

ENACTING AND/OR RETREATING:

A THEORY OF REGISTERED NURSES' PRACTICE OF ACCOUNTABILITY

by

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ABSTRACT

In the current context of health care, the registered nurses' perception and enactment of accountability may be constrained by many factors out of their control. The purpose of this research was to examine how registered nurses perceive accountability and translate this to professional practice. A Grounded Theory approach was adopted to explore 11 registered nurses' understanding and experiences enacting accountability in clinical practice. Data were obtained through semi structured interviews. The theory that emerged provides a detailed portrait of the process of enacting and/or retreating from accountability. The process encompasses 4 stages where the registered nurses: develop personal understanding, then gain professional knowledge, find their way in the complex healthcare system and concludes with becoming professionally confident. The development of the stages exposed a multitude of challenges faced by the registered nurses in fulfilling accountability expectations. Importantly, the registered nurses' expended significant effort in finding a balance between their individual accountability and the collaborative accountability of the healthcare team and organization which contributed to retreating from accountability. The contextual factors of financial and human resources, institutional culture and healthcare system processes were found to contribute to the registered nurses enacting and/or retreating from accountability. The study findings illustrate the importance of ongoing reflective practice, mentorship and continuing education, all of which have implications for nursing educators and healthcare executives in preparing and supporting registered nurses' in practice. Further research on the concepts of this theory of accountability is needed to obtain a greater understanding of how the concepts can be operationalized within the context of current healthcare systems.

LIST OF ABBREVIATIONS USED

RN	Registered Nurse
PHSOR	Provincial Health Services Operational Review
CINAHL	Cumulative Index to Nursing and Allied Health Literature
ERIC	Education Resources Information Center
ICN	International Council of Nurses
CAN	Canadian Nurses Association
CRNNS	College of Registered Nurses of Nova Scotia
CST	Critical Social Theory
GT	Grounded Theory
CGT	Constructivist Grounded Theory
ICU	Intensive Care Unit
ER	Emergency Room
H1N1	Influenza A Virus Subtype
LPN	Licensed Practical Nurse
MOCINS	Model of Care Initiative in Nova Scotia
VAC	Vacuum Assisted Closure Device
PYXIS	Automated Medication Dispensing System

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CHAPTER I INTRODUCTION

Accountability in nursing is an integral part of professional nursing practice. Nurses make decisions in a variety of settings and circumstances each day to ensure that patients receive quality care. A professional nurse has the responsibility and accountability to practice within his/her scope of practice, calling upon his/her knowledge and skills to make decisions in the best interest of the patient and the organization (O'Rourke, 2006; Rowe, 2000; Snowdon & Rajacich, 1993).

Personal and professional learning experiences have enabled nurses to understand that accountability is a legal, ethical and moral obligation to patients, families and health care agencies in order to meet a standard of care and practice. Standards are defined, monitored and evaluated by regulating bodies and employing agencies. In the course of my practice, I have noted nurses increasingly fail to demonstrate accountability in their practice.

Background and Significance

Experience and observations in my practice and engaging in discussions among nurses has revealed that nurses increasingly believe final accountability lies collectively with healthcare agencies and physicians. The perception of individual accountability appears limited. This has significant implications in the delivery of quality care, limiting adverse outcomes in our health care system and the promotion of professional practice. Conversations among registered nurses are often laden with excuses for questionable decision making, and directing blame toward physicians or organizations as though they hold the final responsibility for care. Registered nurses need to be enacting their

individual accountability to deliver quality patient care, improve work environments and advance the profession of nursing by owning individual accountability (Nicklin, 2004). Nurses in our current healthcare system are confronted with the increased societal awareness of the needs and rights of every person to receive optimal healthcare. Patients and their families are more knowledgeable than ever before and seek to be involved in their care and to share in the decision making regarding care (Coulter, Parsons, & Askham, 2008).

Nurses are seeking ways to meet the challenges of providing individualized care, while dealing with the innovations and changes in models of care delivery and scopes of practice. Nurses are well placed to take a lead in sharing accountability with patients because they are involved in planning, managing and delivering patient care on a daily basis. The concept of accountability, if clearly understood can be enacted collaboratively to deliver individualised care and to adapt to innovations in practice and altered scopes of practice. Scopes of Practice, Standards of Care, and people centered care will be explained in the literature review.

In December of 2007, an Atlantic province released the document The Provincial Health Services Operational Review (PHSOR). The PHSOR team looked extensively at the healthcare system of the province and determined that the existing system was not sustainable without extensive transformation of all services, programs, facilities and systems. With an increased focus upon accountability as the solution to the healthcare crisis (Nicklin & McVeety, 2002), it is believed research conducted to better understand accountability will contribute to the changes being implemented in an Atlantic Canadian District Health Authority. The PHSOR report made 103 recommendations for ways the

province can transform the healthcare system. A new Collaborative Care Model for delivering acute care was one of those recommendations. The Collaborative Care Model was founded on the underlying premise that all care of patients and families is collaborative. Collaborators include the patients, family members and the interdisciplinary team. The role of collaborators is to contribute to the patients care as needed to ensure it is delivered in a safe and knowledgeable manner to achieve optimal outcomes. The Model focuses on four key areas where transformation must occur. The four areas are: People, Process, Information, and Technology. The two areas that would benefit most from this accountability study are people and process. With implementation of the Model, the Registered nurses' role will be optimized to become the patient care coordinator. With this change expanding role accountability becomes very important to understand. It is essential that Registered Nurses understand their individual accountability. For example how this may affect one's scope of practice. Secondly many processes within the healthcare system have been deemed inefficient and ineffective and limiting the achievement of optimal outcomes. By understanding the registered nurses operational role in collaborative accountability the province and districts will be better informed to make decisions about organizational changes.

Nationally, healthcare organizations have restructured and revised models of care with the intent to increase efficiency and effectiveness and the delivery of quality care. Changes in healthcare environments have led to the expectation that nurses be accountable in their practice (Nicklin, 2004). Accountability, as a concept, has been relatively well defined, but it has not been carefully studied by nurses within the

transformation of healthcare organizations to understand the operational use of the concept of nurses' individual accountability in clinical practice.

Today it is universally clear that there is no single source of accountability for patient care. Clearly all members of the health care team share in accountability of quality patient care delivery. The focus of this study will be on nurse accountability. The consideration of what accountability means in nursing practice is a key part of the foundation of nursing practice. According to the literature, accountability means being responsible and as a consequence taking blame when something goes wrong. Harber and Ball (2004) and Milton (2008) espouse that this approach to accountability reduces its scope and may lead to defensive nursing practice. A broader view of accountability is that it is an inherent confidence as a professional that allows a nurse to take pride in being transparent about decisions made in practice. In order to best understand the concept one must look at the four types of accountability that frame a nurses' practice: professional, ethical, legal and employment accountability.

Professional Accountability

Professional accountability is central to nursing practice. Nursing is based on promoting health and wellbeing of patients through accountable nursing practice. Professional accountability means nurses respect principles of conduct that maintain the patient's trust in the individual nurse and support for the nursing profession. Professional accountability is broad in scope encompassing traits from one's manner of dress, to bedside decision making. The cornerstone of nursing practice is the sacred trust patients place in the professional acting accountably (Rowe, 2000).

Ethical Accountability

Ethical values form part of nurses understanding and ability to operationalize accountability in clinical practice. These ethical values come from different sources. Society determines morality and what is acceptable ethical nursing practice. For example, society does not approve of nurses participation in active euthanasia. There are other areas of morality where society accepts that the practice may be approved, but recognizes that a nurse's own set of attitudes, values and beliefs may prevent their participation. For example, some nurses may find it unethical to counsel a patient contemplating a termination of a pregnancy. Attitudes, values and beliefs shape an individual's approach to nursing care. Being aware of these personal values and beliefs and how they developed will enable the nurse to be aware of possible conflicts that may arise surrounding accountability. Ethics form a significant part of accountability (Milton 2008; Snowdon & Rajacich, 1993).

Legal Accountability

The law is a major area of accountability for nursing practice. The law is a set of rules, regulations and cases that provide an interpretation of how to act in society. Two systems exist in Canada: civil law and criminal law. Both systems require accountability and citizens, including nurses, must have the understanding that there are penalties for failing to follow the rules set out by law. In law, nurses have accountability to the patient (civil law), to the public (criminal law), to the employer and to the profession (Wiseman, 2007).

Employment Accountability

Employers play an important role in accountability. This role is very complex and has significant implications for the individual nurse. Nursing interventions are linked and reviewed through professional, legal and ethical accountability criteria in the context of employment settings. Nurses need to have a sound understanding of agency policies and procedures, contractual agreements with unions, and occupational health and safety regulations in order to make knowledgeable and informed decisions (Deppoliti, 2008).

These four areas of accountability: professional, ethical, legal and employment are integral to the foundation of nursing practice. In order to frame practice it is essential for nurses to hold the knowledge and understanding that each area of accountability is inter-related and inter-dependent.

Professional nursing accountability is the central focus of this study because patient care outcomes rely upon nurses being answerable for the quality of care delivered (Savage & Moore, 2004; Nicklin, 2004). Little research exists about how nurses perceive, understand and enact accountability in practice.

Nurses hold a position of responsibility in which they are relied upon by other people and have an accountability to the public, professional licensing and regulating body, employers and the law for their actions. Performance excellence and enacting one's individual accountability is dependent upon the nurse's self confidence, along with self reflective and critical thinking abilities (Manojlovich, 2005). Nurses have a responsibility, accountability and answerability to deliver safe, knowledgeable and

effective care based on current evidence, best practice and validated research (CNA, 2005).

Nurses' perceived reluctance to exercise accountability may indicate that they are faced with confusion surrounding their individual accountability. Research to date provides limited insight into accountability, it is significantly lacking in how nurses understand and operationalize individual accountability.

Brown, Porcellato and Barnsley (2006) use the analogy of a suitcase to describe the concept of accountability. They state that in healthcare we know two things about this suitcase: the first is that it is very important, the second is that it is very challenging to unpack, evaluate and understand it's contents, and ultimately determine whether we have truly achieved how we might exercise accountability. "Understanding this information is the key content of the suitcase-information about expectations and performance being the life-blood of accountability-provides us with a lens to evaluate and compare accountability strategies" (Brown, Porcellato & Barnsley, 2006, p. 74).

Purpose of Study

The purpose of this Grounded Theory study was to generate a substantive explanation of how nurses working in acute care settings perceived and understood individual accountability in nursing practice. The results of this study are important to all nurses in all areas of practice, senior health care administrators in planning the delivery of patient care and educators who prepare future nurses for practice. This knowledge can be used by practice environments to maximize accountability and, by educational settings and regulating bodies to develop learning programs and competencies specific to

accountability (Besner, 2006; Nicklin, 2004; Rowe, 2000; Savage & Moore, 2004). This explanation is vital to all involved in the delivery of quality patient care, and curricula development in nursing education programs.

Research Question

What are nurses' perceptions and understanding of individual accountability in the acute care sector of clinical practice? Study objectives were: to explore how nurses defined accountability; individual accountability; how nurses learned and understood the concept of accountability; to whom did nurses believe they were accountable; and how nurses demonstrated accountability in their practice. The goal of this qualitative study was to describe and explain what individual accountability meant to the participants.

CHAPTER II REVIEW OF THE LITERATURE

A critical review of the research regarding nurses' perceptions of individual accountability in clinical practice is presented in this chapter. The aim of this review was to understand the current evidence and the gaps in the understanding of how nurses' perceive and enact their individual accountability in clinical practice. The CINAHL, MEDLine, PubMed, ERIC and Sociological Abstracts databases were reviewed using the search terms: *accountability, nurse, clinical practice, quality care, professional practice*. This chapter will begin by exploring definitions of accountability and establishing the definition to be used in this study. In conjunction, Statements of Accountability, Standards of Practice, and Standards of Care will be explored in relation to accountability. The concept of accountability will be reviewed in healthcare literature in the context of the individual nurse and collaboratively with healthcare systems, agencies and interdisciplinary teams. The chapter will conclude with a summary of the evidence, the gaps in the literature, and the rationale for the research study.

Defining Accountability

The discussion about accountability in nursing is wide spread. It is considered to be one of the central concepts in professional nursing practice. The review of the literature surrounding accountability indicates it is a concept that has been discussed since Florence Nightingale and the inception of nursing (Rowe, 2000). The historical and current literature is saturated with definitions of accountability, however the challenge of understanding how accountability is perceived understood and enacted prevail throughout nursing's history (Savage & Moore, 2004). In the literature, accountability definitions

generally center around the four types previously described: professional, ethical, legal and employment accountabilities.

Brown, Porcellato and Barnsley (2006) define accountability through the means used. For example those interested in legal accountability definitions will focus on the punitive and lay blame. They do point out that more recently the literature suggests accountability is seen as a relationship and a way to deliver quality care. Degeling (2000) defines “accountability in terms of the functions that it is claimed to perform and the benefits that are claimed for its existence” (p. 4).

Savage and Moore (2004) in their study found the meaning of the word accountability to be elusive and ambiguous variously linked with retrospective analysis of practice, a way of apportioning blame but also as something that promotes good practice and professionalization. With this amorphous definition it is perhaps understandable that nurses struggle with the operational use of the concept in clinical practice. This research also suggested that accountability for making decisions appeared to rest with the person with the most expertise; however, practice protocols were seen as limiting the accountability of nurses in comparison to their practice partners.

Snowdon and Rajacich (1993) described accountability in terms of an interrelationship between responsibility, autonomy and authority. Milton (2008) defined accountability from a societal view that it is a concept that is an essential element in quality healthcare. It is associated with a pluralistic expectation that patients are articulating their needs and want a less paternalistic and authoritative healthcare system.

The word accountability is difficult to define because it is an ethical concept often used synonymously with other concepts such as answerability, autonomy, responsibility, blameworthiness, liability or in terms of the expectation of account-giving. With the use of these terms occurring interchangeably it creates confusion and ambiguity. In nursing, accountability is linked with clinicians having individual responsibility for keeping themselves current, knowledgeable and competent in all aspects of their work. The commonality found in the definitions of accountability is being answerable for one's decisions (Milton, 2008; Savage & Moore, 2004; Snowdon & Rajacich, 1993).

The current literature surrounding the concept revealed that the understanding of accountability among registered nurses is ambiguous (Brown, Porcellato & Barnsley, 2006; Savage & Moore, 2004). The literature was also laden with a host of vague musings about accountability and varying theories that assume nursing's understanding and the operationalization of their individual accountability (Brown, Porcellato, Barnsley, 2006; Bry, Stettner, & Marks, 2006; Nicklin, 2004; O'Rourke, 2006; Rowe, 2006; Savage & Moore, 2004; Snowdon, & Rajacich, 1993).

For the purpose of this study accountability was defined as being responsible and answerable for actions or inactions of self in the context of providing quality patient care. In addition to definitions of accountability a number of professional organizations and associations have position statements on accountability. These are not definitions but rather statements about accountability.

Statements of Accountability

The International Council of Nurses (ICN, 2006) Code of Ethics espouses that a nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. “The Canadian Nurses Association’s *Code of Ethics* for Registered Nurses is a statement of the ethical values of nurses and of nurses’ commitments to persons with health care needs and persons receiving care” (CNA, 2008, p.5). The code serves as a basis for ethical practice and states “Nurses are accountable for these ethical responsibilities in their professional relationships with individuals, families, groups, populations, communities and colleagues” (CNA, 2008, p.6).

The College of Registered Nurses of Nova Scotia (CRNNS) under the provincial legislation of the *Registered Nurses Act* is responsible for protecting the public. The College achieves this mandate by promoting good practice, and intervening when practice is unacceptable. Each provincial regulatory body, such as the CRNNS, establishes and maintains the standards for nursing practice that registered nurses must meet in their day-to-day practice to ensure the delivery of safe, ethical and competent nursing care (CRNNS, 2003). On a day-to-day basis, registered nurses are expected to meet their standards for nursing practice. They are held accountable and responsible for making decisions that are consistent with safe, effective and ethical practice.

Clearly international, national and provincial regulatory agencies assign responsibility and accountability for professional nursing practice through regulations that include broad yet legally binding statements for the scope and standards of

professional nursing practice. In order to be accountable nurses' act under these standards and codes of ethical conduct that are grounded in philosophical principles of fidelity and respect for the dignity, worth and self determination of people (Milton, 2008). Despite these regulating agencies guiding nurses practice surrounding accountability challenges prevail.

Accountability is cited in accordance with international, national and specialty nursing organizations' codes of ethics and professional scope and standards of practice. International and national codes of ethics and provincial professional standards of practice statements incorporate the concept of accountability. The emphasis in all the documents of accountability is placed on the individual nurse.

Standards of Practice

Nursing is a self-regulating profession, meaning that the provincial or territorial governments delegate to the nursing profession, by statute, the power to regulate itself in the interest of the public. Standards are necessary to demonstrate to the public, and other stakeholders that as a profession nursing is dedicated to maintaining public trust and upholding the criteria of its professional practice. One of the characteristics of a self-regulating profession is the development of standards of practice, based on the values of the profession. For nurses in Canada, these values are articulated in the Code of Ethics for Registered Nurses. Regulatory bodies for nursing have the legal requirement to set standards of practice for registered nurses to protect the public in their province or territory. Together, the code of ethics and standards provide the basis for nursing practice in Canada. Therefore, the provincial and territorial regulatory bodies establish, monitor

and enforce standards of professional practice and conduct. Standards of Practice enable nurses to promote safe, competent and ethical practice (CNA, 2003; CRNNS 2003).

Scope of practice is a term used by licensing and regulating bodies of a profession that defines the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency. Each province has laws, licensing bodies, and regulations that describe requirements for education and training, and define scope of practice (CNA, 2003; CRNNS, 2003).

Nurses both registered and licensed, physicians, pharmacists and other health professionals are recognized in the literature to be key components in the sustainability of the healthcare system. Scopes of practice are important issues that need to be addressed in terms of healthcare sustainability. A review and analysis of nursing scopes of practice will promote a more efficient delivery of care (Villeneuve, & MacDonald, 2006). The primary purpose of changing scopes of practice is to meet the healthcare needs, serve the interests of patients and the public safely, efficiently and competently. Scope of practice should reflect the degree of accountability, responsibility and authority that the healthcare provider assumes for the outcome of his or her practice.

Kelly's (2004) article suggested that nursing Standards of Practice and Scopes of Practice are vague and shallow and do not allow for nurses expanding roles and the accountabilities in addressing healthcare challenges. She writes that critical care nurses have actively sought autonomy and the associated accountability to practice medical duties. However in this drive to enlarge scopes of practice they have found that their

legal standards of practice and care are held to that of a physician. She concludes “In essence the nursing profession needs to be clear about its professional standards and values and share in the collaboration and interprofessional work to address healthcare challenges” (Kelly, 2004, p.36). Quality healthcare can then be delivered by accountable nurses, physicians and an interdisciplinary team working purposively yet synergistically.

The changes in scope of practice of the registered nurse must be made on the strength of the best evidence and the impact on patients, and not driven by human resource shortages. One example of this is the Pharyngitis Delegated Medical Function policy that was adopted within a Health Authority in Atlantic Canada permitting nurses to assess, treat and discharge patients with low acuity sore throats from the emergency room without seeing a physician (Houk, & Macdonald, 2008).

Standards of Care

The care provided by nurses is guided by standards of care. Standards of care are developed and implemented to define the quality of care provided. These standards communicate the expectations of nurses in similar situations but also promote accountability for the nursing care provided. Nursing standards of care are developed at a national, provincial and agency level.

Nurses operationalize the standards of care by the delivery of patient centered care, the administering of physician orders, and by following employing agency policy and procedures. Nurses have numerous individual responsibilities in regards to nursing care that include monitoring patients, completing nursing assessments and interventions, the documentation and recording of the patient’s care, and communication with the

interdisciplinary team. Negligence may occur if a nurse fails to follow the standards of care. Nurses are held accountable for providing care that is reflective of the Code of Ethics, Standards of Practice and Standards of Care.

Individual Accountability

In the Code of Ethics and position statements of Professional Regulatory bodies accountability for behaviour co-exists with autonomy. Individual professional autonomy was defined by MacDonald (2002) as the understanding that a nurse has a right and responsibility as a member of the profession to act according to the Standards of Practice and Standards of Care. This autonomy means a nurse has the authority and knowledge to be independent of medical and employer expertise. For example, a nurse may know more about current best practice regarding wound care management than physicians. When a physician's order or an agency policy conflicts with nursing standards the nurse's autonomy and accountability implies a right to object. Autonomy is the right of professional self-regulation and having control over ones function in the work place. Accountability is the responsibility of answering to this control.

An accountable individual is prepared to explain and to receive credit or blame for results of decisions made. In my previous experiences many nurses wanted credit for being accountable and responsible but often stopped short of accepting responsibility for decisions made. A nurse uses the Codes of Ethics as a guideline for practice and in turn must accept the individual responsibility and accountability for the results of judgements and actions. Individual nurses articulating and acting upon professional values associated

with accountability is essential for the discipline of nursing, in order to fortify and enhance integrity and trust with one another, communities and society as a whole.

Accountability is recognized as a multidimensional, complex, and even problematic concept and requires further examination from a nursing perspective (Savage & Moore, 2004). Nurses must engage in self reflection about their practice routines and the individual accountability and responsibilities associated with patient care. The development of a nurse centered approach to an accountability model that fits with current models of care delivery would demand nurses to constantly reassess, and engage in self-reflection to improve their practice (Savage & Moore, 2004). This would involve the nurse developing their own personal theory of his/her own practice, bringing together personal, experiential and scientific knowledge and with which improvements to practice can be initiated (Deppolitti, 2008).

Brown, Porcellato and Barnsley (2006) discussed accountability as the suitcase in healthcare, “we pack accountability with meaning, carry it around with us and open it to explain everything from the quality of our relationships with and expectations of one another, to our requirements for more transparency in the use of resources, to our diagnosis of problems and remedies for improving our healthcare system” (p.72). The healthcare literature that includes nursing, is well versed in this practice of popularizing concepts without completely understanding or evaluating them through sound research. For example, there is a large volume of literature on the concepts of caring, autonomy and collaborative practice, yet how healthcare professionals employ these concepts remains elusive (Savage & Moore, 2004). Milton (2006) called for nurses to self-reflect on their practice routines believing that personal accountability and responsibilities

associated with quality patient care will result. Individual accountability does not stand independently in nursing practice, collaborative accountability is also a responsibility in maintaining a quality healthcare system.

