ABSTRACT

Background: The increased incidence of health challenges with aging means that nurses are increasingly caring for older adults, often in hospital settings. Research about the complexity of nursing practice with this population remains limited.

Objective: To seek an explanation of nursing practice with hospitalized older adults.

Methods: Design. A grounded theory study guided by symbolic interactionism was used to explore nursing practice with hospitalized older adults from a nursing perspective. Glaserian grounded theory methods were used to develop a mid-range theory after analysis of 375 hours of participant observation, 35 interviews with 24 participants, and review of selected documents.

Results: The theory of Orchestrating Care was developed to explain how nurses are continuously trying to manage their work environments by understanding the status of the patients, their unit, mobilizing the assistance of others, and stretching available resources to resolve their problem of providing their older patients with what they perceived as "good care" while sustaining themselves as "good" nurses. They described their practice environments as hard and under-resourced. Orchestrating care is comprised of two subprocesses - building synergy and minimizing strain. These two processes both facilitated and constrained each other and nurses' abilities to orchestrate care.

Conclusions: Although system issues presented serious constraints to nursing practice, the ways in which nurses were making meaning of their work environment both aided them in managing their challenges and constrained their agency.

WHAT DOES THIS RESEARCH ADD TO EXISTING KNOWLEDGE IN GERONTOLOGY?

- Nurses assess their environments and their older adult patients, leverage the assistance of others, and stretch resources to provide what they define as good care.
- Nurses are challenged by constrained resources in caring for hospitalized older adults with increased functional needs.
- The language nurses use to quickly prioritize their older patients' needs limits their ability to explain the complexity of older adults acute care requirements.
- Nurses' strategies in managing older adult care assisted them to cope with systemic challenges but constrained their agency.

WHAT ARE THE IMPLICATIONS OF THIS NEW KNOWLEDGE FOR NURSING CARE WITH OLDER PEOPLE?

- Nurses have key information about how system challenges intersect with the complex needs of older people.
- Clearer communication about the complexity of older people would occur if the language nurses use in assessing their patients was clarified.
- Better understanding of nurses' pivotal role in communication and care of older people would enhance the effectiveness of interdisciplinary healthcare teams.

HOW COULD THE FINDINGS BE USED TO INFLUENCE POLICY OR PRACTICE OR RESEARCH OR EDUCATION?

- Gaps in policy that addresses supportive older adult care are explained through nurses' strategies in navigating hospital systems.
- Further research is needed to understand how a sense of reciprocity fosters effective nursing and interdisciplinary teams.

- Nursing education about older adults must be tailored to include the challenges of complex healthcare contexts.

INTRODUCTION

The increased incidence of health problems that occur with an aging population (World Health Organization [WHO], 2013) means that nurses are increasingly caring for older adults within hospitals; workplace challenges in those settings, such as short staffing and an emphasis on efficiency rather than quality, undermine nurses' abilities to provide basic nursing care (Austin 2007; Rodney & Varcoe, 2012). While there is evidence suggesting that nurses are able to influence their work environments and the care of their patients (Musto & Schreiber, 2012; Newton et al., 2012), there is little research examining nurses' perceptions about how they manage their practice with hospitalized older adults and factors that facilitate or constrain their efforts.

BACKGROUND

Older adult care is challenging because, with increasing age, people become more susceptible to complications (Graham et al., 2009; Fedarko, 2011). To some degree, these complications result from the failure of hospital systems to support appropriate care for older patients with chronic health conditions and their resulting complex needs (Peek et al., 2007; Sellman, 2009). Older adults' poor outcomes are related to patient factors in combination with care provider and system issues (Hickman et al., 2007; Baztan et al., 2009). Given nurses' twenty-four hour presence with hospitalized patients, understanding nurses' practice perspectives can provide direction for improving care of hospitalized older adults.

The literature is replete with information about managing specific care issues affecting older patients, such as falls or delirium; however, there is a paucity of studies examining nurses' perceptions of how they provide such care. There are two related

areas within the literature that illuminate some of the most pertinent issues: perceptions about aging held by nurses and society; and institutional systems of care in settings where nurses work.

Perceptions about aging

Many scholars have suggested that ageist views are influencing healthcare delivery for older adults, specifically nursing practice. Higgins and colleagues (Higgins, Van Der Riet, Slater, & Peek, 2007) found that nurses often viewed hospitalized older adults as a "waste of time" (p. 10) and caring for them as more time-consuming than caring for younger people. AUTHORS (2008) study also revealed nurses' negative perceptions of older adults. Their qualitative data clearly showed nurses' frustration in caring for an aging population in a system not designed for managing their complex needs. Nurses saw these barriers in managing older adult care as a reflection of negative societal perceptions about older adults. Sellman (2009) took this idea a step further in his editorial describing hospitals as "institutionally ageist [because] older patients who do not fit the prescribed, almost industrial, model of hospital admission and discharge are identified as a problem" (p. 70).

