

The Experiences of Registered Nurses in Fulfilling Their Role in Patient Care Planning
within Acute Care Settings

by

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Submitted in partial fulfilment of the requirements
for the degree of Master of Nursing

at

Dalhousie University
Halifax, Nova Scotia
August 2012

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DALHOUSIE UNIVERSITY

DATE: August 2, 2012

AUTHOR: Shawna Hudson

TITLE: The Experiences of Registered Nurses in Fulfilling Their Role in Patient
Care Planning Within Acute Care Settings

DEPARTMENT OR SCHOOL: School of Nursing

DEGREE: M.N CONVOCATION: October YEAR: 2012

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DEDICATION PAGE

This thesis is dedicated to my family. To my husband Rob who has encouraged me to strive towards achieving many of my personal and professional aspirations. To my son Regan who was a much wanted and welcomed surprise along this journey. Your lively spirit and sense of inquiry is a continual source of joy and pride. To my mother-in-law June Hudson who has provided constant support and resource during this time. To my parents, Cyril and Mary Elizabeth Musgrave, who have provided strength and inspiration to me, as well as, a source of support and encouragement throughout my graduate program.

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ABSTRACT

Documentation of care plans by Registered Nurses (RN) within acute care is imperative. There is scant research related to the experiences of nurses with written care plans within this context. The purpose of this study was to describe RN's experiences with care plan practice.

Qualitative descriptive methodology informed by a socio-ecological perspective was used to conduct this inquiry. Ten participants were recruited from four medical/surgical settings. Six RNs, two Clinical Educators and two Health Service Managers participated in semi-structured interviews. Two themes with associated sub-themes were derived utilizing thematic analysis: *Unwritten Care Planning* and *Modernizing Care Planning*.

Study findings concluded that unwritten care planning was the experience described by participants. Factors influencing participant's experiences of care planning included unclaimed accountability, care delivery processes and context of care. Participants also described strategies to enhance care planning practice. This research can guide practice improvements and builds upon existing care plan research.

LIST OF ABBREVIATIONS USED

ALC	Alternate Level of Care
CCI	Collaborative Care Initiative
CDHA	Capital District Health Authority
CH	Capital Health
CIHI	Canadian Institute for Health Information
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CLPNNS	College of Licensed Practical Nurses of Nova Scotia
CNA	Canadian Nurses Association
CRNNS	College of Registered Nurses of Nova Scotia
CSI	Corpus Sanchez International
CTA	Care Team Assistant
JPNC	Joint Provincial Nursing Committee
LPN	Licensed Practical Nurse
MOCINS	Model of Care Initiative in Nova Scotia
RN	Registered Nurse
SE	Social-Ecological Model

ACKNOWLEDGEMENTS

At this time I would like to thank the 10 registered nurses who graciously volunteered to be part of this study. Through the sharing of their personal experiences and perspectives new and enriched knowledge was generated that can be applied towards the enhancement of RN practice and future professional development initiatives.

I would like to extend sincere gratitude to my thesis supervisor Marilyn Macdonald who has been a mentor and supporter of me throughout my graduate studies. Marilyn has provided me with constant and timely support and guidance throughout my research. Marilyn's ability to impart her extensive knowledge and wisdom in relation to qualitative methodology has allowed me to grow and learn throughout my research study. Also, I am fortunate to have had an opportunity to have Ruth Martin-Misener as part of my thesis committee. Ruth's thoughtful reflections and feedback have allowed me to critically challenge my thoughts and ideas and provided additional clarity to my writing throughout this process. I would also like to thank Mary Ellen Gurnham who is not only part of my thesis committee but is also a role model and a colleague. Mary Ellen has provided me with constructive and valuable views and perspectives throughout my research, as well as, continual advice and direction.

I would also like to acknowledge the many financial contributions that have been provided to me during my part-time graduate studies. Namely: Dalhousie School of Nursing Master of Nursing Admission Scholarship, Dalhousie Graduate Studies Scholarship, Electa MacLennan Memorial Scholarship, Nova Scotia Renal Program, and Capital Health Nurses Helping Nurses.

Finally, I would like to particularly thank my family and friends for their continual love, support and encouragement. The past five years have been filled with many life transitions, challenges and opportunities. Your commitment and collective will has been a resource and inspiration to me during my studies.

Chapter One: Introduction

Increased patient acuity coupled with shortened lengths of patient stay compounds the complexity associated with the planning and delivery of patient care (Dunnion & Griffin, 2009; Elf, Poutilova, & Ohrn, 2007; Hudson, 2010). Furthermore, today's healthcare milieu of multiple care providers, complex treatment regimens and greater patient and family engagement in their healthcare decisions demands for written plans of care that are safe, effective and high quality (Elf et al., 2007; Hudson, 2010). The registered nurse (RN) has a pivotal role to play in the plan of care process. Accordingly, factors such as how individual registered nurses perceive the utility of written care plans and how that responsibility gets supported within the acute care practice environment may influence how the RN attends to his/her plan of care responsibilities (Cornett & O'Rourke, 2009; Lucero, Lake, & Aiken, 2010; Thompson et al., 2008). In fact, there have been recent opinions within nursing literature that written care plans by nurses constitute nothing more than a paper exercise and are void of utility or purpose (LaDuke, 2009). However, the final evaluation report for phase one of the Model of Care Initiative in Nova Scotia (MOCINS) indentified and recommended that plans of care for patients are not adequate and require focused attention (Tomblin Murphy, Alder, MacKenzie, & Rigby, 2010).

In light of this information it can leave one to question, what are the factors that influence an acute care registered nurse's ability to fulfill his/her role in planning care for patients? Accordingly, the purpose of this qualitative descriptive research study was to start to explore and describe the experiences of RNs with written care planning within acute medical and/or surgical unit(s) in the Capital District Health

Authority (CDHA). The thesis begins with providing a synopsis of the problem under investigation in Chapter one, followed by an overview of related literature on the topic of inquiry in Chapter two. In Chapter three, study methodology, theoretical perspectives and study methods are explained; study findings are presented in Chapter 4, and discussed in Chapter 5.

Care Plan

A care plan can be described as the identification and creation of a plan to help address or mitigate a patient's actual and/or priority needs inclusive of teaching and/or discharge needs (Potter, Perry, Ross-Kerr, & Wood, 2006). Typically, goals and/or expected outcomes are developed to evaluate progress towards meeting the need along with the discernment of appropriate interventions to address the need(s) (Potter et al., 2006). In most cases, the plan of care is documented within the patient's health record and is accessible to all healthcare providers to review. Development of a care plan is typically based on assessment and interpretation of many factors including a patient's biological, psycho-social and determinants of health and the information is collected in a variety of ways including: physical examination, observation and patient interview (Potter et al., 2006). A nursing care plan is in keeping with the definition and concept as outlined, however, a nursing care plan or the nursing component of the plan of care may also contain the formulation of nursing diagnoses. The nursing diagnosis is determined by the RN once the assessment data have been collected, interpreted and validated by the patient/family. Validation of the patient needs by the patient helps to ensure that nursing care and service is directed in the most appropriate manner (Potter et al., 2006).

Nursing Care Planning Practice at CDHA

Whilst there may be pockets of individual and/or unit practice within CDHA in which documented care plans exist, for the most part, RN care planning practice and/or inter-professional plans of care in which RNs would be part of the inter-professional team do not exist (personal communication via Collaborative Care Initiative CDHA staff interviews, Fall, 2010). Informal conversations with registered nurses and/or conversations held with registered nurses in this researcher's professional practice role revealed that often the RN considers the nursing kardex as the plan of care for the patient. However, examination of the standardized nursing kardex (see Appendix A) revealed that the format and headings of the kardex are structured around the retrospective input of patient information and data. It does not lend itself to the prospective documentation of a goal orientated plan of care for a patient and mostly serves as a vehicle to communicate the tasks or interventions required for the day or shift.

CDHA policy direction in relation to RN and Licensed Practical Nurses (LPN) practice outlines the need for the RN to assess the patient care needs and in so doing determine the complexity and predictability of a patient (Capital Health, LPN Skills Policy, 2010). Specifically, from an LPN patient assignment perspective within acute care there is a need to have the patient's needs initially identified, assessed and a plan put in place to address and/or meet the needs by the RN if an LPN is to fully function within their role, education and competence for a patient or group of patients (CH, LPN Skill Policy, 2010). Without a written plan of care it can leave one to question how is the patient assignment constructed and what factors go into

determining and deciding the appropriate nurse provider when care needs are not explicitly structured or clearly identified within the healthcare record.

Capital Health's 2013 Milestones include five main strategic streams including: person centered health, citizen engagement, innovation and learning, transformational leadership and sustainability (See Figure 1). The overarching principles supporting the milestone's framework include the need to embed and integrate accreditation standards, quality and patient safety practices, accountability and evidence informed decision making practices into the five main streams. Additionally, the need to promote and support enablers like policy and procedure direction and values based approaches to care delivery are also highlighted within the milestones. Included within the innovation and learning mandate is the need to have models of care implemented in 75% of patient care service areas inclusive of medical and/or surgical settings. While not explicitly stated, one of the foundational tenets of the model of care redesign is the need to have healthcare providers working to their full scope of practice. Therefore, one could extrapolate that working to full scope of practice requires the RN to fully enact their role with respect to developing the nursing component of the plan of care. The risk of not having a written plan of care is that from an accountability perspective it makes it challenging to discern who is to perform what care interventions or what monitoring or evaluation activities. Additionally, a structured and written plan of care would provide documented support as to why particular interventions were selected, how assessment findings led to informing care interventions and what expectations of patient's roles were within the plan.

Statement of the Problem

In the last several years, role optimization of the RN has precipitated much discourse within published literature, national and provincial platforms and within local healthcare organizations (Besner, 2008; Canadian Nursing Advisory Committee, 2002; Capital District Health Authority Collaborative Care Initiative, 2010; Davidson, Halcomb, Hickman, Phillips, & Graham, 2006; Model of Care Initiative in Nova Scotia (MOCINS), 2008; Romanow Report, 2002). Moreover, the Nova Scotia RN Act (2006) helps to define the role of the RN within acute care and the legislated direction required of RNs in terms of developing a plan of care for patients. Despite these numerous reports and legislative mandates, documented plans for acute patient care that are either developed by the RN or co-developed with the healthcare team, patient and family remain elusive (Greenwood, 1996; Hudson, 2010; Karkkainen, & Eriksson, 2004; D. LeBlanc (personal communication, September, 2010).

To add further to the discourse is the belief by some authors that registered nurses perceive the care planning function as busy work which leads to excessive, time-consuming documentation that ultimately detracts from direct patient care activities (Dahm & Wadensten, 2008; Daws, 1988; LaDuke, 2009). Seemingly, what appears to be valued by some members of the healthcare team, formal operational leaders, and RNs themselves is the acquisition and delivery of the technical component or tasks performed by nursing through a medical model orientation (Cornett & O'Rourke, 2009; Laschinger, Gilbert, Smith, & Leslie, 2010; Sabiston & Laschinger, 1995). In fact, one could argue that little has changed in the past three and half decades since care planning first emerged in the nursing literature and in clinical practice environments. That is, like the theory practice gap, the ability and

practicality of an RN developing and maintaining a written plan of care for patients remains, for the most part, unfulfilled (Thompson et al., 2008). However, there has been recent synthesizing and pulling together of related care plan research findings for the purpose of creating a conceptual model which begins to highlight the complexity of the care planning process (Elf et al., 2007). Qualitative studies such as this one can begin to help augment the conceptual model work of authors such as Elf et al.

Given that the major influencing paradigm of modern healthcare is the move towards inter-professional collaboration and in turn collaborative patient care plans, it is salient that studies are performed to describe nurses' experiences with care planning that influence these deliverables. Namely, how does the organization of nursing work, the presence of barriers to optimizing RN practice, and/or the current views held by registered nurses related to care plan activity influence the registered nurse's ability to perform the care planning process? Additionally, if the RN is to truly step into an inter-professional collaborative role it will be imperative that the RN's role and scope is clearly optimized and understood by all and most importantly by registered nurses (Cornett & O'Rourke, 2009). Furthermore, there is a dearth of empirical research both internationally and nationally related to describing or exploring RN experiences that influence ability to complete the care planning role. Thus, I was interested in understanding how RNs, health service RN managers and clinical registered nurse educators describe the care planning role within acute medical and/or surgical care (Edmunds, Ward, & Barnes, 2010; Guba & Lincoln, 2005).

Purpose of Study

The purpose of this research was to begin to describe the experiences of RNs related to care planning practice in order to further understand the absence of care plans within the acute medical and/or surgical context.

Research Question

Therefore, the research question guiding this research was: What are the experiences of RNs in fulfilling their role in developing the nursing component of the plan of care for patients within medical and/or surgical acute care settings?

Position as a Researcher

The topic of inquiry had particular meaning and relevance for me and I believe my professional experience was instrumental in shaping my decision to conduct this research. That is, I am an RN with over twenty years of acute care nursing practice and have held various positions within this setting ranging from staff RN to clinical educator and professional practice leader. Additionally, I have had first-hand knowledge of a RNs work from my own family accessing the acute care system. More specifically, I have witnessed RNs struggling with how to articulate their role and scope of practice. Moreover, I have seen instances in which RN's have not assumed a care coordination role nor planned for nursing interventions that would have truly affected the patient's outcomes in terms of facilitating a comprehensive discharge and/or enhanced the patient's ability to perform self-care. Finally, it is my belief that prospective plans of care for patients that recognize the patient and family's self care agency and capacity have a purpose and function in today's healthcare and that the registered nurse has an integral role to play in that process.

Chapter Two: Literature Review

Introduction

The following databases and sources were consulted for the literature review: Canadian Health Records Collection, Canadian Institute for Health Information, Canadian Nurses Association website, Canadian Public Policy Collection, CDHA Policy and Procedure webpage, Cumulative Index to Nursing and Allied Health Literature (CINAHL), College of Registered Nurses of Nova Scotia (CRNNS) website, Medline, Nova Scotia RN Act, PubMed and Proquest: Nursing and Allied Health. Key words and terms used for the literature search included: accountability, care delivery, care planning, nurses, nursing care plans, responsibility, role, role enactment, role optimization, scope of practice. Databases were consulted using both indexing terms and keyword searching methods. Searches using above terms were adjusted as necessary.

The development and evaluation of care plans with or for patients requiring nursing care is seemingly the right thing to do. However, it is important to remain grounded in factors which can influence nursing practice and service delivery such as the current acute care context, the role of the registered nurse within that setting and the needs of the patient and family requiring acute care services. Therefore, this literature review was organized around the following topics: 1) the acute healthcare landscape within Canada and Nova Scotia, 2) common care needs of acute care patients as outlined in various commissioned national and provincial reports, 3) RN role optimization, RN role enactment, and regulations for the registered nurse as highlighted in a number of research papers, government reports and published articles, 4) relevant CDHA and CRNNS documents and 5) finally, the concept of care

planning in terms of the general state of knowledge surrounding nursing care plans along with relevant care plan research.

The Acute Healthcare Landscape

Canadian Landscape. The Canadian healthcare system, including the structure and delivery of healthcare services, is undergoing major transformation and change nationally and locally (Bauer, Fitzgerald, Haesler, & Manfrin, 2009; Corpus Sanchez International Consultancy (CSIC), 2007; Joint Provincial Nursing Committee (JPNC) Implementation Monitoring Committee, 2003; Squires, 2004). Healthcare organizations and operations managers are held accountable for service delivery changes and healthcare employers are requiring that healthcare professionals practice in a manner that considers evidence when making healthcare care decisions (Irvine, Sidani, & McGillis-Hall, 1998). Furthermore, patients and families are also demanding more active involvement in their healthcare plans (Irvine et al., 1998). Adding further contextual complexity is that healthcare reform and changes are taking place against an acute care backdrop of sicker patients with multiple co-morbid conditions, reduced and expected decrease in patients' length of stay and the execution of highly technical care delivery approaches (Bauer et al., 2009).

It has been said that if “access” and “wait times” had been the healthcare focus at the beginning of this century within Canada then “value for money,” “appropriateness” and “quality of care” may very well define us now (Canadian Institute for Health Information (CIHI), 2010). The direction as proposed in Romanow's (2002) landmark report still remains relevant to today's healthcare transformation initiatives. That is, the Canadian healthcare system and healthcare organizations must ensure that patients receive appropriate, high quality and safe care

by the appropriate provider (Romanow, 2002; CIHI, 2010). Based on this mandate, the Canadian healthcare system is currently and into the future tasked with varied and numerous objectives related to sustainability of care and services, clarification of provider roles and accountabilities and the need to support healthcare providers in the enactment of their role(s) (Irvine et al., 1998; Squires, 2004). As well, echoed in relevant Canadian grey literature reports are additional key themes related to the need for: provider role optimization, coordination and delivery of appropriate, client-centered, quality care and the need for accurate system, provider and patient outcome data to influence and inform service delivery and practice (Alberta Health & Wellness, 2008; CIHI, 2010; CSIC, 2007; Health Council of Canada, 2006; Registered Nurses' Association of Ontario, 2006).

Nova Scotia Context. Locally, there are serious and significant concerns that the province of Nova Scotia cannot afford to continue to fund the healthcare system in its current state (CSIC, 2007). In view of this, the province of Nova Scotia, in 2007, commissioned Corporate Sanchez International Consultancy (CSIC) to review the current provincial healthcare system and create recommendations to ensure provincial healthcare system sustainability. Overall, the report concluded that despite the increase in healthcare demands and complexity of care, care delivery models have not changed in the past two decades to mitigate these issues (CSIC, 2007).

Furthermore, the CSIC (2007) team noted significant gaps between best practice and the application into practice by Nova Scotia healthcare providers inclusive of registered nurses. These findings are aligned with other recent reports on the status of healthcare in Canada (CIHI, 2010). The Nova Scotia provincial CSIC (2007) report further postulates that the current Nova Scotia healthcare system and the providers of

care are not functioning and practicing at the level Nova Scotia patients need and deserve and that provider roles must be organized in relation to the needs of the patient.

The findings from the CSIC (2007) report served as a springboard for the Model of Care Initiative in Nova Scotia (MOCINS). The MOCINS was initiated as a provincial wide initiative in 2008 with a specific focus on acute care. The objective of the movement was to work collaboratively with district health authorities to create new and sustainable models of care that support provider role optimization, care process redesign and to explore ways to effectively leverage technology and information as a means to ensure safe, optimal patient care and to improve outcomes (Nova Scotia Department of Health, 2008).

Several recommendations have been offered from the reports that have been discussed to ensure healthcare sustainability and enhanced provider practice. Specifically, within Canada, there is a disconnect between the utility and relevance of the data collected by healthcare organizations in relation to the interactions patients have with healthcare systems and providers (CIHI, 2010; CSIC, 2007; JPNC, 2003). That is, the data and information currently collected cannot adequately inform us about the quality and appropriateness of the care a patient receives (CIHI, 2010). Therefore, at national, provincial, healthcare organizational system, unit and provider levels there is an impetus to build a culture that uses data and relevant information to inform and direct system wide and bedside care decision-making and to implement technologies such as databases and electronic documentation systems to support healthcare information processes (CIHI, 2010; CSIC, 2007; Dudgeon, Knott, & Viola, 2004). This will require a significant shift in assisting all stakeholders

including operational leaders and direct care providers in understanding and utilizing such resources. A step forward with respect to registered nurses' practice is the creation and adoption of care planning as a potential and viable medium in which to live out the change.

Common Care Needs of Acute Care Patients

National Perspective. According to Canadian Institute for Health Information (CIHI) data, between 1994 and 2000, the acuity and complexity of people treated in acute hospitals regardless of age has increased steadily (JPNC Implementation Monitoring Subcommittee, 2003). Furthermore, several Canadian government reports and research studies have highlighted the aging demographics of patients' requiring acute care services and that many more will live longer with progressive and debilitating illnesses requiring the services of acute care (Alberta Health & Wellness, 2008; CSIC, 2007; Dudgeon et al., 2004).

In relation to chronic disease management, hospitalizations per 100,000 for diabetes in Canada, for example, are above international averages (CIHI, 2010). Furthermore, adults with diabetes are more likely to be admitted to hospital for serious, sometimes life-threatening, complications and conditions and once hospitalized, adults with diabetes also tend to have longer lengths of stay (CIHI, 2010). Another subset of patients that can be found within the acute healthcare system is individuals whose condition and status no longer require the care and services of acute care. These patients are deemed as Alternate Level of Care (ALC) patients. It has been reported that in 2008–2009, 62% of ALC patients had stays of more than one week, 24% stayed more than a month and 5% stayed more than 100 days in acute care beds (CIHI, 2010). In terms of patients requiring palliative care services it is

expected that this patient cohort will utilize almost every sector of the healthcare system inclusive of acute care (Dudgeon et al., 2004). Thus, the need for plans of care to ensure symptom management, continuity of care and the maintenance and improvement of functional status or the prevention of further de-conditioning is required while these patients and patient populations wait for alternate placement or care and/or transition to home (CIHI, 2010; Dudgeon et al., 2004).

There is growing recognition of the need to provide co-coordinated, needs-based and integrated care across sectors for patients with chronic and progressive diseases and the consequences of substantial and unnecessary cost, unmet patient needs and inconsistent care management if not done (CSIC, 2007; Dudgeon et al., 2004). Furthermore, it has been proposed that improvements to documentation processes within acute care are needed if we are to demonstrate how providers' assessments, interventions and evaluations impact patient outcomes and care practices such as in the case of chronic disease management (CIHI, 2010).

Nova Scotia Perspective. The Nova Scotia perspective mirrors the Canadian context with respect to high burden of chronic disease management, high degree of ALC patients taking up acute care beds, advancing citizen age and the complexity and acuity of patients requiring acute care services. Specifically, we have a high burden of chronic diseases, such as diabetes, asthma, heart disease and cancer, with an estimated \$80 billion price tag in associated healthcare costs (CSIC, 2007). With respect to an aging provincial population, it has been estimated that by 2021, the percentage of our provincial population that will be over the age of 65 will be approximately 22.0% of the Nova Scotia population (CSIC, 2007). Currently, this age cohort consumes approximately 50% of hospital-based care, a pattern that mirrors

utilization across the country (CIHI, 2010). The projected increase in the number of people over 65 will place unprecedented demands on acute care utilization within Nova Scotia (CSIC, 2007).

Finally, given the identification of care needs of acute care patients from a national and provincial perspective, it has been asserted that creation of an outcome-oriented, patient centered provider culture is a requirement (CSIC, 2007). Specifically it has been stressed in both provincial and national reports as well as an international literature review that there is a need for a renewed focus on discharge management practices (Bauer et al., 2009; CSIC, 2007; CIHI, 2010). Furthermore, one of the major areas of focus required within Nova Scotia is the need to ensure patients' plans of care are developed to ensure continuity of care when patients are moved or transferred to other acute care units during their acute care stay (CSIC, 2007). In keeping with this requirement, it has been noted in an American nursing research quantitative study that registered nurses can play a vital role in care coordination and RNs have an opportunity to influence strategies that could mitigate the potential negative outcomes associated with patients transferred to multiple units during their stay (Kanak et al., 2006).

RN Role Optimization, Role Enactment, and RN Regulations

The term role has been defined as the enactment of a specific and defined set of behaviors, competencies and activities within a particular context or setting such as that of acute care (Squires, 2004). Scope of practice, while often not consistently well defined within regulatory, related policy documents or published literature, can be described as the activities and responsibilities in which a profession or individual has the knowledge, judgment, skill and authority to enact based on legislation and

regulatory body policy documents (Besner, Doran, & Hall, 2005; Canadian Nurses Association, 2007; Irvine et al., 1998). Role optimization is the ability to fully perform a role through the enactment of the activities and duties within one's scope of practice (Irvine et al., 1998). What's more, the Nova Scotia RN Act (2006) explicitly notes that nursing practice includes the identification of a nursing diagnosis and the development and revision of the nursing component of a patient's plan of care based on evaluation of patient outcomes.