Collaborative Accountability

Accountability in healthcare is viewed as essential. How accountability is enacted is not well understood or explained therefore the enacting of accountability becomes clouded for nurses and other members of the healthcare team. The ambiguity surrounding accountability that exists at the bedside with the individual nurse is also perpetuated at other levels of the organization.

As patient care needs continue to increase in complexity in acute care patient settings and nurse's scope of practice evolves to keep pace with these changing demands, it is imperative that models of care foster individual and collaborative accountability in practice (LeClerc, Doyon, Gravelle, Hall, & Rousell, 2008). This paper described how the Autonomous-Collaborative Care Model fosters autonomy and accountability in nursing practice. Nursing care delivery models are mechanisms for organizing and delivering nursing care. They focus on structure, process, outcomes or some combination of these. The Autonomous-Collaborative Care Model is based on the premise that patient care assignments are related to the scope of practice of each nurse. Within this model of care registered nurses, licensed practical nurses and personal care workers work collaboratively and are individually accountable for the care they each provide. Collaborative accountability in practice is sharing in the planning, decision making,

problem solving and goal setting within the healthcare team for the delivery of quality care.

Collective accountability was found to be positively correlated with work effectiveness. Laschinger, Shamian, and Thomson (2001) examined work environments that fostered professional practice by specifically examining the effect of magnet characteristics on the effect of collective accountability. Magnet hospital research has shown that nurses are attracted to hospitals that promote: autonomy and accountability, control over the practice environment and good nurse/physician relationships. It is known that Magnet Hospital characteristics are related to: low burnout, higher job satisfaction, lower mortality, higher patient satisfaction (Aiken, Clarke, & Sloane, 2002). The high financial cost associated with implementing the strategies required to address the types of organizational social structures that promote these characteristics has limited their adoption in Canada.

Deppoliti's (2008) research explored and identified that new (defined as having less than 3 years experience) registered nurses are challenged with an overwhelming sense of responsibility and accountability in practice. Clearly educational institutions and employing agencies must assume responsibility in preparing nurses for practice. Understanding how nurses learn and exercise accountability will help both educational and employing agencies to better fulfill this responsibility.

No literature was found that explained how nurses learn to be accountable, how nurses defined accountability, and how to practice accountably. The literature also indicated that accountability is a solution to the problems in healthcare whereby

increasing nursing accountability there will be a reduction in the potential for adverse events (Bry, Stettner, & Marks, 2006; Nicklin, 2004; Savage & Moore, 2004). With this concept not well defined and articulated, nurses' contribution to solutions is limited. The need for understanding and strengthening accountability is central to the future of healthcare and the professional practice of nurses.

Accountability requires the integration of personal and professional self-understanding and the responsibility for one's actions and decisions. The nature of professional accountability obligations has shifted towards accountability based on health care system surveillance and rules (Degenling, 2000). Nurses and other health professionals are confronted with expanding health care system requirements to provide more with less, while continuing to be obligated to meet standards of practice stipulated by regulating bodies. For example the explicit requirements for evidence based and patient centered care. The increasing requirement by employing agencies to use evidence based research to frame care is central to collaborative individual accountabilities. This is reflective of nurses' facing increasing individual accountability obligations.

Nurses have been increasingly required to work within a much more extensive accountability framework to balance clinical autonomy in providing quality care with transparent accountability. New and senior nurses are not being prepared for these transitions (Deppolitti, 2008). This expanded accountability is accompanied by financial restraints, increased recognition of patient involvement and a greater emphasis on the professionalization of nursing (Villeneuve, & MacDonald, 2006). For nurses, current accountability obligations are more extensive than the degree of autonomy they are permitted to exercise (Savage & Moore, 2004).

Financial restraints have resulted in organizational restructuring and have created healthcare environments that are laced with stress and mistrust. Patient involvement with care has increased over the last decade with access to medical information over the World Wide Web. This easy access to medical information has created a culture of patients and their families wanting to share in decisions about care modalities. The continual emphasis and push on the professionalization of nursing in tumultuous healthcare environments creates added confusion to the nurses' individual and collaborative accountability.

George (2003) determined that attention needed to be paid to understanding how accountability currently exists in healthcare and how efforts to improve accountability would benefit patient outcomes. The paper focused on the accountability mechanisms in healthcare and how they mediate between service providers and communities and between different kinds of health personnel at the primary healthcare level. This work exposed the complexity of the concept of accountability as well as the influence of context on enacting accountability while working with the public and health care providers to improve sexual health in rural India. She explained this complexity through power imbalances in hierarchal environments, limited public participation and the challenge of engaging health care professionals. George (2004) concluded that having the necessary information, discussion, and negotiation were necessary elements of accountability. In addition to this organizational and social structures must be such that power gradients are minimized to permit those involved to exercise their respective accountability. Collaborative accountability measures required those involved in decision making and policy development be open to the changes they bring.

Professional autonomy is clearly valued by nurses, but must be matched by a clear understanding of professional accountability (Deppolitti, 2008). Stewart, Stansfield, and Tapp (2004) found that nurses' autonomy was diminished when nurses' knowledge, skills, and expertise were not recognized or valued. The recognition and valuing of nurses' knowledge, skills and expertise are characteristics of Magnet Hospitals.

Wade (1999) writes "professional nurse autonomy is defined as belief in the centrality of the patient when making responsible discretionary decisions, both independently and interdependently, that reflect advocacy for the patient. Critical attributes included caring, affiliative relationships with patients, responsible discretionary decision making, collegial interdependence, and proactive advocacy for patients" (p.310). Accountability is viewed as the the primary consequence of professional nurse autonomy. Her work links empowerment and autonomy that lead to job satisfaction, commitment to the profession, and the professionalization of nursing.

Macdonald's (2002) work suggested that individual and professional autonomy is socially constructed and the capacity and opportunity for autonomous action was dependent upon particular social relationships and the power structures where nurses are embedded. The ability to exercise one's autonomy depends on social relations and social institutions and should therefore be understood as relational. All the literature supports that accountability co-exists with autonomy.

Harber and Ball (2004) called for redefining of the concept and process of accountability. They argued that the process is focused on blame and avoidance rather than on individual accountability for the delivery of safe quality care. The literature

suggests that the majority of adverse events occur because of flawed systems and processes. The exploration of accountability within health care systems may contribute to exposing nurses experiences in systems that do not necessarily support the autonomy necessary for accountability in practice.

Besner (2006) supported this through her research in stating that the development of an accountability framework will link scopes of practice, role functions and outcomes that nurses are responsible and held accountable for. “The development of an accountability framework that links nurses scope of practice to their health promoting role functions and to the outcomes for which they are held accountable provides a mechanism for identifying actions that can be taken by nurses and others to help strengthen our health system” (p289). Literature searches did not reveal any nursing accountability frameworks.

Summary of Evidence

In only a small number of studies have accountability processes been examined. There is no research that specifically addresses nurses understanding and perceptions of individual accountability in clinical practice. All the literature, recommends that strengthening the concept of accountability is central to the future of nursing and healthcare (Brown, Porcellato, & Barnsley, 2006; Bry, Stettner, & Marks, 2006; Deppolitti, 2008; Harber & Ball,2004; Laschinger, Shamian, & Thomson, 2001; Milton, 2006; Nicklin, 2004; O’Rourke, 2006; Rowe, 2006; Savage & Moore, 2004) .

Milton (2008) concluded the nursing Code of Ethics, Standards of practice, and Standards of care speak to the necessity of individual and collaborative accountabilities.

Despite the existence of these documents a gap exists in the enactment of this concept, she concluded self reflection is the key to address this gap. In contrast Kelly (2004) argued that these documents do not reflect and support nurses roles through accelerated changes and unprecedented healthcare challenges.

Brown, Porcellato and Barnsley's (2006) work concluded that before we can address the healthcare crisis using accountability, health care professionals need to understand each others accountabilities and have transparent processes that evaluate these accountabilities. Besner (2006) and Wiseman (2007) suggested that the development of an accountability framework would better position nurses, other healthcare professionals, employing agencies and policy makers to address health care challenges using this concept.

Overall the literature focused on how nurses must be accountable in their practice with little relevant literature that explored nurse's views of accountability and how they come to understand professional accountability. The literature suggested that if you want to improve the standard of care then you must first improve the standards of practice. Improving the standard of practice and promoting safe quality care is based on one's understanding of professional role authority, responsibility and accountability (Nicklin, 2004; O'Rourke, 2006; Rowe, 2006; Savage & Moore, 2004).

In summary, the investigations in which accountability was specifically examined have yielded limited insight into how nurses enacted their accountability obligations. By exploring individual nurses' perceptions of their accountability in clinical practice these results can contribute to nursing's existing body of knowledge as well as creating the

potential to change educational curriculums, bedside practice and organizational structures.

Gaps in the Literature

Despite longstanding claims to the centrality of accountability to nursing practice in both the literature and the code of ethics little is known about how nurses perceive and enact accountability. This gap in the literature and nursing knowledge demonstrated the need for research. The knowledge generated from this research will contribute to the continuing evolution of the nursing profession and improved patient outcomes.

CHAPTER III METHODOLOGY AND METHODS

Philosophical and Theoretical Perspective

The researcher's ontological and epistemological position need to be compatible with the methodology. Researchers choose a research paradigm that is congruent with their beliefs about the nature of reality and knowledge. "We are all influenced by our history and cultural context, which, in turn, shape our view of the world, the forces of creation, and the meaning of truth" (Mills, Bonner & Francis, 2006, p.3). Individuals who deny the existence of an objective reality assume a relativist ontological position (Guba & Lincoln, 1989).

Constructivism

Constructivism is a philosophical stance that denies the existence of an objective reality, " asserting instead that realities are social constructions of the mind, and that there exist as many such constructions as there are individuals (although clearly many constructions will be shared)" (Guba & Lincoln, 1989, p.43). A constructivist approach requires: "the creation of a sense of reciprocity between participants and the researcher in the co-construction of meaning and ultimately, a theory that is grounded in the participants' and researcher's experiences. Secondly, it requires the establishment of relationships with participants that recognize power imbalances and attempts to modify these imbalances. Thirdly it necessitates, the clarification of the position the author takes in the text, the relevance of biography and how one renders participants' stories into and through writing" (Mills, Bonner, & Francis, 2006, p.9).

Epistemologically, constructivists believe that it is impossible to separate the researcher from the concept being studied. “It is precisely this interaction that creates the data, that will emerge from the inquiry” (Guba & Lincoln, 1989, p.43).

Critical Social Theory

Critical Social Theory (CST) is the lens that will be used to inform the study methodology. CST is a means to frame an inquiry, with the aim of liberating groups from constraints that interfere with balanced participation (Freire, 1990). CST can be traced back to the Frankfurt School of Germany in the 1920’s and was inspired by critical Marxist philosophy. The prevailing assumption of the critical social paradigm is that knowledge ought not to be generated for its own sake but should be used as a form of social or cultural criticism. (Kincheloe & McLaren, 2005).

“ CST is concerned in particular with issues of power and justice and the ways that the economy; matters of race, class, and gender; ideologies; discourses; education; religion and other social institutions; and cultural dynamics interact to construct a social system” (Kincheloe & McLaren, 2005, p. 306). The use of CST for research purposes is based on the assumption that people are capable of self-reflection and that people have a basic need to act independently. Freire (1990) defined praxis as the process of reflection that enables us to understand the world in which we practice. This in turn allows us to make sense of ourselves, what we experience and how we act. Carr (1996) believed that the process of reflection is central to the evolution of nursing knowledge.

Critical social theorists believe that the insistence on scientific objectivity as the sole mediator of rational thought invalidates human perceptions and experiences (Boychuk Duchscher, 2000). CST maintains that knowledge as truth is socially constructed and that the facts are only relevant in the lived experiences. In the context of nursing, CST helped illuminate the concept of accountability in different social situations, among nurses, and between nurses and patients, and within the interdisciplinary team.

CST has been used in nursing studies to describe the power assumed by nurses, their self development, and education. Mooney & Nolan (2006) discussed how CST in nursing education can assist by creating a context whereby reflection and action can impact practice. Nurses must learn to question, understand and come to terms with their position in order to be accountable and act on behalf of themselves, patients and organizations. As discussed by Browne (2000) the use of CST is increasingly used in nursing inquiry to frame studies to uncover the fundamental ideologies upon which nursing knowledge is developed. Accountability is socially constructed and a fundamental ideology of professional nursing practice and CST helped to inform this exploration of nurses' perceptions of this concept. The importance of reflective practice, is evident in the study findings and is a core element in the critical social theory approach.

CST is explicitly definable, which is useful in studying concepts that are less discernable (Kuokkanen, & Leini-Kilpi, 2000). As discussed previously, in nursing,

accountability is an ambiguous concept and this work benefitted from the well outlined and mature view through a CST lens.

CST was used in numerous studies that looked at African American healthcare needs. Boutian (1999) found that using a CST approach to science was very beneficial in identifying marginalized population needs. A CST lens was also used in a study by Malone (2006) in looking at nursing's role in tobacco control and identified that smoking is a socio-political issue and the focus needs to move away from the individual. Boychuk Duchscher's (2000) work found the benefit's of using a CST framework in nursing education. CST applied to nursing education provided students and faculty an opportunity to share a revisioning and reconstruction of current educational ideologies which are potentially oppressive and coercive to the successes of today's student entering challenging healthcare environments.

In qualitative research, the investigator is responsible for declaring personal assumptions and notions that may influence the research process. I chose to explore nurses' perceptions of accountability because I have seen its significance in my practice. I have not attempted to portray myself as objective or neutral and I believe there are multiple realities.

I was interviewed so I would have the opportunity to have a first hand experience with the interview process. I was interviewed by a skilled nurse interviewer/researcher with extensive knowledge of Constructivist Grounded Theory. I entered into this process with assumptions and personal and professional beliefs and examined and explored these before engaging in the research process. I contacted Dr Kathy Charmaz, a Sociologist

and founder of Constructivist Grounded Theory Methodology, who very much favoured this approach and indicated it was a “novel plan”. Dr Phyllis Stern, a Nurse Researcher and Grounded Theory expert, was also contacted and she too supported this approach to aide in learning and uncovering biases. As the principal investigator I wanted to understand and explore my own biases before undertaking the interviews with participants. These biases and beliefs were recorded so throughout the research process I was able to refer back to these notes. Once the analysis of data began, I compared the analysis with previously recorded biases and beliefs to determine if these were guiding the analysis rather than attending to the perspectives of the participants. The information gathered from my interview was not be used as data. My biases, assumptions and beliefs were exposed and to the best of my knowledge were considered throughout the research process to see if they were driving it or co-constructing it. The information gathered during my interview was used for my own learning. This strategy is consistent with addressing the trustworthiness and the reflexive stance of me as the researcher.

In the search for a research methodology and theoretical lens that provided an ontological and epistemological fit with my philosophical beliefs, I was drawn toward constructivism and CST. Constructivist/G.T. methodology and methods guided this study. I used the interactive relationship between myself as the researcher and the nurses as the participants in this study while exploring the concept of individual accountability.

Grounded Theory Methodology

In research paradigms Grounded Theory has a dual meaning. For some it is a popular methodology in qualitative research and to others it is a scientific research

approach that is quantifiable. The common threads are, firstly that it is an orientation toward theory development and secondly that it is used to explore the social processes that are present within human interactions. Lastly in both domains it is referred to as the constant comparative method.

The roots of grounded theory can be found in the interpretive tradition of symbolic interactionism. “Symbolic interactionism directs grounded theorists to assume that meaning is made and constantly changed through interaction and becomes embedded in social context” (Wuest, 2007). “ The term ‘symbolic interactionism’ was invented by Blumer (1937) and his development of the interactionist approach together with naturalistic inquiry is a key influence on grounded theory” (Heath & Cowley, 2004, p.141).

Grounded theory as a qualitative method is a form of field research in the post positivist paradigm. Field research refers to a qualitative research approach that explores and describes phenomena or concepts in naturalistic settings such as hospitals, clinics or long term care facilities. Grounded theory as a scientific methodological approach is positioned in a positivist paradigm. According to Glaser (2004) this approach becomes problematic when mixed with qualitative descriptive analysis because it creates confusion as the fundamentals of each approach do not blend.

In both paradigms, the method systematically applies specific procedural steps to ultimately develop a grounded theory, or theoretically complete an explanation about a particular concept or phenomena (Benoliel, 1996). Theory is allowed to emerge from data and is ultimately tested and grounded against the real world.

Origin of Grounded Theory

Barney Glaser and Anselm Strauss are the founders of Grounded Theory which is based on the frameworks they used in their work with dying patients. Glaser and Strauss (1967) developed the method and published the first text addressing the method issues: *The Discovery of Grounded Theory*. The nature of Grounded Theory is contentious due to differences that grew between Glaser and Strauss who were the co-authors of the original and seminal text *The Discovery of Grounded Theory* published in 1967. Both argued for theory that was grounded, generated and developed progressively through interaction with the data. The approach at the time was seen as revolutionary because it challenged the dominant quantitative model in social science research both in terms of its artificial divisions between theory and research and in the inferior role assigned to qualitative research (Charmaz, 2000, p. 511).

Glaser is a quantitative researcher and claims no ontological or epistemological stance. He espouses that he works from an objectivist position and that all is data and that Grounded Theory not be considered a qualitative methodology. He argues that when Grounded Theory procedures are intertwined with qualitative data analysis methodology Grounded Theory becomes distorted obscuring any knowledge generation (Glaser, 2004). After the publication of *The Discovery of Grounded Theory* Glaser and Strauss worked separately. Glaser developed the theoretical side of grounded theory in his 1978 book *Theoretical Sensitivity*, while Strauss developed a more hands on approach (Charmaz, 2000). The objective of Classic Grounded Theory method is the discovery of middle

range theories using a systematic set of data collection and analytic features (Glaser & Strauss, 1967).

The differences between the two can be summarized by saying that Glaserian or Classic Grounded Theory comes from a purist approach in rigorous positivist traditions. The expectation is that an open attitude to the research occurs where the investigator is professionally naive and allows theory generation to occur naturally and directly from the data and is not compromised by the investigator's values, attitudes and beliefs. In contrast Strauss's Grounded Theory could be described as a pragmatic approach with a more structured attitude to theory building with a prescribed use of analytical tools and guiding principles and a relativist position. Strauss's approach to Grounded Theory altered over time and this was captured in his books written with Juliet Corbin (1998 & 2008). Strauss and Corbin's position assumes an external reality that requires the researcher to maintain objectivity while recognizing bias.

Glaser's (2004) publication *Remodelling Grounded Theory* demonstrates subtle changes in his original ideology and is viewed by Wuest (2007) as a typical shift in thinking that is related to a changing social context that occurs normally over time. A second generation of Grounded Theory developed with Kathy Charmaz's constructivist interpretation, drawn more from the original writings of Glaser and Strauss than the later writings of Corbin and Strauss. The results have been that Grounded Theory has emerged as an analytical tool which combines Glaser's deductive attitude toward data analysis, with Strauss's inductive methods and Charmaz's position of multiple realities that arise from an interactive process.

This methodological approach to Grounded Theory provides a guideline for the investigation of human experiences with the intent of developing explanatory frameworks that specify relationships among concepts (Charmaz, 2000). Charmaz (2006) accepted Glaser's and Strauss's (1967) invitation to use Grounded Theory flexibly. She views Grounded Theory methods as a set of principles and not prescriptive methodological rules. She espouses that the principles may be adapted to each study.

Grounded Theory has evolved into three approaches to building theory grounded in the data. Since its initial development Grounded Theory has diversified. In research studies, such adaptations to the methodology are generally acknowledged by the investigator.

Good qualitative research is ultimately relational and relative to the interests and values of various communities of knowledge users and producers. The usefulness of qualitative research comes from this relational context and the utility of results (Sandelowski, 1997). Nurses' perceptions of individual accountability is a socially constructed process and is best approached using Constructivist Grounded Theory to engage participants and to generate a substantive explanation of the process of how nurses perceived and exercised accountability.

I situate my self in a constructivist paradigm with a CST lens, grounded theory was selected because of its utility in generating concepts to form a theory that explains the process surrounding nurses practice of accountability. Grounded Theory allows the interpretivist social researcher's social construction of meaning to be articulated in a way that a description of social facts or observations seem to emerge. Grounded Theory

conducted within a constructivist framework seeks to theorize the socio-cultural contexts, and structural conditions that enable the individual accounts that are provided. This approach has complemented the belief that accountability is socially constructed and allowed for the nurses' realities to be explored.

Methods

Data Collection

Data collection methods are the structured or unstructured processes of gathering information from participants about the phenomenon being studied (Creswell, 2007). The decision about what type of data collection methods to be used was guided by the researcher's question along with my worldview and philosophical and theoretical position. The data collection methods used for this study included semi-structured interviews, along with field notes and the researcher's journal accounts. The following outlines how the recruitment, sampling, interviewing and the field notes and researcher journal were used for data collection.

Recruitment.

Nurses working in acute care units at a tertiary care centre in Atlantic Canada were targeted to participate in the study. Participants were primarily bedside clinicians, but clinical leaders and middle level managers were included to add representativeness to nurses working in acute care. Inclusion criteria included that participants be registered to work as a nurse in the study settings and be currently employed in acute care. Participants were fluent in English, held a diploma, or a baccalaureate in nursing and

were male and female. All the research participants joined the study voluntarily. Exclusion criteria were those nurses who have been practicing for less than one year. This decision was made because of role uncertainty and a transitional phase new graduate nurses are faced with.

Participants were recruited through an advertising poster on the hospital bulletin boards, a notification on the hospital employee website, registered nurse email list serve and a letter mail out to all directors, unit managers and educators in the hospital settings (Appendix A). Once the potential participants expressed interest in the study they were sent a letter (Appendix B) which provided an overview of the study, the research purpose, and what would be expected of participants.

Sampling.

The initial participants were self identified and contacted the investigator expressing their interest and then willingness to participate in the study. The technique of convenience sampling was used to identify these first three participants. A convenience sample chooses the individuals that are easiest to reach or sampling that is easily done. Convenience sampling does not represent the entire population so it can be considered biased. This approach was then followed by maximum variation sampling also called a maximum diversity sample or maximum heterogeneity sample which is a special type of purposive sampling. Purposive sampling was used to deliberately interview nurses with varied experience and education, and who were considered knowledgeable about accountability. Sampling resulted in the recruitment of self identified male and female

participants, diploma, baccalaureate and masters prepared who had been practicing from one year to thirty years in the acute care study settings.