Kjorvin and colleagues' (2011) post-structural discourse analysis of nurses' talk about older adults with postoperative delirium led them to suggest that societal ageist perceptions contribute to the normalizing of "confusion" in older adults – the term nurses used when asked to describe older adults' postoperative delirium in the context of their practice. Similar findings were reported by Neville (2008) who conducted a discourse analysis on the charts of older people who had experienced delirium while hospitalized.

His analysis reveals that the written language used to describe delirious older adults was negative, reflecting a view that they were "worthless" (p. 463).

Institutional systems of care

There is evidence to suggest that hospital work environments are characterized by systems of care that are not suited for older adults and allocation of resources that reinforce ageist views (Peek et al., 2007; Sellman, 2009; Rodney & Varcoe, 2012). In response to care structures, a variety of methods to deliver acute care more appropriately to older adults have been developed, such as specialty older adult units, or geriatric resource nurses (Peek et al., 2007; Capezuti & Brush, 2009). Unfortunately, research studies examining these specialized models have focused on patient outcomes, without specifically examining nursing practice (Hickman et al., 2007). Scholars have identified that hospital systems influence nurses' abilities to provide care (Boltz et al., 2008; Goveia, 2009; Rodney & Varcoe, 2012). The contribution of hospital environments to how nurses' engage in their practice is very complex and, in part, related to nurses' perceptions of the need to be efficient due to scarce resources (Plavish et al., 2011; Newton et al., 2012; Rodney et al., 2013).

An emerging area of research focuses on acute care practice environments and nurses' perceptions about how these environments influence their practice (Cheek & Gibson, 2003; Boltz et al., 2008; Kim et al., 2009; McKenzie et al., 2011). Cheek and Gibson's descriptive exploratory study of the issues affecting the provision of nursing care to hospitalized older adults identified the pivotal role Registered Nurses (RNs) had in managing the care of hospitalized older adults. However, they indicated that RNs frequently lacked the knowledge, staffing resources, and status within their organizations

to effectively manage older adults' care. Although their study offered insights into nursing practice with hospitalized older adults, the contribution of multiple data collection strategies to their findings was not specified and they did not include observations of nursing practice. Researchers have surveyed nurses using the Geriatric Institutional Assessment Profile to understand their perceptions of geriatric care environments in US and Canadian hospitals (Boltz et al., 2008; Kim et al., 2009; McKenzie et al., 2011). Participating nurses indicated they could provide geriatric care when older adults were valued within their institutions, their institutions supported collaboration, and geriatric resources were available.

In summary, nurses' negative beliefs about aging are documented in hospital settings (Higgins et al., 2007; Neville, 2008; Kjorvin et al., 2011), and the systems within healthcare institutions frequently do not support appropriate care of hospitalized older adults (Peek et al., 2007; Sellman, 2009; Rodney & Varcoe, 2012). Evidence also supports the claim that nursing practice with this population is fraught with challenges (Plavish et al., 2011; Newton et al., 2012; Rodney et al., 2013) although how nurses enact their practice in the context of these challenges in not well understood. Thus, the aim of this study was to explain how nurses' manage practice with hospitalized older adults from the perspective of nurses.

METHODS

Theoretical Framework

Symbolic interactionism (SI) provided the theoretical framework to guide this study. SI is a framework emphasizing meaning-making that occurs as individuals act toward one another and symbolize objects and shared beliefs that are present in social

environments (Mead, 1934; Blumer, 1969). Since nursing practice is influenced both by nurses' relationships with individuals in their care and other healthcare providers, as well as the social environment in which nurses work, SI is an appropriate framework to guide inquiry into the complex social issues related to nursing practice with hospitalized older adults.

Design

We used a grounded theory (GT) design guided by SI because GT offers a systematic and rigorous approach to examining complex human processes (Glaser & Strauss, 1967; Glaser, 2001), and seeks to explain how participants are managing a problem that is central to them (Glaser, 1992; 2001). The Glaserian interpretation of GT includes concurrent data collection and data analysis, theoretical sensitivity, use of constant comparison, theoretical sampling, and extensive memo writing (Glaser & Strauss, 1967).

Participants

Purposeful, snowball, and theoretical sampling were used to recruit participants (Polit & Hungler, 1991) from two units in two different hospitals: a geriatric unit (GU) in a tertiary care hospital and a medical unit (MU) in a community hospital, both located in an urban area on the west coast of Canada. Although the MU did not only admit older adults, on any given shift all but one or two beds in the 20 bed unit were occupied by older adult patients. The nursing complement had shifted on both of these units within the last five years from primarily registered nurses (RNs) to a staff mix that included licensed practical nurses (LPNs) and patient care aides (PCAs).

