured spaces and the ‘underground’ was a way of living with and negotiating tensions that interrupted patient safety. The findings also establish a basis for inquiring into how well situated and organized the ‘underground’ system and work-arounds are as an alternate parallel safety system. For example, who has access to alternate safety systems, and how is initial access established? What was apparent is that, faced with unresolved issues potentially affecting the safety of patients in the

healthcare system, operating room nurses, at least in this study, will seek alternate ways to ensure the safety of patients.

Lastly, this study speaks to the relationship between patient safety and operating room nurses' constant vigilance. Patient safety, through constant vigilance, is not a list of steps or items worked through, discretely. Patient safety is a frame of mind achieved through constant vigilance, through the constant awareness of what surrounds oneself and others. It is an awareness of how one's actions or inactions can ripple throughout one's environment, and, what this may mean for others in the same environment or even a different context. Vigilance in nursing and healthcare is not a new concept in the literature or in practice. However, it is one that too often, and perhaps too easily, slips into the background of daily nursing work and remains unnoticed until the consequences of inattention become apparent and at times irreversible.

In research to examine how unchecked technological practices dissected nursing into assembly line tasks, Marck (2000) noted how the relentless speedup of nurses' work replaced almost without notice, the healing practices of watching over patients, thorough reports and clinical judgments, vigilance, and the deeper complexities of clinical care (p. 71). In some instances, technically preoccupied care providers "forgot to gather pertinent clinical information" and "frequently failed to express when or why such knowledge mattered for sound clinical care" (p. 67). In addition, Marck discovered that some nurses' worries, based on vigilance and their observant clinical judgments, were devalued by coworkers, sometimes to the point of patient harm (p. 67). Even though the operating room nurses in this research approached patient safety through constant vigilance, with others freely commenting on their nursing practice, they also often felt repercussions for commenting on or questioning the practice of another colleague or environmental safety concerns.

In reflecting on performance in medicine, Gawande wondered, "What does it take to be good at something in which failure is so easy, so effortless" (2007, p. 3). He concluded that an essential element of being a better practitioner was vigilance, along with doing the right thing and ingenuity. Gawande argued that competence in practice was not enough to ensure good and safe practice. Rather, having accepted the responsibility of caring for others, this responsibility is met through vigilance in practice. When one's attention is captured in such a

way as to move one's gaze away from the reality of what is necessary to ensure good and safe patient care, Marck (2000) warns that "all too easily, we lose a sense of who we are and, therefore, what it is that we must do" (p. 67). Thus, this research informs practice, research and education by revealing the need to develop constant vigilance as an attitude and expectation in one's work in the early stages of education as a professional, ethical and moral responsibility to the patient and fellow colleagues in ensuring patient safety in the operating room.

Evident in the findings was the diverse range in how nurses, physicians, and administrators understood, and therefore supported, patient safety in the operating room. This diversity reveals the need for the explication of a common understanding of patient safety in the operating room to incorporate profession specific and context specific safety matters. For example, there currently is no document available and common to all operating rooms that describes and provides examples of specific events, or types of events, that require follow up in terms of patient safety. However, this type of document could never be exhaustive or complete in form because of the always-evolving safety concerns. Nurses in this study did indicate that they would ask others if a specific incident required follow up, or that they somehow should know which incidents required reporting. These differences in interpretation of safety events would lead to differences in achieving patient safety through constant awareness.

There is considerable safety research focused on nursing and teamwork in the operating room, but an essential aspect that must be given more attention is the notion of constant vigilance in nursing practice, and accordingly, in teamwork. Nursing presence is felt at every level in the operating room and nursing is tasked with a great deal of responsibility there. Research must ask how constant vigilance, the focused awareness to what is occurring in one's environment, can better support patient safety. This study revealed how easily eclipsed constant vigilance can become with the many competing demands of operating room work. Regardless of what safety procedures or processes are implemented, patient safety advances will impede unless all health workers engage in constant vigilance and understand the direct bearing this has on patient safety. To experience patient safety through constant vigilance is to imagine patient safety as an always event, rather than a sometimes or good enough moment of time. Thus, the nurses' safety experiences did not reflect a

focus on any specific professional groups or individuals. Their safety experiences revealed how constant vigilance focuses on the awareness of others, no matter who they are and one's environment, and thus is a way of practice that establishes a basis for approaching patient safety in the operating room as a collective responsibility by, and to, others.