Creswell (2006) cautions that there needs to be flexibility in qualitative research when choosing the sampling strategies used to recruit participants. The rationale for this flexibility is that sampling can change often during a study and without flexibility opportunity may be limited. Concepts began to emerge from the data, theoretical sampling was used to confirm and extend concepts. Theoretical sampling is a term used by Glaser and Strauss (1967) to describe the process of choosing new participants to compare with data that has already been coded and an initial analysis has been completed. The goal of theoretical sampling was to gain a deeper understanding of analyzed cases and facilitate the development of an analytic frame and concepts.

Theoretical sampling was the final technique used in identifying participants. Theoretical sampling occurred based on the categories as they emerged. Middle managers were included when it became evident that there was a need to better understand organizational leadership in cases where the previous participants had discussed management as contributing to their ability to operationalize accountability. After interviewing the first six nurses and coding the transcripts some of the codes and categories related to managerial support, organizational systems, processes and culture. This led me to move forward by conducting interviews with clinical leaders and nurse managers in attempts to understand the gap.

Purposive and theoretical sampling contributed to enhanced variation in the sample and to richer data. Saturation may occur at any number of interviews, the goal

was to have the data explain as much as possible the process of enacting accountability. In the data analysis phase of this study categories were considered saturated when no new information was added to the understanding of the category with subsequent interviews (Creswell, 2006). Data became saturated after eleven interviews. The participant sample was completed with eleven registered nurses employed in various nursing units of four large teaching hospitals and /or health centers in urban Eastern Canada.

Personal characteristics.

The eleven participants in the study ranged in age from 26 to 65, with 1 participant in the 26 to 35 age category; 3 participants in the 36 to 45 age category; 5 participants in the 46 to 55 age category; 2 participants in the 56 to 65 age category. The 5 participants in the 46 to 55 age category comprised 45% of the study participants which closely parallels the number of registered nurses in this age category in the Canadian workforce (CNA, 2008). The average age of a registered nurse practicing in 2008 was 45.1 years (CNA, 2008). Of the eleven participants 9 were female and 2 were male, this reflects the ratio of male to female registered nurses in the Canadian workforce (CNA, 2008).

Educational profile.

The participants in the study all completed their formal nursing education in Canada. Seven of the participants (64%) were diploma prepared with three of these nurses reporting that they have taken one or more post RN courses working towards a bachelor of science in nursing. Four of the participants (36%) were baccalaureate prepared with one having completed a post RN degree and one with a second science

degree. According to CNA (2008) 62.2% of registered nurses working in Canada reported a diploma as their highest level of education and 34.7% reporting a baccalaureate degree in nursing.

Professional nursing experience.

In the study, 6 of the participants (55 %) had more than that 25 years of experience working as a registered nurse, of the remaining nurses 1 has been practicing for 6-10 years; 2 have been practicing for 11-15 years; 1 has been practicing between 16-20 years; and 1 has been practicing for 20-24 years. The majority of the registered nurses interviewed have worked in a multitude of facilities and practice areas. The current practice areas of the participants included: the emergency room, general medicine/surgery, operating room, mental health, critical care and middle level administration. Overall, the study sample closely reflected the registered nurse workforce profile in Canada.

Interviews.

Interviewing is a technique that is primarily used to gain an understanding of the underlying reasons and motivations for people's attitudes, preferences or behaviour. Informal and semi structured interviews were held with each nurse participant. The interview was face to face with the participants at a private location and time of their choosing. All the interviews lasted from sixty to ninety minutes with each being digitally audio-recorded with the participants consent. In line with a grounded theory approach the focus of discussions evolved as the study progressed.

Semi-structured and structured interviews were designed so that each participant was asked a set of similar questions. This was particularly important with the goal to make comparisons across individuals or groups of individuals. The interviewer initiated the conversation, presented each topic by means of specific questions, and decided when the conversation on a topic had given participants the opportunity to fully explain their perceptions and experiences (Creswell, 2006).

The interview guide (Appendix D) illustrates general topics and sequencing of the questions and discussions. The research questions were used to frame the interview guide and were developed from a constructivist perspective focusing on social processes. “A good interview question should contribute thematically to knowledge production and dynamically to promoting a good interview interaction” (Kvale, 1996, p.129). The interview questions explored and probed nurses understanding of accountability in practice.

Prior to interviewing participants the researcher chose to be interviewed by an experienced interviewer with an expertise in Ground Theory methodology. This experience exposed the fundamental ways of conducting qualitative research interviews. The researcher chose to analyse her own interview. This exercise contributed to a better understanding of personal attitudes, values, beliefs and assumptions involving accountability. This allowed the researcher to expose and identify biases that could have potentially interfered with the interview and analysis processes. During the entire interview and comparative analysis period the researcher referred back to her own

interview three times to re-orientate herself to ensure her own beliefs were not silencing the perspectives of the participants.

The researcher contacted each potential participant to explain the objectives and the research questions of the study. In addition each potential participant received a research package for review prior to the interview.

Individual semi-structured interviews occurred outside of work hours at a location the participants chose. The interviews occurred in hospital conference rooms, offices, physician lounges, and participants homes. The participants were interviewed to obtain data concerning what accountability meant to them and how they enacted accountability in their practice. Prior to the interview each participant completed the demographic sheet (Appendix E) and signed a consent form. With permission each interview was audio recorded and the conversation evolved using the interview guide (Appendix D).

Building upon the constant comparative approach used in Grounded Theory and the associated emerging theory, the researcher explored particular avenues at greater lengths as the interviews continued. For example, as it became increasingly apparent that nurses often felt powerless which repeatedly constrained their ability to enact their accountability, the researcher undertook greater exploration of this in subsequent interviews. The interview guide was altered as such codes emerged from the data. Also discussion regarding upbringing and the learning of accountability prior to formal nursing education was generated. These additions were within the guidelines set out by the Ethics approval board and did not require any amendment. The interviews varied in duration from 45 to 90 minutes. A number of the interviews went longer after the audio

recording had stopped, when participants would say; “Oh I meant to mention this...” These discussions lasted 10-35 minutes with quite often very rich data being shared. The participants appeared to be much freer in their discussion about sensitive issues without being recorded. These data were incorporated into each interview through the researcher’s field notes. Three of the interviews occurred in the registered nurses work place after they had completed their shift. These interviews took longer than others as the three participants took time to debrief about their day and any particular incidents that had occurred. After the completion of each interview the recordings were transcribed verbatim and analyzed consecutively.

Field Notes and Researcher Journal.

Field notes were recorded by the researcher, during or after interviews on the phenomenon being studied. The notes represented the first phase of the analysis of the perspectives of the participants being studied during or immediately after the encounter. Field notes allowed the researcher to assess the participant and record what they observed in an unobtrusive manner. Field notes were recorded after each interview and entries were made in the researcher journal. The researcher journal was a compilation of notes the researcher made as a reminder to do or avoid certain actions that helped or hindered the process as well as thoughts the researcher was having about the study.

Field notes were made after each interview about the issues raised and captured the researcher’s thoughts, perceptions and understandings of what materialized and these were incorporated into the findings. The researcher journal was used by the researcher to self reflect about the personal research experience. The use of field notes and the

researcher journal in this qualitative research added a dimension and richness to the data. These data collection methods are consistent with social constructivism and an interpretive approach to the methodology of grounded theory.

Data Analysis

The analysis phase began with the preparing and organizing of the text data in transcripts and concluded with reducing the data into groups through a process of coding and condensing codes to a final representation of written theory. Keddy et al (1996) espoused that Grounded Theory has significantly more interpretive power if used with a theoretical framework. The data analysis occurred using a CST lens to provide this interpretive power. The good qualitative interpretation will be the inquiry that is “living, life-like and for life” (Sandleowski, 1997, p.13). Demographic data (See Table 1) were collected and used as part of the analysis of data (See Appendix E).

Data were professionally transcribed. The transcripts were read to flag any initial thoughts or ideas. This was followed by the second stage, the writing of memos. Memos are short documents that one writes to oneself as one proceeds through the analysis of data. “Memo writing is the pivotal intermediate step between data collection and writing draft papers. Memo writing constitutes a crucial method in grounded theory because it prompts you to analyze your data and codes early in the research process (Charmaz, 2006, p.72). The third stage requires the search for potential categories through the codes in data.

Table 1 Characteristics of Individual Participants

Study Name	Gender	Age	Education	Years of Practice	Practice Area
Fannie	Female	36-45	Diploma	21-25 years	Emergency
Flossie	Female	46-55	Diploma*	>25 years	Emergency
Emily	Female	56-65	Diploma	>25 years	Emergency
Tiffany	Female	26-35	BSCN	6-10 years	Emergency
Gracie	Female	46-55	Diploma*	>25 years	Operating Room
Smith	Male	36-45	BSCN**	11-15 years	Mental Health
Wendy	Female	46-55	BSCN-post RN	>25 years	Emergency
Rachel	Female	56-65	Diploma*	>25 years	Nurse Manager
Reg	Male	46-55	Diploma	>25 years	Intensive Care
Stella	Female	46-55	Diploma*	>25 years	Nurse Manager
Starr	Female	36-45	BSCN	11-15 years	Surgery

*Indicates courses towards post RN BSCN

**Indicates another degree outside of nursing

Constant comparative analysis.

Constant comparison is the method of GT analysis. This can be described as the coding, hypothesizing and the categorizing of data using the process of constant data comparison interview with interview. The evolving development of the grounded theory followed several stages. These four stages of coding – initial, focused, axial and theoretical - as defined by Charmaz (2006). A good code is one that captures the qualitative richness of the phenomenon. “Coding means categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data” (

Charmaz, 2006, p.43). “Coding is the pivotal link between collecting data and developing an emergent theory to explain these data” (Charmaz, 2006, p.44).

Grounded theory provides a procedure for developing categories of information (initial and focused coding), interconnecting the categories (axial coding), and building a “story” that connects the categories with theoretical propositions (theoretical coding).

The interview transcripts were coded following two general steps, line by line coding followed by more focused coding to identify conceptual categories. The first stage (initial coding) had the investigator comparing data to data, and viewing what participants saw as problematic. The questions the data exposed in initial coding were: what is these data a study of and what does this data suggest. Charmaz (2006) advises to code line by line and incident by incident while using words that reflect action. The advantage of this phase is the early identification of foundational codes and the first analysis of fit and relevance. The transcripts of the interviews were coded with words that described the actions of the registered nurses their perceptions, understandings and experiences of accountability. In this stage of analysis, data were coded using substantive codes that reflected the substance of the data. These substantive codes sometimes also used the words of those interviewed. Initial codes were provisional, comparative and grounded in the data.

Focused coding is the second stage in coding. These codes were more directed, selective and conceptual than the word by word in initial coding. They started to synthesize and explain larger segments of data. "Focused coding means using the most significant and/or frequent earlier codes to sift through large amounts of data. Focused

coding required decisions about which initial codes made the most analytic sense to categorize the data incisively and completely” (Charmaz, 2006, p. 57). As data were gathered, substantive codes were continuously compared and contrasted, patterns and categories began to emerge. These categories developed from the grouping or clustering of codes that seemed to fit together. Further categories were then compared to categories, where relationships and linkages between them gradually became evident. Memos were subsequently written to elaborate upon the processes, patterns and assumptions made.

The third phase of coding was axial coding. Axial coding aided in the development of a major category. The purpose of axial coding was to sort, synthesize and organize the data and reassemble it (Creswell, 2007). Axial coding answered the questions of who, where, when, why and how and with what consequences. “ Axial coding related categories to subcategories, specified the properties and dimensions of a category, and reassembled the data fractured during initial coding to give coherence to the emerging analysis” (Charmaz, 2006, p. 60). Axial coding helped the researcher engage in a deeper exploration of data and to apply an analytic frame. This stage was very important in providing the foundation for more extensive analysis.

Due to the large number of related categories, higher level categories were identified and then others subsumed under them in a process of reduction. These categories were mutually exclusive and exhaustive and together explained all the variations observed. Categories were then linked to generate the substantive theory (Charmaz, 2006).

Theoretical coding was the final stage of coding, it identified possible relationships between categories developed in focused coding. Theoretical codes were integrated and conceptualized as to how the other codes were related. Theoretical coding tells the analytic story. Data analysis resulted in the identification of four central categories: “Developing personal understanding”, “Gaining professional understanding”, “Finding the way”, and “Becoming professionally confident”. In the analysis of this written research I have used actual quotations from the participants to provide a rich description of their perceptions. These quotations will help to present the detail, context and emotion attached to their described experiences and understandings of accountability (Sandelowski, 1997).

Through the process of analysis external contextual elements that affected decision making were identified. These will be further explored, described and discussed with attention to theory development in Chapter IV.

Trustworthiness in the research process.

Trustworthiness is a method of legitimizing the research. In qualitative research it is demonstrated through the researcher’s attention to accurately representing the study participants’ experiences. “Criteria for trustworthiness in qualitative research are closely tied to the paradigmatic underpinnings” (Morrow, 2005, p.251). The four processes that a researcher can use to ensure trustworthiness are: credibility, dependability, transferability and confirmability (Morrow, 2005; Creswell, 2006; Struebert & Carpenter, 1999; Tobin & Begley,2004). In addition to these processes, the meaningful

understanding of participant constructions requires consideration of context, culture and rapport (Morrow, 2005).

Credibility.

Credibility was achieved in this study by ensuring that the processes used were explicit, that the data could be traced and as the researcher I explained where I situated myself. In qualitative research this is termed reflexivity or axiology. The analysis process was an iterative and reflexive process. Systematic processes of gathering and analysing data were thoroughly explained so that an outside person could analyze the data and reach similar conclusions. This was achieved through digital interview recordings, field notes, chronological journaling, and data organization, coding and analysis using Inspiration software, a computer aided research organization software. A sound record of all the activities of the research further established credibility. The ultimate assurance of credibility occurred through prolonged engagement with the subject matter and careful data management (Struebert & Carpenter, 1999).

Dependability.

Dependability is the likelihood of another researcher observing the same finding using the same methods and processes and arriving with the same results under similar circumstances. Dependability was enhanced with the altering of the research questions as new findings emerged during data collection. The process of Grounded Theory requires initial sampling and the immediate review and coding of data. This process exposed any need for changes in research methods, thereby building dependability. Dependability

pertains to the importance of the researcher accounting for or describing the changing contexts and circumstances that are fundamental to qualitative research.

Transferability.

Transferability refers to the probability that the findings would have meaning to others in similar situations. In other words findings are written in such a way that those reading them can determine if they are applicable in another setting. In qualitative research because there is not a single truth or interpretation the focus will be on the utility from case to case (Tobin & Begley, 2004). Transferability was built in by the thorough description of the analysis, the explicit description of methods used to gather data and the conceptual explanation of the findings. While this study was conducted in acute care settings those evaluating the findings are expected to discover how transferrable they are to other practice areas.

Confirmability.

Confirmability refers to the degree to which the results could be confirmed or corroborated by others. It is also the agreement among researchers that the knowledge generated is meaningful to the researcher and the participants. It is concerned with establishing that the data and interpretations derived from the data were not figments of imagination (Tobin & Begley, 2004). This process was actualized by the clear illustration of evidence and thought processes that led to the findings and conclusions (Struebert & Carpenter, 1999). One method used to achieve this was member checking.

I contacted several of the participants to verify the emerging concepts that made up the theory (Charmaz, 2006, p.111).

Ethical considerations.

Ethical requirements are a critical consideration throughout the research process (Creswell, 2007). Ethical considerations are central to all phases of the research process. The researcher role requires attention to be paid to the confidentiality, vulnerability and sensitivity of the participants in the study. This research proposal was submitted and approved by the Ethics Review Board of the study setting before proceeding with the study.

The consent form (Appendix C) was signed by the participants prior to the interview. Each participant was informed of the following: the extent of involvement as a participant in the study; the right to withdraw from the study at anytime; measures taken to protect identity; the confidentiality of information; and the potential benefits of the research itself.

The interview would be in person and will last for 60-90 minutes. All participants were informed that they could withdraw from the study at anytime or they may refuse to answer any questions posed.

The ethical principle of confidentiality was strictly adhered to through the participants choosing anonymous study names, by being interviewed in a private location, the non- identifying of specific units and hospitals in the data analysis, and where each participant chose whether they wanted to keep their interview recording or

have it destroyed. These are the strategies that were employed to assure that no one was identifiable. The transcriptionist hired to transcribe the interviews was required to sign a Confidentiality Agreement (Appendix F). Each participant was advised in the Consent of Participation Form that there was minimal risk and no personal benefit to participating in the study. A possible risk was that during the interview the participant may recall clinical situations that caused distress in the past. If this should happen the participant could stop the interview and re-scheduling would be accommodated. Anonymity could not be afforded the participants because they were being interviewed. Careful attention was made in the written analysis to use quotes that could not be readily linked to any one participant. There were no anticipated benefits to participants in this study however, each was aware they would be contributing to the development of nursing knowledge regarding clinical accountability.

Concluding Comments

“ The ancient Romans had a tradition: whenever one of their engineers constructed an arch, as the capstone was hoisted into place, the engineer assumed accountability for his work in the most profound way possible: he stood under the arch.” (Armstrong, 2006). With this study exploring nurses’ perceptions, understandings and beliefs surrounding the concept of accountability, I will uncover where nurses perceive the arch to be and where they choose to stand in relation to the arch. Here in lies the limitation but also the power.

CHAPTER IV FINDINGS

The purpose of this grounded theory study was to generate a substantive explanation of how registered nurses' perceive and operationalize accountability in clinical practice. The specific aim of the research was to answer the following questions: (a) how nurses define accountability; (b) how nurses view individual accountability; (c) how nurses learn and understand the concept of accountability; (d) who nurses believe they are accountable to; and (e) how nurses demonstrate accountability in their practice.

The RN participants in this study were employed by a single district health authority in Atlantic Canada, and worked in various practice settings which included: Emergency, Intensive Care, Operating Room, In Patient Mental Health, General Surgical and Medical units. Data consisted of 11 interviews with nurses working in or managing these clinical areas. The research methodology was grounded theory.

The analysis of the Registered Nurses' interview discussions demonstrated how each personally came to know and understand accountability. The general consensus was that personal experiences, upbringing, formal education, work experiences, institutional culture, professional relationships and societal expectations are integral parts of how nurses come to know accountability and how they choose to operationalize this in clinical practice.

The theory that emerged is that registered nurses enacted as well as retreated from accountability. The main concern of these nurses was how often they were challenged in their ability to fully operationalize their individual accountability. Nurses learn professional accountability through personal, educational, experiential, social and

professional means. The theory developed incorporates four stages: (1) Developing personal understanding; (2) Gaining professional understanding; (3) Finding the way and (4) Becoming professionally confident. The enactment as well as the retreating from accountability occurs in a context and the contextual factors that influenced the process were institutional culture, human and financial resources, and health care system processes. The theory will be outlined, explained and illustrated followed by an explanation of the contextual factors.

Enacting and/or Retreating: A Theory of Accountability Practice

Enacting and/or retreating is the process employed by registered nurses to manage accountability in their practice. Enacting accountability meant that nurses provided the care they believed necessary and readily made independent decisions while acting within hierarchal healthcare environments. In fully enacting accountability the nurse had the capacity to give an account of what was done and provided a rationale for any decisions made or not made. Nurses who enacted accountability may have delegated responsibility to others but remained fully accountable for this delegation. Although accountability is not a visible and palpable concept, the nurses readily enacted it when they were able to deliver care to their patients based on their clinical judgements, felt supported and observed positive outcomes for their patients. Retreating from accountability meant that nurses consciously or subconsciously did not fully enact accountability practices. In retreating from accountability the nurse did not provide the care required nor take ownership for care decisions made or not made. Nurses retreating from accountability either lacked awareness of retreating or provided significant rationale and explanation for the behaviour.

Enacting and/or retreating from accountability can occur at any stage in the process. The degree to which the registered nurse enacts is related to the stage in which he/she is situated. A full explanation of the stages will be presented and a brief reference is made here for the purposes of explaining the central concept of the theory. For example a person situated in the first stage of developing personal understanding does not have the knowledge or the professional expectation to operationalize accountability outside of their personal world.

During the second stage (Gaining Professional Understanding) of enactment the nurse is developing knowledge associated with professional expectations. This can often be complicated if conflict occurs with an individual's personal beliefs and understandings and the profession's expectations. As a result an individual may retreat because of this conflict. Retreating may also occur from a deficiency in professional knowledge and understanding.

In the third phase (Finding the Way) registered nurses expended significant energy in attempting to position themselves in the organization to meet the expectations of patients, families, employers, licensing bodies while being true to themselves and their education. The potential for retreating from the enactment of accountability existed and nurses found their way through experience and in navigating the system.

The final stage (Becoming Professionally Confident) of the enactment of accountability occurred as registered nurses continually advanced in their personal and professional understanding. This advancement occurred through experience, mentorship

and with self reflection on past experiences which aided in the creation and building of professional confidence.

Enactment of Accountability

The enactment of accountability was best illustrated when participants explained how they defined and then provided the care they believed patients needed on any given day, and further substantiated with the example given by a participant who spoke of performing a focused abdominal assessment, making a decision to do blood work, treat the patient's fever and start an intravenous all according to clinical standards, orders and policy. Another example was provided by a participant who spoke about a patient she admitted from the operating room after a total hip replacement. She reviewed the patient medication list and found discrepancy between two forms. She stated that she spoke to the patient's daughter who verified the error. She called the surgeon, he ordered the correct medications and the medication administration record was accurately completed. A third example was given by the participant who spoke of administering medications and after assessing the patients allergies found they were allergic to a derivative of the drug the physician had ordered. He went on to say that he consulted with the physician and had the order changed. The participants gave multiple examples of enacting behaviours.

Wendy described an experience in which she fully enacted accountability, and then experienced the "heaviness of accountability". She vividly described the situation during the H1N1 outbreak where suddenly registered nurses were doing complete

assessments on patients and discharging them without seeing a physician if they did not exhibit certain signs and symptoms.

“Now you’re working by yourself, you don’t have that group think around you, that group of people, and it was very uncomfortable. . . Like, you know, we were given these guidelines and everything, so. . . I was made to feel that I will be supported in what I’m doing here, because it’s new, I’m uncomfortable with it, it’s not something I’m used to having had to do in the past. But I’ve got all these guidelines and all these people up above and around me have come up with this and they’re saying they’re going to support me, and so I’m believing that and I’m going to carry on with that. So, you know, filling out these forms, signing my name to it, so there was a paper trail to it at all times. But it was, like I said, the key thing was I felt very supported but it was still heavy.” (Wendy)

Retreating from Accountability

Retreating from accountability was obvious when the nurses’ gave examples of themselves or colleagues consciously or unconsciously avoiding decision making and taking ownership of care. This was identified by the participant who spoke of her attempts to advocate for her patient not to be discharged when the patient was drowsy, unsteady on her feet and not maintaining normal oxygen saturations after being administered intravenous Dilaudid for back pain. The nurse explained she attempted to relay her concern to the discharging physician and clinical leader with negative response. The nurse re-iterated that she was told the department was closing and the patient would be discharged into her husband’s care and would “sleep it off”. Another participant recounted a medication error that had occurred under the care of three nurses when they neglected to verify and calculate the continuous medication infusion rate.

