THE SOCIAL ORGANIZATION OF NURSING PRACTICE IN THE HOSPITAL SETTING AND THE INFLUENCE ON THE DEVELOPMENT OF CONFLICTING WORKING RELATIONSHIPS BETWEEN REGISTERED NURSE PEERS

A Dissertation Submitted to the
School of Graduate Studies in partial fulfillment of the
requirements of

Degree of Doctor of Philosophy in Medicine
Memorial University

October 2020

St. John's Newfoundland

ABSTRACT

The term conflicting working relationships (CWRs) is used in this research to represent working relationships between nurse peers that are non-collegial, uncaring, and non-supportive. These types of relationships have been reported in the research literature using many different labels including incivility, horizontal violence, and bullying and are known to be a source of job dissatisfaction, disengagement, and burnout. Despite efforts to limit the occurrences of CWRs between nurse peers, incidents of CWRs continue to occur. Using institutional ethnography, this research explored and made visible the relationship between the social organization of professional nursing practice in the hospital setting and the development of CWRs between Registered Nurse (RN) peers. Three aspects of the social organization of professional nursing practice, *should nursing*, *double domination*, and the *big picture* were revealed as creating disjunctures, frustrations, and tensions for nurses that were significant in the development of CWRs. The findings of this research further illuminate how conflict has become institutionalized and how there is a need for strong nursing leadership to advocate for workplace processes and contexts that support healthy and productive working relationships between nurse peers. The results of this study offer important insights into the ways CWRs between RN peers are influenced by the extra-level processes and relations of ruling that govern professional nursing practice. Through increased clarity of these factors, it is hoped that this research can be used to open a dialogue for leaders to discuss how nursing practice could be organized in a way that supports more collegial practices between RNs.

Key words: nursing, institutional ethnography, conflict, relational practice

ACKNOWLEDGMENTS

Firstly, I would like to express my sincere gratitude and appreciation to my Supervisor Dr. Martha Traverso-Yepez, Co-Supervisor, Dr. Shirley Solberg, and Supervisory member, Dr. Alice Gaudine for their guidance, feedback, and encouragement throughout this research process. I feel blessed to have had such a dedicated, supportive, and patient supervisory committee to assist me throughout this journey. Each committee member provided me with their unique expertise and insight, and I cannot thank them enough for everything that they have done for me.

Secondly, I would like to thank my colleagues from the Centre for Nursing Studies. They have supported me from day one of the PhD program, I will always be grateful for their love and support. Denise English, Natasha Fulford, and Robyn Noseworthy, we were most definitely the "dream team." To my colleagues from the College of Registered Nurses of Newfoundland and Labrador, I thank each of you (and in one case, a significant other) for your consistent support and reassurance. Michelle Carpenter, I thank you for proof-reading, believing in me, and for always having my back.

Thirdly, I want to thank my family and extended family. My Mom and Dad, Cindy, and Scott for always supporting my career goals and life pursuits. My husband Ben for all his technical support, love, and encouragement, and my children, Tyler, Logan, and Rowan for their understanding for the days when I was "busy." I want to thank my dearest friends, Kara, Kara, Kerry, and Tasha for always being there for me no matter what. Kara Pender, your positive attitude, and contagious smile got me through some tough days, thank you my friend. Thank you to the wonderful ladies of Seraka

Dance Company for making me take breaks and dance. I love you all. I also want to thank all the participants for sharing their stories and making this research possible.

Finally, I want to acknowledge how thankful I am for the scholarships I received from the College of Registered Nurses of Newfoundland and Labrador, the Registered Nurses Union of Newfoundland and Labrador, Eastern Health, and Memorial University of Newfoundland for the Ellen Gillis Memorial Scholarship. The financial support provided by such scholarships are invaluable in helping doctoral students achieve their goals. I would also like to affirm that the work as presented, including the tables and figures, is my own.

TABLE OF CONTENTS

List of Tables

List of Figures

List of Appendices

Chapter One – Introduction to Conflicting Working Relationships (CWRs)

When I first became employed as a nurse[1], I was surprised by how difficult it was to adjust to the busyness of an acute care hospital setting and the multitude of demands placed upon me as a registered nurse (RN). I found that by the end of a set of twelve-hour shifts, I was physically and mentally exhausted, and I needed my days off to recover. I did not like being that tired. However, I accepted the busyness of nursing practice as a requirement of the profession. What was harder to accept was that in this hectic environment, it was also common for me to witness a variety of behaviours among nurses that were unexpected. Some of these behaviours were non-collegial and often resulted in conflict between nurse peers.