Of the 24 study participants, 18 were RNs, three were LPNs and three were PCAs. Although PCAs are unregulated care providers and not nurses, they were sampled to provide examples of how nurses were providing care for older adult patients within nursing teams that included PCAs. The average age of the participants was 41 years (range 25- 58 years). Their level of education in the healthcare field varied by job category, ranging from 4-6 months (PCA) to 12 months (LPN), with the RNs having completed either a two-year diploma program or a baccalaureate degree program. *Insert table one.*

Data Collection

Data collection included participant observation, semi-structured interviews, and examination of documents related to nursing practice. Three hundred and seventy-five hours of participant observation were conducted, over a variety of times in a 24-hour period, which included weekends and holidays. Participant observation provided opportunities for the first author to see nurses in action in a variety of care situations. The first author conducted thirty-five semi-structured interviews with 23 of the participants, which included eight repeat interviews to obtain feedback on the developing theory. Situations that occurred during participant observation and how common these instances were in relation to older adult care were explored in the first round of interviews. The researcher also examined documents that nurses considered meaningful in guiding their practice. These included posters containing older adult care information; written information used in care planning, and the Kardex (a written document intended to present important patient care information quickly).

Ethical considerations

Prior to conducting this study, ethical approval from the university and the relevant health authorities was obtained. In the context of participant observation, the first author explained the purpose of her presence to other healthcare providers who were working with participants and older adult patients and provided them opportunities to participate as bystanders, which allowed their interactions with nurse participants to be included as data. Potential bystanders were assured that documentation of their words and actions would only occur with their written consent.

Data analysis

Data analysis occurred concurrently with data collection; we used constant comparison and the techniques of intense memo writing, three stages of GT coding (open, selective, and theoretical), and theoretical sensitivity (Glaser & Strauss, 1967; Glaser, 1978; 2001). SI guided data analysis because we attended to nurses' interpretations of their interactions with one another and with objects, such as the Kardex (Mead, 1934; Blumer, 1969). Memo writing helped to conceptualize and theorize about the data (Glaser, 1978).

In open coding, incidents were labeled, compared with one another, and similar incidents were clustered together, which led to the development of categories and their properties. Selective coding occurred by delimiting the coding to a core category and its properties (Glaser, 1992). Theoretical coding was used to explain how the sub-processes and their properties were related to one another and the core category. Key to conceptualization of this theory was ongoing discussion among the researchers and referring back to the theoretical framework of SI.

Theoretical sensitivity, or the "researchers' knowledge, understanding and skill" (Glaser, 1992, p. 27) fostered theorizing about what was being observed from different perspectives. The researchers attended to the potential for their perspectives to direct their theorizing, which was carefully considered and compared with participants' perspectives.

Rigor

Rigor incorporated general considerations for qualitative research and more specific criteria for GT methods. In general terms, we documented openness and adherence to a philosophical perspective by providing a transparent decision trail regarding theory development (Sandelowski, 1986). The GT elements of fit, work, relevance, modifiability, parsimony, and scope were attended to by examining how the theory, incidents, and categories fit with how nurses were processing their problem in changing contexts. Discussing preliminary ideas about the theory with participants and accounting for the most variation possible with the least number of concepts also attended to GT elements of rigor. Finally, writing journals about nursing practice and discussions with the other researchers enhanced the first author's reflexivity, while the that researcher used relationality to attend to power and trust with participants through stressing that the researcher was there to learn about nurses' experiences and was a nurse as well as a researcher (Hall & Callery, 2001).

RESULTS

The theory of Orchestrating Care was developed to explain how nurses are continuously trying to manage their work environments by understanding the status of their patients, their unit, mobilizing the assistance of others, and stretching available resources to resolve their problem of providing their older patients with what they

perceived as "good care" while sustaining themselves as "good" nurses. The nurses tried to achieve those goals in practice environments they described as hard and under-resourced. Participants defined good care as keeping their patients safe, individualizing care, enhancing patients' function, and providing comfort care. Top priority was keeping patients safe which meant protecting patients from potential harms from patients' conditions, the environment, and/or other healthcare providers. Individualizing care was perceived as providing patients with some choice around their care. Enhancing function was regarded as mobilizing patients and encouraging independence so they could return home. Providing comfort care was presented as advocating for reducing invasive interventions to reduce suffering when older patients were dying. Nurses explained that sustaining themselves as good nurses was striving to achieve professional competencies and meeting their obligations to their patients.

Orchestrating care is explained through the two sub-processes *building synergy* and *minimizing strain.* Nurses needed to build synergy with other care providers and families, and minimize their own strain because hospital environments contributed conditions that made care of older adults harder, made nurses more likely to feel misunderstood, and had nurses identifying inadequate resources. One nurse explained: "First line is always suffering. I would like to see my co-workers happy and healthy, and patients getting good care. It's not a reality" (RN 13, MU).