The registered nurses’ portrayed being in a constant battle, both personally and professionally to enact accountability. They spoke of the struggles arising when their

own personal values and beliefs about providing nursing care did not coincide with expectations of patients, families, regulating bodies and employers.

“Because even working on a floor when it’s busy, you feel out of control, you just think, okay, is anybody blue, no. You do your ABCs, for CPR, is everybody breathing, is anybody blue, okay they’re all good, so everything’s fine, so then you prioritize after that. Everything else is irrelevant. . . .You have only two hands, you have to do what you can prioritize and do” (Starr).

Starr went on to say that you never feel fully satisfied and accomplished. She said nurses are desperate to be able to sit back, reflect and say I did a great job and I made a real difference in the lives of this patient and their family. Tiffany took it further saying the constant energy required to work at an ‘all out’ level eventually leaves you empty. “It is terrible to say but you put up your blinders and you do what you have to do to get to the end of your shift with the least amount of hassles” (Tiffany).

Factors contributing to retreating arise with the experience of negative outcomes and the feeling of personal responsibility and possible error or shortcomings. One nurse referred to an experience where a patient unexpectedly arrested and died after she had administered an IV medication. The nurse spoke of the rationalization that occurred in her mind questioning if everything had been done and then done correctly. She battled with her intellectual self telling her this was part of being a health care professional and her emotional self questioning her skill. She spoke of lacking the confidence in her knowledge, skill and ability when something so unexpected occurred.

All of the participants felt considerable pressure to be individually accountable while trying to adhere to the collective accountability expectations. They described a process where multiple healthcare professionals have varying and differing levels of responsibility and accountability which may or may not be in congruence. A number of

participants spoke of enacting their individual accountability and having it conflict with other professionals accountability expectations. The challenge was to adhere to your own professional responsibilities yet maintain the collective accountability of the team. This is rooted in a person trying to be an individual within a group dynamic. The challenge of being one of a group and assuming ownership for group action or inaction while at the same time being individually accountable in turn had a significant effect on both personal and group outcomes. The overarching power resides within the group's collective accountability but also leaves significantly more opportunity for retreating. See Figure 1

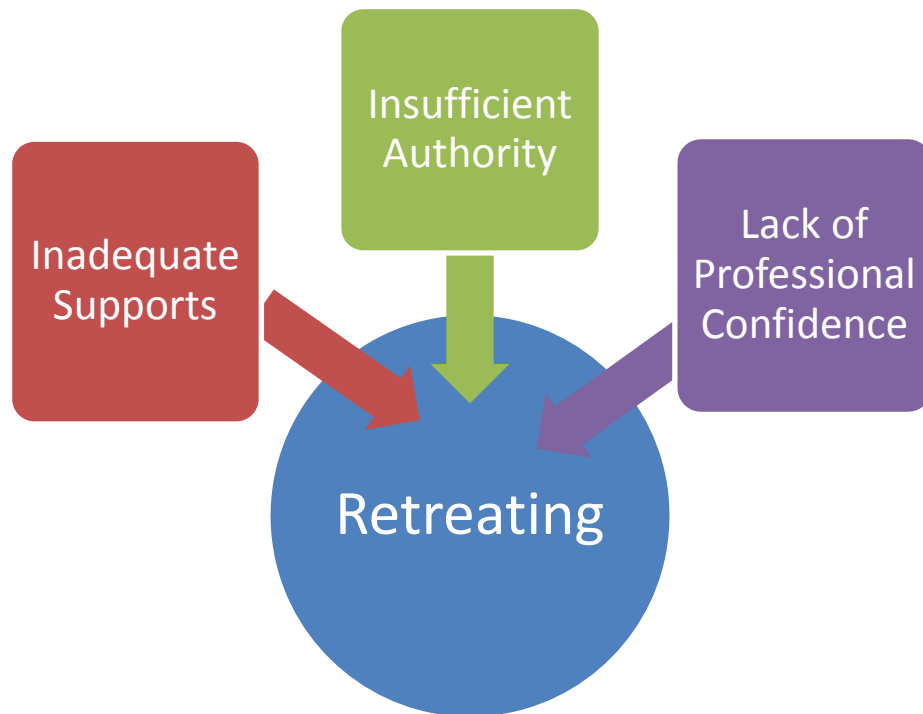


Figure 1 Process of Retreating from Accountability

The Process of Retreating from Accountability was aided by one or more of three factors: (1) Inadequate supports; (2) Insufficient authority and (3) Lack of professional confidence. Inadequate supports was the single most common reason given by

participants for retreating from accountability practices. They further defined these as lack of equipment, staff shortages, and a need for stronger effective leadership. Insufficient authority also caused retreating behaviours. Nurses spoke of feeling powerless in a system created around consequences and punitive repercussions. The nurses spoke extensively about difficult situations where they did not feel their voice was heard and chose not to challenge this.

Many of the participants expressed frustration because they believed that they had the knowledge and experience to make decisions, yet the doctors always had the final authority. The nurses' spoke of wanting to be accountable and an active participant in decision making but retreating resulted.

“I think we rely on the final accountability being with the physician, I think we rely on that a fair bit...although we are saying we are looking out for this patient's best interests and, you know, this is the right thing to do, we really in a way are, are hiding ourselves underneath the doctor's ultimately doing, and, and following, in allowing that, let us make these opinions or these judgments, because we know ultimately it's not us that's making that final decision” (Wendy).

While the participants considered experience and confidence as contributors in the operationalization of their accountability practices, a number of them spoke of the “lack of professional confidence” when making decisions and felt this was the primary reason in not fully enacting their accountability. Some participants expressed having feelings of inferiority around physicians and the system as a whole by stating “We know where our place is and if we cross a certain line we are quickly put into our place” (Gracie). Critical Social Theory (CST) lens exposed the oppressive features of healthcare systems that registered nurses are working in and face on a daily basis. These oppressive features contributed to the registered nurses enacting and/or retreating from accountabilities.

All of these incidents and situations expressed the participant's passion, fear, frustrations and exhaustion in operationalizing accountability. Nurses' enacted and/or retreated from accountability based on the stage in which they were in and on the contextual factors at any given moment. The depiction of the process of the registered nurses' enacting and/or retreating accountability is portrayed in Figure 2. The schematic diagram depicting the Process of Enacting and/or Retreating demonstrates the complexity and multifaceted nature of accountability. The spiralled central portion of the diagram explains the various stages in the process of accountability. The process begins with the individual development of personal understanding of accountability. The spiral moves upward with the process of gaining professional knowledge and receiving the registered nurse title. The third stage demonstrates where the registered nurses began their career and follows as they find their way in the complex healthcare system. The fourth and final stage in the process of enacting and/or retreating is the attainment of professional confidence. As the diagram depicts an individual can expect to move through the four stages of the process of enacting and/or retreating. There were however contextual factors that influenced situations to the extent that participants reported retreating from accountability, that is returning to the stage of gaining professional knowledge, and therefore were not practicing at the level expected of a Registered Nurse. The four arrows at the top and bottom of the diagram illustrate these external or contextual factors of human and financial resources, institutional cultures and healthcare system processes that provide constant pressure on the stages in the spiral. The contextual factors and forces contributed to the process of the development of enacting and/or retreating from

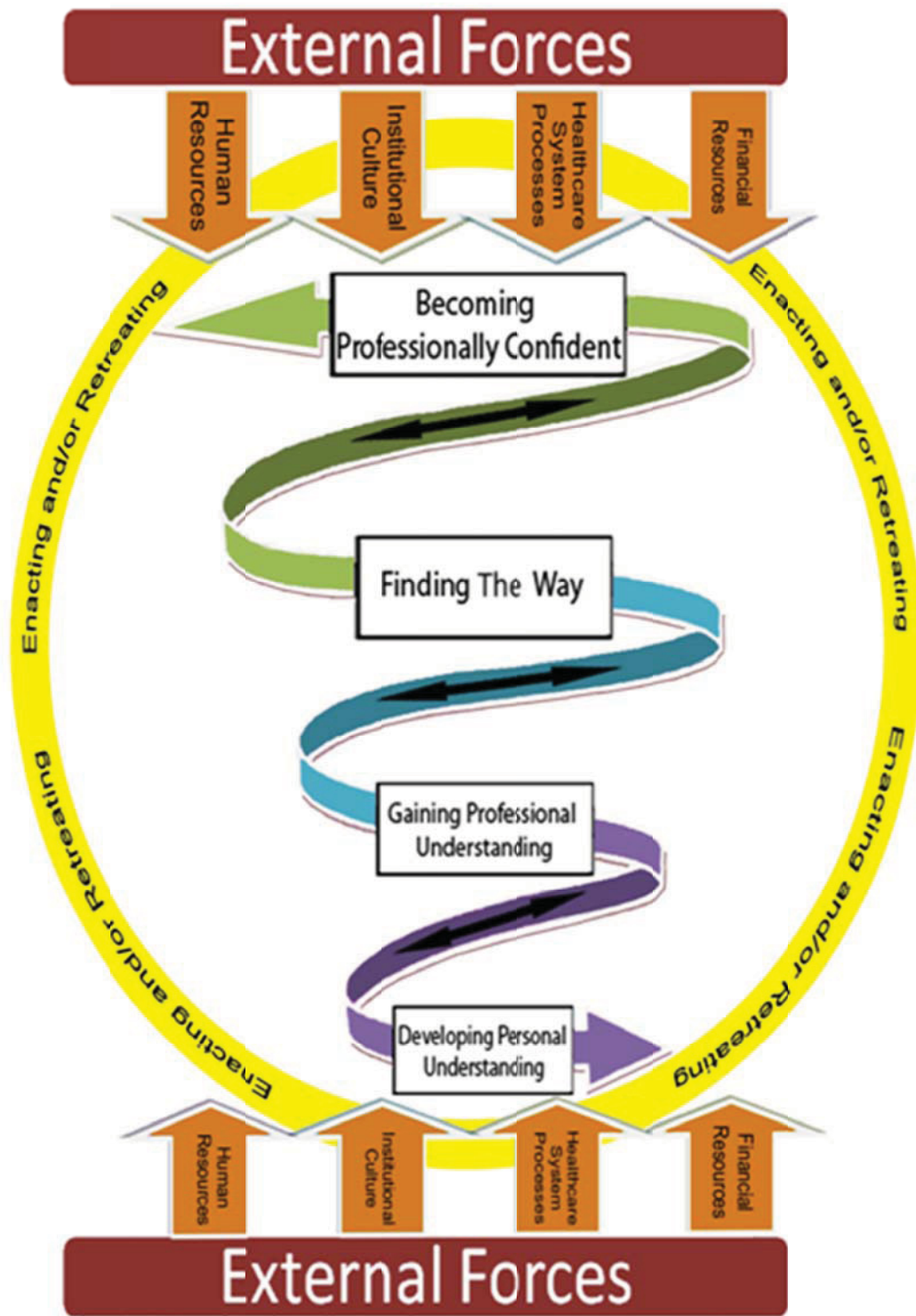


Figure 2: Process of Enacting and/or Retreating

accountability. The circle that surrounds the spiral depicts how enacting and/or retreating from accountability is constant and influenced by stage as well as context.

Through the exploration and analysis of data and the theory development it became evident in the process of enacting and/or retreating from accountability happens progressively and on a continuum. The development of this continuum mirrors the data and stages within the theory. It is important to note that while an individual can be at any place on the continuum one can become stalled or backslide at any point.

Nurses enacted and/or retreated from accountability based on the stage of the process that they were in and on the factors influencing the context of care. The stages of the process will now be explained and illustrated followed by a discussion of the contextual factors influencing the enactment of accountability.

Developing Personal Understanding

Developing personal understanding means nurses were initiated into the notion of accountability through: parental/guardian expectations, early work responsibilities, family influences, individual morals and integrity, values and beliefs, altruism, doing no harm and from the consequences of certain behaviours. All participants talked freely about their upbringing and how this impacted their understanding of accountability. The majority spoke of this being directly tied to who they are today in relation to accountability practices. They spoke of their parents having certain expectations regarding behaviour and responsibility. Five participants spoke of a “good Christian” upbringing, early responsibility and work experiences, and the fear of the consequences of not adhering. Rachel pointed out that for her:

“Just being very active in the church and having brought up to. . . try to be a good Christian, you know, the do unto others, or the platinum rule, whatever you want to call it. To me it’s a basic sort of thing, so that has an influence” (Rachel).

Participants described the influence of the church in their upbringing and expressed the belief that they felt this led them to have a high level of personal expectation of accountability in everyday life.

“If you have grown up to be a selfish individual, never had to share anything or care about anybody else but themselves, then it’s very hard for you to portray a caring, to be a caring, compassionate, trustworthy role model or nurse to care for other people...When you develop those principles from a young age, you grow up to be a young adult with the same, the same sort of behaviours and, and principles so there, those are your standards that you live by, so you, you should practice by those, too, technically” (Flossie)

All participants identified that they learned about accountability in their childhood and readily suggested that this carried over into their professional accountability.

“It’s something you learn as a child. I mean, having grown up in a family of sisters, you know, you could always try and blame the other sister, but really, my mother and father just didn’t accept that, you know, we were always, if you make an error, if you make a mistake, if you did something and it didn’t quite work out the way you had hoped, you know, then it was your, it was an expectation you would own up and say, you know, I made this error, I made this mistake, or it was me that did, when, and there’s that accountability as well as it can be a good thing, you’ve done something that’s great, you’ve got the credit for what you’ve done” (Stella).

Through all the interviews, the individual’s morals, values, integrity and beliefs were readily identified as impacting accountability practices. Participants explained that having started to work at jobs outside of home at an early age helped them form their personal accountability practices.

“I have five older sisters, who made me very accountable for what I did, in my home life. So I think it starts at home, you know, with, how you’re raised...when I was 12 I started babysitting, so I had that responsibility of child care, and. . . I

was a Sunday school teacher, at an early age, so all of those things. I started work at 16, you know, as a student at a part time job” (Rachel)

Family influence was central in all the participants developing an understanding and the expectation of accountability.

“It’s just something I was taught growing up. It is something your family breeds into you. It just depends on how, how you’re brought up and what kind of family life you have...we always had certain responsibilities as kids and if, you know, we didn’t uphold those responsibilities then, you know, we’d lose other things you can’t have, so you learned really quickly that, you know, there’s certain things in life that you had to do and if you didn’t do them properly and we didn’t do them right, then there was consequences” (Tiffany).

Fanny spoke very positively of being raised in a community where everyone worked together for the greater good of each other. She spoke of those who did not work together as being separate from the community.

“We lived in a very small community where everybody basically, in a lot of ways, worked together. It was fishing community where all the men, cooperatively fished together, and you were reliant on each other, and you had to be accountable, you had to be trustworthy, you had to be, you know, a member of the community and be able to pull your weight in the community and help others or the community wouldn’t work”(Fannie).

Smith spoke of taking ownership of the good and bad as a youngster and how this transferred into his professional career and accountability practices.

“As a young child, I guess it’s a sense of what you call a conscience. You know, you always got rewarded when, even if you did the right thing, I mean, I remember my father, after I broke a window, you know, coming out and me saying, Yeah, that’s my baseball and going through that, knowing, but he said, yes what you did was wrong, but it’s good that you came up. That always stuck with me, that sort of always came through, you know, the doing the right thing” (Smith)

A number of the experienced participants (46-65 years) made multiple references to the notion that younger generations seemed to be lacking a sense of accountability and

have *laissez faire* attitudes. They believed these attitudes came from being raised to be entitled, being coddled and from a lack of consequences for actions. They referred to this as ‘generational accountability’. The mid and late career nurses both expressed concern for what they perceived as less committed attitudes and work styles in younger generations of nurses. Although the mid career nurses also expressed the same concern but with less frequency and frustration. This was not born out by the younger participants in the study. Three participants raised the issue that they felt that younger nurses had significantly more confidence and were able to articulate and challenge issues of care. These nurses felt that baccalaureate programs provided this. They spoke enviously of this taking them years of experience to develop. Though they felt the younger generation of nurses were more confident in challenging care issues they did not see that they more readily enacted accountability.

In summary, Smith concluded that developing your personal understanding of accountability is very individual.

“Accountability is each person’s own philosophy. I mean, whether it’s punitive or, or just a altruistic sort of perspective. You know, I think it’s a person’s own, a person’s own motivation, to be a good clinician” (Smith).

An individual’s development and understanding of accountability is personal. This is supported by LaSala’s (2009) work on moral accountability. Her work speaks of the core values of human dignity, respect, caring, compassion and moral integrity as being central not only to the interactions with patients and families but also nurses’ interactions with one another, members of the interdisciplinary team and others. These personal values are in part transferred into the development of professional understanding. All the participants ranked these values as being essential and imperative for developing their

professional understanding of the individual. This finding is also evident in the work of (La Sala) on moral accountability where she espouses that a “sense of oneself or personal identity (self understanding) informs ones actions- that which an individual understands is the right thing to do is consistent with that which he or she does” (p.431).

Gaining Professional Understanding

The participants explained that gaining professional understanding consisted of formal education, as well as experienced gained with entry into practice within the discipline of nursing. This stage is multifaceted and similar to stage one in that it varied from individual to individual. Nurses believed the process begins with formal education, and consisted of two sub processes; legal expectations and societal expectations. For one to gain professional understanding the ability to move forward is dictated by self reflection and one’s own personal internal desire to ‘care for’, ‘do good’ and achieve professional status. Each individual nurse decides on what this professional status will look like for them.

The registered nurses who participated in the study could be divided into two groups: those that are diploma prepared and those that are baccalaureate prepared. Both groups had similar understandings of accountability. All the participants went to great lengths in attempting to define what accountability meant to them as a professional. Despite the differing educational levels all participants struggled in defining responsibility and accountability and used these words interchangeably. The general consensus of the participants was that accountability is greater than responsibility, but how it was different proved to be difficult to articulate. However, the baccalaureate

nurses had greater ability in articulation and reasoning regarding accountability. Baccalaureate education of nurses is undisputed in the literature as building and enhancing professionalism within nursing (Taylor, 2008). Part of professionalism is the ability to articulate what nursing is and does.

Discussions occurred about the formal teaching of accountability in the participant's respective nursing programs. None of the participants could clearly recall any teaching of accountability in their nursing programs. This was similar for both those in diploma and degree programs. All participants felt they were told to be responsible and accountable but could not provide specific details about how this was relayed. One diploma participant stated "It was just expected in nursing school that we were to be accountable and we feared the consequences and did not really understand- the who, what, where, when, why and how- it was just because..."(Gracie).

Each participant had opinions about what their programs provided and what was lacking.

"I think it's a lot of the generational and societal attitudes. That things are more self-centered, people are more self-centered. And it's not so much. . . a team effort, and honestly, I think a lot of the nursing schools nowadays don't really promote the team effort. There's individual patient care on a lot of floors, you know, total patient care, whatever you want to call it. And that does not build teams. Because you're not encouraged to work together"(Fannie).

Other participants felt that gaining professional understanding of accountability occurred through experience and reflection.

" I think it's just experience. I honestly don't think I came out of university fully understanding accountability, they might have said it, but until you encounter it, you don't really understand it. Because we were taught it, we were taught what the College does, we were taught the standards, we were taught the Code of Ethics.

We were taught all that. But until you actually come out and actually see and put those kind of standards and that into place, you really don't, I didn't know, coming out. I mean, I knew I was a registered nurse and I was accountable for my actions, but I don't think to the extent of what I guess ultimately it could lead to if something happened" (Starr).

Self reflective practices were discussed by six of the participants as a means for working through issues and enhancing personal and professional growth and development. Self reflective practice as a means for professional growth is described throughout nursing literature (Levett-Jones, 2007) as, deliberate and focused self reflection for enhancing individual accountability for continued competence. This type of purposeful reflection is viewed as the most potent form of critical thinking which aides professional development and is also the basis for improving quality care.

"But there are some people, if you reflect, then you have to change, and a lot of people don't necessarily want to change, either, because change is tough" (Stella).

"I think everybody does over time become more self aware, and so, but there's varying degrees of it and some are better at it than others and I think it comes down to, if you truly want to be self aware you will be. . . and maybe you don't want to know sometimes" (Wendy).

Six of the participants spoke about the feeling and sense of being a nurse at all times and the responsibility and accountability associated with this.

"I think that you have to be accountable, I'm a nurse and it's a profession that we have, and I think that you have to maintain accountability, not only here from 7 to 3, or whatever shift you're working, but I think the accountability extends 24/7" (Emily Rose)

And in Wendy's words...

"It's not just being responsible for any action that you do as a nurse, which you are, but it's, even when you don't do anything or if you are asked for advice from a neighbour. .It is still there, that accountability is there all the time, whether you're doing a specific thing related to nursing, or choosing not to do something

for somebody. It all comes down to, you know, that you are a nurse and you, there is an expectation. . . a standard that you work by and live by” (Wendy).

Some of these participants explained that they did not feel they were adequately prepared for this in their educational programs. All the participants very clearly and powerfully conveyed the point that a sense of individual accountability resides at the core of their professionalism. That is, these nurses desire to be accountable and the desire was internally motivated.

This sense of personal commitment to patients and families appeared to arise from the very core of participants sense of themselves as explained by Emily Rose “Professional accountability to me is anything to do with betterment or that could improve or that could help any other person, you know, whether they’re your client or whether it’s your next door neighbour”

And then similarly, in Rachel’s words,

“And so all of those are inter-twined. And I think that the difference really from the human being, the general human being, that then changes when you become a registered nurse it is the professional piece of it, that now changes you from being a lay person to a nurse with professional accountability”

Another essential ingredient associated with the innately related natures of professionalism and accountability was that of doing the best one can as explained by Stella.

“You go into nursing believing you want to do good, what’s best for the patient. And so I think that’s just how I learned it through my nursing, you know, we had very strict instructors that, you know, this is the correct way to do it because this is the best practice and therefore the best that I can do” (Stella).