A mixed-methods study in Alberta, Canada focused on the examination of barriers and facilitators on nursing scope of practice as described by registered nurses (Oelke et al., 2008). Results from the study demonstrated that registered nurses often have difficulty clearly articulating the role of nursing and in defining their scope of practice (Oelke et al., 2008). Specifically, the study reported that registered nurses defined their practice by a series of tasks or activities such as performing dressing changes or administering intravenous medications (Oelke et al., 2008). In addition, the study highlighted that RNs experienced difficulty in describing the differentiation of their role to that of a licensed practical nurse (Oelke et al., 2008). These findings are consistent with other international, qualitative research studies in which exploration of registered nurses scope of practice and how that differs to that of diploma prepared, practical nursing colleagues has implications in terms of role conflict and intra-professional conflict between the two nursing bodies (Eagar, Cowan, Gregory, & Firtko, 2010).

RN Role Enactment. It has also been presented in various nursing role concept analysis papers that the ability of an RN to actualize their role within a practice setting can vary significantly based on the relationships between nurses and

physicians, other members of the inter-professional team, the health services manager and among registered nurses themselves (Irvine et al., 1998; Squires, 2004).

Moreover, from a structural perspective the Canadian Nurses Association (CNA) along with RN researchers have cited several factors which influence nursing practice such as clinical context, an individual registered nurse's level of competence, employer policies that either support or constrain practice and the needs of the patients within that context (Besner et al., 2006; CNA, 2007). Adding further complexity to the role optimization discourse is that several Canadian provincial reports, research studies and published articles have stressed that from a macro or system level view, RN scope of practice legislation translated by nursing regulatory bodies into practice statements or standards of practice documents are often left to healthcare organizations and clinical units to discern (Alberta Health & Wellness, 2008; CSIC, 2007; Oelke et al., 2008; Squires, 2004). This can potentially leave organizations to misinterpret related documents and make inappropriate decisions in relation to the RNs' role and scope of practice within their organizations (Alberta Health & Wellness, 2008; Oelke et al., 2008).

RN Regulations. Within Nova Scotia, there is an evident disconnect between what is stated in the RN legislation act and the application to practice. In particular, the final outcome evaluation report for the Model of Care Initiative in Nova Scotia outlines findings suggestive of the need for significant improvement in establishing written patient plans of care within acute care in which registered nurses would have a key role (Tomblin Murphy et al., 2010). However, as previously mentioned, the Nova Scotia CSIC report (2007), as well as, an international study exploring missed nursing care suggested that structural and process related factors such as lack of

supplies and equipment and inadequate support services have influenced the ability of the registered nurse to fully practice and function in their required role. It has been reported that registered nurses have “taken up the slack” in terms of assuming non-professional activities at the expense of unfulfilling and/or underutilizing their professional training, skill and qualifications and that some of the most frequently omitted nursing care roles include patient teaching and care plan development (CSIC, 2007; Kalisch, 2006). In light of the MOCINS outcome evaluation report findings with respect to care planning, there may need to be additional review and mitigation of the factors mentioned above within the ongoing work of MOCINS. Kalisch (2006) and others have also noted several implications in terms of patient safety concerns such as inadequate discharge planning and increased incidence of adverse patient events when professionals such as RNs are not being utilized effectively to perform the roles they are required to do (JPNC, 2003).

As a way forward there have been numerous recommendations made to ensure the adequate, appropriate and effective utilization of RNs’ knowledge, skill and scope of practice within acute care. Several key points have been highlighted within local provincial, as well as, Ontario and Alberta government documents and the research work of Oelke et al. (2008). These points include the need for all vested parties inclusive of government, regulatory and employer sectors to work collaboratively to ensure that RNs are working at an appropriate and optimized scope of practice. That is, assurance that RNs are equipped with the knowledge and tools to successfully practice, to review and potentially redefine scope of practice based on patient care needs and the emerging demands for health services, as well as, a need to pay attention to clarifying and defining the scope of practice of the RN that is

different from that of the LPN (Alberta Health & Wellness, 2008; Besner et al., 2006; CSIC, 2007; JPNC, 2003; Oelke et al., 2008; Tomblin Murphy, Birch, & MacKenzie, 2007). Some have also argued that there is a need to further and fully examine and describe how the RN currently functions in the practice setting, what factors are shaping the ability of the RN to fully step into their role and how can those factors be addressed or mitigated (Health Council of Canada, 2006). If one considers that over 60% of the workforce within hospitals is registered nurses (CNA, 2007) then the time is now to ensure the appropriate utilization, and optimization of registered nurses and that the outcomes RNs directly and indirectly contribute to such as participation in plan of care are defined and evaluated.

CDHA & Regulatory Care Planning Document(s) Review

There was a need to examine existing policy and regulatory documents that have or may have an influence on RN practice with respect to the care planning role of the RN. Therefore, a review of RN national association, provincial regulatory, CRNNS related care planning documents and CDHA policy materials was conducted. Key findings and information contained within the selected documents can be located in Table 1.

Care Plans

General State of Knowledge Surrounding Nursing Care Plans. There is a paucity of recent literature related to addressing or researching the critical issue of RN care planning and/or related documentation of care plans (Dunnion & Griffin, 2009). There appears to be substantial writings in relation to care planning and the role of the RN dating back to the 1960's and into the 1980's as evident on the Medline Database (Daws, 1988). Literature from that period centered on the

opportunity for the RN to use the nursing process as a framework to help shape and support the development of a nursing plan of care and to define the RN's role in patient care (Catherman, 1990; Daws, 1988). Moreover, additional and substantial work was performed within the nursing academic centers in relation to developing a nursing classification system and taxonomy to begin to describe the nature, impact and practice of registered nurses (Peck, 1989; Carpenito-Moyet, 2010). Specifically, international classification systems such as the North American Association of Nursing Diagnosis (NANDA), Nursing Intervention Classification (NIC) and Nursing Outcome Classification (NOC) were a major influence on how care plan exercises were taught within university and schools of nursing, as well as, utilized within the clinical settings (Carpenito-Moyet, 2010; Herdman, 2008; Peck, 1989). Furthermore, location of a qualitative inquiry study retrieved from the late 1980's discussed attitudes of RNs in relation to the use of individualized care plans (Daws, 1988). The author concluded that RNs require peer mentors in practice if care planning was to be sustainable (Daws, 1988). It would be fair to say that this recommendation still holds relevance in today's nursing practice.

However, in the 1980's and 90's there was some movement and disengagement within the nursing profession and in turn within the practice settings away from formal documented care plans and the nursing process (Varcoe, 1996). In keeping with this trend, others began writing about the urgency to critically examine the need for potentially outdated, ritualistic, self-serving practices that offered little relevance to nursing practice (Fonteyn & Cooper, 1994). These views and opinions display polarizing perspectives that stand in stark contrast to the commission and advisory committee reports and provincial mandates that have been discussed in the

earlier section of this proposal (MOCINS, 2008; Canadian Nursing Advisory Committee, 2002; Romanow Report, 2002).

LaDuke (2008; 2009) proposed that care plan development is little more than an academic exercise that serves to help nursing students learn how to problem solve, and provides little use or framework in the real practice setting and acute care context. LaDuke (2009) reported that developing and writing care plans distracts from the need for the RN to be more actively involved in direct patient care activities at the bedside. Moreover, there has been very little nursing research that addresses the quality of nursing care and the examination of the interconnectedness between nursing process, plans of care and patient outcomes (Daly, Buckwalter, & Maas, 2002; Davies, Edwards, Ploeg, & Virani, 2008). A systematic review by Moloney and Maggs (1999) could not refute or substantiate that having a written nursing plan of care had any impact on patient outcomes within acute care. However, there have been some related ancillary qualitative studies that described missed nursing care on medical-surgical floors such as care planning and patient teaching activities and highlight the potential implications for quality and patient safety outcomes (Kalisch, 2006). Additionally, there are some reports that highlight that RNs can have a direct impact on patient outcomes for improving pressure ulcer prevention, preventing patient falls, and reducing length of patient stays when they are involved in the patient's plan of care (Lichtig, Knauf, & Milholland, 1999).

Care Plan Research. A fairly recent international qualitative descriptive study was retrieved in which the author interviewed 20 registered nurses from three acute care units for the purpose of exploring how the structure and content of a computerized nursing care plan software implementation affected the nurse's view of

their documentation experience (Lee, 2005). The study findings suggest that nurses perceived the application primarily as a tool to promote memory with respect to linking assessment findings to nursing diagnosis or problems (Lee, 2005). They also used the technology as a teaching aid for themselves in terms of providing them with access to a multitude of potential care interventions that could be employed within an individual's plan of care; including ones that may not have been considered (Lee, 2005). Additionally, a quantitative study by Daly et al. (2002) reported on the effects a standardized nursing nomenclature electronic care plan format versus paper care plan design had on RNs' uptake in practice within a long term care setting. As well, the authors were interested in investigating the impact both care plan formats would have on both patient and organizational outcomes. Results of the study suggested that there were more documented nursing interventions on the computerized care plan as compared with the paper format (Daly et al., 2002). Additional research surrounding how the increase in documented nursing activities could influence both patient and organizational outcomes would be required (Daly et al., 2002).

The impetus for both of these research studies appears to be the need to ensure that RN practice, as well as, the activities they perform, are captured and made visible within the electronic chart and to ensure user compliance and satisfaction with the information technology application (Daly et al., 2002; Lee, 2005). Moreover, due to the electronic medical record movement there have been recent energies focused on the need to re-instate nursing classification systems into the electronic medium to ensure documentation systems capture nursing practice and nursing sensitive patient outcome data correctly (Hannah, White, Nagle, & Pringle, 2009). An example would

be the establishment of the Canadian Health Outcome for Better Information and Care project (HOBIC).

A more recent concept analysis paper by Elf et al. (2007) presented an exploratory, comprehensive and novel illustration of the interplay of a multitude of hypothetical inter-related concepts in relation to structure, process and outcome variables that may influence the care planning process and the quality of care planning activity. Specifically, the authors used a system dynamics methodology and Donabedian's Process Model to outline and map a non-linear model of the care planning system depicting how various factors such as patient assessment processes, staff competency and patient and provider communication approaches interface and influence care planning practice (Elf et al., 2007). To formulate the factors at play, the authors have drawn upon existing studies and literature related to care plan documentation, use of practice guidelines, patient engagement in clinical decision-making principles and organizational structure required to support practice performance. Specifically, it is highlighted and assumed that the quality of the assessment process used to determine the patient's needs, the care culture within a given context and the professional knowledge of the provider are key considerations with respect to the quality of the care planning process (Elf et al., 2007). The model is the first published or known attempt at depicting a conceptual care planning model and has proven to be a useful reference in discussing the findings of this study. Furthermore, the model could be used as a framework for the purposes of understanding the relationships between a number of different factors such as professional knowledge and skill and the potential exploration of less well known

factors such as the capacity and power of the unit in relation to their influence on the care plan process (Elf et al., 2007).

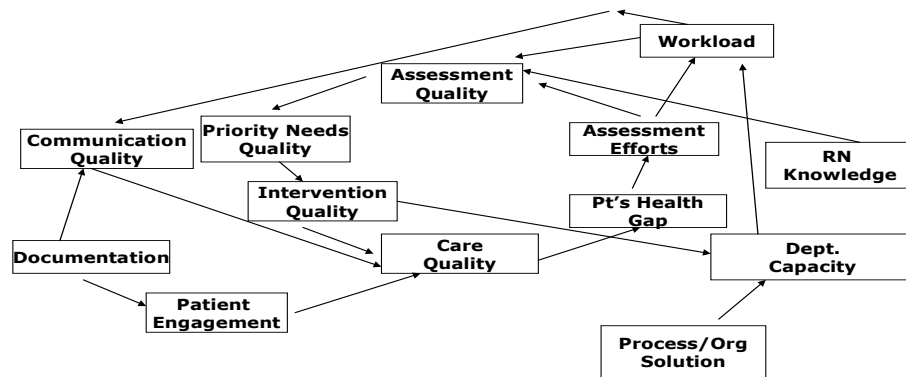


Figure 2 Adaption of Care Planning Conceptual Model by Elf et al. (2007).

Lastly, there have been 2 recent international studies that explored factors and conditions that influence the RN's implementation of individual and standardized care plans respectively (Jansson, Pilhamar, & Forsberg, 2011; Jansson, Bahtsevani, Pilhammar-Andersson, & Forsberg, 2010). Findings from the qualitative study exploring implementation of an individual plan of care noted the importance of explicit management expectations of RNs in relation to their role in care plan adoption, individual RNs' clinical experience and the use of internal change agents as a way to increase implementation uptake (Jansson et al., 2011). The quantitative, retrospective study related to the implementation of standardized nursing care plans revealed additional factors (Jansson et al., 2010). Specifically, the need to explore the use of internal facilitators who have a well established knowledge of evidence-based

nursing practice and the need to have a foundational understanding of how the patient and family are to be engaged in the care planning process (Jansson et al., 2010).

Literature Review Summation

Findings from this literature review revealed that from a national and provincial healthcare perspective, major changes with respect to the structure and delivery of healthcare are underway and required to ensure sustainability of the system. Specifically, a renewed focus on role accountability for both administrative personnel and clinicians, role optimization, patient engagement in care decisions and quality of care processes have been deemed necessary to help address and ensure the needs of acute care patients with complex care needs are met. Provincially, the Model of Care Initiative was implemented specifically within acute care to help mitigate the issues that have been identified in various provincial and national healthcare reports.

In keeping with the current acute care milieu, several national and provincial data health information sources have identified key trends with respect to the population and the care needs required as they access and undergo care and treatment along the acute care continuum. Namely, an aging population with numerous co-morbid chronic conditions such as diabetes will make up a major cohort of patients requiring acute care services. Furthermore, it has been postulated that it will be imperative that these patients have written plans of care that help focus care requirements to key areas of patient need such as symptom management and maintenance or prevention of further decline in activity of daily living function. In addition, care plans will be required to help support continuity in care as the patient transfers or move to other areas along the continuum.

Given the acute healthcare context and the trends with respect to patient needs it is has been postulated within this literature review that RN role optimization is required to help implement the nursing services required to meet the technical and complex needs of this patient population. However, it has been identified that role enactment by the RN is influenced by several factors including role clarity, role expectations and accountability and the structure in which registered nurses are expected to perform and execute their role.

Studies have highlighted gaps in required RN care activities such as patient teaching and subsequent care plan development within acute care. As well, there have been recent studies that explore ways to increase documented care plan adoption by registered nurses through the implementation of computerized information technology. There have been ancillary studies in which exploration and description of registered nurses' perceptions of what working to full scope of practice within acute care entails. As well, there is existing and supporting national and provincial grey literature and local RN legislation documents that speak to the need for healthcare providers, in particular registered nurses, to function at optimal scope of practice. Yet, there is a dearth of relevant and recent literature directly related to the topic of this research inquiry. That is, this researcher has not located any published literature and/or research studies that address, in any great depth, how RNs describe their understanding of what care planning is or could be, how they currently implement that component of their practice or what factors contribute or influence their care planning practice.

Based on the above findings from the literature review, it is reasonable to say that little description of RN experiences with care planning practice within their acute

care environment have been provided with any depth in the literature. This study will help to further explore and understand the experience of acute care RNs with the care planning aspect of their practice.

Chapter Three: Methodology

Introduction

In this chapter I present the essential assumptions of qualitative research and the theoretical perspectives that informed my research. Secondly, I have provided a review of the qualitative methodology used to conduct the research, its congruence with the theoretical perspectives used for the study and its alignment with the topic of inquiry. Research methods employed in this study are discussed. Namely, sampling methods, recruitment strategies and ethical considerations are reviewed. The chapter concludes with a discussion centered on data collection methods, data analysis and how trustworthiness was established within the research process.

Philosophical Assumptions of Qualitative Research

A qualitative approach to research is guided by a worldview and/or a set of assumptions and was appropriate to employ for this study as the aim of the research was to study social relations or problems and how individuals or communities of practice describe, view, relate and translate meaning about these relations or problems into their lives or practices (Creswell, 2007; Flick, 2006). There is a clear differentiation in the philosophical assumptions between qualitative and quantitative methodology. That is, qualitative seeks to explore or understand the research inquiry by taking an emic or insiders' subjective view of experiences, descriptions and beliefs of the phenomenon as opposed to trying to examine the issue by taking an outside approach through the use of data collection methods such as surveys (Ospina, 2004). Additional philosophical assumptions that underpin qualitative inquiry have been defined and are discussed and highlighted below.

Creswell (2007) describes five basic philosophical assumptions which underpin qualitative research and these assumptions have underpinned this research project. Specifically, an emergent research design was used for this study and the study was conducted within the acute care context and with study participants who practice within acute care and who have experience with the topic of inquiry. An epistemological perspective relates to the relationship between the researcher and that being researched (Creswell, 2007). An exemplar of this viewpoint in relation to this study was evident by my acknowledgement and integration of my own professional and personal knowledge of RN practice within acute care in influencing the need for this study. An axiological view can be described as a perspective that addresses the role of values within the research study (Creswell, 2007). Furthermore, it has been highlighted that research is a “value laden” endeavor and that “bias” can and does exist within the research process (Creswell, 2007, p. 17). Accordingly, my approach throughout the research study was to remain open to the information and data as it was revealed through the participant interviews, literature review and care plan document(s) review. Additionally, I reflected on and documented my own personal views and perspectives related to the data in a reflective journal during the study.

A common understanding of an ontological perspective within qualitative research is that the nature of reality is viewed as a subjective and specific experience held by an individual (Streubert & Carpenter, 2011). Furthermore, there exists the possibility that multiple and potentially diverse views are possible based on the individual’s experience. Therefore, this notion had particular relevance and utility for this study as the purpose of this study was to describe the experiences of registered nurses from multiple and diverse registered nurse, nursing roles within acute care.

Namely, health service managers, clinical registered nurses and clinical registered nurse educators were recruited for this purpose to help facilitate an emic account of the topic of inquiry (Streubert & Carpenter, 2011). Rhetorical perspective deals with the language used within the research process (Creswell, 2007). Namely, the study informant's experience and the research findings have been reported in such a way as to preserve the views of the RNs who participated in the study (Streubert & Carpenter, 2011). For example, participant's own language and qualitative terminology such as credibility versus validity were used and included in the research report.

Theoretical Perspective Informing the Research

The major sensitizing theoretical perspectives that informed this study were constructivism and the Social-Ecological (SE) Model. The intention of this study was to describe the perceived realities of the study participant's care planning practice within acute medical-surgical settings. Therefore, a constructivist perspective informed the research process as it aligned well with the topic of inquiry and my position as a researcher. One of the central tenets of constructivist philosophy is relativism (Dombro, 2007; Guba & Lincoln, 2005; Weaver & Olson, 2006). This includes the need and belief of the researcher that exploration of the multiple and complex subjective realities and perspectives that practitioners hold in relation to their practice is required (Creswell, 2007; Dombro; Guba & Lincoln, 2005; Flick 2006). Accordingly, I was interested in describing and further establishing understanding of the views RNs, operational registered nurse managers and clinical registered nurse educators practicing within acute medical and/or surgical settings held in relation to the role and function of an RN in developing a nursing plan of care

(Creswell, 2007; Guba & Lincoln, 2005). Given the purpose of the study and the potential for diversity of perspectives and contexts, the need to employ inductive strategies, in other words, letting the data speak, as opposed to traditional deductive research approaches was required (Flick, 2006). Additionally, the ability to utilize an emergent research design, as well as the ability to use sensitizing concepts or theoretical perspectives as opposed to the need to start from established theories added flexibility to this research project (Creswell, 2007).

Another assumption consistent with the constructivist's paradigm from an axiological stance is that all research regardless of methodological approach is value laden and that the research is influenced by the beliefs and values of both the researcher and the respondents (Creswell, 2007; Flick, 2006). Accordingly, I believed that RNs have the ability to enhance and exercise their personal and professional agency to help shape and influence their practice role in relation to care planning. However, it was my belief that additional research that begins to describe the experiences of RNs with care planning was a necessary first step if registered nurses, clinical registered nurse educators and health services managers are to begin to understand how care planning practices are currently viewed within acute care.

As well, the Social-Ecological (SE) Model was used as a conceptual framework to help support and structure data collection and interpretation (See Figure 3). A social-ecological model is based on the premise that an individual's actions, choices or practices are based not only on their own personal attitudes and beliefs, but are also shaped and influenced by the interactions between and interdependence of various factors at five different levels or dimensions of aggregation (Cassel, 2010; Strack, Lovelace, Jordan, & Holmes, 2010). That is, the model depicts the

interdependency of the individual and interpersonal behaviors and practices and the organization, practice community and system/policy structure(s) of the social ecology (Strack et al., 2010). Specifically, the application of the SE model allowed for a richer description of the contextual factors that are situated within the social-ecological levels (Strack et al., 2010; D Meagher-Stewart (personal communication, December, 2010). For example, in terms of the focus of this research, the social-ecological framework was useful to help describe how individual level factors such as the knowledge and competency of the individual RN influences the individual's beliefs and practices, however, organizational factors such as how the structure of RN's work, care delivery systems and organizational policies influence care plan practices were also described and discussed (Cassel, 2010; Strack et al., 2010).

The SE model has been frequently adopted within health promotion research streams. Namely it has been utilized to help explain the nutrition and exercise patterns of persons by exploring the environmental and social contexts in which behaviors and practices appear (Cassel, 2010). However, the model had relevance and applicability to this topic of inquiry as there was a need to describe multiple-level interpersonal, organizational and individual factors influencing behaviors, attitudes, and practices, and how RNs function within the context of the workplace (Cassel, 2010; Strack et al., 2010; Thorne et al., 1997).

As was previously outlined in the care planning literature review section, there has been an initial and recent attempt to begin to depict the complexity of the care planning process as influenced by many different concepts including RN competency related to care planning, workload demands, leadership capacity and workplace policy (Elf et al., 2007). Through the use of the social-ecological model added

description and depth in relation to Elf's conceptual illustration was possible. That is, this study was able to add the RN's voice and description of some of the domains depicted in Elf's care planning conceptual model.

Methodology

A qualitative approach was adopted for the purposes of this research. Qualitative methodology is in keeping with a constructivist's perspective and proved to be a very effective approach as the nature of this research was to uncover specific questions or queries related to why, what or how a particular behavior(s), pattern(s), structure or process had influence and implications for registered nursing care plan practice (Neergard et al., 2009; Sandelowski, 2000). Moreover, from an epistemological perspective qualitative research is in keeping with the tenet of interrelatedness between researcher and that being researched. This philosophy aligned nicely with the researcher's position in relation to this study and the topic of inquiry. Qualitative research also had congruence with the need for the researcher to develop a closeness and familiarity with the participants and practice context under investigation as the goal of the research was to get to a level of adequate description of the issue under investigation (Creswell, 2007).