Nurses regarded the healthcare system as a root cause of challenges in providing good nursing care in general and even more challenges if the population they were caring for was older adults. One nurse clarified: "The system, it's not set up the best for nurses. If the resource is not there for us we cannot do our best. It's so limited. But each one of

the nurses I think we are trying to do [our] best for the patient" (RN 13, Second interview, MU). Because orchestrating care was a dynamic process, nurses developed lines of action to build synergy and minimize strain in a system they regarded as failing them in their efforts to provide good care.

Building synergy

Building synergy explained how nurses gathered information, shared information, and worked with others to assist them in resolving their problem, which was to provide good care and be viewed by themselves and others as good nurses. The nurses *did reconnaissance*, *passed information*, and *navigated relationships*.

Doing reconnaissance involved ongoing assessment where nurses gathered information about the status of their patients, staffing levels, the physical environment of the hospital unit, and available resources. Because everything around them, including the health status of their older adult patients, was constantly changing they needed to constantly update their assessments. "Every time you go in the room you're doing an assessment. Things can change quickly" (RN 5, GU).

Nurses used the language of "acute" and "heavy" to summarize their assessments of patients when assigning them to members of the nursing care team and deciding where they should prioritize their time. As one nurse explained: "older adults are heavy. [You] need time, patience to toilet them, give medications and they would like to chat with you" (RN5, GU). And yet nurses reported that they were "given the same amount of people" (RN5, GU) as were units with predominantly younger patients, even though they argued that older people required more time to provide care due to their slower cognitive processing and an increased need to support their activities of daily living (ADLs). Heavy

patients were described by nurses as those needing more assistance with activities of daily living or mobilization. They would receive lower priority for RN care (versus LPN or PCA) than patients who nurses described as having more acute needs. Acute patients were viewed by nurses as unstable and at risk for mortality or morbidity from their problems.

Passing information explained how nurses were conduits of patient-related information between and among patients, families, and members of the healthcare team. Nurses used passing information to encourage cooperation from patients and their families, who were more likely to follow nurses' requests if they understood why things were being done. Listening to patients and families concerns assisted in "get[ting] that helping relationship going" (LPN 3, MU). Nurses passed information to other members of the nursing team and to other healthcare providers to encourage cooperation and support to meet patients' needs. That cooperation influenced how effectively they could orchestrate care. The importance of nurses passing information was especially relevant when older adult patients were cognitively impaired, either due to dementia or delirium, and could not articulate their own concerns.

Although nurses relied on a number of communication tools to aid them in passing information, they identified the Kardex (a document with facts to guide patient care) as their primary tool for the nursing team. A field note highlights the significance of the Kardex.

> The RN spoke to the other nurses about the importance of information being written in the Kardex, saying it was their primary communication tool (Field note, GU, August 1).

Unfortunately, the Kardex was frequently inaccurate, which required nurses to take time to complete missing elements critical to planning the care for their patients. Passing information was based on nurses' knowledge about medical information in relation to a particular patient, unit routines, and routines of other healthcare professionals.

In *navigating relationships*, nurses were negotiating spoken and unspoken expectations about working in teams that were constituted by members occupying a variety of roles and possessing varying levels of experience. Good working relationships were required for nurses to figure out how to maximize cooperation with constantly changing team members. This was important because when "everybody works together and knows their job, [it's] nice and smooth" (PCA, GU). Nurses explained that it was particularly important to work together when caring for an older population because the functional changes associated with acutely ill older patients often required more than one nurse to help with transferring and mobilizing.

Nurses held common understandings that being a good helper and reciprocating assistance were associated with being a good team player. A nurse who helped would anticipate possible patient care needs and support team members without being asked. The ability to anticipate necessary patient care needs varied with the educational level and years of experience of nursing team members. One nurse described the importance of reciprocity: "when I do it [answer other nurses' bells], those nurses tend to do my bells too. It's give and take. It's more give and take when you do that" (LPN 3, MU). The notion of reciprocity was complex because often the role of the RN required knowledge and skills that could not be reciprocated by the LPN or PCA.

The nurse participants identified a helping hierarchy among the healthcare team with doctors at the top and nurses at the bottom. One nurse elaborated: "We accommodate the doctor. It is the hierarchy and it just has to be" (Field note, July 16, GU). The nurses' willingness to navigate relationships influenced how they worked with other healthcare professionals, especially those who they did not completely trust. Nurses experiences of being excluded from decisions related to their patients contributed to a lack of trust in relationships and limited their willingness to engage in open communication. Their reduced communication with other healthcare professions negatively affected nurses' efforts to build synergy as part of orchestrating care with other health care providers. Ultimately, limited participation with other providers left the RNs with the largest share of responsibility in building synergy, with more experienced RNs shouldering more responsibilities than novice nurses.

Minimizing strain

The nurse participants minimized strain by making the most of their available resources, supporting and guiding one another, and reframing their practices in ways that created a supportive network to provide good care and be viewed as good nurses. Their nearly exclusive trust and almost complete reliance on each other for minimizing strain could undermine their engagement with other healthcare providers, patients, and families. Minimizing strain incorporated *maximizing resources*, *sharing experiences*, and *reframing the work*.