I experienced a conflict with a nursing peer shortly after I completed my orientation to a new unit. Orientation is an employment requirement in the health care setting, and my orientation consisted of some classroom instruction, followed by a specified amount of time co-signed with a senior nurse. The goal of being co-signed is to provide a new nurse with enough knowledge to provide patient care independently, competently, and safely. However, unit orientation is not standardized, and it differs between units. On a night shift after my orientation was complete, I received a report on a challenging patient assignment, so I prepared a priority list of tasks to complete. Caring for this patient would require the coordination of many complex nursing skills including the simultaneous administration of a variety of blood products, the use of new equipment, and the navigation of care obstacles such as securing intravenous access.

[1] The use of the term nurse refers to a registered nurse unless otherwise specified.

Reflecting on my behaviour that night, my co-worker may have perceived me as being too confident for a nurse who just recently completed an orientation. However, I expected that if I needed help, I would receive it because, in this unit, there were always two nurses assigned to work together, assisting each other as required while caring for their patient. I did require a lot of help and I asked for assistance numerous times throughout the night from the nurse co-assigned to work with me. I felt overwhelmed with caring for my patient and I felt less confident in my decisions and skills. I could sense through my co-worker's interactions with me that continually asking for help was bothersome and I was not surprised when I was denied any further assistance. My co-worker and I were both enmeshed in a culture where nurses were expected to be competent to work independently in all situations, and this belief was endorsed by the model of nursing care used in the hospital setting. However, nurses have voiced that it may take many years of nursing experience to acquire the knowledge and skills required to navigate and manage complex patient care and nursing situations successfully (Oyeleye, Hanson, O'Connor, & Dunn, 2013; Rankin, 2009). Also, even with many years of experience, an integrated team-based approach might be required for more complex nursing practice (Dickerson & Latina, 2017; Scott, Mannion, Davies & Marshall, 2003).

Looking back, I could have been more vocal and requested to be reassigned to another patient, but instead, I did not because I did not want to be labeled incompetent. It took me a long time to realize that I did not want to be labeled incompetent because, with the profession of nursing, competence is valued. This reflection was different from my draft reflection at the beginning of the research process. In that reflection, I took the situation personally, and I felt the need to vindicate myself from blame in the events that

occurred. I still did not want to be thought of as incompetent; instead, I wanted to assign blame to the nurse that did not help me. I did not self-reflect on the role that I played in the creation of the experience, or how the ideals embedded in the profession of nursing (with respect to competence and more) influenced the situation, or how I perpetuated the outcomes.

As my research progressed, my initial thoughts and feelings regarding the research topic and questions changed and evolved, and I conducted a more critical self-reflection. Through a more critical self-reflection, and putting my ego aside, I have come to see how I could have played an equal role in the creation of my experience and the events that followed. Eventually, I realized that I had responded to the situation emotionally and was embarrassed by my inability to handle my patient assignment. Instead of confronting the situation, and moving forward, I avoided the nurse with whom I had the conflict and as a result, I contributed to a strain in my working relationship with that nurse on the unit, and I eventually left that hospital. This experience was the catalyst that prompted my research journey. As I became driven to understand how conflict between nurse peers has become so pervasive in professional nursing practice.

1.1 Professional Nursing Practice

In 2015, the Canadian Nurses Association (CNA) released a *Framework for the Practice of Registered Nurses (RNs) in Canada* to "promote a common understanding of RN practice among nurses, students, and stakeholders in Canada" (p. 3). The framework begins by defining RNs as "self-regulated health care professionals who work autonomously and in collaboration with others to enable individuals, families, groups,

communities, and populations to achieve their optimal levels of health" (p. 5). It further states that RNs use "philosophical thinking" and "critical analysis" (p. 6) with respect to nursing knowledge, where nursing knowledge is organized and communicated using concepts, models, frameworks, and theories from nursing as well as those from a variety of health-related disciplines. N*ursing practice* is described as built upon this foundation of nursing science. RNs are further noted to practice in a variety of roles and contexts including direct-care, education, administration, research, and policy.

P*rofessional practice* is associated with the privilege of self-regulation and the accountability that RNs assume for their practice to ensure public protection and trust (p. 7). For the purposes of this research, *professional nursing practice* refers broadly to the work that nurses do in carrying out their roles and responsibilities, as self-regulated professionals.