Specifically, a qualitative descriptive approach was selected as the methodology. Naturalistic inquiry and the philosophy of naturalism were the underpinnings associated with this qualitative descriptive approach (Neergard et al., 2009; Sandelowski, 2000; Sandelowski, 2010). The major aim of naturalism is to describe the lived realities, beliefs, practices and/or behaviors of the participants in the context in which the topic of inquiry occurs (Harris, 2003; Sandelowski, 2000; Sandelowski, 2010). Some of the major tenets of naturalistic inquiry are: no prior

commitment to a theoretical perspective or stance informing the research, the ability to use a variety of knowledge sources including researcher experience, empirical data and models (Neergaard et al., 2009; Sandelowski, 2010). It has been said that a qualitative descriptive approach is the least theoretical of the qualitative methodologies (Neergaard et al., 2009). Nevertheless, this does not mean that qualitative description is a method that is “stripped entirely of its theoretical or disciplinary underpinnings” Thorne (as cited in Sandelowski, 2010, p. 79). That is, qualitative description takes a lead or cue from the existing knowledge base of the subject matter and from the clinical knowledge, skill and judgment of the researcher (Neergaard et al., 2009; Sandelowski, 2010; Thorne et al., 1997). Accordingly, for the purpose of this research study, the data collection, interpretation and discussion components of this study were informed by the SE model as previously outlined. This does not mean, however, that the SE model was imposed upon the research study (Sandelowski, 2010). That is, the researcher remained open to the potential need to move away from the SE framework if further investigation during a participant’s interview had warranted or directed the interview in another path. Furthermore, the researcher remained flexible to not applying the SE framework during the analysis phase had the study findings not had relevance or alignment with the model (Sandelowski, 2010). However, the SE model did prove to be useful in helping with data interpretation in the discussion section of this study.

Sampling Approach

A purposeful sampling approach was utilized for this research project. Purposeful sampling is a sampling style used frequently within qualitative research studies whereby the researcher purposefully recruits individuals with experience of

the phenomenon being studied (Creswell, 2007, Neergaard et al., 2009; Sandelowski, 2000). Purposeful sampling is a strategy in which as many participants are interviewed as required in order to get a clear understanding of the topic of inquiry (Chang, Voils, Sandelowski, Hasselblad, & Crandell, 2009; Creswell, 2007; Patton, 2002; Streubert & Carpenter, 2011). Specifically, a type of purposeful sampling technique that was employed within this study was snowballing (Streubert & Carpenter, 2011). Snowballing is utilizing one informant to locate another informant who has experience and knowledge of the phenomenon of interest (Creswell, 2007; Streubert & Carpenter, 2011). In the case of staff RN recruitment, this technique proved useful as the last few participants were difficult to initially recruit due to inability to reach some of this cohort. For example, access to information on the study purpose due to working hours may have contributed to the initial low staff RN recruitment. Additionally, and in keeping with a qualitative descriptive study design, maximum variation sampling was employed. Maximum variation is a popular sampling strategy in which the researcher identifies and sets out at the beginning of the research the need to sample participants based on criteria that differentiates the informants thus enhancing the potential that findings will be reflective of different perspectives (Creswell, 2007). The purpose of using this additional typology was to gain expansive knowledge of the subject of interest and also to meet some pre-selected criteria to ensure participants had experience with the subject matter (Creswell, 2007; Neergaard et al., 2009; Sandelowski, 2010; Thorne et al., 1997). Specifically, maximum variation was employed through the identification and differentiation of the informants into three participant populations. Namely, staff RN, clinical registered nurse educators and health services managers.

It was imperative to invest in a sampling strategy that captured RNs within acute care that held various roles and functions within that environment and who had direct knowledge and/or experience with care planning and the work patterns and organizational structure of the work environment (Thorne et al., 1997). As previously stated, there was an assumption by this researcher that there was a potential for a multitude of factors to be at play that influenced the role of the RN in completing the function of patient care plan development, such as educational needs, workplace processes and leadership capacity. The targeted participants listed were able to provide a rich description of their experiences with care planning practices and also were able to describe other realities or dimensions not previously considered by the researcher and/or previously described in the literature (Elf et al., 2007; Thorne et al., 1997).

Study Sample, Sample Size & Setting

Seven medical and/or surgical care units at CDHA served as the setting for the potential participant pool. The sample was 10 participants from 4 of the seven CDHA medical/surgical areas. Specifically, participants included 6 staff registered nurses, 2 health service managers who are registered nurses and 2 clinical nurse educators. All 10 of the participants were female and baccalaureate prepared; one participant was currently enrolled in a graduate nursing program. The health services managers' managerial experience ranged from novice (< 3 years) to over 25 years. Both clinical educators had over 20 years of clinical experience and 2-3 years of experience in their current educator position. The staff RN sample consisted of registered nurses who held not only staff RN roles but also had acquired clinical leadership experience through student RN clinical instructor and charge nurse roles. Three of the staff RNs

had 2 years clinical experience, 1 had 6 years and the other had more than 15 years of experience.

In qualitative research, it is anticipated that saturation of identified themes will be reached when enough rich data have been collected to develop the themes and analysis of subsequent participants' experience reveal no new experiences or descriptions not already captured within the identified themes (Creswell, 2007). Accordingly, recruitment ceased with 10 participants as the data collected were rich and descriptive thus saturation was reached more readily (Morse, 2000). Moreover, the intention behind this research was not to generalize the information but rather the intent was to describe the particular experiences of the participants with the topic of inquiry (Creswell, 2007). Additionally, employing the sampling approach of maximum variation helped to mitigate the potential for thin data and enhanced the ability to collect diverse descriptive data (Creswell, 2007; Neergaard et al., 2009; Sandelowski, 2000). As well, the topic of inquiry and the intention for the research was clearly stated and the data required to describe this topic of inquiry was readily obtained by employing participant interviews thus reducing the need for sample sizes larger than 10 (Chang et al., 2009; Creswell, 2007; Milne & Oberle, 2005; Morse, 2000; Morse, 2010; Patton, 2002; Sandelowski, 2010). To further ensure I obtained adequate data for description and analysis I completed a follow-up telephone call with 2 participants to confirm my description of the findings and to ensure the themes identified required no further exploration or description not outlined in the first interview (Morse, 2010).

The rationale supporting the need to sample more staff RNs in comparison with clinical educator and health service manager participants was that the staff RNs are

the primary ones responsible for developing the nursing component of the plan of care and so they are the ones who have the most direct experience with the topic of inquiry and are the cohort most directly affected by the practice of care planning.

The study sample, as mentioned, included health services managers, clinical RN educators, and staff RNs from the medical and/or surgical practice units within acute care at CDHA. Furthermore, within CDHA, there are approximately 32 acute medical and/or surgical inpatient units. Given the research timeline and scope of the research, only 7 units from the 32 units were selected as a focus for the study recruitment process. By focusing on 7 units I was able to obtain the targeted sample cohorts and the sample size. That is, there was approximately 40 staff RNs per unit, 8 clinical educators and 6 health service managers from the 7 units to draw upon.

Inclusion/Exclusion Criteria

All participants were required to be licensed as registered nurses holding positions within the acute care units for a minimum of 1 year. Furthermore, the medical and/or surgical areas selected needed to have had an opportunity to be exposed to some of the provincial model of care mandate with respect to RN and LPN role optimization within their workplace setting (MOCINS, 2008). This inclusion strategy was required to help ensure the registered nurses recruited had been exposed to, at a minimum, some preliminary discussions and awareness related to role optimization and the need for patient plans of care so that they had some preliminary engagement with the research topic (Milne & Oberle, 2005). These study participants not only had some opportunity to recently experience the topic of inquiry but also had some time to either personally reflect upon or apply their professional

responsibilities and roles related to developing the registered nursing component of a plan of care and/or their leadership role in supporting practice.

Exclusion criteria included RNs and health services managers who were working and/or managing sub-acute areas such as transitional care units or intensive care units, acute care managers who did not hold an RN license and practice environments in which no work had been completed with respect to RN and LPN role optimization. Non RNs were excluded from this study as the intention of this study was to focus on RNs' subjective description of the topic of inquiry. Intensive care units were excluded as the practice context in terms of patient acuity and staff to patient ratios was not consistent with the targeted participant population or practice environment context under study. Acute care units in which role optimization had not occurred and there had not been opportunities provided to discuss role clarity, accountability and scope were not considered to be the same context as the other units that were the main interest for this study (Cornett & O'Rourke, 2009).

Ethical Considerations

I am currently working as a RN in a professional practice role within CDHA. Although smaller community hospitals outside my current healthcare district could have been potentially targeted for this inquiry I was particularly interested in focusing my study on acute care within a large tertiary care center. Whilst I believe that there are factors that can influence the role of the RN in performing care planning functions in smaller acute care hospitals, I believe the context I have begun to describe rests more within acute care settings in which there are additional or different complexities contributing to factors which affect the structure and organization of the registered nurse's work. Specifically, given the academic mandate of CDHA there were

opportunities for the RN to interface with many more disciplines, allied health and medical students and residents and I was interested in describing how these interfaces impacted upon the work of the RN and their ability to attend to some of the other roles like care planning.

Creswell (2007) maintains that a critical step within the research process is for the researcher to establish rapport with the study participants and to familiarize themselves with the research settings in order to establish rapport and in turn capture quality data. I believe that my current professional practice role equipped me with facilitation skills and familiarity with these practice settings that helped to meet these objectives. However, some have cautioned that studying one's own workplace poses risks to the quality of the data, disclosure of less than favorable data and sets up potential power imbalances between researcher and the study respondents (Creswell, 2007). Accordingly, during the research interview and analysis phases I did not engage in professional practice work within these practice settings. This strategy was employed to help mitigate researcher bias and influence over the study respondents, as well as to help reduce confusion surrounding my role as a graduate student versus my role as a CDHA professional practice leader (Creswell, 2007). Some additional ethical principles and processes also needed to be applied and used throughout the research process to help address these risks. Namely, there was a need to clearly establish for both the researcher and research participants when the research began and ended so as to lessen confusion and expectations if the researcher was required to work with any of the study participants or practice settings in my professional practice role post study (Miller & Bell, 2002).

As with any research study, approval for the study was obtained through the completion of an ethics application process. Accordingly, the CDHA Ethics Committee was provided with a copy of the research proposal for review and approval (Creswell, 2007). Additionally, the ethical principles of participant informed consent and voluntary participation were upheld (Creswell, 2007; Flick, 2006; Miller & Bell, 2002). RNs enrolled in the study were informed at the point of consent they were free to withdraw from the research study at any time with no fear of work related reprisal. Freedom to withdraw from the study was presented to the RNs enrolled in the study during the consent process and re-visited with the informants at points along the research process (Flick, 2006). See Appendix B for the CDHA informed consent form.

A written and verbal description regarding the focus and intention of the study, how the confidentiality of the respondent's comments would be maintained, known risks and benefits of the study and the need for the respondents to participate in the interview process and in the reading of interview transcripts was provided to each participant (Creswell, 2007; Flick, 2006; Miller & Bell, 2002). Specifically, the use of non-identifying descriptors within the data representation, formal written and oral presentation of the research project were used. Data collected in the participant interview(s) were only seen by the researcher, transcriptionist and my research committee (Boynton, 2005). Protection of the data was maintained by keeping interview transcripts in a locked filing system on the researcher's work premises (Flick, 2006). Potential benefits of this research such as the ability for RNs to reflect on their own care planning practice, the potential for additional future related studies

and the potential identification of recommendations and strategies to enhance care planning practices were highlighted to the potential participants prior to enrollment.

The preservation of the participant's welfare is an important consideration and component of conducting sound ethical research (Flick, 2006; Morse, 2007).

Accordingly, there was the potential that during the interview process the questions posed and the participant's reflection and response to the questions may have caused some participant's to question their registered nursing practice and may have evoked feelings related to how they perform their nursing role. Therefore, time within the participant interview(s) was planned and allotted for as a means to provide an opportunity to discuss concerns if they arose and to provide additional resources such as on-line practice resources, peer mentors and reading material as required.

However, this strategy was not required during the interview process. Finally, an opportunity for participants to ask additional questions related to the research was offered to the participants initially and ongoing throughout the study (Creswell, 2007; Flick, 2006; Miller & Bell, 2002).

Recruitment Strategies. RN researchers have a professional accountability and responsibility to ensure the research design along with the recruitment of informants complies with ethical standards and that the protection of the rights of the participants is considered and maintained (Streubert & Carpenter, 2011). Specifically, with respect to recruitment of participants, areas requiring focus are the process used to gain access to study participants and the relationship of the participant and researcher (Creswell, 2007; Streubert & Carpenter, 2011).

In terms of gaining access to potential study participants and the initial establishment of researcher-participant relationship it was imperative to gain access to

respondents who had perspective and experience with the topic of inquiry (Lee, 2006). Therefore, recruitment strategies entailed several approaches. For example, the researcher negotiated an opportunity to engage in preliminary dialogue with potential acute care informants as a means to explore possible research relationships and to provide opportunity to highlight the focus and intention of the research as required (Lee, 2006). Therefore, health service managers were initially contacted via e-mail to explore the opportunity of offering 2 information sessions/per unit at convenient times (during staff meetings and/or education days) for each of the 7 medical/surgical areas. Additionally, to help mitigate researcher influence and participant coercion, health service managers and clinical nurse educators were asked to post the study advertisement in their clinical areas for the clinical RN staffs to review (Miller & Bell, 2002). A study overview was provided on one of the medical/surgical units. Based on the study overview provided one of the staff RNs volunteered to be a study participant. However, this strategy was not required on all targeted recruitment settings as recruitment of 3 staff RNs occurred voluntarily once the initial study advertisement was disseminated. As well, the snow-balling approach proved successful in obtaining the last 2 staff RN participants. In addition, health service directors were contacted and requested to forward the study advertisement to the health services managers and clinical nurse educator potential participant pool(s) as a means to help establish initial communication. Based on this approach 2 health services managers and 2 clinical nurse educators contacted the researcher to express interest in being a participant.

Additional activities were planned to help support the unit presentations including preparing sample questions for review, providing information in relation to

targeted sample and sample size, and preparing to address any individual or collective questions or concerns (Milne & Oberle, 2005). Dissemination of focused advertisements on CDHA websites was also planned. However, in the end these strategies were not required.

Data Collection Methods

Given the complexity and context of the acute care practice environment, the need to collect data from multiple sources was necessary. This included the execution of participant interviews with three RN cohorts (staff RN, clinical nurse educator and health service manager) and the need to review and wherever possible relate these findings to organizational policies and regulatory and legislation document(s). Multiple data sources were required so the researcher could begin to fully describe the context of nursing practice within these acute settings, as well as how the RNs described their current care plan practice within this context. This approach to data collection was required as the intention was to adequately describe the experiences of RNs with care planning in their respective care delivery settings (Sandelowski, 2010). Particularly, semi-structured open ended questions with probes were designed for the participant interviews (Hsieh & Shannon, 2005; Neergaard et al., 2009; Patton, 2002; Sandelowski, 2010).

Individual, semi-structured, audio recorded interviews were conducted through the use of an interview guide (See Appendix C). The duration of the interview ranged from approximately 30 minutes to 1 hour (majority lasting 45 minutes) in duration. Interviews were held in an onsite meeting room away from the direct clinical practice area with the exception of one participant who preferred to meet in a conference room in the clinical area. In terms of the transcription of the

audio-recorded data, a transcriptionist was hired for this step of the research process. The procedural steps that were followed in the transcription of the data included verbatim transcription of both the researcher and participant statements, denoting turn taking of researcher and interviewee and breaks and ends of sentences (Flick, 2006). As well, a second review of the participant interview transcript was conducted by me for comparison with the audio recording to help ensure accurate description was achieved (Flick, 2006). Individual interviews were selected as a means to ensure participants were able to provide their individual and subjective description of their experience with care planning. The use and balance of probes and active listening helped to enhance the clarity and depth of the participants' responses and to ensure the individuals' voices were heard in the interviews (Milne & Oberle, 2005; Neergaard et al., 2009; Patton, 2002; Sandelowski, 2010).

Furthermore, the interview included gathering some initial, demographic information such as years of medical and/or surgical RN experience and directed questions were aimed at describing the individual's current practices followed by their beliefs about care plan use with patients in acute care (Patton, 2002). To enhance the clarity of the interview questions and in turn the descriptive richness of the responses, attention to using singular questions, embedding consistent and known participant terminology within the interview questions and the use of prompting words such as "please describe" were employed (Patton, 2002). Additionally, focusing on closing the interview in a manner that allowed the participants to describe any additional perspectives or factors related to the topic of inquiry was employed (Patton, 2002). Lastly, to help ensure the active reflection of the researcher in relation to ethical implications and considerations that could have emerged throughout the

research process, a reflective journal in which documentation of questions and concerns and the rationale for decisions was maintained (Miller & Bell, 2002).

The social-ecological framework was used to structure the participant interviews thus allowing RNs the opportunity to describe experiences from multiple levels of influence. For example, the participants were able to describe how their daily work breakdown and their role was structured within the workplace, as well as how other team members' work affected the care planning ability of the RN from an inter/intrapersonal level (Kalisch, 2006).

Data Analysis

Data analysis in qualitative research is a process which entails preparation and organization of the collected data for analysis, interpretation and representation (Creswell, 2007; Flick, 2006; Miles & Huberman, 1994). More precisely, data such as text data were sorted, reduced into themes through a coding procedure and then further reduced for display and discussion (Creswell, 2007). Data management consisted of manual organization of interviews and field notes text into hard copy and computer files with memoing of ideas and principles that arose for the researcher during the coding and analysis of the data (Creswell, 2007; Miles & Huberman, 1994). Furthermore, analysis of the data was an iterative process as data collected from the interviews and derived from the reflective journal were reviewed many times during and post collection of the interview transcripts.

Thematic analysis, is one of the more common frameworks used with qualitative studies and therefore was selected for the data analysis component of this research study (Aronson, 1994; Braun & Clarke, 2006; Sandelowski, 1995). Furthermore, thematic analysis has been recommended as one of the first and foundational methods

for new researchers to use as it builds a core competency with analytic skills that can serve the researcher in future research endeavors (Braun & Clarke, 2006). However, the process of how to go about performing thematic analysis has also been cited as one of the least well described (Aronson, 1994; Braun & Clarke, 2006). Nonetheless, there have been some writings with respect to outlining some of the key steps with this method that will be highlighted and discussed with respect to this study below.

At the center of thematic analysis is the need to identify patterns and then themes within the data (Aronson, 1994). The first step performed in the process was the collection and preparation of verbatim transcribed interview transcripts for analysis. The first four interview transcripts were reviewed several times in order to enhance familiarity with the data (Aronson, 1994; Braun & Clarke, 2006). From there, the development and assignment of codes to the interview text data was performed (Aronson, 1994; Braun & Clarke, 2006). The researcher then analyzed the subsequent data in the remaining interview transcripts and began to identify and relate the data wherever possible to the previously identified codes of the first four interviews (Aronson, 1994). Following this, the researcher combined and/or collapsed related codes if possible and then structured the codes into themes and sub-themes (Braun & Clarke, 2006). The themes and sub-themes were considered as relevant and meaningful data units derived from the codes that when combined together started to paint a descriptive picture of the RNs' experiences of care planning practice (Aronson, 1994). Finally, the researcher needed to ensure a reasonable and critical argument could be made to support the themes as outlined by Aronson (1994). This was accomplished within the discussion component of the research study by relating the themes to relevant literature on the subject matter (Aronson, 1994).

Accordingly, the data from the audio interview transcripts were transcribed verbatim by a professional transcriptionist affiliated with Dalhousie University. The first 4 interview transcripts were read to ensure familiarity and comfort with the written words and to get a sense of the whole within each transcript and the reflective journal notes kept by the researcher (Creswell, 2007; Sandelowski, 1995). From here reflective notes were memoed in the margin of the transcripts and a summary outlining the key concepts the researcher believed were contained within each document were documented. Descriptive coding of the data was produced from the retrieved text data in the course of conducting the study and/or modified to accommodate new insights about the existing data as new data were collected (Hsieh & Shannon, 2005; Miles & Huberman, 1994; Neergaard et al., 2009; Sandelowski, 2010; Sandelowski, 2000). Following the coding of the first 4 interviews, the remaining text data was thoroughly reviewed, compared to the other transcripts and assigned codes to assess and determine commonalities/differences among the text and codes and codes were collapsed wherever possible. As well, extraction of potential outlier text or codes for further analysis was performed with the focus on reviewing these units to determine if they were distinct new codes or if they held true to an existing code (Creswell, 2007; Hsieh & Shannon, 2005; Neergaard et al., 2009). This was done to ensure the codes reflected the descriptions and perspectives of the participants (Creswell, 2007). Additionally, to help ensure correct and appropriate assignment of codes the first interview and corresponding codes were shared and discussed with my thesis supervisor. Finally, the researcher conducted a further analysis of the data as a means to categorize findings into themes and sub-themes. It is the intent that the themes and sub-themes derived from the analysis of the data

represent and depict the essence of this research inquiry: experiences of RNs in fulfilling their role in planning care for patients.

Related policy documents introduced in the literature review section of the proposal were used within the interview guide. Furthermore, reviewed documents and their influence over care planning practice were described within the data analysis themes and sub-themes as applicable. Additionally, documents were discussed, as appropriate, within the discussion chapter if they were relevant and could be related back to the findings and relevant literature. These aspects of the data analysis and discussion components of the research were necessary so that the identification of influencing factors related to policies or organizational levels could be identified and potential strategies to enhance or mitigate these factors could be highlighted (Sandelowski, 2010).

Data representation in keeping with qualitative description expected deliverables was produced as a descriptive summation of the information organized and represented in a manner compatible with the data (Sandelowski, 2000). Therefore, representation of the data consists of displaying the data within themes and sub-themes. In turn, the researcher was also interested in describing how the findings intersected with the previously conducted and reported literature findings used to inform the intention for the current research such as the Elf et al. (2007) depicted conceptual representation of the care planning process (Creswell, 2007; Miles & Huberman, 1994; Neergaard et al., 2009). Accordingly, relation of the study findings to the Elf model has been conveyed in the discussion chapter of this research.

Establishing and Maintaining Trustworthiness

The aim of establishing trustworthiness in a qualitative study is to help substantiate that the topic of inquiry and its related findings have meaning and merit to others besides the researcher (Lincoln & Guba, 1985, p.290). Furthermore, soundness with respect to qualitative studies can be demonstrated by the ability of the researcher to comprehensively include, confirm and accurately account for the research participant's information and experience(s) (Creswell, 2007; Streubert & Carpenter, 2011). Additionally, one of the perceived advantages with a qualitative descriptive design is the low inference analysis of the data which in turn should help to enhance the credibility, authenticity and accuracy of how the RNs' perspectives were described and represented within the data findings (Milne & Oberle, 2005; Neegaard et al., 2009).

To help ensure the trustworthiness of the research some of the following elements have been emphasized by many within qualitative research circles and it is these criteria that are discussed and applied to this study: credibility, confirmability, transferability and dependability (Lincoln & Guba, 1985; Streubert & Carpenter, 2011).

Credibility. Credibility involves the evaluation of whether the research findings depict a plausible interpretation of the data which was drawn from the research participants' narratives (Creswell, 2007; Streubert & Carpenter, 2011). To uphold credibility standards and enhance the integrity and quality of the research several strategies were adopted.

Triangulation of data from the interview participants (i.e. staff RN, health service manager and registered nurse educator) was performed as a means to enhance

the credibility of the study findings, as well as, the comprehensiveness of the inquiry description (Lincoln & Guba, 1985). Additionally, a review and description of related CDHA policy and regulatory documents within the literature review section helped to illuminate additional factors within the organizational and policy levels integral to the SE model that can influence care planning practice (Cassel, 2010; Shenton, 2004; Strack et al., 2010). Through the use of triangulation techniques the potential for richer description of credible data was greater (Lincoln & Guba, 1985).

To further establish and enhance credibility for this research project several techniques were employed. Namely, to enhance the integrity of the research, the interview guide was distributed to my thesis supervisor, my research committee and 2 professional practice RN colleagues to help ensure my interview questions were aligned with my topic of inquiry and were consistent with my methodological approach (Neegaard et al., 2009; Hsieh & Shannon, 2005).