Maximizing resources required nurses' creativity to extend their physical resources and time because of the way resources in their institutions were organized. One participant clarified that hospitals are "24/7 facilities that run Monday to Friday"

(Bystander 4, GU). Patients, families, and nurses were present and working together outside of normal work days and usual work hours because many other health care providers and support workers had 9 to 5 schedules five days a week. When other workers were absent nurses had to fulfill the roles usually occupied by these healthcare providers and know where to find supplies and equipment during hours when many departments were closed.

Nurses maximized their resources through time efficiencies by grouping ('chunking') many tasks together, especially for patients on isolation. Chunking tasks reduced the time spent donning the isolation garb needed prior to each encounter with patients. Nurses also relied on one other for information about where to find supplies and equipment because it was a continuous "struggle for [resources] throughout [the] shift" (RN 12, Second interview, MU). Nurses' struggles included obtaining basic supplies, such as food, bedpans, intravenous poles, and thermometers. Older adult patients were more likely to require assistance with ADLs as a result of the functional changes associated with acute illnesses in an older population; thus the struggle to find the basic supplies for their patients was acutely experienced by the nursing team.

Nurse participants also maximized resources by juggling time between goals. They had to choose between enhancing function of some of the heavy patients and meeting the acute needs of other unstable patients. One nurse elaborated: "We'll have one [acute] patient that takes up so much time that you're not able to take a[nother] patient for a walk. We have to juggle the acuity." (LPN 1, GU). Nurses linked sudden deterioration in one patient's condition to abandonment of plans to aid other patients in

improving their function, which older adults were more likely to require. One patient's safety would usually trump another patient's needs for enhancing function.

By *sharing experiences*, nurses supported and learned from each other about how to orchestrate care. It also provided opportunities for nurses to debrief about their challenges in caring for an older population and learn from one another about how to respond to acute patient care situations. As one nurse explained: "It was a traumatic event and you want to share. You want to express your feelings. It's so important" (RN11, MU).

Through sharing experiences, the nurses defined themselves as being committed to a kind of care that nurses who were not working with older adults did not value and possessing an understanding about the complexity of older adult care that these other nurses did not comprehend. "Some young nurses they don't really like to work with older adults, they don't really work [out]. They come and go and say they are losing their skill" (PCA2, GU). Unfortunately, for many nurses, sharing negative experiences and relying on each other's support resulted in their characterization of the healthcare system as the sole cause of their failure to provide good care. Sharing their failures allowed them normalize their experiences because "when you have a nurse on your side it eases your stress (LPN2, GU). They avoided addressing their shared accountability for failing to achieve their goals for patient safety and function so they could preserve their image of themselves as 'good' nurses who were in impossible situations.

Because nurse participants acknowledged that their goals for their patients were frequently not met and they needed to maintain their images as good nurses they had to *reframe the work* to minimize their strain. For example, nurses reframed their routines

while restraining older adult patients. They acknowledged that restraining patients was not in keeping with hospital policy, inconsistent with their goals of promoting function, and detrimental to patients' autonomy and wellbeing but nurses reframed their actions as necessary to keep patients safe. One of the participants illuminated how nurses shifted an undesirable practice to a positive intervention. "Technically a geriatric chair is a restraint. Sometimes, it's a comfortable chair that gives you a position change and they're safe and maybe they'll even settle and fall asleep" (Bystander 1, GU). Nurses referred to geriatric chairs as "safety restraints" highlighting how pervasive their reframing had become, to justify their activities through their primary (yet narrowly defined) goal of keeping patients safe.

The information and relationships that nurses developed in *building synergy* and their reliance on one another when *minimizing strain* helped with supporting and learning from one another, but those activities reinforced their views that they could only rely only on each other. Part of that reliance was accepting practices such as the use of restraints that did not always align with their goals or their professional competencies and obligations to their patients. They were able to sustain their perception that they were good nurses operating in a bad system; unfortunately, their perceptions contributed to perpetuating some non-evidence based and potentially harmful practices, limited their opportunities to build synergy with other healthcare professionals, and undermined their professional autonomy.

DISCUSSION

Orchestrating care contributes to our understanding about how nurses managed patient care for older adults in what they described as unsupportive institutional

conditions. This theory is comprised of the two subprocesses *building synergy* and *managing strain* that explain how nurses focused on working with others to leverage better care than they could accomplish on their own and maximizing their efforts to provide care in institutions they considered poorly designed for older adult care. Our discussion will focus on four key areas highlighted by the theory: symbolizing older adult care; working in complex teams; emphasizing safety; and learning from each other.