1.2 Research Background

RNs belong to a profession that is grounded in a tradition of providing care, empowerment, and well-being to others (Canadian Nurses Association [CNA], 2017; Myers, Côté-Arsenault, Worral, Rolland & Deppoliti, et al., 2016). To adhere to the tradition of providing high-quality care, there is the expectation that RNs work together in a professional and collegial manner (Padgett, 2013). Nurses are also ethically bound by their code of ethics to create a moral environment that supports peers, identifies issues, and maintains respectful interactions with colleagues (CNA, 2017). However, in the nursing profession, it has become increasingly common to hear about troublesome relationships involving non-collegial, uncaring, and non-supportive behaviours and

practices between nurse peers, especially within the hospital setting. Over the last three decades there has been a significant amount of research investigating these troublesome relationships between nurse peers and it has been represented and reported using a variety of different labels (Roberts, 2015).

Labels include interpersonal/intraprofessional conflict (Duddle & Boughton, 2007; Guidroz, Wang, & Perez, 2012), workplace aggression (Farrell, Bobrowski, & Bobrowski, 2006), incivility (Alshehry, Alquwwez, Almazan, Namis & Cruz, 2019; Anderson & Pearson, 1999; Layne & Henderson, 2019; Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013; McNamara, 2012; Oyeleye, Hanson, O'Connor, & Dunn, 2013), workforce conflict (Dewitty, Osborne, Friesen, & Rosenkranz, 2009), nurse-to-nurse conflict (Rocker, 2008; Woelfle & McCaffrey, 2007), lateral violence (Coletti, Davis, Guessferd, Hayes, & Skeith, 2012; Embree & White, 2010, Roberts, 2015), psychological harassment (Fornés, Cardoso, Castelló, & Gili, 2011; Trépanier, Fernet, & Austin, 2013), horizontal violence (Armmer & Ball, 2015; Becher & Visovsky, 2012; Ditmer, 2010; Duffy, 1995; Dumont, Meisinger, Whitacre, & Corbin, 2012; King-Jones, 2011; Taylor, 2016; Walrafen, Brewer, & Mulvenon, 2012; Weinand, 2010), and bullying (Bennett & Sawatzky, 2013; Berry, Gillespie, Gates, & Schafer, 2012; Cleary, Hunt, & Horsfall, 2010; Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012; Hutchinson, 2009; Hutchinson, Vickers, Wilkes, & Jackson, 2010; Katrinli, Atabay, Gunay, & Cangarli, 2010; Lewis, 2006; Randle, 2003; Roberts, 2015; Yildirim, 2009). Less used labels include hazing, mobbing, relational aggression, and disruptive behaviour (Taylor, 2016).

Labels have been useful because the precise terminology allowed for the identification of differences between specific conflict behaviours and the establishment of categories used for comparing events. Labels have also allowed researchers to calculate statistics to estimate the rate of occurrence and the scope of the problem. My critique of the use of different labels is that, in most cases, the respondents did not differentiate their experiences by type or label; they simply recounted their experiences, leaving it to the researcher to define their experience for them.

In my research I decided to use the term conflicting working relationships (CWRs) to describe the experiences of conflict between RN peers more broadly, moving away from attempting to generalize individual interpretations of events into categories as represented by the various labels. As every conflicting event is different depending on the local context, circumstances, and subjective interpretations, generalizations from the commonly used quantitative approaches do not provide an accurate understanding of what is happening. As a nurse myself, who has experienced and witnessed these kinds of behaviours in my professional practice and who has read about the detrimental effects that conflict has on nurse professionals, patients, and the health care system, I felt the need to gain a more comprehensive understanding of CWRs, and that a more critical investigation was warranted. For reasons to be explored more in depth throughout this research, institutional ethnography seemed to be a good fit to conduct this study.

1.3 Institutional Ethnography and the Research Problem Being Explored

Institutional ethnography (IE) is a method of inquiry located within the theoretical approach known as the "social organization of knowledge" (Campbell, 2006, p. 91; Smith

1987) and it refers to how “things [are] being put together systematically, but more or less outside a person’s knowledge, and for purposes that may not be theirs” (Campbell & Gregor, 2008, p. 18). The aim of these investigations is to make clear how the purposeful organization of the activity of people relates to power structures (Campbell & Gregor, 2008).