Fanny remarked that she had become more clearly aware of her personal commitment to being accountable in light of the frustration she had experienced with

some colleagues who were less diligent in their work practices and the seeming unfairness of this situation to her and others in providing a higher quality of care. The participants were not committed to being accountable only because it was expected of them as a professional; this commitment was also personal. This ideal is supported by LaSala's (2009) philosophical work on moral accountability and integrity. She is quoted "During times of uncertainty, increased vulnerability, and hopelessness, nurses must renew their sense of purpose in their work with patients, families, other disciplines and one another". She suggests by doing so nurses promote and sustain a caring, healing practice in their interactions with others and themselves.

"I think it all depends upon the person. I mean, accountability for some people might be that, you know, if I do a practice so I'm not going to cause harm to another person. And really that's what moves me.....another views person is accountable because it, from a punitive sort of perspective, they want to be accountable because it reinforces a practice to make sure that you don't make mistakes" (Smith).

All the participants spoke of being driven by the desire to make a difference in patients and their family's lives.

"When I first graduated, I would just follow these orders and do them as I was saying. So yes, I'm accountable for whatever I do, and if I don't do what those orders say, then I'm accountable for that, but really I'm only expected to do what those orders told me to do, I wasn't really expected to do any more than that or anything different than that. Somebody was always dictating for me what, whereas as I got further along and maybe it was because I ended up working in Emergency rooms and ICUs, I don't know, but I would think more for myself and then as soon as you start thinking more for yourself, then you're more responsible and more accountable for what you're doing. So maybe, but it's still not a one day doing it this way, the next day you're doing it that way. It was over time that that happened" (Wendy).

Legal and Societal Expectations

Legal, and societal expectations are sub-processes of gaining professional understanding and enactment of accountability. Each of these sub-processes required the registered nurse to have formal knowledge of the law, licensing requirements, Code of Ethics, Standards of Practice and an understanding of how the general public views nurses and their role.

Legal expectations.

All participants spoke of the legal aspects of accountability. By legal participants meant keeping patients safe and protecting their professional license to practice. A number of participant's spoke of the burden they faced with the knowledge of potential law suits from events occurring daily in a healthcare system where they witnessed chronic understaffing, lack of communication, inadequate prioritizing and staff apathy. They spoke of frequent adverse events and near misses. For example one nurse spoke of an adverse event where a confused patient was to be monitored by a patient attendant but the clerk did not call to book the attendant because the previous day nurse did not transcribe the order. The patient was left unattended while the nurse was receiving report from the night shift the patient crawled out of bed and fell on the floor. The nurse expressed fear of the repercussions from both a legal and administrative perspective. She was concerned for the patient's well being by wanting to ensure the patient had not sustained any fractures. She wanted to notify the patient's family but was advised to 'leave it alone'. During her description of this incident her emotions ranged from anger to frustration to a rawness when her eyes welled with tears and she threw her hands up saying "What do you do?" She went on to say "The system fails patient's everyday and I

feel responsible and accountable for these people and their families but helpless in what I can do to make it better”.

The participants varied in their understanding about legal expectations. The first participant talked about how nurses’ perceived working in a group reduced the accountability expectations and that there was no financial gain from litigating nurses. It was explained that nursing care on general units is provided by a group of nurses working a shift, that working as part of this group reduced the expectations of an individual’s accountability. One participant explained that she felt nurses are not viewed as targets of responsibility because physicians and the employing agency have a greater legal responsibility. The complainant would also receive more financial benefit from focusing on others. In addition the general public is very empathetic to nurses and the work that they do in challenging conditions and environments.

Participants perceived nurses’ working as a group in the care of patients diluted individual accountability and further diluted accountability when care extended beyond the group and included the interdisciplinary team.

“You know the law suits are going to be, they typically don’t sue nurses, They’re going to go looking for the deep pockets and, for one thing, they’re going to go looking, oh yes, nurses do have a licence...but we’re also a group, it’s not just one of us, so if there’s five or six nurses on during a shift...I think we sort of feel as a group that’s a bad thing, it’s a bad way to look at it because as a group we’re less accountable because it’s not individually on us personally. It can be. I mean, if you’re the only signature on the chart or whatever, it does come down to that. But, I think we feel a little more, or a little less vulnerable, or whatever because we’re in there as a group, whereas the physician is by themselves. It’s a set of circumstances-, if we don’t it’s just the way we work as a group.” (Wendy)

A second participant spoke of the increased need to protect herself from potential

legal repercussions in situations she felt were completely out of her control. For her, this involved keeping journals of events and non identifying copies of charts to support her. She feared that because of constant staff shortages and heavy workloads that it was only a matter of time before an incident occurred and that she may be called upon and wanted to be prepared with her personally documented events because she did not feel her employer would support her in legal proceedings. She explained the calling of ‘Code Census’ had become routine and predictable. Code Census is an alert that is called on the overhead paging system informing all in-patient units that the emergency room (ER) beds are all full and each inpatient unit is required to immediately make a bed available for an ER patient. She went on to say that these patients are often housed in patient lounges, hallways and other non designated care areas. This situation forced current patients to be discharged before being well enough to go home and resulting in their return two days later much sicker and she stated “and the cycle continues”.

In addition to concerns about accountability and liability in clinical practice, participants also had accountability concerns related to their license to practice nursing. The College of Registered Nurses of Nova Scotia requires that all nurses licensed to practice adhere to Standards of Practice. When the nurses’ individual accountability practices violates the standards both individually and collectively they believed they risked discipline.

Participants shared they would attempt to expose these types of situations by completing occurrence reports. Occurrence reports are anonymous online reports that are completed for any unusual incidents, errors, or near misses that occur in hospitals. Healthcare administrators and risk managers use them to identify trends, anticipate

problem areas and to recommend corrective actions. Some participants spoke freely of completing the online occurrence reports as this was the only way managers would know “the hell we work in” while others did not feel this made any difference and only made them uncomfortable and more vulnerable despite the anonymity. The nurses’ who completed the occurrence reports went on to say they felt accountable to their employers to keep them abreast of what was happening on the front lines but felt they were not responded to.

Four participants acknowledged that their ability to practice as Registered Nurses was based on fulfilling their accountability obligation to their licensing body. Some of the participants made specific reference to the College of Registered Nurses of Nova Scotia formal accountability mechanisms, for example the annual exercise of “Building your Profile”. As part of a registered nurses licensing requirements each nurse is responsible to annually complete a tool that “is based on the principle that continuing competence is maintained and enhanced through reflective practice, lifelong learning, and the integration of learning into professional nursing practice ... three processes that also enhance professional accountability” (CRNNS, 2004, p.3).

Most of the nurses believed that first and foremost they were accountable to their patients. Those that discussed accountability to CRNNS felt that the required portfolio was too lengthy and feared being called upon to present their portfolio. Rachel clearly articulated “ Obviously, the first level of responsibility and accountability is to the College and the guidance received from the Standards of Practice”.

Beyond this specific mention of the College, some nurses made direct reference to protecting themselves legally stating that they felt their employers ‘did not have their

backs’ and they ‘needed to protect themselves’. For example two participants raised the H1N1 outbreak, where the use of the protective masks was to be limited because of a supply shortage. The nurses asked ‘how are we to protect ourselves’ when we are told it was unlikely any transmission would occur through the regular masks. This created scepticism as to whether the employer was really looking after the employees needs. The nurses talked about looking after themselves by stock piling masks.

One participant spoke of being floated to a specialty area and being required to take an assignment as a new graduate nurse, and the insecurity of not knowing how to handle the situation and feeling pressured to ‘pull her load’. She remains grateful to a nurse she did not know but whose words changed her and contributed to her understanding.

“And this nurse said, I’ll tell you one thing and one thing only: you have one license and only one license, and if you put yourself in a situation that you are unable to handle, you could lose that license and you may never get it back again. And I remember her saying that clear as can be, and thinking, thank you” (Starr)

At times participants appeared uncomfortable in their conversations about the legal and professional expectations and the overall reason for this seemed to come from a sense that the healthcare system is overstretched. Some nurses’ found the discussion and exploration of accountability painful because they believed the circumstances they are required to work under made enactment of both individual and collective accountability impossible at times. One participant spoke of a situation where they were reprimanded for an incident that was created because policies were outdated. All the nurse participants in their interviews made reference at some point to a healthcare system that is being held together by a thread. Emily Rose commented that during her career she has

witnessed the erosion of the healthcare system and is anxious to retire because ‘I am unable to do my job adequately and I fear the consequences’. Three participants made reference to it only being a matter of time until something very grave occurs which ends up on the front page of the newspaper and the evening news to raise the attention of the public to then demand inquiry and change. Emotion was high and frustration was very evident because they believed that administration is reactive and not proactive. These participants spoke of feeling helpless in making change happen and that change would not occur until society demanded it. They ultimately spoke of struggling with finding a balance in achieving professional expectations when control is often beyond what the individual can accomplish.

Societal expectations.

Societal expectations of nurses caring for patients in the health care system included the expectations of the trusted angel, hand maiden and the ultimate giving of ones’ self in caring for others. This ideology has been transferred for generations and often meets resistance from professional organizations and nurses themselves. Some participants discussed how they really feel these notions have not changed dramatically and that this in itself degrades one’s accountability.

One participant spoke of a recent experience where she was given a list of duties to complete by a patient’s family member. These duties included washing and putting rollers in the patient’s hair, trimming her finger and toe nails, and getting her up to the commode chair every two hours. The nurse spoke of frustration and anger at the families attempt to control her work with tasks that required significant amounts of time. She

spoke of families not understanding the heavy work loads and how nurses can no longer do all the 'extra things'. The expressed frustration focused on the public not understanding that nurses provided significantly more complex care than the tasks expected. The scope of nursing practice goes well beyond personal care yet this work remains relatively obscure to the general public. Besner's (2006) work suggests that nurses must have the ability to understand and then articulate what is nursing's unique contribution to patient and family care.

Societal expectations were viewed by participants as contributing both positively and negatively towards professional understanding. Some of the nurses acknowledged that society influenced perceptions and delivery of care.

The fact that nurses are in the top five of trusted professionals (Nafziger, 2010) was viewed very positively.

"Patients come in with a blind trust that we're going to do what's best for them, I truly believe they do, because they're fearful, they don't know, they have fear of the unknown, they don't have medical backgrounds, and they trust in us" (Stella).

Health care challenges are part of the daily news and participants expressed concern that despite this heightened awareness vague understandings of what registered nurses do along with the overextended systems and processes continued to create accountability challenges. One participant spoke of requests from patients and families asking her to diagnose and suggest treatment during triage. Triage being the process of determining the priority of patient's treatment based on the acuity and severity of illness when presenting to the Emergency Room. She went on to say "I understand why patients and families do this, they just do not want to further burden the system and waste their

own time waiting hours to see a doctor but requests like this left the nurses in a potentially very vulnerable position” (Tiffany). In this situation all is well if the assessment and treatment given were correct. If the nurse provided treatment options that were incorrect the patient could experience delays and set backs in treatment. If the nurse does not provide any information at all and the patient waits hours to see a physician only to be told that there is nothing that can be offered for treatment the experience is negative and the nurses feel they have lost credibility. This can be viewed as enacting or retreating from accountability. Nurses spoke of these types of challenges occurring everyday in their work life.

“I think accountability has changed with society in many ways. Society doesn’t seem to want to take as much responsibility for things any more and generally seems like that’s kind of the way things are going, in a lot of ways, we’re in a very. . .me-centered society. Where I grew up was more a community-centered environment, a community-centered society. Even 20 years ago, when I began to practice, or 24 years ago when I began to practice, you were more concerned and more aware of all the professional people who worked on your floor, You were concerned with doing well by them as well as with them. And there doesn’t seem to be that much, or not that much, but as much of that any more. And I think a lot of that is society’s reflection. That in a lot of ways people don’t have to take responsibility for their actions” (Fannie).

This participant expressed frustration with the invisible work that nurses do which is never talked about but is the central reason for positive patient outcomes.

“Automatically the doctor gets praised for, you know, curing them, or whatever, but, when we, if you took the number of minutes that the doctor was involved in this person’s, you know, month long care in a hospital, realistically, yeah. But, if you go back to, you know, 30 years ago, where all we did was follow the orders, so then it was this physician giving us the orders and we did all these things and the patient got better, now it’s, we’re more involved in the care plans and the, you know, ways of maybe altering what we do or don’t do with this person that, and thereby having more of an effect on their well being and their outcomes, people don’t see this” (Wendy)

This was reinforced by another participant saying “Living behind the scenes day after day over time contributes to a persons feeling of being a valued team member and may

ultimately affect accountability practices” (Gracie).

The participants did speak of feeling very supported by the public but there is a dichotomy that prevails. Societal expectations and what nursing is able to provide can be two very different things.

“You’re accountability is, you know, your practice, your scope of practice, , your guidelines, your job description, all of those things fall under that. So if you’re following all of that, then your quality of care is going to be exemplary..... The perception of what is great care is always left for negotiation, isn’t it, because some patients won’t necessarily like, regardless if they’ve got the best care they could possibly get, it may not be enough for them, because their expectation was different than what was, than what was needed” (Stella).

Developing personal understanding and gaining professional understanding of accountability lead participants to finding their way in the process of enacting accountability.

Finding The Way

Every registered nurse interviewed discussed the painful journey of entering, maintaining and moving forward with their practice in the healthcare system. They described a journey laden with stress, uncertainty, and fear, where these emotions drive every action, decision and experience. The nurse participants used the term ‘finding your way’ which is the concept I have used to explain how the registered nurses advanced along the continuum of accountability from being a new graduate nurse, beginning employment in a new area, and maintaining a position as a senior nurse. One participant suggested this is just ‘learning to survive’ the everyday. All participants agreed they strive to be competent, confident and active team members. Although they felt this was not always achievable. When this was not achievable or minimally achievable they felt it was for reasons out of their control and occurred in various ways.

The nurses discussed these various ways of finding their way through the sub processes of Individual Personal Paths and learning to Navigate the System. Personal Paths included educational preparation, trust, collegial respect, continued learning and mentorship that contributed to individuals finding their way. Navigating the system is what nurses do in order to be able to more fully enact their accountability or may in some cases lead to retreating from accountability.

Personal Paths

The majority of the registered nurses' spoke of instances in their early years as a practicing nurse or being an experienced nurse on a new unit and the explicit need to become part of the team and "find your way". The differences became apparent in their approaches on how they achieved this.

Tiffany spoke of feeling disappointed in her nursing education. She felt very ill prepared to enact accountability.

"I do not think that any of us are well prepared, at all. We were prepared some, but not for the reality of it. Yeah. It's certainly a completely different aspect being a nursing student, getting very little clinical practice, and a lot of, you know, theory practice, and actually doing it in real life, was, was quite eye-opening" (Tiffany).

She spoke of this transitional period as being overwhelming and stated it was a matter of just trying to survive and not cause anyone harm. All other participants spoke of similar transitions, those with baccalaureate degrees spoke with greater emotion of the significant stress and learning required over those that were diploma prepared. The explanation for this appears to have come from the diploma nurses role as students in the daily operation of the hospitals. For example in diploma schools senior student nurses

were left in charge of patient units and overseeing the care of junior student nurses. This required the senior diploma student nurses to enact accountability at an earlier time in their careers and with the junior student nurses observed the senior students in charge. The baccalaureate nurses did not speak of any type of similar experiences in their education.

All the participants spoke of the element of trust in each other as being integral in their ability to practice accountably. Hartrick, Doane & Varcoe's (2007) work readily supports the relational aspects of working together harmoniously in meeting accountability expectations. Their work suggests that nurses' personal identity and social location shape interpretations and the willingness and capacity to relate with patients and colleagues. They go on to discuss how trust and mistrust can enhance or impede accountability practices. They concluded that familiar relationship concepts of trust, empathy and respect work synergistically with obligation, accountability and the 'do good' action and that more attention needs to be given to relational practice. "I think trust is huge. I mean, it's not something you give away freely or lightly. It's an unwritten rule, that when you have it, you want to trust, and you need to trust, because everybody's doing the best they can for the outcome of the patient" (Stella).

Many spoke of a transitional period with colleagues as they came to know each other and whether they could 'trust' the other to care for their patients as they cared for them. They spoke of this trust developing over time and that in fact they did not trust all of their colleagues. This explained why this really impacted their own ability to enact accountability and even created an extra burden on them. Reg spoke of situations working with colleagues he trusted in comparison to those he did not...

“Sometimes like I won’t, even think twice, with the acuity of your patient or who’s covering, but other times like a half hour break may turn into 10 minutes or even won’t go at all because you worry. . .But I know there’s one guy I work with all the time, like he knows what I’m going to do before I do it, we just work together, been working together for 5 years now, and so it’s huge element of trust there. I could go in in the morning, if I have the sickest patient in the unit, I could drive to (area), and drive back, with him covering my patient, and I know 8 hours later, everything is, perfect. Whereas, I know he’s accountable. Whereas somebody else, not everybody, but some I wouldn’t go to Tim Horton’s in the same building to get a tea” (Reg).

He then went on to discuss working alongside those you do not trust and needing to be extra vigilant, not letting your guard down and constantly being aware of what they are doing to ensure patients do not suffer. This extra burden in your day to day work adds an extra level of stress.

Gallagher (2010) reported that nurses were willing to carry the added burden rather than report poor practice because of the fear of consequences. The reasons and rationale given for not reporting included: the fear of being viewed as disloyal to colleagues and employers, the added burden and stress of being called upon, violating codes of conduct by breaking vows of confidentiality, and the risk of being ostracised by colleagues and supervisors.

All participants conveyed a commitment to deliver high quality care to patients. “First and foremostare my patients in terms of being accountable to them” (Gracie) and “I think ultimately our accountability goes to the patient” (Stella) and “I am accountable to my patients and their families” (Reg). For example, some of the participants expressed the belief that most people are drawn to nursing because of the desire to want to help others and the level of commitment to do good and ensure no harm.

“You go into nursing believing you want to do good, what’s best for the patient. And so I think that’s just how I learned it through my nursing, you know, we had very strict instructors that, you know, this is the correct way to do it because this is the best practice. It makes you a bit black and white I guess. And, because there’s not room for grey, probably say when you talk to most nurses, yeah, they would look at it as a more punitive thing, that they’re accountable and it feels heavy” (Stella).

In finding their way, participants spoke of avoiding conflict and the potential for discipline regarding decisions made or avoided. This included “covering your ass at all costs”. For example explicit documentation such as “Dr Green notified of patients deteriorating status- refused to come and re-assess patient”. One participant spoke of the challenge of working within the new model of care and the LPN she worked with not notifying her of a patient’s low blood pressure. She spoke of feeling responsible and accountable and in a vulnerable position if something happened to this patient.

The registered nurse participants spoke extensively about their work experiences, their ‘first job’ leaving lasting scars and/or fond memories. Many attributed these experiences to who they are as a registered nurse today. They spoke of learning first hand good and bad accountability practices. As work experiences grew professional confidence increased and the ability to operationalize accountability seemed easier.

“Practices change, then, as that accountability evolves... And it can go either way. Yeah, you know. They can go to be a kinder, gentler person with a different philosophy and a different way of thinking, or it can you make this very hardened person that, you know, I’m sure you didn’t want, when you graduated from nursing did not envision yourself to be. ...Created by fear- I think there’s a lot of fear- nurses eat their young....I think, they’ve gotten bit when they were younger and, you know what I mean? I always say, do you ever remember the first time you were thrown in the ditch? And people will tell you, exactly who she was, or who he was, what physician, what patient, what other co-worker, and they all remember it vividly” (Stella)

One participant validated this in relating an experience where she felt degraded and that her intelligence was insulted.

“I did have one doctor who used to, I asked something about a temperature, he replied ‘yours is but to reason why, yours is not to do or die’.... That’s what he said to me, and I asked him something about a patient’s temperature. . .I can’t remember why, but I just remember to this day his words” (Wendy)

She went on to say that this incident occurred early in her career and is still with her. She spoke about how this two minute interaction impacted her confidence to practice and ability to operationalize accountability.

Other participants spoke of initially being naive in their work, diligently following orders but soon learning ‘the doctor nurse game’ was essential for survival. In 1967 Dr Leonard Stein first identified the nurse-doctor game. He espoused that the interactions between the doctors and nurses were carefully managed so as not to disturb the fixed hierarchy resulting in game play. To play the game nurses appeared to be passive and make recommendations that looked like they were initiated by the doctor. The nurses’ role in game play was to be responsible and accountable for patient care but also for the nourishment of the doctors ego and professional self.

“When we first start out, we were green as grass and we have a learned job to do, and we know we have to practice in a safe way. But we’re not quite, I shouldn’t say, I just remember being a, a young, graduate nurse moving into a rural area and whatever the doctor ordered was what we did, and very quickly we learned that not all of the things that they asked us to do were the right things to do. We knew we had to have orders to actually perform tests and, and give drugs and whatever dressings we had to do, but over the years, it became quite apparent that we were doing things that we weren’t necessarily supposed to be doing, but because the doctor ordered it, that’s what we should do. And we learned how to chart it properly and cover our bases, and we knew the right questions to ask before we did things” (Flossie).

Other participants spoke of mentorship in learning to find their way and showing others the way. “I learned accountability through experience, and probably through other people, especially mentors” (Emily Rose). Flossie supported this testament in discussing a clinical situation where she was acting as a mentor to a junior colleague:

“A young girl needed a chest tube, a Heimlich, and not that I wouldn’t go right to the policy and look it up, but if I had not had a student or a new grad with me, I would want to show her that this is what you do. You know, if this is the first time that you’ve done this procedure, and it was, I wanted her to know that you would refresh, you refer to the policy, you know, and make sure that you had everything in order, your equipment and so on, and make certain that before you went in there to set up and assist with this procedure, that you felt confident that what you read was what you’re going to do and, and that was the right thing to do. So if she had not been with me, I probably wouldn’t have made reference to the policy just because for 30 years we’ve been putting chest tubes in and nothing too much has changed. But as a young grad, I think that it’s important that before you’re learning the experience, or learning the skill, that you make sure that you’re doing it right the first time, to learn it the right way. So you’re being a mentor” (Flossie).

Seasoned experienced nurses those with greater than 20 years experience referred to the younger nurses as not having the same degree of accountability compared to those who described themselves as “one of the old girls”. They spoke of the need to provide positive mentorship to new nurses to try and teach a greater level of accountability. One participant stated “They’re going to be looking after me one day and I want to ensure that they have what it takes” (Gracie). Very profoundly Stella quoted “Mentorship is a significant part of enacting one’s accountability, either positively or negatively, depending on your previous experiences” (Stella).

Emily Rose spoke of mentoring a student nurse where they overheard an inappropriate conversation between two registered nurses outside of a patient’s room.