Nurses in this study used the language of 'acute' and 'heavy' to label their patients as they were *building synergy*. Symbolizing care in this way is common in many areas of gerontological nursing practice. The term "heavy" is a common one for nurses, and it reflects the taken-for-granted view that older adult care is hard physical work and requires less thinking (Brown et al., 2008; Xiao et al., 2008; Flood & Clark, 2009; Kjorven et al., 2011).

Nurses' decisions to symbolize certain older adults as heavy are situated within a broader social perception of older adults as using too many scarce healthcare resources (Evans, 2007; Garret & Martini, 2007). Other scholars have described a similar discourse associated with older adult care and its contributions to how resources are allocated (Neville, 2008; Kjorven et al., 2011). Such social perceptions help to explain why nurses' use of the symbol heavy to label patients undermined their efforts to engage with managers in a way that communicated the complexity of care and their need for more staff and resources. Because providing older adult care was uncritically viewed as lacking in complex thinking skills, nurses failed to articulate the complexity of these patients, many of whom were experiencing both chronic and acute health challenges.

This study offers novel insights about how older adult care is enacted through complex teamwork. Roles within the nursing team and nurses' perceptions about their value within the multidisciplinary healthcare team influenced how they could *build synergy*. Being part of a nursing team comprising a variety of roles, educational preparation, and experience levels was challenging, in part, because nurses symbolized helping and reciprocity as key to being a good team member. In complex and changing work situations with rapid changes in patient status, team members with different levels of preparation could not always make equivalent contributions to patient care. Other studies have described the impact of roles and experience in how nursing teams are constructed and individuals work together (Schmalenberg & Kramer, 2009; Duffield et al., 2010; Harris & McGillis Hall, 2012); nursing teams are increasingly being characterized by a variety of skill mixes without overt articulation of older adult patients' care needs, or a clear idea about how to best construct these nursing teams.

The findings also contribute to understanding the difficulties that occur when healthcare teams are viewed as hierarchical with contributions regarded as varying in value. Research suggests that older adult care is improved when there is collaboration among healthcare disciplines (Boult et al., 2009; Arbaje et al., 2010); however, knowledge about constructing effective non-hierarchical multidisciplinary teams or nurturing relationships within healthcare teams has not been fully developed.

The theory of orchestrating care highlights how nurses caring for older adults come to emphasize safety as a primary goal of care in their effort to minimize strain. This extends Rodney and Varcoe's (2012) understanding about how notions of scarcity inform nurses' constant struggles for resources. Using non-evidence-based practices to promote

a narrow definition of safety highlights the prominence of "safety first" within nurses' socially constructed hospital environments. Nurses caring for older adults are increasingly framing their practice in terms of risk management and "safety work" (Ludwick et al., 2008; Schofield et al., 2012). The theory of orchestrating care supports these scholars' explanations of how nurses constructed keeping patients safe in narrow ways as a means of defining a manageable practice of safety, and extends our understanding by linking nurses' activities more explicitly to scarce resources. Moreover, this study has shown that utilizing practices that are not evidence-based (such as restraints) to keep patients safe not only served to undermine other goals for older patients (e.g., mobility function) but also has the potential to increase nurses' workloads over time (patients who become deconditioned from being restrained require more extensive nursing care). Furthermore, nurses were challenged to sustain their image of themselves as "good" nurses when they engaged in activities that were not evidence-based.

Finally, *minimizing strain* explains how nurses were learning about providing older adult care through their interactions with each other. Orchestrating care in constrained work environments suggested that nurses did not believe they had the time or resources to follow many of the "best practice" guidelines that were promoted by their workplaces; therefore, they used practices they learned from one another. Similarly, Estabrooks (2008, 2009) has identified nurses as more likely to learn from their co-workers, than from "evidenced-based" practices that are identified in the literature.

Nurses in this study were learning from one another in extremely challenging situations that contributed to their perceptions that the problematic healthcare system was

not going to improve; they had to learn how to respond to urgent situations in that context. Nurses' abilities to successfully *orchestrate care* were undermined not only because they found themselves in work environments with serious structural constraints but also because the meanings they assigned to their work served to constrain their agency. Privileging nursing knowledge based on practice experience over knowledge based on theory and research when facing practice challenges perpetuates the idea that time spent taking care of older adults is equal to knowledge about how to best take care of them (Brown et al., 2008; Flood & Clark, 2009; Ironside et al., 2010). In other words, the depth of nursing knowledge work required to care for elderly patients with complex health challenges is largely invisible and mostly unsupported by healthcare agencies.

STUDY LIMITATIONS

The theory of orchestrating care is limited because it does not include the perspectives of older adults and other healthcare professionals. Moreover, novice nurses' unique perspectives were not explored in-depth. A grounded theory study can highlight problems and sensitize health care providers and policy makers to the complexities of nurses' care for older adults but is not immediately generalizable to other settings.