Another strategy frequently used to enhance credibility is member checking which can be described as the procedure of returning data themes and/or final report findings to the informants in order to assess whether they recognize the findings and believe them to be accurate and credible (Lincoln & Guba, 1985; Neegaard et al., 2009; Streubert & Carpenter, 2011). I conducted 2 follow-up participant telephone calls to ensure the data collected and analyzed was consistent and credible with what the participants believe they described (Lincoln & Guba, 1985; Neegaard et al., 2009).

Confirmability. Confirmability can be described as a process measure with respect to the fact that the researcher needs to clearly lay out the data, evidence and thought process that supported their findings (Lincoln & Guba, 1985; Streubert &

Carpenter; 2011). Accordingly, I utilized a peer review process. That is, my supervisor acted in the role of external, secondary reviewer of the research process. My supervisor critically reviewed and questioned me about the research methods and my analysis of the research (Lincoln & Guba, 1985). Additionally, as a means to improve the confirmability of the research, I reflected on and kept a journal about my research decisions made with respect to data collection and analysis activities, my own assumptions and how they impacted on my ability to facilitate the participant interviews and analyze the research data (Milne & Oberle, 2005; Neegaard et al., 2009). A formal journaling process helped to establish an audit trail of the research process and can be made available upon request for those who wish to examine my study design and methods. Additionally, my assumptions have been made explicit in this final research paper through the positioning of me as the researcher within the research and throughout the methods section of the paper.

Transferability. Transferability is defined as the probability that the research findings have meaning and relevance to others in similar contexts or situations (Streubert & Carpenter, 2011). In terms of enhancing transferability, I have included a written description of the context in which the study was conducted, participant demographics and the data analysis methods used (Shenton, 2004; Streubert-Speziale & Cameron, 2008). These activities should help potential researchers or consumers of the information to make decisions as to whether or not the research findings from this study can be transferred to their context (Streubert & Carpenter, 2011). Also, as previously mentioned I used maximum variation as a sampling strategy and therefore have triangulated the study participants into three groups (staff RN, clinical educator, health services manager) to help enhance the potential for transferability of the

research findings and utility of the research findings to other clinical areas and reviewers of this research (Streubert & Carpenter, 2011).

Dependability. Dependability is an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation (Streubert & Carpenter, 2011). The researcher is required to continually reflect on and account for the emerging and evolving dynamics and conditions in which the study is occurring and is required to translate this knowledge into potential refinements or changes to the study design as required (Lincoln & Guba, 1985). The question of research dependability can only be answered if credibility has been demonstrated (Streubert & Carpenter, 2011). Therefore, triangulation of the study participants, as well, employing a review of multiple levels of related legislative, regulatory and CDHA organizational policy documents was outlined and performed to help uphold the dependability principle. The reflective journal also could serve as a resource for my thesis committee to review as a means to inspect my reflections on emergent issues, conditions that arose during the study and the choices I made with respect to recruitment approach, analysis and depiction of study findings.

Chapter Four: Findings

A qualitative descriptive methodology approach accompanied by thematic analysis is appropriate for full description of an issue or topic of inquiry that may not have been previously well described (Sandelowski, 2000). The findings of this study will be conveyed in this chapter through the description of the study participants perceived experience of RN care planning practice. The analysis will also depict how these experiences influence or shape their practice.

Data analysis resulted in the identification of two themes; Unwritten Care Planning and Modernizing Care Planning. Unwritten Care Planning is constituted by three underlining subthemes: (a) Unclaimed RN Accountability; (b) Drivers of RN Practice and, (c) Falling off the Radar. During the analysis of the participant interviews, these subthemes were identified as distinct yet related to unwritten care planning. The second theme identified in the data was Modernizing Care Planning and is constituted by two subthemes: (a) Back to Basics and (b) Untapped Opportunities. The theme Modernizing Care Planning and related subthemes addresses the potential strategies articulated by the RNs to revitalize care planning practice within acute care and the need to reconsider and/or consolidate existing processes to streamline work and enhance care planning practice. These two themes and associated subthemes will now be presented and supported by the data.

Unwritten Care Planning

The theme ‘unwritten care planning’ is defined here as the lack of documentation of a plan of care by a registered nurse for a medical and/or surgical patient within the healthcare record. The description of RN care planning practice by the study participants in their medical and/or surgical practice setting is that written

care planning practice by the registered nurse, for the most part, is non-existent.

Moreover, three accounts, one from each of the study participant cohort(s)

perspectives described unwritten care planning as follows:

... Formally, I don't think the plan of care is documented. [NM2]

... It is unwritten care planning. [NE1]

... The care plan is on the back of our Kardex. However, I hate to say this, it's usually blank on the back of the Kardex. It doesn't get filled out. You know, I hate saying that it's blank. You know, it was definitely stressed while I was in nursing school. However, when you get out of school, it's not filled out.

[SN2]

Despite the RN practice of not documenting a plan of care there was unilateral reporting by the nurses in the study that an RN is actually fulfilling their role in planning care for their patients. Specifically, there were data in which most of the study participants articulated that a registered nurse or even the licensed practical nurse based on their experience with the patient/patient population can intuitively and instinctively know what nursing care is required and that planning care is happening on a daily basis "in their heads" albeit not formally documented. Examples of this description were:

... I've never done a care plan for a patient in the 3 years I've worked. I think it's more so in your head of basically what you're thinking, you know, the plan of care for the patient. But we don't actually have a written care plan on our unit [SN5].

... The LPNs have it all unwritten in their head just as much as the RN based on experience, you know [NE1].

When asked to elaborate on what they meant by in their heads and the role of the nurse in care planning, some participants expanded further to indicate that care planning in their heads centers mostly on the clinical tasks required for patients. This was evident in the following descriptions:

... The RN and LPN role still feels like it's all built around tasks [NE1].

... But care planning is more related to providing clinical skills than related to planning care [NE2].

Whilst, some participants described and acknowledged how “in their heads” needs to evolve to something more for patients and the RN:

... What I see as care planning, it's very informal. It's all in the nurse's heads.

So patients could follow a path a little bit more quickly, a little bit more efficiently if things were a little bit fine tuned with written care plans [NE1].

... The plan of care would tell me where the patient is at in this point in time, what happened and where the patient needs to go. So it could be quickly identified what the needs and outcomes are expected for the patient [NE1].

Participants explained how being an experienced medical surgical RN meant that the nurse had expertise and knowledge for specific patient populations. That is, some of the participants who had experience with surgical patient populations specifically described that nurses who care for surgery patients in their practice setting know what types of standard nursing care activities are required such as post-op pain management and the nursing assessments required to monitor the patient's progress or outcomes without having to write it down in a structured care plan. An example of this was described by [NM1]:

... I think there's a good knowledge base for the patient population and an understanding of what's required for a pre-op patient, inter-op, getting ready for the OR and the post-op care. Is it formally written down? Sometimes it is and sometimes it isn't.

When asked to further elaborate on unwritten care planning practice by the RN within their current medical/surgical setting(s), again, all participants' noted that the nursing kardex would be considered by most nurses to be the plan of care for patients. In fact, when patients are initially assessed and admitted to the unit it is the kardex that is the primary data transcription form used to capture patient diagnosis, current activity of daily living requirements and care requirements such as O₂ therapy or glucose monitoring schedules as described by the study participants. Furthermore, the kardex is used routinely as an ongoing communication tool to highlight immediate care needs or consults to other disciplines. However, in its current state the kardex is not structured in a way that lends itself to a more comprehensive approach to capturing care needs, nursing interventions and evaluating outcomes. When asked if the current kardex offers that type of structure and focus so that the RN could get an overview of the plan [SN6] offered this response:

... No, you wouldn't see that.

Whilst, another described the following:

... You can look at a kardex and just get where they are today, but it doesn't tell you how long or what happened for them to get there [NE1].

Interestingly, some study participants held different expectations of other health care professionals or specialty consult RN roles involved in patient care with respect to a documented care plan. For example, a few participants explicitly

expressed that they would expect to see documentation by a social worker or other allied health member in the progress note of the chart in relation to what their discipline specific plan of care was for the patient. Additionally, there was anticipation that those RNs in consult role(s) such as enterostomal therapy (ET) would provide written and formalized documentation of their patient assessment(s) and plan of care. However, inter-professional collaboration and written documentation of an inter-professional care plan does not routinely occur. Specifically, [NE1] described the following practice(s) with respect to how consult RNs document and how inter-professional care planning takes place:

... You know someone with a new ostomy, the RN would consult ET. The ET will come with their care plan for teaching the patient and/or family. Then, the ET would follow it. The care plan is not done collaboratively with an RN who is looking after the patient. Each discipline appears to work in their own little silo.

The implications of not having a written plan of care were also discussed with the study participants. Specifically, in terms of patient and/or family involvement in their plan of care it was noted that the communication process related to the plan of care was not well defined. That is, a patient's involvement in their health plan may or may not be happening informally during the multidisciplinary and/or medical rounds process, as well, the charge nurse is the primary nurse who attends rounds and liaises with the multi-disciplinary team; not the assigned RN. For example:

... I'm not sure that the patient is as involved in the plan of care. I still see it very much as being the healthcare team that is setting the plan of care and the patients are doing it [NM2].

... The charge nurses are usually the ones to consult [social worker, home care etc.]. They get to know the patient. Sometimes they seem to get to know the family [and patient] sometimes even better than, you know, the nurse looking after them [SN2].

Furthermore, there is no defined, written plan of care from either a multidisciplinary or nursing perspective to guide the discussion.

Introduction of Subthemes

The descriptions by the study participants of care planning practice within their medical/surgical settings revealed that written care plans for patients are not being prepared. Several factors have been described by the participants as having influence over this current state of unwritten care planning. Namely, beliefs that care planning is happening informally in the registered nurses and licensed practical nurses head. Moreover, as described by many of the participants, the rationale for the practice of not writing the plan of care was that the nurse through their experience and familiarity with the patient population and the medical/surgical unit would know what care the patients would require from nursing and thus not require a written plan. Furthermore, some described that the nursing kardex is a form that could be considered the written plan of care for the patient, however, upon further exploration some of the participants described that care planning in the head and the information contained in a written kardex mostly centered on task execution as opposed to prospective care plans. Likewise clear communication processes between the multidisciplinary team, assigned registered nurses and the patient with respect to care planning were described as lacking thus adding further issue to the practice of unwritten care plans.

Additionally, three distinct subthemes were identified in relation to ‘unwritten care planning’ and described by the participants as contributing to the non formalization of written care plans by the RN. These sub-themes relate to the responsibilities, accountabilities and expectations of RNs who practice in these acute care settings, as well as, the existing care delivery model and documentation structure and processes associated with nursing practice. Finally, the description of current values, beliefs and reflections held about care planning practice by the participants were described.

Unclaimed Accountability

‘Unclaimed accountability’ means that the registered nurses are either not fully aware of their role and responsibilities related to a particular domain of nursing practice and/or they are not taking ownership for responsibilities required to fulfill the role of a professional RN. Unclaimed accountability also refers to lack of establishment of consistent monitoring or performance expectations on the part of the unit or organization to ensure accountability is assumed and maintained. Furthermore, accountability that is left unclaimed can have implications for registered nurses, nursing practice and more importantly the patients under the RN’s care.

The RNs in this study recounted that care plans are not being formally developed or written within the patient’s healthcare record on any substantial or consistent basis. Participants perceived that this omission in accountability was rooted in the fact that currently there are no clear practice expectations for RNs in relation to the development of the nursing component of the plan of care. For example [SN2] stated:

... I think it's partly because it's not very well stressed. There's not a big influence, you know, to have that filled out.

Participants recounted that expectations related to care planning documentation practices and/or responsibilities with respect to patient/family engagement in plan of care are not well known, understood or acknowledged by some of their RN peers. Moreover, there were no consistent or standardized quality activities such as chart audit processes being used to monitor or track performance in relation to RN documentation practice in the workplace setting. Participant [NE1] summarized the general state of the overall nursing documentation practice as, "the worst she has ever seen". For example, despite the description by most of the participants that the kardex is considered to be the working plan of care, participant [SN3] described a lack of accountability on the part of the nurses in even keeping this documentation up to date:

... I find the kardex(s) really aren't updated as well as they should be. I think some people just don't see that it's important or just don't do it. They don't think they have to.

Another description by participant [NM2] was:

... I'll go through [nursing documentation] for days and days trying to figure out where this patient is and what we're doing. I find it very, very hard to find a nursing entry in the progress notes unless there's been a huge occurrence or event or something.

Additional findings related to unclaimed accountability as described by the study participants centered on a notion of shared accountability for RN practice. That is, accountability for RN practice standards that are clearly within the scope of

practice of the RN such as written care plan development have been shared and in some instances filled in or taken up by others. Namely, the charge nurse and/or health services manager have been noted to step in to act in the capacity of care coordinator, discharge planner and/or care plan developer for some patients who were perceived to require a more formalized care planning approach. Examples of these findings within the data were:

... Usually if somebody is going home with an extra bit of care at home, the charge nurse looks after everything. You see, it's not usual that we do it [discharge planning]. I know we should but we don't [SN5].

... You'll see a lot of the charge nurses doing parts of care planning when it comes to the discharge planning [NE1].

... I do see it as being the charge nurse that kind of takes it [planning care] on herself and initiates the consults and makes sure the consults are followed up, makes sure that the right people are integrated in the patient's care more so than the RN [NM2].

However, for the majority of patients who were primarily considered to have routine surgical or medical needs there was a profound sense by several of the participants that written care plans were not really necessary and therefore accountability for care plan development was not assumed. For example [SN4]; [NE1]; and [SN1] respectively indicated the following:

... There's a pretty structured but not written care path that our patients follow. That is something that when you're hired, you learn about.

... You know what the nurses usually do for their patients. For example, you know, everybody is supposed to get up on certain day. So the care planning to date on the units that I've worked have been very much unwritten.

... You know it's just like when you're driving a car. You know, you're driving a car. You know that when you're going to turn, you put your signal light on. It's just one of those things that just becomes so automatic, you just don't, you don't need to write it out anymore.

The study participants also shared additional insights about the implications of how the lack of role accountability with respect to written care plans can potentially influence novice nurses or nursing students' care planning practices. Specifically, lack of written care planning practice by practicing RNs can leave the student nurse or novice RN to question the utility and relevance of care planning in their practice and their accountability for same. As a practicing RN with less than 2 years experience, one of the study participant's [SN9] had this to say about the realization that written care plans were not being prepared in actual practice:

... It was actually kind of a shock when I first started to work because I thought why did I spend countless hours working on care plans and they don't even matter in the actual real world. I thought what a waste of time.

Whilst another [SN3] offered this insight:

... Nursing students realize they aren't used as much as they are led to believe they are used in the hospital setting.

As well, some participants highlighted that the practice of unwritten care plans can create the potential for nurses working with patient(s) in their practice setting(s) to be unclear about what the plan of care is and the associated expectations and

accountabilities of them in assuming and documenting care for assigned patients; leading to potential gaps in both patient care and role responsibilities. Accordingly, participant [SN5] described this as:

... For example, I'm part-time right now so I'm not there all the time. So when I come in and I have a patient that I haven't seen ever, I have no idea what the plan of care is and I have to figure it out as the day goes on. You don't know what the expectations are for that particular wound [example of patient need], like where they actually expect to go [wound outcomes].

Staff RN participants described an inability to clearly discern how day to day differentiation of RN and LPN practice gets lived out with respect to planning care. Again, similar to the findings in the overall unwritten care planning theme, the experience level of a nurse be it RN or LPN influenced the description by some of the study respondents about role differentiation, scope of practice of RN and LPN and care planning accountabilities. For example, both a formal clinical leader and several of the staff RNs in the study provided a description of RN practice as being similar or the same as that of the LPN within their acute care setting. That is, similar or the same with respect to care assignments, care activities and managing/planning care responsibilities. This was evident by descriptions such as this [NM2]:

... Certainly when I have a junior RN crowd, some of the LPNs do feel they know more and they should be able to do more. For example when a patient develops acute chest pain, they [LPNs] feel they know so why can't they just do it [manage and plan the care]? I think sometimes the RNs have a hard time understanding, well, if they know [LPNs], why can't they just do it? I find the RNs grasping at trying to figure out what their role is.

To further describe unclaimed accountability participants explained that practice expectations from the College of Registered Nurses and the employer were poorly understood by many registered nurses making it challenging to translate required expectations into real life practice. Study participant [NE1] concluded that:

... Care planning is mentioned in our scope of practice and in our organizational RN and LPN differentiation of practice guideline. But to me, it's all. It doesn't tell you how to do it. It doesn't tell you anything. To me, it was like putting the cart before the horse.

During the course of the participant interviews, descriptions such as “you don't see the RNs guiding the care plan or writing the care plan” [NE1] led to the identification of a fundamental gap with respect to failing to own the RN care planning practice despite being educated and authorized to perform. Several factors can influence or shape how the RN views or accepts their accountability for care planning. Namely, clarity of role expectations within the practice settings, expectations with respect to patient engagement in the care planning process and unclear or inconsistent quality practice and performance monitoring processes were described by some during the participant interviews.

This lack of clear differentiation between RN and LPN practice within the discipline of nursing has been previously studied and reported in the literature (Oelke et al., 2008). RN and LPN practice differentiation, specifically, with respect to the need for the RN to develop a plan of care and in turn determine the complexity and stability of the patient is considered foundational to clearly ensuring provider role clarity, optimization and effective utilization of existing human resources. This study bears out existing findings.

Relation of Unclaimed Accountability to Unwritten Care Planning Theme

Study participants' descriptions of the current state of RN care planning practice within medical and/or surgical settings revealed that written care plans are predominantly not performed within their practice settings. Unclaimed accountability by the RN over their care planning responsibilities was identified as a subtheme underpinning the practice of not documenting a nursing plan of care. Furthermore, based on the participants' accounts, some of the factors influencing this unclaimed accountability centered on a lack of role clarity, performance management expectations and consistent quality monitoring practices. Moreover, supporting documents from a regulatory or organizational perspective were described as not being particularly useful to help understand role expectations and how to step into the care planning role by the RN. As well, similar to the unwritten care plan finding, the more practice experience and familiarity with the patient population the RN or LPN acquired was described as having an influence on whether some of the participants saw an actual need for the care plan to be documented. Implications related to unclaimed accountability over care planning practice were also described by the participants. Namely, practice gaps with respect to agency RN staff or core RN staff that have been off for several days meant not having a good picture of what the focus of care was or where the patient was with the trajectory of their plan of care. Finally, the fact that written care plans and accountability for same remains unclaimed was described as having an influence over novice RN's perceptions as to what their accountability is for written care plan formation.

Drivers of RN Practice

‘Drivers of RN’ practice denotes the key structural and process factors that were described by the participants as having a significant influence and demand on the acute care RN’s time. Specifically, examples of structural influence such as the nursing care delivery model for the unit and process related areas such as documentation were described. Furthermore, these structural and process factors were reported as directing a major component of the work and the practice of the registered nurse and the roles they execute on a day to day basis.

There was a sense by the RNs within the study that the context of medical and/or surgical practice settings influenced and directed the practice of the registered nurse. Particularly, patient acuity, length of stay and patient flow were the drivers for how nurses organized and prioritized their work leaving little room by the participants’ accounts for written care planning activities to be incorporated into their day. Participant [SN2] described the acuity, complexity and labor intensive focus required on the part of the RN for some patient care requirements in their surgical environment:

... For example, the other day I had a fistula that was leaking constantly. It would take about 4 hours [dressing]. So, that was 4 hours out of my day taken from, we could say, care planning.

Another participant [NM1] offered the following description with respect to patient acuity and patient length of stay:

... We can talk about busyness and acuity of patients. All of these factors support the need for care plans. They support it but they’re a barrier at the

same time. You look at short discharge times. You look at notice to discharge and all of those things. The bed is not cold and someone else is in it.

Impressions by several of the participants within the study suggested that time to incorporate care planning activities in their work would be difficult if not impossible to procure or maintain in their practice. Exploration or description of time revealed a dichotomy between perceptions of time detractors and potential harvesting of time for nurses in their daily work. That is, the nurses in this study perceived that the time required to develop and document a care plan would take away from direct care activities the RN would be required to perform such as dressing change procedures or medication administration. However, some of the participants expressed another perspective with respect to the time required to search for the relevant clinical information in the patient's health record. Accordingly, discernment to try and piece together an account of a comprehensive patient story, expected patient outcomes given the lack of a documented plan of care was described as an issue for the RN. For example, participant [NE1] and [NM1] said respectively:

... You wouldn't be able to quickly glance at the chart and see where the patient was [with their plan of care].

... You may see a small notation on a kardex that this problem has been identified but the measures that have been taken are not written out and they're not communicated.

However, a few of the participants expressed the need for the RNs to re-evaluate how to utilize and maximize their time, as well as, how they determine and prioritize their work. This was evident in the following statements:

... Honestly, I think that they [RN] don't build the time in their day for it [care planning] [NM1].

... Especially our senior nurses, would see that as [taking away some of the care tasks they perform], you know, they're not fulfilling their duties, they're not doing their job if they don't give everyone backrubs [SN5].

The current documentation processes, as the participant's described, lend themselves to having to duplicate documentation efforts and/or require review of multiple documentation sources such as the nursing kardex, progress notes, nursing care flow sheets to get an overall snap shot of required care and evaluation of care interventions. Furthermore, the required documentation by the nurse is directing their practice, so much so, that the RN is actually executing the collection of the data without, at times, really having or taking the time to think about how this information informs nursing care for the patient(s). An example of this was provided by [SN1] when asked about nursing documentation and associated forms:

... Paperwork is a huge barrier because there's so much of it. Like for example, fall risk assessment. Like people just see that as oh, yeah, we have to do that again. You know? But it really is important in... I mean that, if you look at it in that way, it is part of your plan of care, you know, you're identifying the need. There's just so much paperwork that people [nurses] just see it as being paperwork and more of it.

Noteworthy within the study interviews was how the nursing admission assessment is currently used to guide or direct nursing practice and care plan development. That is, based on the participants accounts, there is a missed opportunity or disconnect in how the admission assessment could or should serve to

identify and plan care for patients. Currently, the admission assessment is being utilized primarily as a data collection tool and not taken to the next level in terms of interpretation of the data and formation of a plan. When asked how the initial admission assessment form was used, participant [SN5] stated:

... Basically it just stays there [in the chart] and nothing is really done with it. Some of it [data] is transcribed to the kardex but that's about it.

Participant [SN5] expands upon their response by saying:

... Well, it [admission assessment] is viewed as a single entity, but it can help.

Another [SN2] indicated the following:

... It is mostly a data collection tool.

Also, the current state of the forms associated with the admission process were explained by many of the nurses to be numerous and non-integrated. For example, there is a general nursing admission form, a falls risk form, a Braden Scale skin and wound assessment form plus several others that are required to be completed on admission by either the RN or LPN. However, based on the participants' accounts there appears to be no reconciliation of the information on any of the forms to determine patient needs.

Data from some of the participants indicated a need for care delivery models in some of the acute care settings to be reviewed and assessed in relation to what influence the model is having on current RN care planning practice responsibilities. This was evident through the expressions by both staff and formal leadership RN study participants. Both parties had conveyed that they or other staff registered nurses have indicated that current staffing levels, staffing mix, as well as, patient acuity and the required highly technical care interventions are directing how the nurses prioritize

their day and the work they are able to successfully complete. One of the participant's [NM1] provided this description that lends credence to how RN practice is being influenced and directed:

... Nurses go non-stop from the beginning to the end of their shift and it is very task oriented and it has to be to a certain extent.