She went on to say that the student was appalled at the unprofessionalism and had feelings of confusion as to how to deal with such a situation. She felt accountable to do something but was uncertain how to address this situation.

In finding their way the participants raised and discussed many similar but also different and varying circumstances that have contributed to their knowledge, understanding and operationalization of accountability. Many of these circumstances are influenced by the healthcare system and what nurses must do to manoeuvre and work within the system.

Navigating the System

Navigating the system is what nurses do in order to be able to more fully enact their accountability or in some cases leads to retreating from accountability. It includes what they believe accountability to be and what they do to enhance nurse accountability or to retreat from it. In all the interviews participants spoke of an experience that related to the systems and processes that they work in as contributing to their ability to enact accountability. The nurse participants spoke of the daily burdens of human resource issues, financial constraints, and inefficient systems that created work and often caused harm.

A number of participants expressed their belief in the importance of being accountable to their employers. Participants viewed the system as being 'them' and 'us'. The health care professionals are divided into the frontline workers and administration. All participants felt obligated to be accountable to their employers whether they were front line staff or nurse managers.

The nurse managers participating considered accountability as an outcome of having authority. They saw that accountability as the responsibility that is given to the nurse and it is this responsibility to perform and make decisions within their scope of practice to provide quality care. The managers spoke of the inconsistency and the unpredictability of accountability practices along with the challenge of dealing effectively with this. The staff nurses also considered accountability as having the authority to make decisions also but many expressed the lack of support they felt if they made an incorrect or controversial decision. A number of participants spoke of management making changes on a frequent basis with little communication or fore warning.

An example that was given by 4 participants in 3 different work areas was how the patient assignment kept changing. They all stated this created unnecessary confusion and more stress while being frustrated in not being provided the rationale for change. To deal with the confusion and frustration the participants frequently developed ways of coping and creating a sense of control in their work areas while ultimately protecting their own accountability expectations. One participant spoke of reverting back to the 'old' way of assigning patients on evenings, nights and weekends when the nurse manager was not around. She said that they decided as a team at the beginning of their shift that it was in the patients' best interest that the team could provide a better quality of care using the previous way of making the assignment. She explained that this caused some challenges when the nurse manager became aware that this was occurring. But the participant said "she was just not listening to us, she has no clue as to what works and does not work when making the assignment. We felt a stronger accountability to the patients and the care they would receive than the repercussions from her (the manager)".

Some have focused on documenting accountability awareness.

“I just find it’s so busy. The floor is busy, everybody’s busy. Everybody seems to have more on their plate every day. So people are happy to say, that’s not my job. And, yeah, just hope that it’s going to go away, but it doesn’t. I think a lot of times we like to think that the physician is ultimately accountable. You know, I’ve seen many times written on the chart, physician aware, which is you covering your documenting, I guess, that you made the physician aware. And I’ve also ultimately seen the LPN write many, many, many times, the RN’s aware. Which is the same kind of thing that we’re doing, you know, as long as you make the person aware” (Starr).

This practice of documenting by LPNs that the RN is aware has set up a challenging relationship between the registered nurse and licensed practical nurse (LPN) that is generated by a lack of understanding of each others scope of practice and leads to role confusion and miscommunications. Others have chosen to avoid the accountability expectations by making excuses.

“I tend to see, ‘that’s your responsibility’, you know, the passing of the buck and that, it’s management’s responsibility if this splint didn’t go well or something went wrong, because I was rushed and there wasn’t enough staff, and there was this, and all the excuses that we make, rather than stepping back and saying, this is what I have in front of me, this is what I need to do and I do it the best possible, safest way I can, and I’m accountable for my actions regardless” (Stella).

A number of participants spoke of being blamed when things don’t go well and frequently nurses seemed to feel that physicians quickly pointed to them.

“I’m not going to lie to you, I’ve seen that happen. Something goes bad, they’re looking for a fall guy. Whereas other guys, I think that’s human nature and that’s any profession. Like I said, yeah, yeah, that’s what they call the glory and stuff, but if something goes bad they look for a fall guy and the accountability kind of shifts to the nurse, I guess, things go bad. I’ve seen that often (Reg).

And as Wendy points out physicians rely on nurses to keep them informed and up to date on patient’s conditions. This responsibility for nurses may help the profession in

creating environments that enforce full enactment of accountability. She goes on to say that this proves to be challenging for the new inexperienced nurse who is task focused and also the seasoned, experienced nurse who is 'burned out' and not engaged in their work.

“But the doctors, although they may not. . .I won't say not admit it, but, if something goes wrong, they're a little pissed off that the nurse didn't tell them or give them the heads up or whatever, they depend on us (to keep them informed), because they can't do it all on their own, they do depend on us for that. So that may help make us a little more accountable over time.....it fails when you have your newer nurse, who probably tends to be very task focused and order focused, she's doing A, B, C, D. because that's all they can do, it's a little hard to think outside. Or you have the seasoned, cold, and non-paying attention any more nurse” (Wendy).

Other participants made the point that the importance of being accountable in such a large hierarchal environment creates an environment where one can be less accountable because of the dilution within the system. These participants spoke of a health care system that has many levels of accountability which makes finger pointing challenging if not impossible. A number of participants spoke of situations where there is no way to identify where final accountability rests. This is supported by Chambliss(1996), and Nelson & Gordon, (2006) in relevant literature. Chambliss' work suggests that the “routinization” and “protection” of existing systems and processes enable nurses to retreat from accountabilities. The multi-levelled hierarchal work environments further foster retreating behaviours. The routinization and protection is the health care providers and administrators attempts to maintain control in out of control environments by hanging on to what they know and can predict. Nelson and Gordon's work uncovered that nurses reported they find hospital environments “utterly

inhospitable” leaving nurses conflicted in an environment opposite to that which they envisioned when entering the profession.

One participant gave the example of an 88 year old gentleman brought in to the ER by ambulance for increased shortness of breath with low oxygen saturations, abnormal electrocardiogram and multiple co-morbidities. The patient was triaged and placed immediately by the clinical leader in one of her assigned beds for further assessment. The clinical leader took report from the ambulance paramedics, informed her that this patient had been placed in her bed, then resumed other duties without passing the report on to the nurses. An hour passes the assigned nurse is finished with her other patients and goes to the new patient’s stretcher area believing that the clinical leader has done the assessment and preliminary work up. The nurse finds he has not been assessed, or placed on the cardiac monitor, and that initial blood work and electrocardiogram have not been done. The patient’s vital signs have further deteriorated and the physician is furious that he was not aware of this patient’s arrival. The participant asks where does the accountability lie? She went on to say that paramedics are not to hand over an unstable patient until a nurse is available and further the clinical leader is not to be placing a patient in a bed unless there is someone to care for them. As the nurse assigned to the bed she stated she felt horrible for this event and felt responsible and accountable for the lack of care but recognizes that she does not stand alone. She went on to say that in these instances healthcare providers pull together in the immediate to ‘fix’ the problem, stabilize the patient and then all retreat to their roles. She reported that it was only on rare occasions that there was a debriefing. Through tears she said “This patient

nearly died because of the system but we rallied together, made it right and continued on until the next time- and we all know there will be a next time” (Gracie).

Senior nurses felt that the lack of checks and balances that had existed earlier in their career no longer exists. Emily Rose spoke of her experience where she felt that the system was left to run itself. She stated that over her 30 plus year career she had seen the erosion of the middle manager role. She felt comfortable and confident discussing this because she had worked as a manager as well as a frontline nurse. Emily Rose described her role as a manager 20 years ago as filled with chart audits, continuing education files, organizing annual certifications, and various quality improvement programs. She went on to say that these currently exist but on paper only. Emily Rose in a very matter of fact manner stated that there is no feedback loop and follow up evaluations and because of this the system is left with gaps and lacking accountability. She feels that middle managers are continually reacting to the loudest voice with little opportunity for proactive planning, implementation and evaluation.

Four participants pointed out that there are ‘good’ units and there are ‘bad’ units and you quickly learn which they are. The participants spoke of good units creating and fostering an accountability culture through team efforts, transparent communication and positive working environments. The participants spoke of the bad units as having no communication, people not working together and being in survival mode. The participants identified that their individual accountability practice was either enhanced or depressed in accordance with the collaborative accountability culture on units. This is supported by Hartrick, Doane &Varcoe (2007) in their work on relation practice and nursing obligations. Their research concluded that an understanding of relationships can

turn attention to the connection between attitudes, intentions, judgements and actions.

This understanding can explain the ‘good’ and the ‘bad’ units.

Wendy provided this summation of how individuals contributed to unit culture and accountability practices.

“I said the new nurse is task focused, that the old nurse who’s, I don’t know what you want to call it, it’s not, they’re not task focused any more, but they’re not focused, they are focused on problems and their own anger issues and what not. They’re not, and it’s not allowing them to be observant and cognizant of what is really going on around them, because they’re just like the new nurse there, they’ve got this narrow focus thing on” (Wendy).

Reg reinforces this by talking about people having different foci and priorities which in turn makes navigating the system and ensuring positive outcomes difficult.

“You could be accountable, if it’s a busy day, to be accountable there, that’s great, and there’s stuff here, you know what I mean. If you, then if you focus on this, like with the bed baths and the cleaning, and the cleaning of the room, and look at that, get them vitals later, or I’ll get the pills the next set, or. . .X-rays calling, I’ll just take them down later. That’s the difference, a different person’s perspective on quality of care’ (Reg).

Flossie provided an example of trust in the current system that proved unhelpful in enacting accountability.

“How it is that the facility controls their narcotics and. . .you would witness. . two people would actually withdraw medication and witness them discard and so on, we, over the years, I think of many, many times where, you know, we did actually have two people withdraw the medication because we would both be signing and witnessing taking the medication out. But after you developed a relationship, a trusting relationship with a co-worker, over a period of time, I’m thinking one girl in particular that I worked with all the time for almost 10 years, and you can sort of let your guard down because, you know her and you trust her, you know what you’re supposed to be doing but you would, on many

occasions I can recall saying, oh, yeah, just take that out and I'll sign it for you. Now, I would have to be accountable for signing it and really, in doing that, I really, you know, have to make sure that I see it, so I might not see her actually take it out of the cupboard, but I'm trusting her to say, you know, that, to agree to what she's taken out is actually what she's taken out and not saline, and she's not going to slip it in a syringe and put it in her pocket, and so on. And I think that never really came to light, I would never have considered that would be an issue that you'd have to think about. We knew why we did it the way we did it, but when it actually came to light that, my god, this is has been going on. There are co-workers that I've worked with who have had drug problems. We sort of helped set them up for it. And, that was kind of a, sort of an eye-opening" (Flossie)

Our current systems, processes and ways of working are contributing both positively and negatively to individual accountability practices. An example of bringing positive knowledge and awareness follows in Starr's view of how the Model of Care Initiative (MOCINS) has heightened accountability. The MOCINS is a new collaborative model of delivering healthcare with the goal of delivering high quality care, that is safe, effective, patient centered and cost efficient (MOCINS, 2009).

"The model of care has brought accountability to the forefront. I think it's trying to define that registered nurse line, LPN line, and when the registered nurse should take over. And I don't know if it just kind of morphed its way into a big accountability piece.... I've learned more about accountability than, in the past, I've known it, it's just been brought to the surface". (Starr)

Both the individual personal paths and navigating the system subcategories have explored how these impacted the nurses enactment of accountability. Using a CST lens during analysis has afforded this study the opportunity to demonstrate that the nurses' challenges in navigating the system are directly tied to social positioning within the healthcare organization. As the findings demonstrate nurses' often faced adversity and

struggled in finding their way to accountability which lead to retreating from accountabilities.

Becoming Professionally Confident

All participants agreed that professional confidence is something that an individual must have to be a productive, satisfied and successful nurse. This confidence is imperative to accountability practices so that an individual grows as a person and is able to achieve all they want in their career. Becoming professionally confident does not come easy nor does it come to everyone as the participants pointed out. Those who were successful can see, own, solve and do to meet accountability expectations. Professional confidences prevented retreating from accountability. See Figure 3. This diagram was informed by the work of Connors, Smith and Hickman (2004).

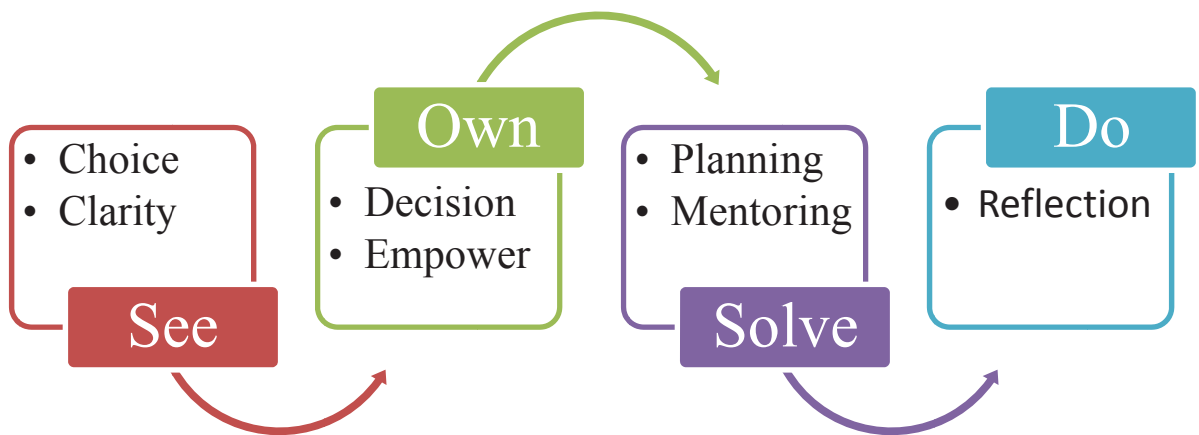


Figure 3 Process of Becoming Professionally Confident

The registered nurse fully enacting accountability, demonstrated professional confidence in the combination of four elements of seeing, owning, solving and doing. The seeing begins with the individual believing they have a choice in the situation and seeing this choice with clarity. Owning means the individual is empowered to take ownership of the situation and make decisions. Through planning and mentoring (feeling supported) a solution is reached by the individual and they move on to doing in the final phase that includes reflection on what has occurred, enhances learning and builds professional confidence. This finding was reflected in the work of Nelson and Gordon (2006) who explained that nurses can gain professional confidence by claiming their scientific and technological knowledge and taking the lead within interdisciplinary teams because they have the interpersonal therapeutic relationship expertise.

“It’s a gradual process over time. It’s not that one day it sort of just changed, it’s kind of, so for me, I guess I’ve become more aware of it over time, as I’ve worked in different places and, you know, you come out of nursing school, you don’t have a whole lot of experience, you haven’t, in life or in nursing, you’re young, usually, and. . .So, that kind of grew over time as well, too, I suppose, in the sense of. . .myself as a nurse and what that meant to me, what that meant to other people, has kind of grown and changed over the years” (Wendy).

Eight of the participants spoke of the experiential aspect of accountability.

“I think there’s a basic level of accountability you have to have as a nurse right out of the get-go. I think your ability to understand accountability grows as you grow, you know, it changes as you grow and, and you respect it in a different way’ (Stella).

The senior nurse participants spoke at length of the acquisition of this ability. They stated that their years of experience, trials and tribulations gave them the confidence required to make enacting accountability no longer burdensome. They spoke of an arbitrary time in their career when it becomes less of a hardship. The more junior nurses

spoke of the pain and agony of gaining confidence in their practice along with making independent decisions. They spoke fondly of the seasoned and experienced nurses' skill and yearned for the day when they would exude such confidence and decisiveness. This gaining of professional confidence reflects by the seminal work of Novice to Expert by Dr. Patricia Benner (1984). Her theory/philosophy proposes that nurses pass through five levels of proficiency as they develop. The final level is that of 'Expert' where individuals are able to zero in on problems and performance becomes very fluid, flexible and highly proficient. From a CST perspective environments that foster self-reflection support the nurse in reaching full understanding of situations at hand enabling action and becoming professionally confident.

The participants spoke of this professional and experiential transformation that occurred throughout their career. They reported that this transformation was very individual. Some choose to and some choose not to become professionally confident. This choice can be conscious or unconscious. Those that purposely choose to exercise continuous self awareness, reflection, motivation and drive for personal and professional growth reported more success in enacting accountability.

Participants spoke of mentorship as providing them with greater skills and professional confidence in their own knowledge and expertise. Tiffany stated "To be a mentor you have to know your stuff, it forces you to be on your toes all the time." She went on to say that her confidence grew after her first mentorship experience. Another participant stated that she was a mentor so that she could give back to the profession. She positively and fondly remembered her mentor showing her the way and helping her build

her confidence through working together. The power of mentorship is widely studied and supports professional development (Wagner& Seymour, 2007).

From the participants perspectives all of the stages affected the perception and enactment of accountability by nurses. They frequently spoke of elements of the health care system that are considered barriers that prevented them from fully enacting their accountability. These included factors such as bed shortages, excessive workloads, human resource issues, inefficient care delivery systems, increased non- nursing duties, blurred accountability boundaries, repetitive documentation, and continual administrative pressures ‘to do more with less’. They also frequently spoke of their personal experiences as a young child to that of a fresh student nurse, a terrified graduate nurse and then to a seasoned practicing nurse always learning and building upon existing accountability practices. All the participants agreed that this learning and building occurred with self reflection, mentorship, developing leadership abilities, and active questioning. La Sala’s (2009) work suggested it is through a sense of shared or collective accountability that nurses recognized the inherent worth and contributions of those with whom they worked, this then fostered professional development through job satisfaction. The development of cohesive teams and shared goals and visions can be further explained and linked to accountability practices.

Though participants believed that having professional knowledge and skills is the basic prerequisite for enacting accountability, they did not consider it to be sufficient. They emphasized that accountability is only fully operationalized when nursing knowledge with evidence informed decision making is applied and implemented by an experienced nurse. They spoke of the experienced nurse who has “seen it all” and

therefore has the confidence to make decisions in any situation. The development of professional confidence is pivotal in the nurse's enactment of accountability. The research by Memarain et al (2007) supported the personal and contextual factors that contributed to a nurse's professional development. Their work concluded that acquisition of professional confidence is facilitated by the personal factors of self respect, developing effective relationships, ethics knowledge and the external factors of organized clinical environments which are led by effective managers. The next section will discuss how these external factors contributed to the nurses' enactment and/or retreatment from accountability.

Contextual Factors

Enacting and/or retreating accountability practices was the central category that emerged in this study. The extent of enacting and retreating from accountability practices was influenced by external contextual factors. Through this the registered nurses' understanding and enactment and/or retreating from accountability was further complicated. The contextual factors that emerged were: human and financial resources, healthcare system processes and institutional culture and will be discussed in relation to each of the theory stages.

The enactment of accountability was carried out to varying degrees by the nurses in their work. The theory of nurse enactment of accountability illustrates how this happened by outlining the four stages of accountability. All of the stages have contextual factors that influence the degree of self- integration of accountability. For example, in stage one as an individual moves from childhood to adulthood the socio-economic status

has the potential to impact the nature and degree of accountability that is acquired. In stage two the educational learning surrounding accountability will affect the sense of accountability.

In stages three and four the employment environment and the environment of the wider healthcare system played an important role in the degree to which nurses were able to enact accountability. If nurses, were required to work in areas where they did not have the knowledge and skills necessary for the work required they retreated from enacting their accountability. This was supported in Gracie's discussion of being floated to a critical care area and being asked to care for a patient being monitored with a neurological pressure monitoring device that she was unfamiliar with. She went on to say that she was fearful during the entire shift, and relied on others in supporting the care she was providing.

When nurses continuously worked under circumstances of staff shortages and were unable to meet the basic needs of patients and believed their patients were at risk this also drove them to retreat from accountability. Emily Rose spoke of feeling drained with the constant day to day pressure of working short staffed, caring for patients of high acuity with limited resources to carry very heavy workloads. She stated that after working a couple of these shifts she became disengaged and did not always hear and see what she should have. Smith spoke of the fear and frustration associated with providing care and feeling there were looming risks to patients and potential deficiencies in care. Wendy validated this when she spoke of colleagues she worked with as being physically present but not really present in the care they provided. She went on to say that often

these colleagues' energies were spent focusing on hardship, inadequacies and just complaining.

In contrast, participants spoke of enacting accountability practices when they felt supported, in a trusting environment with the positive empowerment that resulted from self reflection and mentorship which promoted the enactment of accountability practices. They spoke of trusting and valued relationships between nursing colleagues, physicians, support staff and administrators. Nurses were also empowered by seeing the positive results of the utilization of the Nursing Process through Assessment, Planning, Implementation and Evaluation. This was readily seen in patient care plans created by nurses and the interventions they took ownership for completing and evaluating. The participants proudly spoke of having made a difference that led to positive outcomes and satisfied patients and families.

The majority of participants expressed concern that collective accountability was difficult when so much was out of your control and often conflicted with individual accountability. The central dilemma that each participant felt they faced was this lack of control over many of the contextual elements that contributed to their accountability practices. One example given was to a situation where nurses are routinely expected to take on the care of two and three additional patients when there was a sick call and no replacement coverage was available. Yet the professional accountability to the college leaves them in a precarious position where they know they can not adequately meet the Standards of Practice (2004) carrying the extra patient load. They spoke of feeling trapped, paralyzed, losing themselves, and the incongruence of expectations. These feelings were the result of being able to provide patients only the basic necessities and in

some occasions not even that. The incongruence of what you are educated and licensed to do and what you realistically can do leaves nurses battling with these feelings.

All participants provided examples of accountability dilemmas they frequently faced. These dilemmas were directly tied to the contextual factors: negotiating conflicting opinions of care, working in overwhelming environments, advocating for patient needs that conflicted with institutional needs, increasing workloads and the routine expectation of working short staffed to care for patients of increasing acuity.

Summary

The theory of enacting and/or retreating from accountability explains the process that these nurses traversed in their day to day work. My findings have revealed that the registered nurses' have very individual and personal understandings of accountability. The theory of the process of the enactment and/or retreating of accountability is framed in four stages. In the initial stage of developing personal understanding as a child an individual learns about accountability through parental and personal expectations and the consequences of behaviours, early work responsibilities, family influences, and the adoption of morals, values, beliefs and integrity.

In the second stage of Gaining Professional Knowledge an individual garners greater understanding of accountability through the formal means of professional education. The educational process is built along side personal understanding and also varies from individual to individual.

Finding the Way is the third stage where individuals create personal paths through navigating the health care system to secure their place. The challenge in this stage resides with fear and uncertainty, along with a lack of experience and the significant pressures of contextual factors. Self reflection, mentorship and continued professional development lessens the challenge.