IMPLICATIONS

The structural constraints of nurses' work environments contribute to their perceptions of limitations in enacting their agency in their nursing practice with hospitalized older adult patients. How nurses make meaning of the structural constrains they face influences their willingness to bring their practice challenges forward. Nurses have an important perspective that can improve practice and policy decisions and need to be encouraged to share their ideas. Administrators have a role to play in giving nurses

voice through involving them in workplace committees and in forums where they have opportunities to discuss their nursing practice, identify factors that interfere with their ability to provide maximal contributions to older adult care, and be reflexive about how their responses to challenges are contributing to their workload and the stigmatizing of older adults. Moreover, further research is needed to better understand how to facilitate the practice of nursing and multidisciplinary teams in the care of older adults.

CONCLUSIONS

The theory of orchestrating care has offered an explanation of the issues associated with nurses' efforts to manage care of hospitalized older adults. It has also highlighted the importance of nurses' roles in caring for this population. Thus, it is essential that nurses voice their practice challenges and leaders, educators, and policy analysts listen to nurses to collaboratively consider a way forward.

REFERENCES

Arbaje, A. I., Maron, D. D., Yu, Q., Wendel, V. I., Tanner, E., Boult, C., Eubank, K. J., and Durso, S. C. (2010). The geriatric floating interdisciplinary transition team. *Journal of the American Geriatrics Society*, 58, 364–370. doi: 10.1111/j.1532–5415.2009.02682

Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science, 30*(1), 81.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkley: University of California Press.

Boltz, M., Capezuti, E., Bowar-Ferres, S., Norman, R., Secic, M., Kim, H., … Fulmer, T. (2008). Hospital nurses' perception of the geriatric nurse practice environment. *Journal of Nursing Scholarship, 40*(3), 282–289. doi: 10.1111/j.1547–5069.2008.00239

Brown, J., Nolan, M., Davies, S., Nolan, J., and Keady, J. (2008). Transforming students' views of gerontological nursing: Realizing the potential of 'enriched' environments of learning and care: A multi-method longitudinal study. *International Journal of Nursing Studies, 45*(8), 1214–1232. doi:10.1016/j.ijnurstu.2007.07.002

Cheek, J., and Gibson, T. (2003). Issues impacting on registered nurses providing care to older people in an acute care setting. *Nursing Times Research, 8*(2), 134–149. doi: 10.1177/136140960300800207

Dahlke, S., and Phinney, A. (2008). Caring for hospitalized older adults at risk for delirium: The silent, unspoken piece of nursing practice. *Journal of Gerontological Nursing, 34*(6), 41–47.

Duffield, C., Roche, M., Diers, D., Catling-Paul, C., and Bay, N. (2010). Staffing, skill mix and the model of care. *Journal of Clinical Nursing, 19*, 2242–2251. doi:10.1111/j.1365–2702.2010.03225

Estabrooks, C. A. (2009). Mapping the research utilization field in nursing. *Canadian Journal of Nursing Research, 41*(1), 218–236.

Estabrooks, C. A. (2008). Renegotiating the social contract? The emergence of Knowledge Translation science. *Canadian Journal of Nursing Research, 40*(2), 11–15.

Evans, R. G. (2007). *Economic myths and political realities: The inequality agenda and the sustainability of medicare*. Department of Economics and Centre for Health Services and Policy Research, University of British Columbia. Retrieved May 26, 2009 from http://www.chspr.ubc.ca/node/791

Fedarko, N. S. (2011). The biology of aging and frailty. *Clinical Geriatric Medicine, 27*, 27–37. doi: 10.1016/j/cger.2010.08.006

Glaser, B. G. (1978). *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs forcing.* Mill Valley, CA: Sociology Press.

Glaser, B.G. (2001). *The grounded theory perspective: Conceptualization contrasted with description.* Mill Valley, CA: Sociology Press.

Glaser, B. G., and Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Mill Valley, CA: Sociology Press.

Goveia, T. (2009). Comparing notes on workload, patient care and the use of IT. *The Canadian Nurse, 105*(4), 24–29.

Graham, C. L., Ivey, S. L., and Neuhauser, L. (2009). From hospital to home: Assessing the transitional care needs of vulnerable seniors. *The Gerontologist, 49*(1), 23–33. doi: 10.1093/geront/gnp005

Hall, W. A., and Callery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research, 11*(2), 257–274. doi: 10.1177/104973201129119082

Harris, A., and McGillis Hall, L. (2012). *Evidence to inform staff mix decision-making: A focused literature review.* Ottawa: Canadian Nurses Association.