As well, omitted care such as the review and evaluation of a patient's lab work was mentioned by a few of the study nurses as an area of their practice that can get missed in the run of a shift. An interesting finding as described by some within the study was the notion that the care delivery model can influence the work the RN assumes or provides. That is, if the model consisted of registered nurses and non-regulated Care Team Assistants (CTA) it was perceived by some of the participants who had experience with this model that, at times, it could be easier to direct and delegate care to this type of a supportive role versus having to step into collaborative or negotiation of care conversations in models of care which consisted of RNs/LPNs. To illustrate this, one respondent [SN5] relayed the following with respect to RN ability to direct some of the activities of their LPN colleagues:

... You don't want to tell someone to do something. I don't know... I just don't see us being able to tell [LPNs] them to do a particular task when we can do it as well.

Whilst another offered this perspective:

... I think when you change your model of care you have to educate your nurses [RNs] and get them to give up the things they don't need to be doing, which is a major, major initiative to accomplish [NM1].

Furthermore, RN/LPN models of care delivery often resulted in the assignment of patients to RN and LPNs based on tasks and division of labor (for example: 4 patients assigned to RN and 4 patients assigned to LPN) as opposed to clear processes or care delivery structures based on needs of the patients and roles and accountabilities of the providers.

Potential organizational enablers to assist with care planning practice such as policies and procedures were not expressed as being a facilitator or resource for care planning activities, and computer availability to access policies and procedures was described as being limited. For example [SN2] had this to say concerning the alignment of policies and procedures and computer accessibility:

... I am honestly not aware of any policies but there probably is some. Is there not?

... We only have 3 computers on our floor. One of them is generally for the ward clerks, and they're always on it. And the other 2, the doctors are always on. So in terms of computer access, it's very limited.

Additionally, some participants expressed uncertainty with respect to how clinical policies or procedures could assist with the development or evaluation of care plans. From a regulatory perspective there was limited expression of how supporting CRNNS documents could be used to inform RN care planning practice. Participant [SN1] offered the following perspective:

... I'm lucky if I get through finding out policies and procedures, let alone necessarily going to the College and looking to see if there are things there.

However, [NM1] who was currently in a leadership role described how the CRNNS Standards of Practice and Code of Ethics should and need to be used to direct the role of the RN in care planning.

Relation of Drivers of RN Practice to Unwritten Care Planning Theme

Upon reflection during the interview process, written care planning practice was considered by most of the participants to be a desired practice with benefits to both registered nurses and patients. However, there were several factors outlined by the study RNs that make care planning practice a challenge to adopt. Namely, the key structural factors of the medical/surgical practice context and the nursing staffing model were raised. As well, descriptions of disconnects between how the admission assessment data informs care planning activities was described.

The sub-theme of ‘drivers of RN practice’ describes from the perspectives of the participants the current factors that have direction over and to some degree a hold on nursing practice. The participants were able to describe some of the predominant drivers that are shaping RN practice. Namely, medical/surgical context, care delivery model, and the required tasks the RN may need to execute are influencing the roles they take on. Potential drivers of RN practice such as clinical policies and procedures, as well as, CRNNS supporting documents that could enhance care planning practice were either not used or there was no real consensus in terms of how they could or should support the RN. Furthermore, these factors as described by the participants have been to a certain extent influencing the RNs’ ability to step into care planning practice on any real and consistent basis.

Falling Off the Radar

‘Falling off the radar’ is considered to mean losing sight of how care plan activity is prioritized and/or viewed within the work of the RN and/or its worth to patients under the RN’s care. Furthermore, falling off the radar from an organizational and/or CRNNS regulatory perspective is used to describe the participant’s current view(s) on how the organization and/or CRNNS prioritizes or gives credence to care planning practice.

During the study interview(s) participants were asked where on the list of duties, responsibilities or priorities written care plans would reside. Overwhelmingly, most of the RNs described written care plans as low on the priority list; in fact care plans would not even probably make the list. For example:

... Care planning is one of those things that kind of takes the back burner in your nursing practice [SN5].

... Care planning is a very low priority [NE2].

Furthermore, based on some of the participants’ descriptions the execution of tasks is the priority and the must do for many nurses:

... The RN is caught up in tasks [NE2].

... You know, some RNs kind of go in [patient’s room], they do their work and then they leave, and that’s it. You know, they are not really doing a lot of planning [SN1].

... I think it’s getting away from the task-orientated piece of nursing and getting back into understanding why you have to be in the know about everything that’s going on with your patient [NM2].

However, there was a sense that written care plans were developed and in the purview of the RN on rare occasions for some special circumstances. Examples given by some included care plans for complex wound care or patients who were experiencing confusion. In the circumstances where care plans were developed they were described to be well received and used by the nurse as in those circumstances they could see value. Participant [SN1] provided the following experience in relation to the usefulness of care plan development for a specific patient:

... It [care plan] helped all the healthcare providers and nurses on the floor.

During the interviews participants were asked to describe their past experience with nursing written care plans. Reflections and subsequent descriptions by the study participants about their past care planning practice and how that area of their practice was held and lost either as a practicing RN or as a student were illustrated as follows:

... As a student nurse and in my early years of practicing as a registered nurse at the bedside, we had standard care plans and the standard care plans in turn included like the expectations day 1 through day 5 and then we had an unusual problem sheet where we documented the unusual problems and we were very good at initiating those. We've lost that over the years. But from my experience at the bedside, man, that was engrained [NM1].

Additional accounts by some of the participants were useful to help further describe how care planning practice takes a back step to clinical skills as opposed to being integrated during the clinical practicum when a new or graduate nurse is acquiring clinical experience during orientation:

...If you're orientating a staff, a new staff to the floor, and they are a new grad for example they really should be encouraged to do it [care planning]. But

they don't necessarily because they are there to learn their other skills as well [SN4].

Organizationally, despite attempts within the last few years to try and resurrect care planning practices by either the professional practice portfolio and/or health services managers in acute care these implementation attempts have not been successful. One participant who was involved from a practice perspective in this endeavor explained that the lack of a strategic effort or planning approach contributed to unsuccessful adoption at the unit level:

... We looked at what we could do for care planning. Like care plans need to be added to the kardex. Then there was this mad scramble to start care planning and form development. But then it sort of fell to the wayside and the written care plans never did get implemented [NE1].

Furthermore from an organizational perspective, there was the perception that very little direction, consistency or importance is placed on care planning activities for patients or providers. When asked about the importance the organization places on written plans of care, one respondent [SN4] replied:

... Well, considering we don't have a formal written plan of care, I would probably say not too high.

Whilst another [NE1] replied:

... It's wishy-washy at this organization. Some floors have done well and gotten it going [care planning].

As well, several participants described the lack of connection between organizational goals and objectives and required care plan exercises.

When asked about supporting documents or resources in relation to RN role and/or RN care planning practice from a CRNNS regulatory perspective, the majority of the participant(s) did not see the need and/or have not attempted to access their RN college for this area of their practice despite the gap in performing care planning in practice. Examples of responses from the participants included:

... I haven't had the need to look it up so I wouldn't be 100% sure [NM2].

... I'm sure there are things out there. Because your nursing diagnosis and care planning is an important part of your practice so I'm sure that it does exist. I just personally have not ever gone looking for it [SN1].

However, one participant did take it upon themselves to access the CRNNS and College of Licensed Practical Nurses (CLPNNS) website and supporting documents in relation to RN and LPN scope of practice and care planning duties. [NE1] had this to say about the experience:

... Reading on the college website and stuff like that, what the role is of the RN, what is role of the LPN and care planning would come up. And then it was hard to understand [what RN and LPN role was in relation to care planning].

Some of the nurses in the study also believed that the education they received in their nursing curriculum with respect to the how and what of nursing care plans contained a lot of detail and structure that would be hard to recreate in actual practice, basically, making it viewed as unappealing to practicing nurses. Participant [NE1] had this to say about the initial education and exposure they had to care planning practice:

... Care plans as a student were not liked. You know there was the potential for [nursing diagnosis or patient care need] or potential for [nursing diagnosis or patient care need]. Then when you start working and stop doing it, it doesn't make sense to you anymore.

The notion of falling off the radar was also nicely illustrated by study participants who through the course of the research interview reflected on their practice and in particular care planning practices. They realized that the value of care planning had fallen of their radar and participating in the study allowed them to rethink how a plan of care could serve them, their colleagues, the patients and their profession. Some of the participants either initially described written care plans as unrealistic and/or a low priority item. However, at times during the interview process they were able to eloquently describe the value of having a nursing plan of care and how the plan could focus and direct the conversation between the RN and other members of the healthcare team. For example, [SN6] a recently graduated nurse offered this insight about the utility of care plans:

... For us in the acute care setting, it could be that we go to the doctors and say this patient isn't mobilizing because of this reason, and what we've been doing is not working. So, I think as nurses, it would give us something to say this is why it's not working. In black and white, this is what we tried. Or say they want to change something, we say no, it's been working and this is our evidence that it is working.

Whilst another offered this perspective in relation to the benefits of written care planning exercises for both the team and the patient:

... The care plan could help guide their [RN] actions. It could help them evaluate the progress. It could much more effectively communicate the plan to everybody so that everybody is more aware of what's done, by when and what happens if it's not being done [NE2].

Relation of Falling Off the Radar to Unwritten Care Planning Theme

Falling off the radar was how participants described what happened to their written care planning practice once they became integrated as an RN into the practice setting. Additionally, there was descriptions by the participants that little importance and value was placed on having a written care plan either by peers, within their practice area or from an organizational perspective. They described the lack of written care plan value as evident by the non-formalization of written care plans within their settings and the non-existent emphasis placed on care plan activity within orientation education to the practice setting. Furthermore, organizational attempts to retool care planning practice were not well thought out thus driving the practice further out of view. Moreover, the connection between the CRNNS and/or regulatory requirements and how supporting documents may serve to lay foundational practice supports or requirements were not in the purview of most of the participants and/or easily interpreted. Given the current drivers of RN practice coupled with the past experience of how care planning practice was viewed and held as a student RN there was very little time nor willingness for the RNs to reflect upon care plan utility in their day to day practice. However, during the study interviews and upon reflection most of the participants were able to describe the benefit and usefulness of care planning practice for themselves, their colleagues and the patients for whom they provide care. That is, during the course of the interview(s) some were able to articulate how nursing time

and efficiency could be gained with the existence of a written care plan. Furthermore, patient engagement and team communication could be renewed and focused if the actual practice was to document the plan.

Summary of Theme and Subthemes

Unwritten care planning was described as the primary practice within the participants' medical/surgical settings. Numerous factors were described as influencing how this practice is currently held. For example, most of the individuals in the study described the belief that RNs are to a certain degree fulfilling a care planning role by planning care in their heads. However, the activity in their heads does not usually make it to a written plan. Beliefs that the more experienced RN and/or RNs who practice with specific patient populations do not require a written plan were also described.

In terms of the sub-theme unclaimed accountability, several experiences were described by the study registered nurses. That is, the sense by the study participants was that written care plans by the RN is not currently held as a role requirement in their day to day duties or in their place of work. Furthermore, participants described a lack of role clarity coupled with no clear performance expectations or quality assurance monitoring as contributing to this unclaimed accountability.

With respect to the sub-theme of drivers of RN practice, most of the nurses interviewed, regardless of years practiced, described experiences that are directing and or influencing their current care planning practice. Namely, the model of care delivery was raised as an issue for some of the medical/surgical areas. That is, participants from practice areas staffed with registered nurses and licensed practical nurses expressed difficulty in interpersonal communication roles that would require

the RN to discern, differentiate and direct LPN practice. Furthermore, other factors that have an influence on the ability of the RN to perform care plan practice focused on descriptions provide by the participants with respect to how the admission assessment is being performed. Specifically, many of the participants described that the admission assessment is being used by many RNs as a data collection tool only and is not being used to identify patient care needs or care plan requirements. These findings would indicate that knowledge and skill with admission assessments may be an issue and barrier to care plan adoption. As well, additional descriptions pointed to other RN experiences with such things as patient flow, complexity of patients and their treatments and considerable documentation and paperwork requirements for the RN. All of these accounts were described as impacting on RNs' time and ability to step into care planning duties.

The falling off the radar sub-theme provided additional descriptions of experiences and factors that can influence the current care plan practice within medical/surgical settings. For example, given the descriptions by the participants of a lack of clear role expectations for the RN in care planning practice the ability to either perform the function correctly and the importance of completing the documentation has fallen off the radar. Furthermore, some attempts to resurrect care planning practice were described as not well received given the lack of clarity and focus around the associated care plan implementation efforts. Moreover, nursing college regulatory direction in terms of the RN role in care planning was described as not well known and/or not useful to help discern RN role and accountabilities.

Modernizing Care Planning

‘Modernizing Care Planning’ was a relevant and separate theme that was identified in the data. Modernizing care planning means reflecting on what is foundational to nursing then re-thinking care planning in such a way that it responds to patient and technological imperatives. That is, participants described a need to re-connect, revitalize, relate and integrate nursing care planning practice back to a framework or process that they are familiar and comfortable with such as the nursing process. Examples of this can be found in the following passages:

... Ideally the care plan would be based on best practice and probably you would want to link it to a theory. [SN4]

... Use of the nursing assessment, planning, intervention and evaluation is required. If a care plan was set more formally, it could help everyone on the team to look at that plan and then know where to proceed. [NE2]

Plus, many were able to describe the need for the patient to play a more active role in the care planning process. For example:

... The patients need to be involved more. Care plans would need to be more patient-centered rather than nurse-centered which we still do. [NE1]

As well, the need to make care planning practice appropriate for the medical/surgical context was described by a number of participants. Examples of this need can be found in the following descriptions:

... I know in school we did long, long, long written care plans. I just don’t think it would be suitable for acute care. [SN5]

... Well, I think something that would make it more appealing is if we could say more with less, if that makes sense. [SN4].

Modernizing care planning consists of two sub-themes: Back to Basics and Untapped Opportunities. Within these sub-themes the participants' shared insights with respect to needing to hold onto foundational nursing practices such as the nursing process. As well, the participants' were able to also identify some key learning and change strategies that may help RNs to reclaim accountability for written care planning practice.

Introduction of Subthemes

Modernizing care planning was the theme that best described the experiences of the RN study participants with respect to the need to ensure that potential care plan initiatives be based on practical yet foundational nursing practice principles such as the nursing process. A re-focus on inclusion of the patient within the care plan process was highlighted, as well, as the need to ensure that if care plan work is to go forward there will be need to ensure that the application to acute care practice is practical given the context of the acute care setting. The sub-themes of back to basics and untapped opportunities help to further describe the perspectives and experiences of the registered nurses in advancing this imperative forward.

Back to Basics

'Back to Basics' refers to the need to make use of some of the time honored practices that RNs have familiarity and comfort with applying in their everyday practice. Specifically, the nursing process was identified by many as a practice that they routinely utilized in their everyday practice when planning care for their patients. The missing link is the carry through from a documentation perspective of that plan. Also, the term refers to the need for a renewed focus on the clinical leadership that was once present on the medical/surgical units and that participants reported is now

once again required if efforts to change and sustain the written care planning practice by the RN is to happen.

The current state of care planning was described earlier as ‘unwritten care planning’. The nurses believed they do attend to the practice of planning care, however, it is being intuitively constructed in their heads based on the nursing process, the tacit knowledge and experience in their practice setting and the typical patient populations they serve. Interestingly, participants did describe some utility in getting ‘back to basics’ with respect to identifying what the expectations of RN care plan practice needs to be. Some also spoke about the need to revisit the utility and relevance of standards of care development for patient populations for whom they typically provide care. That is, several of the study participants spoke about either past practice or the need to put some effort into the development of standard care plans and the assessment, planning and evaluation process underpinning the plan for surgical patients or patient populations within acute care. Specifically, [NE1] said:

... It would be good if we had some consistency where everybody who comes to general surgery. It may have activity by such and such a date. You know, have a consistent way of assessing pain.

Whilst others also spoke about needing to maintain one of the basic tenets of nursing practice with respect to individualizing care and the need to ensure that the patient’s unique perspective and/or responses to care were highlighted and discerned within a standard plan. Additionally, getting back to basics with respect to the fundamental differentiation in nursing practice of how the nursing care interventions differ and/or complement that of a physician would be a key element required if care planning was to be revitalized within nursing practice. For example, [NE2] was able to eloquently

express the following when asked how a nursing plan of care would differ from that of a medical plan:

... Yes, there's a difference. The nurse is looking at every individual as an entity. She's not looking at the fact they had X surgery. She's looking at every physical need, emotional need. She's looking at their family and how they interact with each other. She's nursing them as well. Looking at their needs after they are going to leave the hospital, after their outside of her care. So she's planning the future for them. She's looking at their past, their history, and bringing it into play.

Participants through their narratives described what they believed to be the roles and responsibilities for the RN in planning care. Through their accounts they were also able to describe their perspective in relation to the discernment and differentiation of the RN role with respect to seeing the bigger picture that is something more than just the execution of tasks or medical interventions. These perspectives speak to knowing the patient, anticipating and planning for the expected and unexpected and seeing the patient's experience and their response to care as a journey. Thus, nursing care plans would need to ensure these aspects of care are represented in a written care plan.

If written care planning practice was to be renewed then the need for clinical leadership in an effort to make that happen surfaced within many of the interview responses. Most of the participants described the need to have direct clinical support to assist with just in time practice questions with respect to assessment, interpretation, needs identifications or best practices from a nursing intervention perspective. Many saw a prime role for the clinical educator in meeting this request. Furthermore, a collaborative and complementary relationship between the health services manager

and the clinical educator was also stated to be a need. That is the manager would set the expectations, determine the monitoring requirements, the educator would provide the content knowledge and both would regroup with staff to ensure uptake and sustainability. An example that highlights this perspective was expressed by [NM1]:

... My role is the overall accountability for the unit. I certainly couldn't do it on my own but I work very closely with my nurse educator on any of those kinds of initiatives to make them happen.

Clinical assessment, in particular how the initial nursing admission is currently situated in the overall practice of the RN was questioned and described on a number of occasions in the interviews. Specifically, [NE 1] indicated:

... They're not using it the way that it was meant to be. Like a Braden Scale or Falls Risk. So it's almost like with those assessments that come out, there should be a care plan that goes with it.

This account acknowledges that there is work to be done within the RN discipline to get back to fundamental practice basics with respect to ensuring assessment is being discerned, interpreted and utilized. However, the description also acknowledges the connectedness between assessment and planning care. Participant [SN3] spoke about their past experience in a long term care unit and the accepted practice responsibility of the RN in terms of how the assessment process was linked to the plan of care.

Moreover, there was a sense that practice expectations were known and carried through in terms of care plan documentation. Participant [SN10] described the following which illustrates these points:

... Based on Braden Scale and Falls Risk, we had to write out a care plan to go with it.

Upon reflection, some were able to make real connections between the assessment process and how that fits with the determination of patient needs and the planning component required to meet the need(s). Participant [SN4] reflected on the need to spend the required time with the patient in an effort to get to know the patient and understand their potential care needs. Specifically, [SN4] said:

... For example, if you are talking to the patient and they have diabetes and you get talking to them a bit more about their sugars and how they're managed. You may come to the realization that they have no clue how to manage their sugars.

This insight speaks to the need to reclaim some of our nursing practice with respect to getting back to speaking with patient's on a deeper and more comprehensive level so that we can fully understand and plan for their needs.

Relation of Back to Basics to the Modernizing Care Planning Theme

The sub-theme of 'back to basics' denotes the general sense and description by several of the participants concerning the desire and need to bring about enhancements to RN care planning practice through the use of well established and practical nursing approaches. There is identification within the descriptions provided by the participants of a need to reinvigorate how the nursing assessment is currently held and utilized as a means to identify patient's needs and care planning activities devised to meet those needs. The data provided by the nurses within this study also point to the need to rethink how we engage and establish the therapeutic relationship with patients and families as a means to determine care and planning needs. Listening and knowing your patient has always been a core value and practice of the RN and what is required now is getting back to that practice once again. Finally, the need to

get back to basics in terms of the clinical leadership within the practice environment was also described as a need if care planning practice is to be enhanced, supported and sustained.

Untapped Opportunities

‘Untapped opportunities’ means seeking out elements of either existing organizational or nursing processes to change or improve upon and/or looking for practical ways to infuse relevant teachable moments into registered nurses’ practice as a means to boost RN care planning practice. Like the subtheme of back to basics this subtheme begins to describe the need to look at the art of the possible balanced with the need to ensure that potential strategies are relevant and applicable to the RN’s current practice and context. Namely, the nurses in the study described the ability to leverage the end of shift report, safety rounds, existing nursing practice councils and organizational policy and procedure developments as a means to start to change the care planning practice. These strategies will be described and discussed below.

End of shift report and the transfer of accountability between the off going RN and the oncoming RN was expressed by all participants as an avenue or a structure upon which care planning practice could be embedded. In fact, participant [NE1] relayed the following regarding end of shift reports:

... I think our report is more of a care plan than everyone thinks it is.

Another, [SN 6] said the following:

... When I did do report, I said it in the written report. I did tell them this is what I tried and this is what happened.

These accounts speak to opportunities to leverage existing processes and practice that the RN partakes in on a regular basis and evolve the process to a new level. That is to one that involves a written care plan that further substantiates what they are either verbally describing to their colleague(s) and/or informally documenting on a non permanent record such as report sheet or kardex.

Another process that has been established within many acute care units is the performance of safety rounds. Safety rounds can be described as the regrouping of the nurses post review of their patient assignment, patients' data and initial observation of their patients. During this regroup key information relating to patients' needs and observation requirements are shared among all members to ensure baseline information on the needs for all patients on the unit is shared. With respect to safety rounds, [NM1] believed the following:

... In my mind [safety rounds] is a very informal care planning because it's what everyone needs to know about the patients on the unit that they're caring for today. For example, Mr. X is not steady on his feet and you need to keep an eye on him. It's also quick and dirty and concrete.

This statement describes and captures an ability to "see the potential" of how the safety round process could serve as a new way to think about the assessment data they are relaying to others and how components of a plan of care for patients could be discerned, evolved and carried forward.

An interesting and novel approach that speaks to the need to evolve beyond just task based clinical education and associated competency was revealed by [SN1].

... Maybe education in the way of, you know, this is maybe how you need to better prioritize your day. You can sit down and have the time to talk with

your patient and come up with these things [needs identification and care plan].

Basically, this description offered by the participant addresses an opportunity for registered nurses to think about what constitutes competent nursing practice that goes beyond just the development of technical skill acquisition. For example, the need to refine and further develop prioritization or communication skills. It speaks to the desire to enhance and equip the RN with additional agency or capacity that will not only serve themselves in their practice but also serve the patient.

Unit practice councils were described as being a part of most of the study participants' work environment. The unit practice council could be likened to a community of practice. In the sense that the council(s) are comprised of staff nurses from a particular area who come together on a regular basis to discuss, review and strategize about nursing practice issues that are impacting on their practice and/or the care of patients. Many of the registered nurses interviewed had either familiarity and/or involvement with practice councils at the unit level. Moreover, most of the RNs in the study expressed that this forum provided an avenue and an opportunity in which to situate the work of revising and incorporating the care planning function into the RN's role. Examples within the descriptions that highlighted this finding are:

... You know, we could bring it up [care planning], talk about it. Maybe look at adapting it [care planning] [SN2].

... I think the Practice Council would be a huge area to bring that forward [care plan adoption]. So, I think using the Practice Council, using the educator to kind of empower that way of thinking [care plan adoption] [NM2].