In the fourth and final stage individual's become professionally confident. This is gained through the experiential aspect of enacting accountable. As nurses grew they felt more comfortable and confident in making care decisions and addressing challenges. This process of professional maturity is not automatically acquired but purposely gained through learning, and experience in a mentoring environment.

The enactment and/or retreating from accountability was controlled more by the organization than the individual. Further, an individual's ability to enact and/ or retreat from accountability in clinical practice contributed to the challenges facing health care. The health care challenges of fragile overstretched systems and unclear system processes contributed to environments that were conducive to retreating from accountability practices.

In ancient Rome, the engineer of an arch stood under the capstone to demonstrate his confidence in the construction, thereby assuming accountability (Armstrong, 2006). Each nurse perceived this arch differently and was uncertain as to who the arch engineer was. The healthcare system and institutional culture dictated whether a registered nurse choose to stand under or more often beside the arch.

CHAPTER V DISCUSSION

The objective of this thesis was to gain an understanding of how registered nurses come to know, understand and enact accountability. In this age of increased emphasis on professional accountability in health care, an understanding is essential to address the discord that often exists between accountability expectations and the registered nurses' ability to meet these expectations.

The specific aim of the study was to answer the following questions: (a) how nurses defined accountability; (b) how nurses viewed individual accountability; (c) how nurses learned and understood the concept of accountability; (d) who nurses believed they were accountable to; and (e) how nurses demonstrated accountability in their practice. The findings from this research have answered these questions, as well as provided the basis for a critical examination of the external contextual factors that contributed to the registered nurses enactment or retreating from accountability.

This chapter is organized with a review of the theory followed by a discussion of the major findings in each stage that explained how registered nurses came to know, understand and enact or retreat from accountability. The discussion will include findings of the study in relation to relevant and supporting literature. Study limitations will be presented and reviewed. The implications of the study findings for nursing education, administration, practice and research will be discussed.

Theory Review

As demonstrated in the previous critique of the literature and existing research, considerable attention has been placed on accountability being a part of the answer and solution to the health care system problems. Beyond the mention of the concept being used to create a system where individuals own decisions, little is written about how nurses' come to know and enact their professional accountability, and how this in general impacts the health care system. This research study in addition to generating an explanation of the enactment of accountability by nurses highlights the interdependencies among healthcare professional's accountability and the systems they work in.

The theory that emerged is that registered nurses enacted as well as retreated from accountability. The main worry of these nurses was how often they were challenged in their ability to fully enact their individual accountability. Nurses learned professional accountability through personal, educational experiential, social and professional means. The theory incorporates four stages: (1) Developing personal understanding; (2) Gaining professional understanding; (3) Finding the way and (5) Becoming professionally confident. The enacting as well as the retreating from accountability occurred in a context and the contextual factors that influenced the process were institutional culture, financial and human resources, and health care system processes. This theory has generated new nursing knowledge that has the potential for creating change in all areas of nursing education, practice, leadership and the organization of healthcare. This theory has opened the door to other research opportunities on this topic.

While the theory presented here cannot provide all the answers for an individual enacting or retreating from accountability it can assist nurses, educators, healthcare leaders, and researchers to consider accountability from a systemic perspective and to be aware of the multiple inter-related stages and factors involved.

Developing Personal Understanding

The registered nurses' personal understanding of accountability, for all participants began at a very young age. The registered nurses' personal experiences regarding accountability had similar threads that wove them together. The similarities included parental/guardian expectations, personal expectations, early work responsibilities, degree of family influences, individual morals and integrity, values and beliefs, altruism, doing no harm and the consequences of certain behaviours.

Participants' enacted and/or retreated from accountability during this stage based on their personal understanding. For example Smith believed he exercised accountability because of his fathers expectation that he take personal ownership for the error when he broke a neighbours house window. He stated "that sticks with you" and provides the foundation for professional practice.

An example of retreating from accountability was given by Gracie when she spoke of stealing a chocolate bar from her brother when she was eight years old. She stated that she had silent regrets and remorse for years, until she professed her guilt to him when she was eighteen and had started nursing school. She felt it was ironic that she chose to cleanse her soul when she entered nursing school run by catholic nuns. She went on to say that the reflection of this experience as a young child left lasting impressions on her and her approach to nursing her patients and families.

All the participants explained how their personal development and understanding of accountability generally had punitive consequences and that the fear of punishment certainly guided them in their childhood accountability decisions.

Gaining Professional Understanding

The gaining of professional understanding by registered nurses consisted of building upon the foundational stage of ‘Developing personal understanding’ with formal education. This was structured with the multifaceted knowledge building social process of post secondary education that intertwined with participant’s individual values, attitudes and beliefs. This also proved to vary from person to person. The participants spoke of similar fundamental teachings but differed in their personal beliefs, attitudes and experiences.

All the nurses interviewed spoke about the vague teaching and experiences they had with accountability in their education programs. A number spoke of the concept of accountability being discussed in their ethics course, but nothing beyond this. One participant suggested “ We came into nursing because we were good girls and the expectation was then we would be good, honest, trustworthy and I assume then accountable nurses- whatever that may mean”.

The participants determined that for a person to gain professional understanding, the ability to move forward is dictated by self reflection and one’s own personal internal desire to ‘care for’, ‘do good’ and achieve professional status. Each nurse decided what professional understanding meant to them.

Fully enacting and/or retreating from accountability occurred during this stage. The primary reason for retreating in this stage was cited as a lack of understanding and fear of not knowing the right thing to do, many then opted not to do anything at all. The act of retreating and doing nothing at all left the nurses feeling empty, unfulfilled, and in some this initiated and lead to a drive to do and know more. A number of participants spoke of the mentors they found in their nursing programs and when they got their first jobs. They felt their mentors taught, supported and guided them.

There was an increased demand and higher expectation of registered nurses in relation to accountability. Participants in this study reported that baccalaureate preparation better equipped the nurse for developing professional confidence and this was supported in the literature looking at the educational level required for entry to practice. Researchers have identified that education does make a difference in how nurses practice. The baccalaureate nursing program includes all of the content that diploma programs have, plus it provides students with a more in-depth study of the physical and social sciences, nursing research, nursing leadership and management, community and public health nursing, and the humanities. This broader and more in-depth education enhanced the student's professional development and the power of knowledge and confidence that then allowed the baccalaureate nurse to make care decisions with a better understanding of the many social, cultural, economic and political issues that impacted patients, and influenced healthcare. (Jacobs, DiMattion, Bishop, & Fields, 1998; Sexton, Hunt, Cox, Teasley, & Carroll, 2008; Wawrzynski, & Davidhizar, 2006). This professional confidence contributed to the ability of the nurse to enact accountability. Also explicit in the findings was that of the diploma student in-charge experience and how this prepared

nurses to assume accountability. Experience also contributed to the ability to enact accountability. Participants described the graduates of two educational approaches as one instilling confidence and one providing experience. The gap that was evident related to the diploma nurses speaking of feeling they had a longer transition period of moving beyond the tasks and being the order follower. Further exploration of this is beyond the scope of this study but it is a point of interest and a potential topic for future research.

As previously discussed in Chapter 2, despite the popularity of the concept, accountability remains ill-defined. The registered nurses' in this study varied in their perspectives on what accountability meant to them, and was reported earlier by (Brown, Porcellato & Barnsley, 2006; Savage & Moore, 2004) . This posed significant challenges for nurses in gaining the professional understanding to consistently fully enact accountability. It would also pose the question of whether educational institutions and curriculums are addressing this.

Mulgan (2000) defined accountability as a “complex and chameleon- like term” (p. 55). The analogy of the chameleon is representative of the registered nurses reports about enacting and retreating from accountability based upon situations and to not be noticed or traced in their paths. Nurses spoke of their own experiences and also situations they had witnessed with colleagues where purposeful and active enacting and retreating occurred based upon the context of situations. This was evident where a participant spoke of giving a patient advice to go to a medical clinic for care when the ER was busy and then not documenting this patient visit for the fear of repercussions if the patient returned and their condition had deteriorated. She went on to say that “ if we weren't so busy I would suggest that he waited”. Another participant spoke of

working with colleagues that avoided asking patients certain questions that would possibly require additional work. The specific example was that of not asking if a patient's bowels had moved by post-op day five, if not they would then be required to administer an enema. She went on to quote her colleague "we are far too busy today to be running with bedpans".

Finding the Way

All the participants interviewed discussed the challenges of entering and then navigating the healthcare system as new graduate nurses and even as experienced nurses. They described a rite of passage every nurse experienced that is weighed down with stress, uncertainty, and fear, where these emotions drive every action, decision and experience. "Finding your way" was the term used by the participants to explain this phenomena. The registered nurses advanced along the continuum of accountability from being a new graduate nurse, beginning employment in a new area, and maintaining a position as a senior nurse. One participant suggested this is just 'learning to survive' the everyday.

"Each day nurses juggled the orders of physicians, the needs of patients, the demands of families, the rules of the law and regulating bodies, the bureaucracy of the hospital and their own physical and emotional limits" (Chambliss, 1996, p. 93). This juggling was at the core of what the registered nurse experienced during this stage of the enactment of the accountability theory. The juggling routine sets the tone for whether the nurse enacts or retreats from accountability. For example, the nurse having worked her sixth twelve hour shift may be physically but not emotionally present during a family conference. At the conference the patient's daughter expressed her fear of her mother

dying in pain. The nurse who was not emotionally present then missed every opportunity to support the patient's daughter and retreated from the accountability of providing family centered care. The nurse was not aware of retreating from accountability.

On the contrary, a nurse fully enacted accountability by consistently verifying each drug on the medication administration record with the physician's order despite the nightly chart check. The nurse frequently discovered errors, and her colleagues made fun of her. It is everyday common situations and dilemmas that created the harmony but more often disharmony that then drove the nurses' accountability enactment.

The constant and at times tension filled back and forth between upbringing, education, personal values and the contextual forces of the healthcare environment, system processes, and societal expectations caused the nurses great distress. The processes that informed the registered nurses' ability to fully enact accountability, are important to acknowledge as well as how these create accountability dilemmas and aid in the nurses enacting and/or retreating from accountability.

The participants all spoke of the 'good units' they had worked on. They discussed the traits of the 'good unit' by how well they worked together, that the nurse managers understood the challenges and empowered them to be part of making change, and patients received really good care. Three participants spoke of horrible experiences and what they believed were the traits on these particular units. One discussed the inefficiencies of always running for supplies- which tempted you to take shortcuts. She added that this unit had the highest incidence of post op infections. The other spoke of the invisible manager who when she did breeze in checked her smart phone while having

conversations with staff. This nurse stated “She had no interest in us and what was going on with the unit and patients -she had her own agenda”. The third nurse spoke of the challenges of getting medications from Pharmacy after a patient had been admitted to their floor. She spoke of the ‘secret stash’ of medications that they stockpiled from patients medications when they had been discharged because of ineffective system processes. These are examples of nurses retreating from accountability because of contextual factors.

These examples provided clear explanations of how unit culture, institutional policy, reactive environments, and working as a team can augment or diminish the nurses in finding their way to accountability. Further these examples influenced the nurses’ development of enacting and retreating accountability behaviours.

“All nurses had the opportunity, but not enough of them seized the moments. Moments are sometimes all the nurse has, but it is up to each individual nurse how each moment will revolve. How one intervenes in these moments will determine how powerful they are as a nurse” (Carpenito-Moyet, 2003, p.3). Through the process of self reflection, continuing education and mentorship nurses’ provided care in the moment and as a result fully enacted accountability.

The hospital culture is not one of full cooperation and agreement that brings all levels of hospital personnel together as equals. Rather the continual change brought about by cost containment measures (specifically unit reorganization and closures, and changing scopes of practice) undercut organizational loyalty and created a climate of distrust and demoralization. All the participants spoke of doing more non registered

nursing duties than RN practice. They provided these examples: stripping and cleaning of stretchers after patients were discharged, daily stocking of bedside carts, computer entry of blood work, and reordering stock medications to mention a few. They went on to say that this drastically impacted the time they had to do patient teaching, discharge planning, developing and updating care plans and attending interdisciplinary rounds.

One example given was when a registered nurse in charge of an area delegated care to another individual in this case an LPN. That LPN maybe responsible for their actions, decisions and scope of practice but it is the registered nurse who was in charge of the delegation that is accountable. The registered nurses, who spoke of this were experiencing moral distress because they did not feel confident in their own decision making and delegation and feared potential repercussions from their employer and licensing body. This was further exacerbated by the high level of acuity and unpredictability of the patient population for whom they were accountable.

The public and employers, and nurses themselves have been socialized to the expectations of a nurse (1) being a caring individual, (2) a professional and (3) a relatively subordinate member of the organization. Chambliss' (1996) research argued that the structure of organizations provided opportunity for individuals to retreat from accountability. "For the individual nurse this means that the organization lets him/her to do things they believe wrong, in the belief that 'that's how things work', 'others know better than I', or 'it's a big place how can I know the whole story?'" (p.118). Nurses chose to turn their eyes and focus on the multitude of tasks they were faced with. Accountability challenges will persist and retreating behaviours will continue just because of the subordinate positions nurses are in. As the data demonstrated nurses

disagreed amongst themselves just what was required for them to fully enact accountability.

Becoming Professionally Confident

The majority of participants spoke of the experiential aspect of being accountable and indicated as they grew as nurses they felt more comfortable and confident in making care decisions. This process of professional maturity is not readily acquired but purposely gained through reflection with time, experience and exposure. Expertise and confidence was gained through trial and error. Participants spoke of the challenges they had experienced with the process of becoming professionally confident.

The participants spoke of developing professional confidence as empowering but being an arduous process, where directives and expectations at times conflicted. The nurse is to be caring yet professional, be subordinate yet responsible, be diffusely accountable for a patient's total well being and yet subjugated to the hospital as their employer and the regulating organization that controls licensure and the adherence to the Standards of Practice. "Nurses are disrespected in the system for which they are the foundation" (Carpenito-Moyet, 2003, p.3). This readily leads nurses to retreating from accountability and nurses may regress back to the stage of Finding the Way as a mode of survival. Nurses, developed greater self-confidence in the process of fully exercising accountability.

"You're still accountable when you're a new grad and you're looking and looking and re-checking and re-checking as to when you're 30 years into it, and not that you don't feel that you have to, but you're more comfortable or more confident that you know what you're doing" (Flossie).

This study illustrates that this self-confidence was acquired through education, experience, exposure, self reflection and mentorship.

There were risks associated with professional confidence and nurses often shied away for punitive reasons as previously discussed. The following comment reflects this, “Accountability practices depend on the individual, some people are very accountable and some people are not and unfortunately those who are not, do not readily recognize this” (Gracie). The point Gracie makes is that an individual nurse has a very individual personal and professional journey to accountability. Others reinforced this by saying the need for mentorship, self awareness, reflection on experiences to develop confidence comes easily to some and unfortunately not to others. This subsequently proved to be challenging for some nurses’ in “becoming professionally confident”. Accountability can be a sensitive topic because most people liked to think of themselves as responsible and accountable.

The nurse’s decision to enact or retreat was related to where they were situated on the accountability continuum. The stage of accountability and the context contributed to determining the nurse’s likelihood of enacting or retreating from accountability.

Patients benefitted from being cared for by nurses who have assurance and confidence about their practice, and the trust needed in that clinical relationship will be reinforced across the whole of the health care profession (Alvarado et al, 2006)

There are imperatives that drive current health care such as technology, chronic illness costs, health human resources, quality care, and patient safety. These imperatives are often the cited reasons for retreating from accountability. Examples given by

participants included working short staffed, changes in equipment as a result of technological advancements with no educational support, and early discharges most often those with chronic illness that then often required re-admission.

Health care research discoveries are reported daily in professional journals and this can significantly impact the enacting and retreating from accountability. For example when policy and procedures are out dated and do not represent current evidence based practice, nurses are left in quandaries. Gallbladder surgery, which formerly required a 5-7 day hospital stay post operatively, now has become a relatively pain free same day surgery through a technique of a small camera and instruments that the surgeon manipulates through tiny incisions. Hydrogen peroxide, iodine and other antibacterial solutions used to and in some areas are still being used to cleanse wounds despite research and evidence that supports the use of 0.9% normal saline to cleanse and prevent wound infection. Micro rate infusion pumps to more safely deliver intravenous medications, vacuum assisted closure device (VAC) that expedites deep wound healing by 75%, and patient controlled analgesic machines that administer on patient demand pain medications. All these are evidence of evolving knowledge to improve treatment while at the same time creating new accountability contingencies for nurses.

Accountability is an essentially contested concept, in that its meaning and people's perceptions of it vary greatly from person to person depending on their values, situations and experiences. Gaining understanding and enacting accountability is clearly a social process and not static which was revealed in this constructivist grounded theory study.

An important point that emerged from the analysis is that the challenges associated with realizing meaningful registered nurse accountability can not be dealt with only at the level of the individual. In order for this concept to be fully operational, accountability needs to be situated within an overall model of health care accountability. In this model, clarity of accountability expectations is required not only for the individual registered nurse but all health care professionals and groups, hierarchies and processes within the system. Institutions that have clearly defined processes, current policy and procedures, transparent decision making, cultures of trust, and open lines of communication will empower each and every employee to take ownership. Along with these is the essential component of constant monitoring and the evaluating of accountability practices. For individual nurses to be successful in becoming and maintaining professional confidence Winston Churchill is quoted “First we shape our structures, and then our structures shape us” (1943).

Limitations

The limitations of a study are those characteristics of design or methodology that set parameters on the application or interpretation of the results of the study (Creswell, 2007). Even though the demographics of the sample participants are nearly identical to those in current practice, the sample may not be truly representative because of the limited number of younger nurses with less than 5 years of experience. The researcher faced challenges recruiting participants under the age of 30, perhaps due to the stage of accountability enactment these potential participants were experiencing.

In order to account for and mitigate undue researcher influence in the interpretation, I began this process by undergoing an interview by a Grounded Theory specialist to attempt to put in evidence my perceptions of what was going on in the accountability process. My perceptions included the notion that accountability was inherent through upbringing and that an individual solely controls their accountability practices. As previously discussed to avoid bias in the analysis process the researcher reviewed her own interview and memos. Also with the researcher having a current clinical practice, she found herself repeatedly analysing situations from clinical practice in relation to the accountability study. This became evident during the data collection and more so in the analysis stages that the benefit of participant observation in the clinical areas would have added another dimension and may have enhanced the explanatory nature of the theory.

Implications

This study represents the perceptions of the eleven registered nurses interviewed. It was my intention to develop a substantive explanation of the realities faced by these acute care front line registered nurses and middle managers and how they understood and enacted accountability. Particularly important is the critical role of the contextual factors in the nurse enacting and/or retreating from accountability. The findings of this study have implications for education, practice and administration as well as research. These implications are discussed in the following section.

Education

The majority of the participants had no recollection of being taught the concept of accountability in their programs. As one participant stated “It was just a given that we be accountable”.

A review of the current curricula presently being taught in nursing education programs is one of the first steps needed to ensure that those entering the profession of nursing acquire the skills, knowledge and attitudes necessary to be fully accountable and responsive in the health care environment. Nursing students must be taught the communication and critical thinking skills to be perceptive, intuitive and articulate in their work. Consistently engaging in self reflective activities will provide opportunities for students to examine their own understandings, experiences and assumptions of practice and accountability.

Further they need to be provided significant opportunity for professional socialization within their programs and levelled experiences of increasing responsibility. Professional socialization involves gaining an identity in nursing, through learning, being interactive and adaptive, and identifying professional values and beliefs (Din mohammadi et al, 2010). With the acquisition of these abilities the future nurses will be stronger and better able to examine and expose the issues that created opportunity for retreating.

There has been an assumption by educators in academia that students come with a foundational understanding of the concept of accountability. The concept is then loosely woven across courses through out curriculums with the expectation that students will

readily grasp the content and apply this understanding into the professional socialization process. These findings have demonstrated this is not adequate. Nurse educators must work toward providing theory regarding accountability that is levelled through programs and is measured to be purposeful and meaningful. This can be done with the concept of accountability being visible and measured in course objectives and clinical evaluation tools.

Further exploration of the term “generational accountability” needs to occur. Better understanding of the concept will help to determine if curricula need to be adjusted to enhance professional knowledge development based on the generation currently in the classroom.

The theory of enacting and/or retreating from accountability should be part of the educational process. Particular attention needs to be paid to retreating behaviours, by describing and identifying the process and the contextual factors that construct environments and cultures that enable this. Besner (2006) argued for the use of an Accountability Framework to aide registered nurses in describing nursing practice in terms of the knowledge and principles that underpin nurses’ roles. This work also found that nurses’ were not able to clearly articulate what motivated their actions related to accountability.

A vital component of nursing praxis should involve activism against the external factors that allow for the retreating from accountability. Nurses’ political voices must be evidence informed, articulate and strong to espouse what nurses need in order to provide the quality care that they can take pride in being fully accountable for. “University

nursing schools give the profession an independent base, and their strong independent voice gives nurses an ally in their efforts to make their points of view heard” (Chambliss,1996, p. 97). From a CST perspective this study was sensitive to variances in power, and relations in the workplace. These findings promote nursing environments that support the development of the social identity of nurses and the impact of this on enacting and retreating from accountability in clinical practice.

Incorporating dedicated accountability theory and practice within nursing curricula will ensure that nurses have the fundamental skills and professional socialization to readily and consistently engage in fully exercising accountability

Nursing Practice and Administration

The implications for nursing practice and administration arising from this research study are numerous. It was an ongoing commentary by the registered nurses’ that administrators lacked awareness of the frontline issues that nurses dealt with on a day to day basis. Front line nurses, managers, and senior administration saw the hospital world very differently and through a very different lens, and the resulting disparities created accountability dilemmas. It became a ‘them’ versus ‘us’. Numerous opportunities for changing this in nursing practice and administration will be outlined.

Practicing registered nurses require a renewed understanding of accountability in practice. This can be offered through mandatory interactive education sessions that provide exemplars of the enactment of as well as the retreating from accountability. Registered nurses in clinical practice also require a sound base for evidence informed decision making to build professional confidence while also improving patient outcomes.

Frequent and ongoing dialogue regarding the use of research in clinical practice needs to be demonstrated through all institutional policy. A celebration of the success and power of excellence in clinical management should be incorporated into annual organizational events. Nurses need to celebrate what they know and do well.

Results of this study have demonstrated that when registered nurses are empowered to take control and ownership of care they provide retreating practices are limited. In addition when given the opportunity to debrief and discuss challenges they face the participants were further empowered to enact accountability.