Hickman, L., Newton, P., Halcomb, E. J., Chang, E., and Davidson, P. (2007). Best practice interventions to improve the management of older people in acute care settings: A literature review. *Journal of Advanced Nursing, 60*(2), 113–126. doi: 10.1111/j.1365–2648.2007.04417

Higgins, I., Van Der Riet, P., Slater, L., and Peek, C. (2007). The negative attitudes of nurses towards older patients in the acute hospital setting: A qualitative descriptive study. *Contemporary Nurse, 26*(2), 225–237. doi: 10.5172/conu.2007.26.2.225

Ironside, P. M., Tagliareni, M. E., McLaughlin, B., King, E., and Mengel, A. (2010). Fostering geriatrics in associate degree nursing education: An assessment of current curricula and clinical experiences. *Journal of Nursing Education, 49*(5), 246–252. doi: 10.3928/0148434–2010002–01

Kim, H., Capezuti, E., Boltz, M., and Fairchild, S. (2009). The nursing practice environment and nurse-perceived quality of geriatric care in hospitals. *Western Journal of Nursing Research, 31,* 480–484. doi: 1177/0193945909331429

Kjorven, M., Rush, K., and Hole, R. (2011). A discursive exploration of the practices that shape and discipline nurses' responses to postoperative delirium. *Nursing Inquiry 18*(4), 325–335. doi: 10.1111/j.1440–1800.2011.00534x.Kirkpatrick, M. K. & Brown, S. (2004). Narrative pedagogy: Teaching geriatric content with stories and the "Make a difference" project. *Nursing Education Perspectives, 25*(4), 183–187.

Ludwick, R., Meehan, A., Zeller, R., and O'Toole, R. (2008). Safety work: Initiating, maintaining and terminating restraints. *Clinical Nurse Specialist, 22* (2). 81–87.

McGillis Hall, L., Doran, D., and Pink, L. (2008). Outcomes of interventions to improve hospital nursing work environments. *Journal of Nursing Administration, 38*(1), 40–46. doi: 10.1097/01.NNA.0000295631.72721.17

McKenzie, J. L., Blandford, A. A., Menec, V. H., Boltz, M., and Capequti, E. (2011). Hospital nurses' perceptions of the geriatric care environment in one Canadian health care region. *Journal of Nursing Scholarship, 43*(2), 181–187. doi: 10.1111/j.1547–5069.2011.01387.x

Mead, G. H. (1934). Works of George Herbert Mead (Vol. 1): Mind, self & society: From the standpoint of a social behaviorist. (C. W. Morris, Ed.). Chicago: The University of Chicago Press.

Musto, L., and Schreiber, R. S. (2012). Doing the best I can do: Moral distress in adolescent mental health nursing. *Issues in Mental Health Nursing, 33*, 137–144. doi: 10.3109/01612840.641069

Neville, S. (2008). Older people with delirium: Worthless and childlike. *International Journal of Nursing Practice, 14*(6), 463–469. doi: 10.1111/j.1440–172X.2008.00721

Newton, L., Storch, J. L., Makaroff, K. S., and Pauly, B. (2012). Stop the noise! From voice to silence. *Nursing Leadership, 25*(1), 90–104.

Peek, C., Higgins, I., Milson-Hawke, S., McMillan, M., and Harper, D. (2007). Towards innovation: The development of a person-centered model of care for older people in acute care. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 26*(2), 164–176.

Plavish, C., Brown-Salzman, K., Hersh, M., Shirk, M., and Rounkle, A. M. (2011). Nursing priorities, actions, and regrets for ethical situations in clinical practice. *Journal of Nursing Scholarship, 43*(4). 385–395.

Polit, D. F., and Hungler, B. P. (1991). *Nursing research: Principles and methods* (4th ed.). Philadelphia: Lippincott.

Rodney, P., Kadyschuck, S., Liaschenko, J., Brown, H., Musto, L., and Snyder, N. (2013). Moral agency: Relational connections and support. In J. Storch, P. Rodney, & R. Starzomski (Eds.). *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp160–187). Toronto: Pearson.

Rodney, P., and Varcoe, C. (2012). Constrained agency: The social structure of nurses' work. In F. Baylis, B. Hoffmaster, S. Sherwin, & K. Borgerson (Eds.), *Health care ethics in Canada* (pp. 97–114). Toronto, Canada: Nelson.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27–37.Schmalenberg, C., & Kramer, M. (2009). Perception of adequacy of staffing. *Critica*l *Care Nurse*, 29(5), 65–71. doi: 10.4037/ccn2009324

Schofield, I., Tolson, D.,and Fleming, V. (2012). How nurses understand and care for older people with delirium in the acute hospital: A critical discourse analysis. *Nursing Inquiry, 19*(2), 165–176. doi: 10.1111/j.1440-1800.2011.00554.x

Sellman, D. (2009). Ethical care for older persons in acute care settings. *Nursing Philosophy, 10*(2), 69–70. doi:10.1111/j.1466–769X.2009.00399

World Health Orgainization [WHO]. 2013. *Global Health and Aging*, author, retrieved November 20, 2013 from http://www.who.int/ageing/publications/global_health.pdf

Xiao, L. D., Paterson, J., Henderson, J., and Kelton, M. (2008). Gerontological education in undergraduate nursing programs: An Australian perspective. *Educational Gerontology, 34*, 763–781. doi:10.1080/03601270802016424