Conclusion

There is considerable research focused on patient safety in the operating room but there is minimal research, especially of a relational nature, that considers nurses' experiences of patient safety in the operating room as a lens through which to view patient safety. Narrative inquiry opens us to learning about and understanding the different contexts that are positive and negative influences on patient safety. This type of research can illuminate the influence of past experiences upon the current context, and encourage conversations about future directions and considerations for patient safety in the operating room.

A consideration of this narrative inquiry is that the shared experiences of the nurses, their conversations, and my interpretations of their patient safety experiences, formed the basis for this research text. I engaged with four operating room nurses to elicit their patient safety stories and to explore the experiences that were informing their stories. The sharing of the nurses' and my perspectives provided a way to consider patient safety by inquiring into our everyday experiences together. It was through our conversations and the overlapping of experiences that stories of patient safety experiences were co-constructed, and created new knowledge about patient safety in the operating room.

As I heard the nurses' stories, and later as I revisited them and composed this research text from them, I was aware how vulnerable one might feel as an inquirer or participant when engaging in this type of inquiry. As participants, the nurses shared many stories with me, aware that what they told me would become my research work. Through the nature of this inquiry and coming to know the nurses' experiences, I understood and accepted what they voiced as essential information. As I wrote the research texts, I tried to ensure that the voices of the nurses' were being heard. I also ensured that the resulting research texts were shared with the participants to provide another opportunity to

incorporate their perspectives concerning any corrections, deletions, or additions of content.

As an inquirer, I was aware that I would be in a privileged position of hearing these stories, and I needed to care for and share these stories in a respectful and ethical manner. I would also become a keeper of those stories for always. At times there was so much emotion, sensation, and movement in a story that I wanted others not only to read the story, but I wanted them to feel the story as it unfolded: through looking inward and outward, through the people in it, and through the past, current, and future of the moment. The rigor of the nurses' narratives, and importantly the rigor of this inquiry, was upheld by remaining wakeful to working within the three-dimensional narrative inquiry space and positioning the texts and discussion along the same dimensions of temporality, relationship, and place. I believe this text, as a relationally derived work, is a sensitive text that elicits the nature of this narrative inquiry research as a transparent process between the nurse participants and me.

The nurses' experiences as written in the stories reflect the ongoing conversation about patient safety in the operating room, today. Just as the patient safety conversation continues to move forward and evolve, the nurses' experiences are fluid and are always becoming. It is my hope that this research offers a new way of understanding patient safety in the operating room; and that it will lead to even more possibilities and more conversations about patient safety. As Clandinin and Connelly (2000) offer, "many narrative studies are judged to be important when they become literary texts to be read by others not so much for the knowledge they contain but for the vicarious testing of life possibilities by readers of the research that they permit" (p. 42). I offer this research text as a place for operating room nurses and readers "to imagine their own uses and applications" (p. 42).

I also considered how the findings of this inquiry could be disseminated so that other operating room nurses could also engage in and continue the patient safety discussion. Dissemination can be achieved through research briefs and publications in professional journals. Posters, conveying specific nuggets of safety related information, are another way of highlighting findings of this research, and act to remind practitioners what is necessary in achieving patient safety. Conference presentations would provide face-to-face contact and offer

opportunity for more conversational discussion with other operating room practitioners.

When I began this narrative inquiry with the four nurses, we wondered what would come out of our conversations and the direction this inquiry might take. What I intended to present in *Behind the Mask: A Narrative Inquiry into Operating Room Nurses Experiences of Patient Safety* was a selection of patient safety stories, told by these four operating room nurses, in a way that would allow this to be understood as one connected text. I also hoped that new insights into experiencing patient safety and new interpretations of patient safety in the operating room would come forth. I believe I have accomplished what I had intended, however, it is for each reader to judge if that belief is well founded. This study informs nursing practice, research, and education about operating room nurses' experiences of patient safety, and how they differ in ways from what we thought we knew. This study illustrated the personal, professional, and relational background and life of four operating room nurses, and each one's influence on patient safety experience. The findings revealed how patient safety is not only providing care in a safe manner, but also how patient safety for these nurses is a state of mind, a constant vigilance of what surrounds them and others. This text highlights the relational aspect of narrative inquiry. It focuses on how individual, and one's own experience, resonate across other's experiences; and how in journeying through a story together and hearing a story retold and unfold, a new context for understanding patient safety in the operating room becomes possible.

As my writing came to end, I again reflected on the nurses' stories, and I thought how these were once stories held *behind the mask*. Through our conversations, Morgan, Carson, Shani, and Lynsey brought their patient safety experiences forward not only as stories about the operating room and patient safety, but they revealed them as stories about relationships, places, families, the past, present, and the future. These were their narratives of living life in the midst, and through these narratives, their storied lives unfolded to situate patient safety, in front of the mask.