In this research I am examining the organization of nursing practice and the development of CWRs between RN peers in the hospital setting. This situation is puzzling as it is expected that nurses would demonstrate towards each other the caring behaviours associated with the profession. Additionally, some researchers have discovered that many CWR behaviours could be validated or justified by using legitimate organizational processes (i.e., hospital policy, occurrence reporting system) (Hutchinson, Vickers, Jackson, & Wilkes, 2006; Lewis, 2004). Furthermore, although not all nurses in the hospital setting demonstrate CWR behaviours toward one another, where they are displayed, research shows this is a significant problem for nurses, the health care organization, and the public (Cleary et al., 2010; Dumont et al., 2012; Farrell, 2001). Consequently, these are the sources of some of the tensions framing the “problematic” of CWRs between RN peers. In IE, the problematic refers to a situation that needs to be examined (Campbell & Gregor, 2008; Smith, 2005).

Therefore, I am using IE to examine how nursing, including nursing knowledge and practice, are socially organized within the hospital setting and how this organization may be linked to CWRs between RN peers (Campbell & Gregor, 2008, p. 18). IE and the concepts of social organization of knowledge and problematic will be further explored in chapter three.

1.4 Research Aim and Questions

My research aim was to explore and make visible how nursing practice in the hospital setting has been organized in a way that contributes to the development of CWRs between RN peers. Specifically, I aimed to explore the social relations in which RN peers were engaged when experiencing a CWR, including how these relations were interpreted, manifested, and perpetuated within the hospital setting, thereby contributing to the development of unhealthy/escalating conflict. As previously explained, I use the overarching phrase CWRs to refer to all the different labels found in the research literature describing this phenomenon. By using this phrase, I mean to refer not only to conflict in the workplace as an expression of disagreements between RNs but also to refer to the escalation and perpetuation of conflict behaviours to the point where they become unacceptable and detrimental to healthy, productive, and collegial working relationships. I began with investigation by posing two broad questions:

1. In what ways does the social organization of nursing practice in the hospital setting relate to the development of CWRs between RN peers?
2. What steps could be taken to promote healthy and productive working relationships between RN peers?

1.5 Research Objectives

To generate data on my two broad research questions, I used the following research objectives:

1. Identify through interviews with RNs who had experienced or witnessed CWR with peers the details of the work (day/night) when the conflict was experienced.

2. Identify the use of texts governing nursing practice (i.e., floor specific policies and protocols, etc.) in the details of the work (day/night) when the conflict was experienced and explore the use/interpretation of texts in the aspects of the conflict.
3. Determine connections between the use/interpretation/activation of texts (and the associated text-mediated discourse) and the development of the CWR.
4. Make a visible representation (construct a map) of the relationship between the social organization of nursing practice identified from the interviews and the development of a CWR.
5. Identify the differences between the details of the work (day/night) context when the CWR was experienced and when a CWR was not experienced.
6. Analyze the data collected and examine how the social organization of nursing practice in the hospital setting contributes to the development of CWRs between RN peers.
7. Identify steps that could be taken to promote healthy and productive relationships between RN peers.

1.6 Research Contributions

Moving away from labelling individual behaviours to understanding how CWRs are institutionally organized contributes to the research literature in three significant ways. The first contribution is by making RNs aware of how the organization of nursing practice influences their thoughts, actions, and behaviours towards each other. Secondly, with increased awareness, RNs are provided with an additional knowledge resource to

draw upon when making decisions regarding CWR events. Thirdly, the results of this research give leaders a platform to open a dialogue about CWRs and the changes needed in the organization of nursing practice to one that promotes an environment that supports healthy and productive working relationships between RNs.

1.7 Organization of Dissertation

I have organized this dissertation into five chapters. Chapters one and two provide the background information necessary to understand my topic of investigation including a critical review of the research on the topic. In chapter three, I explain institutional ethnography (IE) as a method of inquiry and define its key terms. I also position myself as a researcher using IE and provide an outline of the research process using this approach. In chapter four, I provide descriptions of the participants CWR experiences, an explanation of the tools I used to conduct the data analysis, and the information gained from this analysis. This is followed by text analysis and mapping. I conclude this dissertation in chapter five, where I provide a discussion of the *should* nursing, *double domination*, and the *big picture* threads, as well as, on the struggles encountered in professional nursing practice, the institutionalization of conflict, and the need for strong leadership. Chapter five ends with suggestions for nursing leaders to consider when addressing the organization of nursing practice in ways that promote more positive peer relationships between nurses. Also presented in chapter five are the strengths and limitations of this research and a research dissemination plan.