Another interesting opportunity described in the interview data was the ability to tap into the knowledge and more recent exposure of some more junior or novice RNs in relation to helping others understand or appreciate how to perform care planning, as well as, the utility and value of such efforts. That is, some participants were able to describe recent experiences that highlighted what they believed was required care plan information and how they viewed the relevance of care plans in practice. These findings were evident in the following descriptions:

... We don't so much have the written care plans where I currently work. But in the ones where I worked, we had it. It had the date that the care plan would be initiated, we'd have the nursing diagnosis, and then the plan of action, and then the date that you hoped to have achieved it. And it was really good.

[SN6]

... I know we've had nurses that come from [another province] as a new grad. She said she used to love to go to work. She said she could print off a pre-printed care plan and that would help her know what she needed to do for that patient [NE1].

Whilst another more recent RN graduate [SN5] offered this:

... I mean now that I've worked a few years, I know how important they would be to have them [care plans].

Organizationally, some participants were able to describe new ways of doing things with respect to how we orientate new RN staff and how we structure and use documented policies and procedures. Specifically, there was a profound sense by some of the participants, particularly the registered nurses who have staff education experience, that there is a chance to reconsider how we develop and structure our

organizational clinical policies and procedures. For example, a renewed focus on the integration of sample plans of care that correspond with the clinical policy may spark additional thinking and application in the practice setting. Additionally, the staff RNs who were interviewed discussed the potential for reframing the orientation for new nurses coming into the medical and/or surgical setting. Their specific thoughts relate to the need to continue on with the work and practice established in their registered nursing curriculum. Care planning and the central tenets of how care planning is applied in the practice setting could be added to the orientation agenda. Furthermore, some viewed the need for the clinical educator or preceptor to pick up the baton and carry the key lessons and learning through to the practice setting once the new nurse is practicing on the unit.

Relation of Untapped Opportunities to Modernizing Care Planning Theme

Untapped opportunities emerged as a subtheme of modernizing care planning as it spoke to the opportunity to build upon existing and new communication or care processes such as safety rounds that have been adopted within the practice setting. Like the back to basics subtheme this subtheme offered a descriptive view by the participants regarding the need to potentially leverage existing and new practices the RN has knowledge, understanding and comfort with using as a way to modernize care planning practice. That is, using the established practice of end of shift report as a vehicle to verbally communicate and document revisions to patient's care plan to colleagues. As well, the use of the newer safety round practice as a forum to identify and collaborate with other registered nurses regarding new or evolved patient needs.

Summary of Theme and Subthemes

Modernizing care planning was described by many of the participants as a necessary step forward to help re-establish care planning practice by the RN. Yet based on the participants practice experience, there was still a need to ensure a framework such as the nursing process be used to inform subsequent care planning initiatives. As well, a greater need for patient and family involvement in helping to identify and develop their plan of care was viewed as a foundational step in moving forward.

The subtheme of back to basics highlighted the descriptions of the study participants for the need to ensure appropriate and timely access to clinical and operational leadership as a means to help support practice changes with respect to documented care plans. This subtheme also spoke to beliefs that standard care plan creation with room for individualization of patient needs and responses had worked in the past for some participants who had experience with this approach. Finally, a renewed emphasis on how to collect and interpret patient assessment data was highlighted by many of the participants as a foundational step to ensure that the care planning process was informed by assessment findings.

Untapped opportunities developed as a subtheme of modernizing care planning as it spoke to the descriptions and experiences of the participants with respect to leveraging key practice areas the RN already has familiarity with and established practice in performing on a regular basis. That is, the use of the end of shift report as an opportunity to update and revise written care plans. As well, the use of daily safety rounds is a forum in which communication and identification of key patient care needs can be discerned and appropriate interventions identified and

planned. Finally, nursing practice councils were described as an avenue upon which an identified working group could develop care plan formation and supporting resources to help support implementation of a care plan initiative.

Summation of Findings

In this study about RN experiences of care planning within medical/surgical settings the participants described their current experience to be that of ‘unwritten care planning’. Subthemes identified from the participants’ experiences and perspectives that shaped unwritten care unwritten care planning was an ‘unclaimed accountability’ for RN care planning practice. As well, experiences described by the participants identified numerous drivers such as care delivery models that currently influenced RN practice and their ability to develop written plans of care. Furthermore, the sub-theme of ‘falling off the radar’ denotes the descriptions provided by the participants in terms of current beliefs held about care plan practice and why the practice of written care plans have not be in focus for the RN.

The second theme identified in the data was ‘modernizing care planning’. During the interview process the participants were able to describe opportunities and practical ways the registered nurse could infuse care planning activities into their everyday practice. These opportunities were captured within two subthemes ‘back to basics’ and ‘untapped opportunities. These sub-themes illustrated how the revitalization of care plans could be realized and the actions necessary to make care planning practice happen within their acute care setting. The meaning of and implications of these findings will be the focus of the discussion chapter which follows.

Chapter Five: Discussion

A qualitative descriptive study was developed and conducted to further the understanding of RN experiences with care planning within acute medical/surgical settings. The study was conducted within several medical/surgical units in a large tertiary teaching hospital. The study participants consisted of three distinct registered nurse cohorts. Specifically, health services managers, clinical nurse educators and clinical staff registered nurses. A thematic analysis of the data was conducted and two themes were identified: *Unwritten Care Planning and Modernizing Care Planning*. Subthemes associated with Unwritten Care Planning were *Unclaimed RN Accountability; Drivers of RN Practice; and Falling off the Radar*. Subthemes associated with Modernizing Care Planning were *Back to Basics; and Untapped Opportunities*. Additionally, many of the findings within the themes and subthemes related well with the constructs of the Socio-Ecological Model (SE). Namely, the unwritten care planning theme and the associated subthemes revealed predominantly individual, interpersonal, organizational and policy level factors within the findings that influenced care planning practice. Modernizing care planning and the associated subthemes revealed the need to influence and leverage individual, interpersonal, organizational and community (community of nursing practice) level factors to help enhance RN care planning practice.

Accordingly, the discussion chapter has been focused on the presentation of the alignment of the research methodology with the research inquiry, meaning of the themes and subthemes using the SE model as a backdrop for the discussion, limitations of the study and the implication of these study findings for practice and

education. Finally, potential future research inquiries, dissemination strategies and concluding thoughts are presented.

Alignment of Methodology with the Research

The central tenets of qualitative descriptive methodology aligned well with my position as a RN researcher and the constructivist paradigm. That is, I was an RN studying a registered nursing practice issue within the natural setting of the topic of interest and the workplace and the focus of my study was on capturing nurse's multiple perspectives on the topic of care planning. Additionally, qualitative description was particularly well suited to address the research purpose which was to explore and describe the experiences of RNs in fulfilling their role in developing the nursing component of the plan of care for patients within medical and/or surgical acute care settings. The findings of this inquiry furthered understanding of RN experiences, and illuminated how care planning practice within this context could potentially be enhanced and/or adopted (Neergaard et al., 2009). Moreover, the use of the SE model helped provide initial structure in conceptualizing the interview guide and for the interpretation of the study findings. Furthermore, the SE model complemented the chosen methodology as the SE model helped to provide a framework for the comprehensive description of multiple individual, interpersonal and organizational level factors that influence how the study participants described their lived experience with fulfilling the care plan development role within acute care (Sandelowski, 2000). Additionally, descriptive methodology allowed for the opportunity to consider, review and analyze numerous information sources such as organizational and related legislation and RN regulatory documents and participant interviews (Sandelowski, 2010). Through the incorporation and analysis of multiple

forms of data a richer description of the experiences of the RN's care planning role was achievable (Creswell, 2007; Sandelowski, 2000).

My use of a qualitative descriptive approach also allowed me to structure my findings in a way that enhanced the descriptive validity in that I stayed close to the data and the words that the staff registered nurses, clinical educators and health services managers used to describe their reality when it came to care planning and/or the organizational structure that influenced this practice (Sandelowski, 2000; Sandelowski, 2010). This did not mean that no data interpretation on the part of the researcher was required (Sandelowski, 2010; Sandelowski, 2000). What was required was low-inference interpretation. Using this approach enhanced credibility of the data analysis process as it allowed me to stay closer to the words and descriptions as provided by the study participants (Neergaard et al., 2009). Again, the focus of my research was to describe the experiences of RNs in fulfilling their role in developing the nursing component of the plan of care for patients within medical/surgical acute care settings and to give voice to the RNs who contributed to that description.

Finally, given that I was a novice researcher, the use of a qualitative descriptive approach contributed to the development of initial competency and exposure with a research approach. This approach did not require the researcher to try and fit, designate or claim that their work falls within a more traditional methodology such as phenomenology or ethnography as some of these methodologies, borne out of other disciplines objectives, can at times be at odds with representing the unique knowledge mandate of nursing (Neergaard et al., 2009; Thorne et al., 1997).

Theme Discussion Informed by the Social-Ecological Model

Unwritten Care Planning

The theme of “unwritten care planning” is the description provided by the study participants of their lived reality with respect to care plan formalization in their medical/surgical practice environments. Experiences described by many of the participants in relation to this theme were focused on the individual and collective belief that the RN and in some cases the LPN were performing this function, however, the plan was being developed in their heads and was for the most part not documented. Individual factors such as the experience and knowledge of the nurse in relation to the typical patient population within their services were described as reasons why a written plan of care was not required. Most of the participants believed that the kardex would be considered the documented nursing plan of care. However, several of the participants acknowledged there were limitations in the existing form. For example, the current structure of the kardex does not capture prospective plans or patient outcomes. Moreover, the lack of a written plan made it challenging to engage patients in what the plan was or should be. Additionally, unit and organizational structures were identified as contributors to the assigned RN’s ability to fully understand the overall medical plan and patient trajectory thus making it challenging to develop and more importantly evolve the patient’s plan. Specifically, a standard of practice within these medical/surgical environments was the exclusion of the assigned RN in patient rounds with most units opting for the charge nurse to attend on behalf of the nurse providers.

The subtheme of “unclaimed accountability” as described by the study participants influenced the current state of unwritten care plans. In particular, at the

individual level, role accountability and practice expectations in relation to having to perform care planning were not well understood or enacted by the RN. Furthermore, policy related factors such as the use of supporting CRNNS documents such as RN standards of practice were either described as not routinely utilized and/or the interpretation of such documents were difficult for the individual RN to discern. At the organizational level clear practice expectations or monitoring activities have not been consistently adopted or applied. As well, the role of the patient and how to engage the patient in their plan was not well articulated.

Study participants described a fairly consistent organizational practice of having the charge nurse assume the primary role of discharge planner and coordinator of care and this has done little to build capacity and accountability of the individual RN with respect to this key practice domain. Lastly, the participants described how this unclaimed accountability influenced novice nurses' beliefs and attitudes in relation to care planning practice and their so called need to integrate care planning into their practice within acute medical/surgical settings. That is, lack of RN ownership over care planning practice conveys the message to the new RNs that care planning activity is not required nor particularly relevant to nursing practice or patient care.

The subtheme of "drivers of RN practice" revealed individual and interpersonal level participant concerns with respect to time management, communication and delegation skills. Participants described organizational structures and practices such as care delivery models, patient flow, required organizational documentation practices, intensity and complexity of patient care interventions and the associated time required to complete this work as negatively influencing the time

and direction of their work, as well as, their ability to document a nursing care plan. Finally, based on the study participants accounts little time or focus was being used on the part of the RN to take the admission assessment beyond simple data collection to form a written plan. Time and individual RN knowledge as to how to interpret the data have been identified by the participants as contributing to RN practice.

During the interview process the subtheme of “falling off the radar” reflected current individual and collective beliefs held by the study participants in relation to the lack of utility, priority and purpose of performing a written care planning function by the registered nurse. At the individual level participants described the valuing of clinical tasks over that of care planning. Furthermore, there was a sense by some more senior study participants that care planning practice was once a part of RN practice within acute care, however, over time RNs lost the practice due to the nature of the practice environment and the need to perform more direct care activities. Organizationally, there was a sense that more recent efforts to resurrect care planning practice have not been well planned and/or taken up by RNs within the medical/surgical context. Moreover, organizationally and at the unit level the orientation of new nurses into the practice setting does little to reinforce the importance of care planning practice as the focus remains on the acquisition of care tasks. Also, many described that care planning practice based on the structure of how care plans were taught and implemented in their nursing curriculum would not be practical or sustainable in this type of practice setting.

Modernizing Care Planning

During the course of the study interview(s) the theme of “Modernizing Care Planning” was identified as study participants began to consider and describe the art

of the possible with respect to the re-tooling and re-introduction of care planning back into RN practice. That is, during the course of the interviews participants provided insights and reflections on how to update care planning practice. Namely, consideration of how to restructure interpersonal communication processes such as patient safety huddles and end of shift reports to accommodate articulation and documentation of care plan needs were suggested. As well, at the individual level the need to re-establish & revitalize how a key component of the nursing process such as assessment is to be practiced was offered. The ability to improve upon individual RN's knowledge and skill with re-establishing the therapeutic relationship with and engagement of the patient in the plan of care was also raised. Furthermore at the organization level, there was a call for reviewing, streamlining and modernizing key documentation forms so that assessment of patient needs and documentation of respective care plans are user-friendly and doable.

In the subtheme of "back to basics" participants described actions at the individual level that could be exercised by RNs. For example, the translation of patient assessment data into the identification of patient priority needs during the admission process was not currently being practiced in a consistent or skillful manner yet participants could see the value in doing this. They were able to identify that this required a renewed focus and further practice development. As well, at the individual and interpersonal level the ability of the individual or collective RNs to understand and communicate how nursing practice differs and complements physician colleagues and contributes to patient care service was a component of practice that needed to be reclaimed and made visible within a plan of care. Organizationally, the participants believed that clinical and operational leadership was needed from clinical nurse

educators and health services managers if care plan adoption was to be successful. Again at the unit or organizational level, there was a belief that standard care plans had worked in the past and could work once again provided they were modernized to capture individual patient needs.

The subtheme of “untapped opportunities” described by the participants captured the situation at the organizational level. Specifically, several participants described the need to integrate care plan application within clinical policy and procedure documents. As well, the participants were able to provide ways of potentially enabling the practice of written care plans by the RN through the use and re-tooling of key communication processes such as the nursing kardex, patient safety huddles and end of shift report. Namely, many of the participants saw an opportunity to build in times within these key practices to perform documentation of care plans. The incorporation of care planning into orientation efforts for new RNs was seen as a way to continue to embed the importance and learning associated with care plan practice. Whilst, development of education programs to enhance individual competencies such as priority setting, communication and collaboration skills were described by many as a need given the importance of ensuring efficient and effective care delivery. Finally, at the organizational and unit level the participants were able to offer potential strategies to help initiate the work required to develop and sustain care plan practice. In particular, the use of unit based nursing practice councils were viewed as one channel or the establishment of communities of practice another in which to develop and implement a care planning practice change.

Relation of Study Findings to Relevant Literature

Relation of the study findings to relevant literature on the topic of inquiry has been predominantly organized and will be discussed in relation to the experiences of the participants as they have been described within the themes and some of the sub-themes of the study. As well, within each heading, findings will be discussed and related back to the levels of the SE model and relevant literature as appropriate.

Accordingly, the headings are: 1) unwritten care planning, 2) unclaimed accountability, 3) drivers of RN practice, 4) RN optimization, regulatory and clinical leadership supports, 5) RN role enactment and influencing factors, 6) considerations to support practice change, 7) modernizing care planning, and 8) relation of findings to Elf's conceptual care planning.

Unwritten Care Planning

Care plans developed by the registered nurse have been described by some as nothing more than a paper exercise that does not serve the nurse or the patient (LaDuke, 2009). However, some of the most recent literature postulates that nursing care plans have been emphasized as being a vital and necessary document in today's acute care environment (Bjorvell, Thorell-Ekstrand, & Wredling, 2000; Clarke, Kelleher, & Fairbrother, 2010; Greenwood, 1996; Tulloch et al., 2007). Given the increasing patient acuity, shortened length of stays and multiple care providers it is imperative to have a documented plan of care that provides a snapshot of the patient's story, discernment of priority patient needs and the expected outcomes of the care received (Can & Erol, 2012; Mason, 1999). However, based on the study findings from the participants, written care planning nursing practice within their medical/surgical environments is not well understood at the individual and collective

unit level in terms of the value and utility of such efforts. Furthermore at the unit and organizational level and based on the study participant's accounts, written care plans are neither compulsory nor monitored to ensure quality or compliance. Similar issues in relation to the question of care plan utility and the value placed on documented plans of care on the part of practicing RNs and academics have been conveyed in opinion articles and other qualitative studies (Can & Erol, 2012; Greenwood, 1996; Mason, 1999). Additionally, some have argued that quality assurance measures such as chart audits are key activities that require activation within the current healthcare system (Hall, Moore & Barnsteiner, 2008).

The study theme of unwritten care planning also reflects the individual and collective beliefs that RNs are actually completing the care planning function in their heads based on their acute care experience and therefore written documentation is mostly not required in the form of a written plan. Furthermore, the nursing kardex was described by almost all participants as the unofficial plan of care despite the limitations of the kardex with respect to its permanency within the healthcare record.

Unclaimed Accountability

The beliefs and practices described by the participants in relation to experience as a key influence in terms of why a written plan of care is not required coupled with the belief that the kardex is the care plan appears to be having a fundamental influence over how the RN is attending to the performance of care plan documentation and their required accountability to document. Likewise, the RNs' current views indicate that they believe the majority of acute care nurses based on experience and familiarity with a patient population should or do know what the patients require from the RN by way of care interventions. However, these

assumptions may be misguided. Some have pointed out that an individual nurse's knowledge and ability to apply the nursing process and clinical reasoning, as well as the discernment of appropriate nursing interventions is varied and inconsistent (Elf et al., 2007; Greenwood, 1996). What's more, the non-formalization of structured and informed written care plans for individual patients places the RN's professional knowledge, skill and judgment in question. That is, evaluation of how the nurse's assessment and care planning leads to improved patient outcomes is arduous without supporting documentation. This sentiment has been further echoed in an international qualitative study (Fernandez-Sola et al., 2011). More importantly, it can leave the patients at risk for experiencing gaps in their care. That is gaps with respect to identification and individualization of care needs, consistent assessment and execution of required nursing care interventions such as monitoring and teaching activities and a lack of evaluation measures to monitor the patient's progress towards health goals (Fernandez-Sola et al., 2011; Hall et al., 2008). This finding of the registered nurses familiarity with patient populations and acute care experience as being a surrogate for care planning practice or used as rational as to why documented plans of care are not needed has not been previously located in any other care planning studies and is an interesting finding worthy of further exploration.

The concept of person centered care is a key mandate for most healthcare organizations (Hall et al., 2008). Additionally, the need for and the development of an individualized care plan for patients would seem to be a reasonable approach to help fulfill this mandate. The registered nurses within this study consistently described and differentiated their individual beliefs about nursing practice and how it differed from that of their medical colleagues. Specifically, they articulated that the provision of

nursing care is based on the holistic assessment and identification of patient needs. However, very little description of the need to value or incorporate the patient's voice and perspective into their plan was initially offered during the interview process. In fact, the registered nurses in the study described how the assigned nurse is rarely involved in determining and/or planning for example the discharge plan for patients. Furthermore, the way in which patients are engaged in their care or care planning decisions was not well articulated. This study finding with respect to not having clear processes or avenues in which patients can contribute to their plan has been described in another recent care plan action research study (Jansson et al., 2011). However, it was not surprising that this finding was also seen in this study given that written care plans are not performed and therefore potentially not even in the registered nurses purview. Though, if written plans of care are to survive in the future the need to revisit patient engagement and role(s) will need to be explored and incorporated into future care plan developments and the RNs will potentially require additional training and practice to make it happen. This sentiment has been further echoed in an exploratory study looking at factors that influenced successful adoption and sustainability of individual care plans, as well as an article that explored the concepts and variables that influenced quality of care planning exercises (Elf et al., 2007; Jansson et al., 2011).

Drivers of RN Practice

Organizational level factors such as nursing staff mix, required documentation practices, patient flow and workload were described by participants as influencing RN practice within medical/surgical context. Specifically, the time and intensity of the RN's required work coupled with the shortened length of patient stay were noted

within this study as issues that need to be wrestled with by the RN on a daily basis. The time associated with completion of an RN's work had the potential to transcend more than just one SE level. That is, the individual, interpersonal and organizational level situations can all influence how the RN uses and directs their time. The need to manage and navigate multiple agendas inclusive of maintaining patient centered care in the midst of juggling organizational demands such as patient turnover requirements and mediating RN and LPN occupational boundaries have been cited as inter-related activities that influence how the RN profession practices (Allen, 2007). This assertion appears to be playing out within the medical/surgical environments based on the descriptions provided by the participants.

One could also assert that the lack of a care plan is the reason it can take time to discern the plan for patients, determine care priorities, and to assess which RN or LPN provider is required. Moreover, one could argue that time could be considered more as a symptom of something else. Consideration of an RN's time in fact is an interesting concept that has been identified in other care planning articles or studies as a contributing factor that influences RNs' ability to document care plans (Daws, 1998; Elf et al., 2007; Lee, 2005). Specifically, in the studies by Daws (1998) and Lee (2005), time was not adequately described or discerned with respect to what was underpinning the nurses' response related to time. However, reporting of one quantitative study investigating barriers to patient centered care reported that over 64% of the study RNs reported they simply had too much work to do and that the time required to do their work was impacting on their ability to perform key functions such as falls assessments and skin breakdown prevention (West, Barron, & Reeves, 2005).

More recent literature speaks to the need for the nursing profession to develop different core competencies that transcend clinical skill as a means to enhance productivity (Hall et al., 2008). For instance time management, prioritization skills, communication and delegation skills and quality management practices. Many of the study participants described a need for the RN to individually develop many of these skills as a means to enhance effectiveness and efficiency in their work.

Individual level factors with respect to RNs' attitudes and beliefs in relation to time required to perform care plan documentation were also described by the participants. Specifically, individual and/or collective values and beliefs with respect to the execution of tasks and the holding onto of duties that may not require the professional knowledge, skill and judgment of a nurse continues to be a problem within the acute care practice setting. Given the lack of clear role expectations and accountabilities of RN practice in relation to developing the written nursing component of the plan of care other care activities besides care plan documentation are probably being prioritized as these are the direct care duties the RN has comfort and familiarity with delivering to patients. Moreover, some authors have put forth the assertion that the discrepancy between actual and optimized RN practice is based on poor acknowledgement and understanding of the current work realities of the RN in modern healthcare systems (Allen, 2007). However, selection of more direct care interventions and the de-selection of duties like care plan development has implications for the RN profession. That is, the RN now and in the future will be increasingly called upon to perform more as a knowledge professional, using more higher order competencies such as analysis, interpretation, synthesis, care mapping and care coordination (Cornell, Herrin-Griffith et al., 2010).