The results of this study indicated that administrators of nursing needed to re-focus and examine the concept of accountability. Accountability needs to be looked at in relation to culture, processes and systems and as well as individuals. The change of roles with expanding scopes of practice require written policy around accountability boundaries and the education that supports nurses' to develop the necessary skills and professional confidence to enact accountability and then identify retreating practices. When the organization of work changes, so do the conflicts,

“When power relationships are stable and unchallenged, there will be few ethical crisis; the answers are routinized, the decisions are made by clear authorities, and sub-ordinates do keep their jobs and keep their mouths and minds shut. But when the authorities become challengeable, when new constituencies come into being, when new occupational groups begin to define and defend their own turf, then the moral agendas, of these various groups come into conflict” (Chambliss, 1996, p.99).

From a CST perspective illuminates ongoing examples of power imbalances in the organizational culture. These instances of imbalance act as constraints, thereby paralyzing nurses to effect change. The nurses were frustrated with the ‘patient assignment configuration of the week’. Literature suggests that care delivery systems

provide the rules and structure that define accountability and operational processes such as assignments and report for nurses (Alvarado et al, 2006). The participants spoke of the stress of rallying between team nursing, primary care nursing, patient/family centered care and how this impacted their enactment of accountability. Continuing education sessions can help educate nurses to bring awareness of situations and environments that reinforce retreating behaviours. Accountability enhancing strategies can focus on: reducing retreating behaviours by addressing contextual factors, empowering nurses to fully enact accountability, and implementing measures that are consistently monitored and acted on.

Nursing administrators have assumed that because nurses learn about accountability in their nursing education programs they should readily be able to apply the concept to everyday practice and that these practice settings were accommodating to this. These study findings have demonstrated gaps in both of these assumptions. Nurses were not adequately prepared in educational programs for accountable practice nor were the employing organizations primed for enabling accountable nursing practice.

Accountability can be promoted in many ways through numerous administrative processes and tools. For example a non-traditional performance appraisal system that is tied to the education and development of a person. Historically, the annual performance appraisal has not been a priority in health care organizations. One participant shared that she had been employed in one area for eight years and never had a performance appraisal. Another option exists with electronic computer monitoring systems - for example computer medication dispensing machines, electronic patient tracking and documentation systems that enforce accountability with the click of a button. Ottawa General Hospital

(January, 2011) has successfully adopted the familiar iPad for its employees, using an electronic medical records application. The use of technology such as biometrics has brought new levels of responsibility and accountability with the administration of medications using electronic medication dispensing systems such as PYXIS. Technological advancements have made the options for enhancing accountability practices endless - but costly.

The complexity of the concept of accountability is also present in the concept of critical thinking. For very valid reasons, a strong emphasis by senior health care administrative leaders in recent years has been placed on professional practice issues with an overwhelming focus on accountability (Brown, Portcellato, & Barnsley, 2006). The attempts have been directed toward making health care providers accountable through more stringent policy and procedures. Despite this emphasis, accountability struggles prevail. My findings suggest this emphasis will not create sustainable change. Many participants indicated that the degree of accountability to which they are expected to respond had substantially increased over the course of their careers. The ability to enact accountability in the current health care context is laden with challenges and can be impossible at times. The challenges included the delivery of quality care with limited human and financial resources, the inefficient distribution of resources, reactive care delivery systems, and multiple redundant documentation systems. These findings are consistent with Brown et al's (2006) work that suggested if executives are committed to better accountability the approach must be broadened by conducting a health system-level assessment of accountability. "This systematic and transparent approach would help to highlight the extent to which there is documentation or legislation that supports

clear performance expectations, and authority and capacity to act, which would ensure effective measurement systems with good data and results- based action” (p.75).

Although a strong emphasis on health professional accountability is indisputably important in the current health care context it is not enough, holding the registered nurse accountable for a range of competencies is not an effective means of realizing this goal. The research of Connors, Smith, & Hickman, (2004) revealed that people who are clearest about their own personal vision and values are significantly more committed to their organizations than those who are not clear on their vision and values. Further you can hold people accountable to their job descriptions, but you can not hold them accountable for being engaged and committed. You also can not hold people accountable for caring which is the essence of nursing. For nurses to do ‘good’ they must have the power to do ‘good’. The nurse participants in this study did not feel they had the power to do ‘good’- by ultimately fully enacting accountability.

Research

Several opportunities for future research arise from the findings of this study. Foremost, in order for accountability to work effectively as a principle in health systems reform conceptual and analytical clarity is essential.

Even if all registered nurses did share a common foundation with respect to the tenets of professionalism and accountability, they would still differ with respect to their personal history, educational achievements and particular professional roles which directly impacted their accountability enactment. It is important to understand these

similarities and differences in how enacting or retreating from accountability occurs. This theory and its concepts can now be studied to determine their usefulness and ability to predict accountable practice.

Another important avenue for future research would be to establish a clearer picture of accountability with each of the external contextual factors that created the challenges. This information would be most useful for the professional regulatory bodies and associations, health care senior administrative leaders, and academics that are developing courses and curricula to adequately prepare nurses for practice. Studying each of the individual contextual factors of human and financial resources, healthcare system processes and institutional culture in relation to healthcare professional accountability practices, organizations may be better positioned in allocating resources, developing policies and procedures and overall organizational changes.

Some of the participants used a term 'generational accountability'. The mid and late career nurses both expressed concern for what they perceived as less committed attitudes and work styles in the younger generations of nurses. The mid career nurses expressed this concern with less frequency and frustration. Although this concern was not possible to explore because of the lack of younger career nurse participants in the study, this opens opportunity to study accountability related practices by age and experience.

A study that looks at the professional socialization process related to accountability practices in nursing students would look at how students learn to be

accountable in their practice. This along with a review and analysis of nursing curricula may provide some core fundamental knowledge in the acquisition of accountability.

Accountability dilemmas incurred in inter-professional practice models represents another area of research opportunity. Practicing in inter-professional teams is part of the current wave in health care delivery and the study of accountability in these teams will provide important knowledge for this model of care.

“Nurses, like most employees in large organizations, work for someone else, respond to multiple bosses, manage multiple demands on their time, enjoy limited time to think about things, and suffer pressure to get on with the job. The legal, economic, and medical problems they face are immediate. And often they are ordered to do things they believe to be wrong” (Chambliss, 1996, p.118).

Summary

In summary, the aim of this research was to answer (a) how nurses defined accountability; (b) how nurses viewed individual accountability; (c) how nurses learned and understood the concept of accountability; (d) who nurses believed they were accountable to; and (e) how nurses demonstrated accountability in their practice.

When the participants in the study were asked to explain what accountability meant to them, they unanimously interchanged accountability with responsibility. The two terms were often used synonymously. But the consensus was that accountability was somehow greater than responsibility, although they could not articulate how or why. There was and is a significant lack of clarity about how this may translate into practice. All participants explained that being accountable meant being answerable for the care they provided, they coupled this with examples of tasks such as medication administration and psychomotor skills.

The nurses viewed their individual accountability as a moral responsibility to ‘do good’ and ‘do no harm’. They viewed their accountability as power but with associated risks. All the participants readily shared experiences describing their upbringing and how they were taught and held accountable by parents and siblings. They went on to say that this was the foundation for what they were taught in their nursing programs. None of the participants could recall any specific teaching about accountability in nursing school. The majority of nurses felt that they began practicing as new graduates with a level of accountability that then grew with them as nurses. This growth was dependent on time, experience, reflection, mentorship and exposure to various situations.

The participants varied in their ideas and ranking of whom they felt they were accountable too. They cited patients, families, employers, themselves and lastly the regulation and licensing body. Only four participants indicated they were accountable to the regulation and licensing body, which may demonstrate a lack of knowledge regarding licensure. The majority referred to being accountable to their patients and families first and foremost.

Lastly the nurse’s spoke about how they enacted accountability in their clinical practice and gave examples. All but two participants gave examples of tasks and the processes associated with successfully completing the tasks. They frequently interchanged responsibility with accountability in their discussions. When asked to give examples of a lack of accountability, only one participant shared her own personal experience, the other participants shared examples where they had witnessed colleagues retreating from accountability.

Conclusion

The process of enacting accountability through enacting and/or retreating practices was the central social process in the registered nurses daily life.

“ The problems nurses face are not logical quandaries, they are political conflicts, not random events, but recurring patterns; not psychological dilemmas but political conflicts; and they are decided not by the most thoughtful or educated person but by the most powerful. And increasingly that “most powerful person” is not even a human being. It is, instead, an organization or an entire healthcare system” (Chambliss,1996, p.182)

If health care organizations want accountability to become a lasting and an important part of an organizational culture, the concept of accountability must be consciously fostered throughout the inner workings of every aspect of the organization. When dealing with significant financial restraints, nursing shortages, and systems that are overwhelmed on a daily basis with front line nurses saying “Don’t rock the boat,” “Just go with the flow”, “You put up your blinders” and “You can’t go against the system”. An ideology is reflected, by these comments that believes that the bureaucracy is so strongly embedded in the system that as individual nurses they are paralyzed to make or initiate change and must therefore continue and maintain the ‘status quo’. However, creating a culture of greater accountability requires that the system be changed so that through education it defines, through policy it supports, through relations it empowers and through measuring it audits accountability at every level. Until these changes occur, challenges will prevail because of the strong influence that an organization exerts on an individual’s behaviour. As one participant suggested “Accountability - it’s pretty much useless unless you think about it, and bring it up front, and, you know, it doesn’t do anything by itself” (Wendy). The most important point that emerged from this theory is

that the challenges associated with the enactment of accountability cannot be dealt with only at the level of the individual.

“ The ancient Romans had a tradition: whenever one of their engineers constructed an arch, as the capstone was hoisted into place, the engineer assumed accountability for his work in the most profound way possible: he stood under the arch.” (Armstrong, 2006). The individual nurses’ decision to stand under the arch is significantly dependent on the organization. The organization being the engineer enables the process of accountability in healthcare systems. Nurses want to embrace accountability and stand under the arch but they must feel confident that the engineer of the arch, has fulfilled its fiduciary duty to educate, support, and implement processes that create cultures that cultivate accountability. The registered nurses’ limitation is within the educators and the organization’s power.



Capital Health

APPENDIX A

Recruitment Poster

My name is Shauna Houk. I am a graduate student in the Master of Nursing program at Dalhousie University. I am interested in exploring nurses' perceptions of personal accountability on clinical practice. To accomplish this I will be conducting a research study that asks nurses directly about their knowledge and understanding of individual accountability. I would like you to share with me your understanding and experiences with accountability in your clinical practice.

An interview will take place at a location that is private and you are comfortable with. This interview, conducted by myself will be audio-taped and last from 60-90 minutes. Participants will use pseudonyms and will not be identifiable. A second interview by telephone may be by may be required to ensure I have clearly understood your perceptions. This interview would last no longer than 20 minutes.

If you are interested in participating in this study, I would like to arrange a mutually convenient time to further discuss my interest in this topic and answer any questions you may have. You may contact me at 902-494-3498 or by email at shauna.houk@dal.ca or my thesis supervisor Dr. Marilyn Macdonald at 902-494-2433 or by email at marilyn.macdonald@dal.ca.

Thank-you for your interest.

Shauna Houk BScN RN

Investigator



Capital Health

APPENDIX B

Letter of Introduction

September 1, 2009

Dear

My name is Shauna Houk. I am a graduate student in the Master of Nursing program at Dalhousie University. I am conducting a research study that is called “*Exploring Nurses’ Perceptions of Accountability in Clinical Practice*”. To accomplish this I will be conducting a research study that asks nurses directly about their knowledge and understanding of individual accountability.

Accountability is a word that is frequently used among nurses but we know very little about how nurses come to understand accountability. I want to understand more about how nurses learn about accountability, what accountability means to you and how you exercise accountability in your nursing practice.

Nurses will be able to participate in the study based on the following criteria: be working as a Registered Nurse in Capital District Health Authority; and practising as a Registered Nurse for greater than 1 year. All participants will enter the study voluntarily.

The study will consist of an initial interview that may last between 60-90 minutes. The interview, with the permission of the participant, will be audio-taped. You may need to be contacted by telephone after the interview to clarify information you provided during the interview. This will take no longer than 20 minutes and will only occur if clarification is needed after the interview. This will allow the participant to add or delete any information. You will choose an anonymous study name and will not be identifiable.

If you would like to participate in this study or know of nurses who would be interested in learning more about participating in this study, please contact me by phone at 902-494-3498 or email at shauna.houk@dal.ca.

I thank-you, in advance for your assistance and contribution to nursing knowledge.

Regards,

Shauna Houk-Principal Investigator



Capital Health

APPENDIX C

Category B
Consent to Take Part in a Research Study
Participant Information

STUDY TITLE: An Exploration of Nurses' Perceptions of Individual
Accountability in Clinical Practice

PRINCIPAL Shauna Houk BScN RN- Graduate Nursing Student
OR QUALIFIED Dalhousie University-School of Nursing

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STUDY SPONSOR: MITACS - Accelerate Nova Scotia
Mr Ian Baird- Director of Business Development
Office: 506-458-7280 Cell: 506-476-3647 ibaird@mitacs.ca

PART A.

Research Studies – General Information

1. Introduction

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide,

you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you don't understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

We do not know if taking part in this study will help you. You may feel better. On the other hand it might not help you at all. It might even make you feel worse. We cannot always predict these things. We will always give you the best possible care no matter what happens.

If you decide not to take part or if you leave the study early, your usual health care will not be affected.

PART B.

EXPLAINING THE STUDY

2. Why Is This Study Being Done?

Accountability in nursing is an integral part of professional practice. The practice of nursing has nurses

making decisions and judgements in a variety of settings and circumstances each and everyday to ensure that their patients receive quality care. A professional nurse has the responsibility to practice within his/her scope of practice, calling upon his/her knowledge and skills to make decisions in the best interest of the patient and organization.

Accountability is a word that is frequently used among nurses but we know very little about how nurses come to understand accountability. I want to understand more about how nurses learn about accountability, what accountability means to you and how you exercise accountability in your nursing practice.

3. Why Am I Being Asked To Join This Study?

You are being asked to join the study because you have self-identified as wanting to participate or you have been referred by the Professional Practice recruiter as a suitable participant for inclusion in the study.

4. How Long Will I Be In The Study?

While the main part of the study will require one 60-90 minute interview. Your participation in the study would be completed by December 2009.

5. How Many People Will Take Part In This Study?

This study is taking place only in Capital District Health Authority in Nova Scotia. The number of participants in the study will range from 10-12 registered nurses that have been practicing for greater than 1 year.

The interviews will occur over a 3 month period in the Fall of 2009.

6. How Is The Study Being Done?

For this study I expect to interview registered nurses working in front line positions on acute care inpatient nursing units in Capital District Health Authority.

The first phase of the research will involve a 60-90 minute interview with individual practicing nurses. An interview guide will be used and provided to you in advance so you may think about your responses. These interviews will be scheduled outside of your work hours at a date, time, and place convenient for you. Prior to beginning the interview you will be asked to select a pseudonym that will be assigned to the information you provide. This is done to maintain your confidentiality. The interview, with your permission will be audio-taped. The PI may need to contact you for a second interview, after reviewing

the interview transcripts. This contact is in case any clarification of information collected is necessary. This contact will be done by telephone. All the information you have provided will be confidential and you will not be identifiable. Interviews will be transcribed by a professional transcriptionist. Once this is completed the recordings will be destroyed or returned to you if this is your preference. Electronic copies will be uploaded to password protected word files.

The second phase of the research involves analysis of the data and writing of the findings and does not require any participant involvement. You will be asked if you want a copy of the findings and if so how you wish to receive them.

7. What Will Happen If I Take Part In This Study?

If you want to be in this study and sign this consent form, you will have to complete a Demographic Information Sheet and choose a study name. This name will be used to protect your identity during the study and in the written research analysis. Participants are self-referred volunteers.

8. Are There Risks To The Study?

As a participant in this study, you are advised in this Consent of Participation Form that there is minimal risk and no personal benefit to participating in the study. Also be advised that there may be risks that we are not aware of. A possible risk is that during the interview the participant may recall clinical situations that caused distress in the past. If this should happen the participant can stop the interview and re-scheduling will be accommodated. You may find the interview and some discussions you receive during the course of the study upsetting or distressing. You may not like all of the questions that you will be asked. You do not have to answer those questions you find too distressing. At any time a participant may withdraw from the study. There are no anticipated benefits to participants in this study however, each will be aware they will be contributing to the development of nursing knowledge regarding clinical accountability. *A decision to stop being in the study will not affect any work performance evaluations you may have.*

9. What Happens at the End of the Study?

You will be given access to a copy of the final publication when the study is finished.

10. What Are My Responsibilities?

As a study participant you will be expected to:

- Follow the directions of the Principal Investigator
- Complete the Demographic Information Sheet
- Participate in one interview
- A second interview may be required to ensure as the Investigator I understand your perceptions

11. Can I Be Taken Out Of The Study Without My Consent?

Yes. You may be taken out of the study at any time, if:

- There is new information that shows that being in this study is not in your best interests.
- The Capital Health Research Ethics Board or the Principal Investigator decides to stop the study.
- You do not follow the directions of the Principal Investigator.

You will be told about the reasons why you might need to be taken out of the study.

12. What About New Information?

It is possible (but unlikely) that new information may become available while you are in the study that might affect your health, welfare, or willingness to stay in the study. If this happens, you will be informed in a timely manner and will be asked whether you wish to continue taking part in the study or not.

13. Will It Cost Me Anything?

If you decide to participate in this study, please note: The aim of this research is to expand nursing knowledge about accountability. Your information will never be used to develop a process or invention that will be sold or patented.

14. What About My Right To Privacy?

Protecting your privacy is an important part of this study.

When you sign this consent form you give us permission to:

- Collect information from you through private interview(s)
- Share information with the people conducting the study and transcriptionist.
- Information provided in the interviews may be published in the context of this research project but that your name would not be used or associated with this study
- Audio tapes will be given to each participant or the participant will give permission to have the tape destroyed

Access to information

The study Investigator, Research Advisor and Transcriptionist will hear the interview recording and read the transcriptions of the interviews. You will only be identified by your study name

Use of records.

The research team will collect and use only the information they need to complete the Study. This information will only be used for the purposes of this study.

This information will include your:

- Date of birth
- Gender
- Educational background
- Years of nursing practice
- Practice Area
- Information from study interviews

Your name and contact information will be kept secure by the research team at Dalhousie University- School of Nursing in Halifax, Nova Scotia.

It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will kept as long as required by law. This could be 7 years or more.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed.

Information collected and used by the research team will be stored at Dalhousie University School of Nursing. The Principal Investigator is the person responsible for keeping it secure.

You may also be contacted personally by Research Auditors for quality assurance purposes.

Your access to records

You may ask the Principal Investigator to see the information that has been collected about you.

15. WHAT IF I WANT TO QUIT THE STUDY?

If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the Principal Investigator. All data collected up to the date you withdraw your consent will remain in the study records, to be included in study related analyses.

16. Declaration Of Financial Interest

The sponsor is paying the Principal Investigator and/or the Principal Investigator's institution to conduct this study. The amount of this payment is sufficient to cover the costs of conducting the study.

17. What About Questions Or Problems?

For further information about the study call Ms. Shauna Houk who is the Principal Investigator in charge of this study at Dalhousie University and Capital District Health Authority. Ms. Shauna Houk's work telephone number is (902) 494-3498 and email is shauna.houk@dal.ca

If you can't reach the Principal Investigator, please contact Dr Marilyn Macdonald Research Advisor at 902-494-2433 or by email at marilyn.macdonald@dal.ca

18. What Are My Rights?

After you have signed this consent form you will be given a copy. If you have any questions about your rights as a research participant, contact the **Patient Representative** at **(902) 473-2133**.

In the next part you will be asked if you agree (consent) to join this study. If the answer is "yes", you will need to sign the form.

PART C.

19. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

**An Exploration of Nurses' Perceptions of Individual Accountability in Clinical
Practice**

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time.

Please initial whether your audio-tape is to be

- returned or
- destroyed

Signature of Participant	Name (Printed)	____ / ____ / ____ Year Month Day*
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Witness to Participant's Signature	Name (Printed)	____ / ____ / ____ Year Month Day*
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Signature of Investigator	Name (Printed)	____ / ____ / ____ Year Month Day*
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Signature of Person Conducting Consent Discussion	Name (Printed)	____ / ____ / ____ Year Month Day*
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** Note : Please fill in the dates personally*

I WILL BE GIVEN A SIGNED COPY OF THIS CONSENT FORM

Thank you for your time and patience!



Capital Health

APPENDIX D

Interview Guide

- (1) Describe to me your definition of accountability?
- (2) Describe for me what accountability means to you as a registered nurse?
- (3) How did you come to learn and understand the concept of accountability?
- (4) How do you as an individual practice accountably?
- (5) How is accountability related to quality patient care?
- (6) To whom do you feel you are accountable to in your practice?
- (7) Who holds you accountable?
- (8) For what are you held accountable for?
- (9) Tell me of a situation that speaks to accountability in your practice?
- (10) Tell me of a situation where you observed a lack of accountability? Can you tell me why this resonated with you?



Demographic Information

1. Study Name: _____
2. Age: Under 25 _____ 26-35 _____ 36-45 _____ 46-55 _____ 56-65 _____
3. Gender: Male _____ Female _____
4. Nursing Education highest level achieved with year of Graduation.
 - Diploma leading to RN _____
 - Bachelor's leading to RN _____
 - Bachelors -Post RN _____
 - Masters Degree of _____ Discipline _____
5. Number of years experience in nursing practice:
 - 1-5 years
 - 6-10 years
 - 11-15 years
 - 16-20 years
 - 21-25 years
 - Over 25 years
6. Practice Area: _____



Capital Health

APPENDIX F

CONFIDENTIALITY AGREEMENT

Title of Research Study:

An Exploration of Nurses' Perceptions of Individual Accountability in Clinical Practice

Principal Investigator: Shauna Houk BScN RN, Dalhousie University

Thesis Advisor: Dr. Marilyn Macdonald, Dalhousie University,

In order to maintain the anonymity and confidentiality of the people who participated in this research, and to meet the ethical requirements of the project, I understand that anyone working with raw data collected in this project is required to sign a confidentiality agreement. This includes the researcher, thesis advisor, and audio-tape transcribers.

I, _____ agree to keep the information contained within the tapes and transcripts for the above research strictly confidential. I will not relate any segment of this information to another person, nor will I discuss the contents with anyone other than the research team for purposes of clarification and analysis.

Signature: _____

Date: _____

Signature of Principal Investigator: _____

Date: _____

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