1.8 Chapter Summary

I introduced this chapter with a summary of my personal reflection about my experience with conflicting working relationships (CWRs). I then provided some background information on the topic and the rationale for using the phrase CWRs. Institutional ethnography and the problematic were then briefly introduced. This was followed by the research aim, questions, and objectives. I concluded this chapter with a summary of how my research will contribute to the knowledge base and how the remainder of this dissertation is organized.

Chapter Two – What is Known About CWRs Between RN Peers

In comparison to other professions, there has been a disproportionately large amount of research dedicated to investigating conflict occurring between nurses (Cleary, Hunt, & Horsfall, 2010; Embree & White, 2010; Myers, Côté-Arsenault, Worral, Rolland, & Deppoliti et al., 2016; Ditmer, 2010; Duddle & Boughton, 2007; Hutchinson, Vickers, Wilkes, & Jackson, 2010; Taylor, 2016; Weinand, 2010; Woelfle & McCaffrey, 2007; Yildirim, 2009). This may be attributed to the high incidence of CWRs between nurse peers. In this chapter, I will present my review of the extensive literature on this topic, where I explore and critique the ways differing explanations for CWRs have been framed (Campbell & Gregor, 2009). As part of my review of the literature, I highlight the prevalence of CWRs, the research emphasis on individual and interpersonal explanations, and the impact CWRs have on nurses, the healthcare organization, and the public. I conclude with a summary of the potential strategies that have been proposed to address CWRs and some of the limitations of these strategies.

2.1 Prevalence of CWRs between RN Peers

CWRs between RN peers have been found to be a pervasive and longstanding problem that occurs regularly within health care organizations (Allen, Holland, & Reynolds, 2015; Armmer & Ball, 2015; Croft & Cash, 2012; Myers et al., 2016; Pfeifer & Vessey, 2017). However, there have been significant inconsistencies in the reported prevalence. In 2010, Ditmer noted in her commentary on horizontal violence (HV) that 75% of nurses experienced violence, harassment, and intimidation; 80% experienced bullying, and 51.9% of nurses inflicted intimidating behaviours on peers. In 2011,

Dumont, Meisinger, Whitacre, and Corbin (2012) conducted a survey on HV in the United States, which reported that HV happened more than monthly, with more than 80% of respondents experiencing or witnessing at least one of the five behaviours identified as HV weekly or daily. These five behaviours included harshly criticizing, belittling, complaining, raising eyebrows/rolling eyes, and pretending not to notice. Thirty-five percent of respondents in this survey experienced or witnessed all five behaviours daily. Another study conducted in the United States reported that between 19.9% and 53.3% of nurse respondents experienced behaviours consistent with HV (Walrafen, Brewer & Mulvenon, 2012). In the same year, Dewitty et al. reviewed the Center for American Nurses (CAN) report findings that 53% of nurses reported conflict as "common" or "very common." However, the CAN did not provide quantitative data on the criteria used to meet the "common" or "very common" category (Dewitty et al., 2009, p.32). One study reviewed reported that 20.4% of Canadian nurses were frequently exposed to negative behaviours at work within the last six months (Trépanier et al., 2013).

Reports of undesirable behaviours between nurses and the inconsistencies in the reported prevalence have not been limited to North America. In a teaching hospital in Turkey, Yildirim (2009) reported that 21% of the research participants had been directly exposed to bullying in the past 12 months. However, in the same study, 37% of the participants reported having "never" or "almost never" encountered workplace bullying in the same timeframe (p. 504), and the range of nurses who had neither experienced nor witnessed any type of HV during their working careers was between 8.3% and 64.2%. There was no discussion provided to help explain the significant difference in the reported prevalence in that hospital. In 2011, Fornés, Cardos, Castelló, and Gili

conducted a sweeping review of the literature on aggression in nursing in non-North American countries. They found in professions where a whole or part of the sample was made up by nursing staff, the presence of conflict ranged from 1% to 10% in Norway, 27% in Australia, 38% to 44% in the United Kingdom, and 6.2% to 59.8% in Spain (p.187). Sixty-three percent of nurses in Tasmania, Australia reported experiencing many forms (or sources) of abuse including abuse from nurse colleagues (Farrell et al, 2006). The difficulties encountered in accurately determining the prevalence of CWRs between RN peers have been attributed to several variables including the lack of consistent and agreed-upon definitions for the events that occurred, inconsistent research methods, and the absence of a standardized, reliable tool to measure the types and effects of the conflict (Armmer & Ball, 2015; Cleary et al., 2010).