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Appendix A

Sample of Information and Consent Letter to Nurses

Researcher information:
Alice Moszczynski, PhD(c)
4835 McConnell Avenue
Terrace, BC
250-635-4752//moszczyn@ualberta.ca

Supervisor information:
Dr. Patricia Marck
Faculty of Nursing, University of Alberta
7-80 University Terrace, 8303-112 Street
Edmonton, Alberta
780-492-2109

Dear Operating Room Nurse,

My name is Alice Moszczynski and I am PhD Nursing candidate conducting research to explore patient safety experiences of operating room nurses, and how this may impact on patient safety in the operating room. I am conducting this research in partial fulfillment of the requirements for a PhD in Nursing from the University of Alberta.

This letter outlines important information to help you decide whether or not you would like to be in this research. If you agree, I will ask you to participate in approximately 4-6 face–to-face recorded conversations, lasting about 1.5-2 hours each. If for some unforeseen reason a face-to-face conversation is not possible, the conversation could take place by telephone and be recorded. I will talk with you about some of your life stories, as well as any of your stories that you want to share about your past patient safety experiences. The conversations will be private and your name will not be used in the study. The tapes will only be heard by myself, a confidential transcriptionist, and if absolutely necessary by my research supervisors. The tapes and transcriptions will be kept in secure storage for a period of 5 years following the research, at which point they will be destroyed. The typed record of our conversations may be used for teaching others and for writing articles to be published in medical and nursing journals.

I believe that our feeling of whom we are and the experiences we have are influenced by the experiences we had and the stories we tell about ourselves. I will ask you to talk with me in answering the question: what stories of past experiences would you tell to describe patient safety in the OR? We will talk together about these stories.

As a nurse who works in the operating room, the benefits of this research would be in providing me and other health care workers with important information in understanding how nurses make sense of patient safety through past experiences, and how this may impact on patient safety in the operating room. Your information may also contribute to the development of knowledge that may help nurses in other units who have also experienced patient safety issues in their practice.

It is not expected that taking part in this study would cause any harm to you. The only requirement from you is your time and willingness to engage in conversational stories. You may ask any questions about this study at any time. You do not have to take part in this study. If you decide to take part in the study and change your mind for any reason, you may leave the study at any time without penalty. It is possible that you may experience a short-term discomfort by engaging in a conversation with me to discuss past patient safety experiences. You will only be asked to share what you feel comfortable in sharing with the researcher. You must be aware, that if information is shared that indicates a situation of a breach of professional or legal standards, and this situation is not actively in a resolution process, I am obligated to inform the proper authorities. If you are troubled by any conversations, assistance with a counseling referral will be provided.

If you would like to participate in the study, please read the consent form and respond to the questions. Please sign your name at the bottom of the form. Your signature will indicate that you agree to participate in this research by your own choice. If you have any concerns about this research, you may contact Dr. Christine Newborn-Cook, Associate Dean of Research, Faculty of Nursing, at the University of Alberta (780-492-6764).

Are there any questions you would like to ask?

I have read this information letter _____
(Initials of participant)

University Letterhead

Appendix B

CONSENT FORM for Participant

Part 1 (to be completed by the researcher):
Title of Project: Behind the Mask: A Narrative Inquiry into Operating room Nurses' Stories of Patient Safety

Researcher: Alice Moszczynski Phone number: 250-635-4752
Supervisor: Dr. Patricia Marck Phone number: 780-492-2109

Part 2 (to be completed by research participant):

Do you understand that you have been asked to be in a research study?

Yes No

Have you read and received a copy of the attached Information Sheet?

Yes No

Do you understand the benefits and risks involved in taking part in this research study?

Yes No

Have you had an opportunity to ask questions and discuss this study?

Yes No

Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without penalty?

Yes No

Has the issue of confidentiality and anonymity been explained to you?

Yes No

Do you understand that the conversations will be recorded?

Yes No

Do you understand that portions of the final research may be published in professional journals or presented at conferences?

Yes No

Do you understand the researcher is obligated to report any breach of professional conduct that is unethical and not legal, and that is not currently in a process of resolution?

Yes No

Who explained this study to you?

I agree to take part in this study Yes No
Signature of Research Subject:

Printed Name:
Date:

Signature of Witness:

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee:
Date:

This information sheet must be attached to this consent form and a copy given to the research subject.