RN Optimization, Regulatory and Clinical Leadership Supports

Based on the findings associated with this research, consideration of factors influencing care planning practice from a community of practice level and a policy level are interesting points for discussion. The term community of practice for the purposes of this discussion is meant to refer to regulatory bodies or associations such as the College of Registered Nurses of Nova Scotia (CRNNS), Canadian Nurses Association (CNA) and the College of Licensed Practical Nurses of Nova Scotia (CLPNNS). The majority of the participants within this study either identified that they have not resourced their regulatory organization nor have they referenced respective documents to assist them in helping to understand the RN role with respect to care planning, role optimization or differentiation of RN and LPN practice. Only 2 of the study participants described having accessed and/or used CRNNS documents and based on the descriptions provided by them the usefulness of college documents with respect to helping them understand and apply to practice was mixed. In terms of policy level factors there was no mention by any of the participants with respect to how documents such as the RN Act could help to define RN role and responsibilities. What's more, the participants would have been subject to some foundational practice education in relation to RN and LPN role optimization implemented model of care recommendations from a provincial and organizational perspective. Yet, despite this fact descriptions throughout the interviews indicated that adoption, in particular RN optimization was lacking and/or not adequately understood. However, the findings with respect to not accessing or understanding how regulatory documents could support an RN in their practice and the disconnect between the RN Act legislation documents and actual practice have been raised by others (Jansson et al., 2011;

Muller-staub, Lavin, Needham, & Achterberg, 2006). Moreover, other authors have indicated there is considerable collaborative work to be done between regulatory bodies, organizations and practicing registered nurse to help ensure successful interpretation and adoption of standards into practice (Oelke et al., 2008).

Additionally, other care plan studies have indicated that static, one time education sessions are not enough to help implement and sustain the necessary practice changes in relation to RN optimization and their role in care plan development (Clarke et al., 2010; Jansson et al., 2011).

Given many of the above findings, a call for enhanced clinical leadership and focused, deeper conversations with RNs may be needed. That is, conversations with staff concerning role accountabilities, scope of practice and the need to direct and delegate supportive care needs such as bathing to other members of the team so that time could be refocused for the RN to perform the required care plan documentation may be a necessary step. The call for leadership to articulate clear role expectations of the RN and to challenge cultural ideas in relation to which care provider should perform certain care tasks have also been brought forth by other care plan and quality care plan improvement studies (Clarke et al., 2010; Jansson et al., 2011).

Additionally, it has been postulated that it is difficult for nurses to examine and scrutinize their own work and related practices as well rooted beliefs, values and perspectives make it challenging to explore possibilities for practice improvements (Allen, 2007). Hence, the need for multiple strategies that engage, challenge and allow RNs to reflect upon how they can achieve a mandate of optimized practice.

RN Role Enactment and Influencing Factors

It has been noted in the literature that nursing practice processes such as assessment and documentation, as well as, the structure of the practice environment such as the nursing care delivery model and patient population can have some bearing on how the RN enacts their practice roles (Irvine et al., 1998; Jost & Rich, 2010). Ambiguous role expectations on the part of the RN in relation to that of the LPN were described in this study as influencing the practice of the RN. Namely, some of the participants believed that they did not have the ability or skills to direct some activities by the LPN if those same interventions were also within the RN scope of practice or if they perceived that the LPN had adequate knowledge and skill in planning care. A similar finding in relation to the RN not having an understanding of and/or articulating how their practice differs to that of an LPN has been discussed in other studies (Eagar et al., 2010; Oelke et al., 2008). What's more, another output associated with written care plan development by the RN is to help determine patient care needs for the sake of assessing the complexity, intensity and acuity of patient care. This was a key foundational parameter upon which assignment of patients to the LPN was to occur with the CDHA collaborative RN and LPN practice arrangement within acute care and also it is a requirement from a regulatory perspective (CDHA, LPN Skills Policy and Procedure, 2006; CLPNNS and CRNNS Guidelines, 2012). Given the gap in written care plans it can leave one to question how the assignment of care to an appropriate nurse provider presently occurs. The study participants gave some insight into how assignment is determined and for the most part the descriptions focused on the equal distribution of patients between the RN and LPN. All of these

factors have a significant influence over how the RN manages and directs patient care inclusive of care planning activities.

Practice Change Considerations

Whilst, education sessions and dialogue with staff registered nurses, licensed practical nurses and formal nursing leaders was a key component of the model of care redesign for most acute care units within CDHA these findings suggest that conversations and dialogue with staff nurses and formal leaders may not have resonated for all nor provided some with a sense of how RNs were to enact care planning practice in acute care practice areas. Furthermore, some of the organizational attempts to place focus on the need for written care plans have not been successful. Namely, there have been past initiatives in which care plan forms were created and expected to be implemented in acute care. The essence of the experience of some of the study participants with this initiative was that this type of approach was not adequately reflected upon or planned for prior to implementation. Thoughts and recommendations on changes to practice indicate that knowledge and application of change management processes are required so that factors that may impact on the change are identified and addressed (Sparger et al., 2012). The absence of reflection on what care planning should be and/or a planned approach to the change may contribute to the lack of success in changing practice or could further perpetuate the notion that care planning is not required; thus pushing care planning practice further out of view or relevance.

Review of care planning studies that addressed enablers or potential strategies to enhance care planning practice have identified various techniques and approaches that have been attempted to help support implementation and adoption of care

planning practice. For example, the use of organizational strategies such as structured documentation models and the incorporation of computer documentation systems have been explored in terms of their effectiveness in helping RNs complete documented plans of care (Lee, 2005; Muller-staub et al., 2006). As well, educational programs and the employment of external change agents have been described and explored in terms of contributing to successfully influence and enhance nursing documentation practice (Florin et al., 2005). The findings of this research project were consistent with some of these potential strategies. That is, computer access, RN care plan learning and education opportunities, as well as, the need to have some type of consistent documentation process and standard template were expressed by the study participants. The need to base care planning on a theoretical nursing model or the need to utilize external resources or change agents were not mentioned by the study participants. In fact, the participants believed strongly that if care planning was to be incorporated into RN acute care practice the employment of existing resources such as the clinical nurse educators and practice councils would be a viable change management strategy. This finding has been uncovered in other research exploring factors that promote successful care plan implementation as well (Jansson, Pilhamar et al., 2011).

Modernizing Care Planning

The study findings provided by the participants in terms of modernizing care planning practice with respect to leveraging key well established nursing processes such as end of shift reports as a means to either communicate or document revisions to the plan of care have not been previously described in any other located studies. However, a renewed focus on hand-over procedures in recent years has pointed to the

need for focused and structured communication between nurse providers to ensure care needs and safety issues are known and prioritized (Nelson & Massey, 2010; Patterson & Wears, 2010). It is logical to assume that these venues are an important time to at least ensure care plans are updated and revised. In addition, the notion provided by the study participants of reformatting and aligning the kardex structure to help highlight care needs reflected in a standard or individualized care plan that is directly correlated with the admission assessment would appear reasonable. That is given the context of the acute care practice environment documentation processes that can be reasonably and realistically accomplished are needed (Greenwood, 1996).

Relation of Findings to Elf's Conceptual Care Planning Model

Finally, the accounts by the study participants have begun to further expand the knowledge and understanding of RN experiences with care planning and the SE levels at which these experiences play out in the written care planning practice by the RN within medical/surgical context. Furthermore, it is the belief that this research study through the study participants' descriptions of care planning practice has begun to validate and elaborate on the multiple facets of care planning practice identified by Elf (2009). That is the care planning concept analysis paper prepared by Elf (2009) revealed the need to challenge the existing one dimensional approach to care planning practice and move beyond just looking at individual provider's ability and/or compliance in fulfilling the role. Specifically, several of this study's findings have pointed to the need to understand and address interpersonal level factors such as communication and collaboration approaches and patient engagement strategies. Individual level factors such as RNs' knowledge with respect to care planning and the underlining assessment practice need to be considered. Additionally, organizational

responsibility to develop processes and viable solutions to care planning practice are important areas that require attention and focus.

Limitations

This research has contributed to expanding our understanding of the care planning practice of RNs within medical/surgical context. Nevertheless, there are certain limitations that need to be taken under advisement when reviewing and interpreting this research report. Namely, the findings of the study may have limited transferability, given the relatively small sample size and the use of only one recruiting organization. Furthermore, care planning by the RN within the medical/surgical context was the topic of inquiry and therefore limitations in terms of transferability to other healthcare contexts would be a potential issue. The sample, as well, consisted of only degree and/or masters prepared registered nurses, as well, the participants were all white, females. However, two of the three study participant cohorts recruited currently only have females performing those roles. Moreover, the majority of factors described as influencing RN care planning practice could be situated within the individual, interpersonal and organizational levels of the SE model. A larger study may have made additional factors within policy and community levels more explicit. Additionally, given the topic of inquiry and the selected research methodology the goal of this research was not to ensure the recruitment of large samples but rather adequate description of emic perspectives of the inquiry (Morse, 2010; Streubert & Cameron, 2008). Furthermore, this is one of the first research inquiries that has begun to contribute to describing RN experiences of care planning practice from the perspective of the registered nurse and registered nurses in clinical and operational leadership positions.

Implications for Practice

The finding(s) from this research have identified the need for a renewed professional development focus with respect to the RN practice of documented plans of care for patients and the use of evidence informed approaches to care within the medical/surgical context. Currently, the study participants described that written care planning is not an inherent part of their work. Internationally, nationally and locally the disparity between what is required of the RN in relation to care planning practice from a legislated perspective and the actual incorporation into acute care nursing practice remains (Jansson et al., 2011; Nova Scotia RN Act, 2006). The themes describing RN care planning practice are situated within many of the SE levels. Specifically, individual factor(s) and organizational factors such as unclaimed accountability or monitoring of practice expectations for key components of nursing practice have been identified as contributing to unwritten care planning. Therefore, from a practice perspective, there is a need to understand how care plan omission in RN practice influences patient care, patient outcomes, the identification and adoption of evidence and best practices into care delivery and the optimization of nursing roles. Examination of omissions in care and the impact on patient, system and the professional's role has been suggested in other reports that have reviewed the impact omitted care and the lack of role optimization have on meeting patient outcomes (JPNC, 2003; Kalisch, 2006). What's more, an understanding of system, provider and patient impact related to the practice disconnect of unwritten care plans could help to successfully target, plan and execute appropriate strategies to correct or enhance the practice at multiple SE levels.

Recommendations for Practice

Potential recommendations to enhance care planning practice informed by the study participants descriptions and accounts on this topic are as follows: a) providing education that helps RNs describe the RN role and how that differs from the LPN role with respect to care planning function within acute care; b) reviewing current nursing documentation processes and required organizational information to assess for opportunities to consolidate and integrate documentation requirements; c) identifying and consistently implementing a performance monitoring and auditing tool to ensure compliance with expected documentation practice; d) leveraging the results of the audits to engage the RNs in discussions regarding factors or conditions that need to be reviewed and/or corrected to enhance uptake; e) developing patient assignment guidelines based on the key care planning role of the RN and the needs of the patient (i.e. not just equal division of patients between RN and LPN); f) reviewing the existing model of care delivery (as required) to ensure provider roles are optimized, identifying on-going practice development work in relation to RN and LPN practice, ensuring required human resource roles are aligned with patient care needs; g) exploring opportunities to embed care planning knowledge and structure into policy and procedure documents; h) developing care planning documentation tools that build upon admission assessment forms and augment and align with the nursing kardex; i) leveraging existing nursing communication processes such as end of shift report as avenues to embed and document revisions to the patient plan of care; and j) enlisting existing nursing clinical practice councils to help develop and pilot relevant care plan documentation tools and engage the councils in supporting and sustaining the practice change.

Findings from other studies that have examined and assessed practice improvement initiatives such as care plan documentation and patient assessment practices have advocated for the use of many of the strategies listed above (Greenwood, 1996). Specifically, the performance of documentation audits and localized staff discussions post audits has been suggested to enhance documentation practices and support positive behavior modification on the part of the nurse with respect to required documentation practice (Clarke et al., 2010).

Implications for Education

Evidence from this study has shed light on the need to potentially reconsider how we educate new and experienced registered nurses in relation to care planning practice within an acute care setting. Many of the study participants believed there was a need to balance the core elements of what care planning should be with what is practical and realistic for the RN to document and maintain. Interestingly, as reported in this study, differentiation of RN and LPN nursing practice was articulated by some of the study participants as being the same practice for both the RN and LPN in terms of planning care; albeit in their heads. The assumptions that an LPN can plan care the same as an RN is problematic given that the collaborative relationship between the RN and LPN is built on a foundation and assumption that a written care plan helps determine patient complexity and predictability thus making it possible to discern if the LPN is the appropriate provider for the patient (CRNNS & CLPNNS Guidelines, 2010). Additional collaborative education and dialogue for registered nurses, licensed practical nurses, student nurses and operational leaders related to the implications of these types of beliefs and practices needs to be made more explicit from joint efforts by and at the regulatory, curriculum and organizational levels. This suggestion has

been offered in previous studies that looked at the scope of nursing practice and maximization of nursing practice (Besner et al., 2006; Oelke et al., 2008).

Organizationally, there is an opportunity to look at how and what we provide in terms of orientation for novice nurses and registered nurses who transition from other practice environments. For example, re-examination of orientation curriculum and agendas for new nurses with specific focus on how to integrate care planning education within the initial and ongoing orientation and preceptor experience may be wise. Jansson et al. (2011) and others postulate that numerous and varied strategies are required for successful and sustainable practice change with respect to care plan adoption (Greenwood, 1996). Furthermore, a renewed and revised orientation focus is important so that the practice of developing care plans stays on the radar once a new graduate transitions from an academic to a clinical setting. Moreover, to help implement care plans at the unit level, there may be an opportunity for novice RNs to act as change agents in collaboration with other clinical leaders such as nurse educators.

The registered nurse's initial assessment and interpretation of the patient, their health care needs and their self-care abilities and capacity is pivotal to the development of a written plan of care by an RN. However, currently the registered nurses in this study described that the initial assessment is being considered more as data collection. That is, the data is not for the most part being used to inform planning and evaluation activities by the RN. Similar accounts of unstructured, non-systematic initial assessment processes on the part of the RN have been reported elsewhere (Fernandez-Sola et al., 2011). This finding was alarming and requires additional practice development. That is, the development of appropriate educational support

and learning activities is worthy of consideration to help ensure application of critical thinking and judgment when the collection and interpretation of assessment data occurs.

Many of the research participants described the need to make care planning practical and easy to perform. Whilst these principles can probably be met with future care plan design, quality improvement and change management approaches there is a need to ensure that the development of care plan activity is situated within a theoretical framework and viewed with a long-term perspective in mind. Namely, it has been noted by others that often it is the short-sighted perspectives and the needing to develop a form that influences and drives practice as opposed to a framework that helps to inform and guide practice (Greenwood, 1996; Jansson et al., 2011).

Additionally, care plan form development would still require appropriate structure to ensure essential areas of nursing practice and patient goals/outcomes are reflected in the document so as to ensure clear delineation and rationale for care (Bjorvell et al., 2000).

Implications for Policy

As previously outlined, a component of this research study entailed the review of relevant CDHA and CRNNS policy and related documents. In light of the study findings, there are opportunities to re-examine many of these documents. Namely, a re-examination of these policies and documents would help ensure clarity, adherence, and alignment with the intention and objective underpinning their use. Specifically, from an organizational perspective there is an opportunity to consider integration and insertion of care planning components and activities within future policy and procedure revisions. That is, in addition to policy and procedural steps that are often

outlined within clinical skills policies there could also be integration of care outcomes, best practice considerations and evaluation criteria that would be important to potentially consider, execute and document in a plan of care. This strategy would also serve to highlight and refocus the need to address care plan provisions when clinical interventions performed by nursing are required.

In relation to CRNNS regulatory documents there is an opportunity to review specifically CRNNS documents pertaining to the RNs' role with respect to clinical documentation as the wording and language does not directly align or link with what would be expected in relation to care plan documentation. There is also an opportunity to promote dialogue between CDHA and CRNNS in relation to ensuring clarity and accurate interpretation of college and regulatory documents and their implications to practice within acute care.

Implications for Research

Given that the RN assessment forms the basis for care plan development further research is required to understand how the nursing assessment is used to inform patient care needs and/or how assessment is currently being viewed and practiced to further illuminate this study finding. Research in relation to the nursing assessment process would help to further expand our knowledge in relation to key areas of individual level practice such as knowledge and application of the assessment process and how that is associated with care plan practice. Calls for similar types of research have been recommended (Jansson et al., 2011). As well, research related to the interpersonal level competencies of practicing RNs with respect to communication and delegation skills and how these skills are used to enhance and maximize time and efficiency over their work may be necessary to help develop

additional strategies to optimize care planning work. Another related topic that may be valuable to research further is the exploration of existing knowledge and competency of the RN in priority setting, time management and delegation practices.

Rarely can a poor work practice or associated behavior(s) be directly linked to only one factor and so the SE model was useful in helping to discern the multiple levels of factors that can influence RN care planning practice. Furthermore, to effectively turn RN care planning practice to one of a written activity multiple strategies that target and address many of the SE levels would be required and this recommendation has been confirmed by others (Greenwood, 1996). However, application of the SE model when studying RN care planning practice appears to be a novel approach as no previous care planning studies have been retrieved that have used this approach.

Given the inter-relatedness of factors within the various SE level(s) drawing on the model to help clearly articulate the study finding(s) or discussion was a challenge at times. The SE model could still be employed with future research activities related to this topic of inquiry. Though, it may be helpful to focus more specifically on factors within SE levels that have not been adequately described or explored within this research project. Namely, policy level factors like national Canadian Nurses Association reports were specifically inquired about during the interview process to determine if or how these associations and/or documents influenced RN care planning practice. There was limited response or identification on the part of the study participants as to how these bodies and associated documents influenced practice. Likewise, further research that describes and expands upon the study findings related to individual level factors such as accountability over one's

practice and how CRNNS standards of documentation are interpreted and viewed in relation to one's accountabilities may be helpful. Others have provided recommendations in this regard and so further research may be helpful (Oelke et al., 2008) That is, exploration of this issue may point to the need for focused and applicable professional development and learning opportunities in collaboration with organizations and nursing colleges.

Another factor that was described as being an influence over the RN's ability to document a care plan rested at the unit and organizational level with respect to workload and workflow for the RN within acute medical/surgical environments. Further observational research may be helpful to examine key domains of RN required practice and the associated intensity and flow of the required work. Other quantitative studies have performed similar research as a precursor to a practice change and so a comparable study prior to care plan adoption could be helpful (Cornell, Riordan, & Herrin-Griffith, 2010; Cornell, Herrin-Griffith et al., 2010). Observation studies along with adjunctive information such as care context could also help to illuminate what potential care models are necessary given the scope and magnitude of RN work and may help to outline how care can be restructured, re-prioritized or directed to other appropriate members of the team so that the RN can have an opportunity to make care plan documentation a priority and focus.

Many of the participants saw a need for the clinical nurse educator to have a significant role in care plan development, training and implementation. Therefore, research exploration of the required competencies, knowledge and skills required by the clinical nurse educator to step into a clinical leadership and change agent role

would be foundational work to help implement and sustain changes to care planning practice.

Further qualitative studies that begin to explore and describe the unique contribution the RN brings to the inter-professional collaborative team and care planning practice are also needed. Finally, studies that begin to further explore patient engagement strategies and the roles and responsibilities of patients in their plan of care have also been recommended for further research (Jansson et al., 2011). Research that focuses on the patient role will help to inform approaches to care plan activities and to the design of care plan forms.

Thoughts on Knowledge Dissemination

Knowledge transfer and application into nursing practice is an important aspect of the research process (Aita, Richer, & Heon, 2007). Therefore, dissemination of these study findings will be an important first step in beginning to understand how the identified themes are shaping the existing practice so that appropriate strategies to support or mitigate these themes can be identified and implemented. Accordingly, the results of this study will be reported during my thesis defense. To ensure a broad attendance at the defense, notices for the session have been provided to each of the seven medical/surgical recruitment settings. As well, members of the Capital Health professional practice portfolio inclusive of clinical educators and professional practice leaders will be notified of the session.

Spread of these research findings beyond the initial thesis defense was also identified and considered. In view of this there will be a potential to build upon existing work already underway within Capital Health. That is, a Collaborative Care Initiative (CCI) is in process within some of the existing medical/surgical settings.

The mandate of CCI is to transform the patient care experience through ensuring the appropriate care delivery service and alignment of human resources to meet the patient's needs (CCI, 2012). One of the deliverables or outputs of this work is to ensure the appropriate providers and patients are involved in the development of a written plan of care. I am currently involved with this initiative acting in the role of CCI facilitator for one of the medical/surgical settings. This research can inform the development of a benchmarking tool to support and monitor care planning practice. Therefore, I will be able to disseminate this research to medical/surgical unit(s) as they perform CCI related activities.

Additionally, from an organizational level perspective, plans to streamline the RN admission assessment process and to integrate and align the information with the nursing kardex and care plan is currently underway within two medical/surgical areas of CDHA. My plan is to use the research findings from this study to help shape and structure the direction of this initiative. Furthermore, the research findings can be used to help scope out additional professional development and training opportunities for new RN staff. In my current role as professional practice leader I have an opportunity to bring these research findings to the CDHA clinical nurse educator group to discuss how these findings could inform such development and educational efforts. As well, the educators are a resource to most unit based practice councils. Practice councils were a medium that was identified by the study participants as being a potential structure upon which to situate RN care planning practice improvement. Transfer of this research knowledge could also happen within these councils and the clinical nurse educators could be leveraged to initiate and start the discussion(s).

On a national and international level my plan is to submit my research for publication to help disseminate the research findings more broadly. In my perspective, these research finding(s) expand upon existing literature on this topic of inquiry and adds further depth and richness to what has already been reported.

Conclusion

A renewed focus on written plans of care for patients within acute medical/surgical settings is required to ensure the identification of appropriate and consistent care goals, outcomes and care interventions. RN providers will be central to the establishment of this renewed focus. The RN has a pivotal role in the creation of the written plan of care as they are the providers who should hold a comprehensive view of the patient's plan and help to coordinate which other provider resources are required and at what point along the patient's acute care journey are those resources required. As well, the RN is the one who assesses, provides and evaluates care on a 24 hour, seven day a week basis for all patients within their medical/surgical setting. However, as described by the participants within this study, the RN's role in written plans of care is not well implemented. Several factors at multiple levels have been described by the study participants as having influenced this current state of RN care planning practice. It is through identifying and understanding these contributing factors that we may begin to strategize and employ relevant and sustainable process improvements and professional development activities to re-envision patient care planning and the role of the RN within those activities. A qualitative descriptive approach is a reasonable next step to pursue if the intention is to contribute to further understanding of the phenomenon of unwritten care planning.

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Table: Care Plan Document(s) Review

Document /Publication Date	Document Type	Key Message/Content	Implications/Limitations/ and/or Notable Questions
Canadian Nurses Association (June 2010 – May 2015)	Core Competencies Evaluated on RN Examination	<p>Core Competency: Changes in Client/Client Population Health</p> <p>One of the main indicators of competency is:</p> <p>Collaborates with the patient/client in developing and implementing the plan of care. For example: setting priorities/needs, determining timelines to meet the need, selecting relevant interventions, developing learning plans.</p>	Expectation is that a novice entry-level RN has acquired this competency prior to entry to practice.