In addition to the variability in prevalence, there were also discrepancies about who were the most frequent perpetrators and targets of CWRs. Although recognized as a problem within all health care professional groups, nurses seem to be at higher risk for CWRs (Taylor, 2016). For example, some studies identified emphasized the presence of conflict between nurses and physicians (Dewitty et al., 2009; Guidroz, Wang, & Perez, 2012). In addition, some studies identified that conflict between nurses most frequently occurred between nurse managers/administrators and staff nurses (Etienne, 2014; Yildirim, 2009), while other studies have indicated that the highest prevalence occurred between nurse peers (Becher & Visovsky, 2012; Berry, Gillespie, Gates, & Schafer, 2012; Ditmer, 2010; Dumont et al., 2012; Embree & White, 2010; Trépanier et al., 2013).

When a CWR involves two nurse peers, it is labeled *horizontal* violence/ aggression/conflict because of the perceived power equity in the relationship between the

two nurses involved. Yet, many researchers have identified abuse of power from more experienced colleagues against nurses with less nursing experience, such as newly graduated nurses and novice nurses new to a work setting. In situations where there was a potential for this kind of power imbalance, higher incidences of CWRs have been reported (Berry, Gillespie, Gates, & Schafer, 2012; Maddalena et al., 2012; Randle, 2003; Read & Laschinger, 2013).

Furthermore, most of the research indicated that it was a nurse-to-nurse conflict that produced the most significant adverse effects for the nurse (Embree & White, 2010; Farrell, 2001; Laschinger, Wong, & Regan, 2013; Weinand, 2010; Walrafen, Brewer, & Mulvenon, 2012; Wilson, Diedrich, Phelps & Choi, 2011). Nurse-to-nurse conflict was found to be more troubling for nurses than other professionals because of the altruistic and caring behaviours associated with professional nursing practice (Corney, 2008).

Despite the variations noted in the research literature on CWRs, it has been consistently reported that conflict between RN peers happens regularly (Cleary et al., 2010; Dumont et al., 2012; Katrinli et al., 2010; Weinand, 2010). It happens most frequently within the hospital setting (Dewitty, 2009; Guidroz, Wang, & Perez, 2012; Taylor, 2016), and it adversely affects the health and well-being of RNs, negatively impacting the functioning of the health care organization, and compromising quality patient care (Cleary et al., 2010; Dumont et al., 2012; Farrell, 2001; Roberts, 2015). Despite efforts to address the problem, only minimal progress appears to have been made (Taylor, 2016). Therefore, I decided to take a more critical look at the literature.

2.2 CWRs and the Emphasis on Personal and Interpersonal Explanations

Conventional data collection methods have included self-reports using self-completion surveys and questionnaires, participant observation, document review, focus groups, and interviews. Common research methodologies have included descriptive studies (Anderson & Pearson, 1999; Trépanier, Fernet, & Austin, 2013), concept analysis (Embree & White, 2010), naturalistic inquiry (Maddalena, Kearney, & Adams, 2012), and grounded theory (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012). Descriptive studies have been (and remain) valuable since they capture how conflict between nurses can take many different forms depending on the circumstances surrounding the event and on how the individuals involved interpret the events.

As such, a greater proportion of the research has focused on conflict being attributed to individual or interpersonal factors, thus neglecting other levels of influences (Armmer & Ball, 2015; Dewitty et al., 2009; Dumont et al., 2012; Hutchinson & Jackson, 2014; Trépanier et al., 2013; Yildirim, 2009). Although Canadian studies were limited, many American studies found no significant correlation between CWRs and gender, ethnicity, race, years in the profession, age, degree attained, work schedule, tenure, benefit status, or work setting, thus suggesting that individual factors are not significant sources of CWRs (Dewitty et al., 2009; Dumont et al., 2012; Trépanier et al., 2013; Yildirim, 2009). Researchers have shown that CWRs can potentially be experienced by all kinds of nurses. Yet, specific populations of nurses, such as novice nurses, male nurses, or nurses with different ethnicities, are shown to have experienced CWRs more frequently (Becher & Visovsky, 2012; Randle, 2003; Read & Laschinger, 2013; Vessey et al., 2009).