Document /Publication Date	Document Type	Key Message/Content	Implications/Limitations/ and/or Notable Questions
Nova Scotia RN Act (2006)	Acts/Legislation	<p>The practice of nursing is understood to mean the application of specialized and evidence-informed knowledge of nursing theory and health/human sciences in the provision of professional nursing services to patients.</p> <p>Furthermore, it includes:</p> <ul style="list-style-type: none"> - assessing the client to establish the client's needs/state of health - identifying the nursing diagnosis based on the assessment/analysis of data - developing and implementing the nursing component of the client's plan of care - monitoring, revising & evaluating plan based on patient outcomes. 	<p>One could assume that there would need to be a written and structured process implemented into RN practice if this component of the RN Act was to be completely actualized.</p> <p>Helps to clarify and differentiate what RN practice is in relation to the practice of other healthcare providers or disciplines.</p> <p>What is the level of discernment at the organizational and/or individual RN level concerning what this means to practice, process, etc.?</p>
CRNNS Vision, Mission & Ends (2009-2011)	RN Regulatory	<p>Priority #2 states:</p> <p>The health system is strengthened by RNs working to their optimum scope of practice.</p> <p>In order to fulfill this priority one of the requirements is: RNs use evidence to guide the plan of care and</p>	<p>Implies that a component of optimized scope of practice for RN is development and evaluation of a plan of care.</p> <p>Plan of care is referenced versus care plan. May be represented in this way to reflect the RN act language. Is there a shift in how care plan concept is recognized, defined or applied into actual practice?</p>

Document /Publication Date	Document Type	Key Message/Content	Implications/Limitations/ and/or Notable Questions
		evaluation of outcomes.	No mention of nursing diagnosis or assessment underpinning the plan of care. Is there a need to evolve this requirement to make it more inclusive of these mentioned components?
Standards for Nursing Practice 2004	CRNNS RN Standards Document	<p>Standard 3: Application of Knowledge, Skills and Judgment</p> <p>Key Indicators:</p> <p>Each RN</p> <ul style="list-style-type: none"> - applies theory and/or evidence-informed rationale for nursing decisions - applies appropriate knowledge, skills and judgment to assess, plan, intervene and evaluate care and revises plan as needed - records and maintains documentation that is clear, timely, accurate, reflective of observations, permanent, legible and chronological. 	<p>Does discuss the need to apply theoretical and/or evidence-based rationale for nursing decisions and exercise appropriate knowledge, skill, judgment. However, the indicator that speaks to documentation does not link up/align specifically with the first 2 indicators.</p> <p>For example, in some instances there may be a need to be prospective in terms of documenting care interventions to be implemented, in identifying potential needs/issues or in developing a plan of care to be implemented.</p>
CDHA: LPN Skills (2010)	Organizational Policy	<p>Policy Statements included in policy:</p> <ul style="list-style-type: none"> - The level of complexity and predictability of patients is always determined through the RN's assessment of the patient. - The RN is solely 	Implication is that RN needs to have active involvement in the initial and ongoing assessment of a patient and needs to have time and space to interpret data and established plan of care, determine appropriate provider (i.e. RN or LPN) and establish plan for frequent check-in and communication with LPN about

Document /Publication Date	Document Type	Key Message/Content	Implications/Limitations/ and/or Notable Questions
		<p>accountable to establish this status level.</p> <ul style="list-style-type: none"> - Complexity and predictability is made visible via an established plan of care. 	<p>new, changed or complex patient needs.</p>
<p>CDHA: Transfer of Accountability Process & Minimum Patient Information Data Set (2010)</p>	<p>Accreditation Standard for Provider Hand-Off</p>	<p>Minimum Data Set created to structure key information required during hand-over.</p> <p>Requirements include:</p> <ul style="list-style-type: none"> -Goal of patient/family within next 24 hours -Fall/ Skin Breakdown Risks/ Management of Same -Pain Assessment & Management -Discharge Planning 	<p>There is a need to have established plan of care as this is to be one of the main focal points of the verbal and/or written hand-off process.</p>
<p>CDHA Progress Notes (2002)</p>	<p>Organizational Policy</p>	<p>Contains policy direction and guiding principles related to required documentation by nurse in the progress note section of healthcare record. Specifically, the policy direction is that the nurse will use Focus Charting method as the acceptable means to document and the Progress Note documentation is to reflect the following</p>	<p>Lays out the need to have a plan of care as a focal point in which the progress note is built around.</p> <p>Policy is greater than 9 years old.</p> <p>Interesting that the information contained within guiding principles is not a part of the policy statements. This leaves ones to interpret to some degree writing of a focus note is optional</p>

Document /Publication Date	Document Type	Key Message/Content	Implications/Limitations/ and/or Notable Questions
		<p>elements:</p> <ul style="list-style-type: none"> - use of nursing process - the progress note needs to integrates with the patient care plan <p>Guiding Principles are statements that have some flexibility in terms of compliance and are factors for the RN to consider when deciding to document in progress note.</p> <p>Specifically, the policy states: A note is recorded in the Progress Notes when there is:</p> <ul style="list-style-type: none"> significant change in the patient issue/need/status on the care plan and/or an event such as discharge. 	

Figure 1: Capital Health's 2013 Milestones (Selected Highlights)

Adapted from Capital Health, 2008

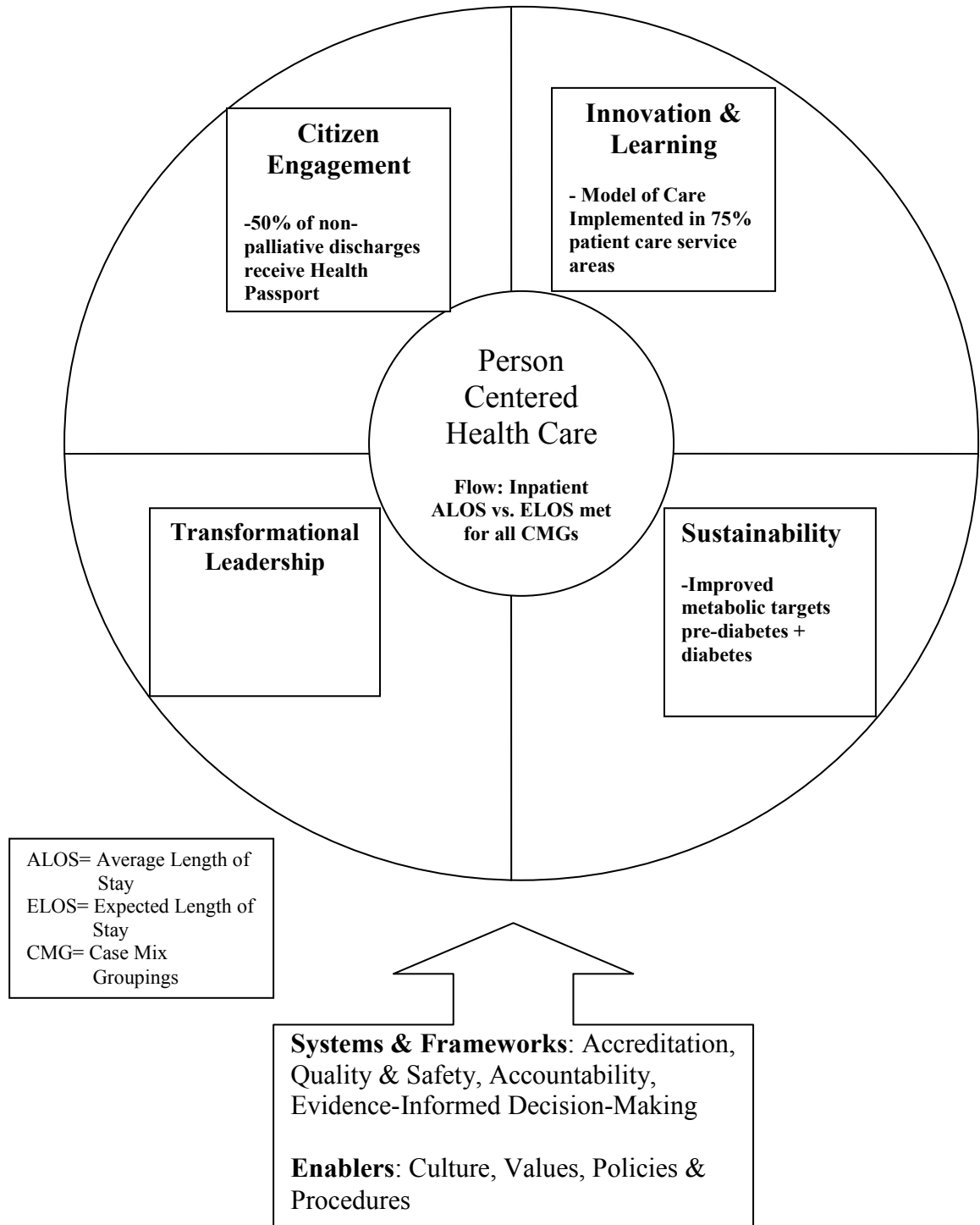
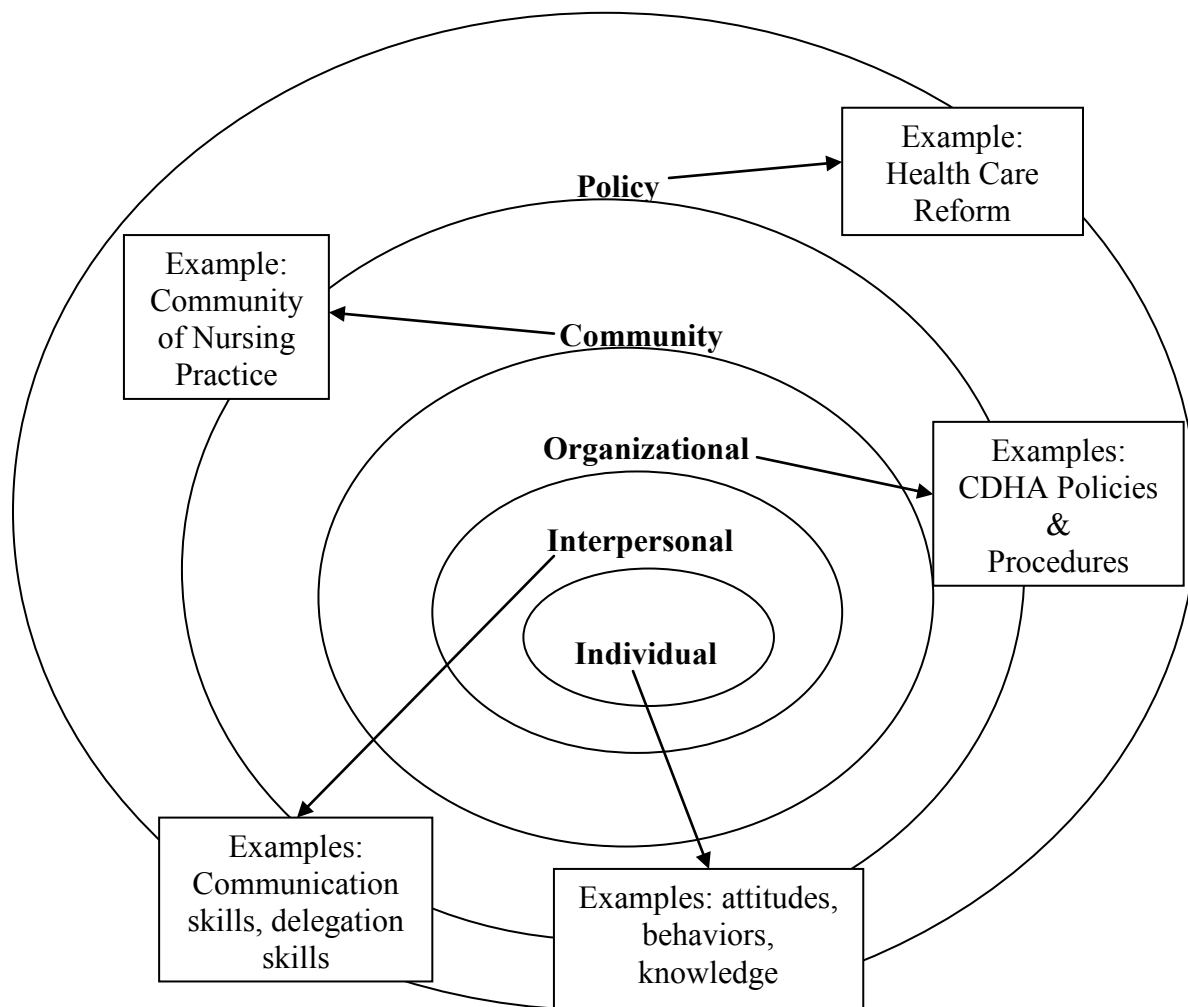


Figure 3: Social-Ecological Model

Adapted and Modified from Cassel (2010)



Appendix A: Sample Capital Health Nursing Kardex

Admitting Diagnosis:		Referring Hospital:	
Admitting Medical Conditions:			
Contact Person:		Next of Kin:	
Relationship:		Relationship:	
Phone: (H) _____ (W) _____		Phone: (H) _____ (W) _____	
Allergies		Advance Directives	
Blood Transfusion Sensitivity		Resuscitation Status	
Type/Screen sent		Date no code order written	
Known Antibodies		Family aware of no code order	
Cultural/Spiritual Practices:		Physician signature on order	
		Name of physician who wrote order:	

Vital Signs	
Routine: O2Sat _____ O2 therapy: F/M _____ % N/P _____	
l/min	
Other:	
Post Procedure Care	
Site _____ post procedure √'s complete _____ h Ambulation	
time _____ h	
Comments:	

Cognitive/Perceptual: LOC:	
Mental Status:	

Speech/Language: _____ Deficits: _____ Aids: _____ Hearing/Vision: _____ Deficits: _____ Aids: _____
Nutrition: Diet: _____ <input type="checkbox"/> Assist <input type="checkbox"/> Full Glucose monitoring: <input type="checkbox"/> OD <input type="checkbox"/> Bid <input type="checkbox"/> Tid <input type="checkbox"/> Qid
Elimination Output: q _____ h Last BM: _____ Skincare: _____ Braden Scale: _____ Catheter # _____ Insertion Date: _____ <input type="checkbox"/> Commode/Urinal <input type="checkbox"/> Bedpan <input type="checkbox"/> BRP
Hygiene/Activity Bath: _____ Mouth care: _____ Dentures: _____ Activity: _____ Aids: <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair Safety: <input type="checkbox"/> Side Rails Other: _____
Daily & Recurrent Bloodwork:
Other Nursing/Medical Interventions: _____ _____ _____ _____ _____

Appendix B: Participant Consent Form



Capital Health

Non-Interventional Study Consent Form

STUDY TITLE: Factors Influencing Registered Nurse's Role in Patient Plan of Care Process within Acute Medical and/or Surgical Inpatient Settings

PRINCIPAL *Shawna Hudson*

INVESTIGATOR: *106 Stonegate Drive, Halifax, NS, B3N 3L2*

(902) 473-1162 or (902) 832-4785

E-mail: shawna.hudson@cdha.nshealth.ca

ASSOCIATE

INVESTIGATORS: Dr. Marilyn Macdonald
Associate Director, Graduate Programs & Associate
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5869 University Avenue, Halifax, NS, B3H 3J5
(902) 494 2433 Fax: (902) 494 3487
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STUDY SPONSOR: *Not Applicable*

PART A.

Non-Interventional 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 researcher 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

PART B.

EXPLAINING THE STUDY

2. Why Is This Study Being Done?

Implementation of documented patient care plans in acute care by Registered Nurses (RN) can be a challenge. Furthermore, patients who receive care within acute care settings often have multiple co-morbid conditions and complex care needs and therefore require plans of care to ensure effective and safe care is provided.

Therefore, the purpose of this study is to begin to describe the factors that influence the care planning role of the RN.

The specific research question for this study will be: What factors influence the RN's ability to fulfill his/her role in developing the nursing component of the plan of care for patients within medical/surgical settings?

There is a need to conduct research on this topic as there is limited research that either describes or explores, from registered nurses perspectives, factors which may influence their care planning practice. A descriptive study is a foundational step to understanding the perspectives of registered nurses with respect to care planning practice by RNs within acute care.

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

You are being asked to join this study because you are a licensed registered nurse who either holds a staff RN, clinical nurse educator or health services manager role, have greater than or equal to 1 year nursing experience within your current medical-

surgical acute care unit, have learned about developing care plans and had exposure to nursing staff role optimization within your clinical setting.

4. How Long Will I Be In The Study?

It is expected that the study will begin in January, 2012 and end in April, 2012. It is anticipated that your participation in the study will involve an initial interview lasting approximately 45 minutes and may also consist of a follow-up phone call to you if the researcher has any additional questions or needs to clarify any information with you from the interview.

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

This study is only taking place at Capital Health and within seven medical-surgical inpatient units. The number of registered nurses expected to participate in this study are 10. Primarily, the participants will be 6-8 Staff RNs, 2-3 Health Service Managers and 2-3 Clinical Nurse Educators.

6. How Is The Study Being Done?

Participants will be interviewed to help answer the research question. The study design is focused on obtaining registered nurse participant's perspectives on factors that influence their care planning practice within acute care.

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

We will do the following as part of the study:

- ensure that participants for the research study meet the inclusion criteria as outlined in Question #3, page 2
- conduct 45 minute, audio recorded participant interviews
- conduct follow-up phone call with you (as required) after you have completed your participant interview

Of course you may change your mind at any time about participating in the study with no consequences at all.

8. Are There Risks To The Study?

There are risks with this, or any study. To give you the most complete information available, we have listed some possible risks. We want to make sure that if you decide to participate or try the study, you have had a chance to think about the risks carefully. Please be aware that there may be risks that we don't yet know about.

INTERVIEW RISKS

- You may find the interviews you participate in 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 or upsetting.
- Measures will be taken to help ensure that your personal information and the information shared by you during the interviews will remain confidential. Your name will not appear in any report or article published as a result of this study. Quotes from study participants will be used to demonstrate study findings but will not be associated with the names of any of the participants.

9. What Happens at the End of the Study?

Following your interview you will be asked if you are interested in receiving a summary of the findings. If you say yes, once the study has ended you will receive a copy of the summary of the final research findings.

10. What Are My Responsibilities?

As a study participant you will be expected to:

- Identify if you have any questions that you feel have not been answered regarding the research and/or your participation in the research
- Identify if you do not wish to continue participating in the research

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 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 and well-being, 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?

Compensation

You will not be paid to be in the study. You will receive a 20.00 dollar gift card to help acknowledge your time and participation in this study.

Research Related Injury

If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your legal rights nor release the Principal Investigator or involved institutions from their legal and professional responsibilities.

14. What About My Right To Privacy?

Protecting your privacy is an important part of this study. A copy of this consent will be placed in a secure locked file cabinet in the office of the researcher at Capital District Health Authority.

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

- Collect information from you
- Share information with the principal investigator's thesis committee
- Share information with the research transcriptionist
- Auditing of researcher work may happen and therefore auditors would have access to the data.

Health records will not be accessed for this study.

The principal investigator, thesis committee members and research transcriptionist will see study records that have identified you by pseudonyms.

As well, other people may need to look at the study records. These might include:

- the CDHA Research Ethics Board and Research Quality Associate

The principal investigator 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
- sex
- years of acute care nursing experience
- years working on the unit
- staff position held
- information from study interviews

Your name and contact information will be kept secure by the principal investigator 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. Quotes from study participants will be used to demonstrate study findings but will not be associated with the names of any of the participants. Information collected for this study, including audio recordings will be 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 principal investigator will be stored in a locked filing cabinet in the office of the principal investigator, located at Capital District Health Authority. The principal investigator will be responsible for keeping the information secure.

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

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.

A decision to stop being in the study will not affect any work performance evaluations you may have.

16. Declaration of Financial Interest

The Principal Investigator has no financial interests in conducting this research study.

17. What About Questions or Problems?

For further information about the study call Shawna Hudson. Shawna Hudson is in charge of this study at this institution (she is the “Principal Investigator”). Shawna Hudson’s work telephone number is (902) 473-1162.

The Principal Investigator is Shawna Hudson, RN, BScN
Telephone: (902) 473-1162

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 **Capital Health Research Ethics at (902) 473-5620.**

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:

**Factors Influencing Registered Nurse’s Role in Patient Plan of Care Process
within Acute Care**

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.

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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I Will Be Given A Signed Copy Of This Consent Form

Thank you for your time and patience!

Appendix C: Participant Interview Guide

<p>Interview Project: Factors That Influence RN Care Planning Practice within Acute Care</p> <p>Interview Time/Date:</p> <p>Interview Place:</p> <p>Biographical Data: Name: _____ Position: <input type="checkbox"/> RN (Staff Nurse) Years of Acute Care Experience: _____ Years Working in Current Unit: _____ _____ Current Staffing Model (i.e. all RNs, LPN, PSW): _____</p> <p>Interviewer: Provide Brief Description of Intention and Focus of Study</p> <p>Interview Objectives: The interview questions have been designed to help describe the following factors that can influence care planning by the RN:</p> <ol style="list-style-type: none"> 1. Current and past practice with care planning 2. Educational resources and opportunities offered and used by the individual RN 3. Meaning attributed to care planning 4. Human and Organizational policy resources available to an individual RN <p>Build Rapport: Reinforce no right or wrong answers. The interviewer is coming from a place of trying to describe and understand current practice and factors that influence care plan practice. Confidentiality.</p>		
Questions:	Social-Ecological Level:	Descriptive Notes:
<p>How would you describe your experience of care planning today?</p> <p>Prompts: See below</p>	Individual	
<p>Walk me through what care planning looks like in the area/unit?</p> <p>Prompts: Where does the plan of care get documented? What is included in a plan of care? How do patient needs get identified? How do you determine interventions to meet the</p>	Individual	

identified need?		
<p>How would you describe your current beliefs about care planning?</p> <ul style="list-style-type: none"> a) What do you believe is the RN's role in care planning? b) What do you believe is the role of the LPN (as applicable)? c) What do you believe the role to be of the patient? d) How does the nursing plan of care differ from medical plan? e) As you reflect on your experience as a student please describe how that experience differs and/or is the same? <p>Prompts: Gets at current reality in contrast to student experience or unit/practice experience.</p>	Individual	
<ul style="list-style-type: none"> a) How could a written nursing plan of care help you in your role? b) How could a plan of care assist the patient(s)? c) To what degree are you able to enact care planning in 	Individual and/or Organizational	

<p>your day to day practice? Prompts: delegation. How do you decide who does what work?</p> <p>d) In your or the nurses day to day practice, where does care planning sit on your/the priority list of responsibilities?</p> <p>e) What are some enablers for you?</p> <p>f) What are some barriers for you?</p>		
<p>What importance does the organization place on having written plans of care for patients?</p> <p>Prompts: How do the Organization’s Milestones and/or Mission & Vision align with care planning?</p>	<p>Individual and/or Organizational</p>	
<p>a) Can you describe for me any educational training either self-directed or structured educational sessions you have had about care planning in the last 2 years? (i.e. workshops, self-directed reading)</p> <p>b) What was some of your key learning from these activities?</p> <p>c) How has these</p>	<p>Individual/Organizational/Community of Practice/Organization of Work</p>	

<p>experiences informed/ influenced your practice?</p> <p>d) What skills would you see needing or would staff need to develop to effectively integrate care planning into your practice?</p> <p>e) Which nursing peers can you/staff resource/access about care planning?</p> <p>Prompts: What it is about them that make them a good resource?</p> <p>f) If written plans of care were to be implemented what would be the role of the HSM?</p> <p>g) What would be the role of the CNE?</p> <p>Prompts: What supports would you require from HSM or CNE?</p>		
<p>a) What access do you have to documents that would help you with care planning?</p> <p>b) What tools/resources</p>	<p>Individual/Organizational</p> <p>Policy</p>	

<p>(documents, policies, manuals) would help you with care planning?</p> <p>c) What policies or documents exist from CRNNS that can help support you with care planning?</p> <p>Prompts: Example: Policy and Procedure, Internet Access, Textbooks, Care Pathways. How might these documents be used by you to support care planning activity?</p>		
Additional Questions (as applicable)		
Clinical Educator or Health Service Manager		
<p>Can you describe for me how nurse care planning is structured on your unit(s)?</p> <p>Prompts: How does care planning fit into the workflow/processes the RN is engaged in? Is there focused or dedicated time to develop/update care plan?</p>		
What do you see your role as in relation to care planning practice on your unit(s)?		
<p>Has there been any dedicated work or focus within the last 2 years in improving care planning practice within your clinical unit(s)?</p> <p>If so, please describe?</p>		
What value would there		