A significant amount of research has been centred on CWR experiences of novice nurses. However, there was also variability in the defining criteria of a "novice" nurse. For example, Maddalena et al. (2012) defined a novice nurse as a RN who graduated "within the past two years or re-entered the profession within the past two years (p.75)," while Read and Laschinger (2013) considered graduate nurses "with a year or less experience" as novice (p. 224). Yet, despite differences in the defining criteria for novice nurses, their experiences were commonly described by the statement *nurses eat their young* (Egues & Leinung, 2013; Flateau-Lux & Gravel, 2014; Hippeli, 2009; Woelfle & McCaffrey, 2007). This statement, attributed to Meissner (1986), has been used to describe the bullying/hazing experiences of novice nurses when first becoming employed. As part of their initiation into the nursing profession, novice nurses were often assigned to care for complex patients without adequate peer support. The practice of nurses eating their young has been perpetuated within nursing because of the deep-seated belief by some nurses that it is necessary to acclimate new nurses into the hectic and stressful nursing profession (Vessey, Demarco, Gaffney, & Budin, 2009). This approach seems based on the idea that new nurses must be made to feel incompetent and powerless to successfully transition into independent nursing practice.

Research conducted with new nurses, however, identified that being adequately mentored in a way that instils confidence in managing the demands of shift work and the nursing role was essential in helping new nurses transition into the profession successfully (Chachula, Myrick, & Young, 2015). Instead, the practice has been to deny assistance to novice nurses in managing their complex patient assignments. Novice nurses noted how this practice leaves them feeling ineffective and powerless (Chachula, Myrick,

& Yonge, 2015; Cleary, Hunt, & Horsfall, 2010; Crowley, 2012; Ditmer, 2010; Leiper, 2005; Vessey, Demarco, Gaffney, & Budin, 2009; Weinand, 2010), reducing their confidence, and sense of professional self-esteem (Randle, 2003). In accordance with Randle (2003), the practice of nurses eating their young expresses and perpetuates a dysfunctional power dynamic between nurses, as new nurses view their experiences as usual and may end up modeling the same behaviours as part of the culture of nursing, especially at hospital work settings.

2.3 A Closer Look at the Hospital Setting: Characteristics and Organization

Some of the literature reviewed provided support for a relationship between the development of conflict and the characteristics of the setting in which nurses worked (Cleary, Hunt, & Horsfall, 2010; Embree & White, 2010; Myers, et al., 2016; Ditmer, 2010; Hutchinson, et al, 2010; Taylor, 2016; Weinand, 2010; Woelfle & McCaffrey, 2007; Yildirim, 209). Over many years, in many different research studies, hospital-based, acute care nursing has been consistently reported as having more significant levels of conflict than community or administrative-based facilities (Cleary, Hunt, & Horsfall, 2010; Dumont, et al, 2012; Dewitty, et al, 2009; Guidroz, Wang, & Perez, 2012; Jackson et al., 2002; Layne, Anderson & Henderson, 2019; Myers, et al., 2016; Oyeley, Hanson, O'Connor, & Dunn, 2013; Taylor, 2016).

A survey conducted by Dumont et al. (2007) reported that the highest prevalence of conflict occurred between RNs working in the acute care hospital setting (83%). Two years later, Dewitty et al. (2009) reported similar results from their survey that indicated shift work was related to nurses reporting conflict as common or very common. The

conflict was noted to increase from days (51.2%) to evenings (57.7%) to night shifts (64.2%), with RNs working rotating shifts reporting the highest amount of conflict (70%). The length of the shift (8 or 12 hours) was also positively related to increased reports of conflict. Nurses working 8-hour day shifts reporting the least conflict while nurses working 12-hour rotating or combined shifts were said to be more significant predictors of conflict (Dewitty et al., 2009). For example, in the literature on HV, recipients of HV usually reported working full-time hours, and frequent overtime (Woelfle & McCaffrey, 2007; Yildirim, 2009; Dumont et al., 2012; Trépanier, Fernet, & Austin, 2013). Other contextual variables frequently identified in the literature as making the hospital-based setting the most stressful for nurses included inadequate staffing, increased patient acuity, heavy workloads, rapidly changing work environments, and time constraints (Jackson et al., 2002; Becher & Visovsky, 2012). Research showing that when nurses were stressed, overworked, and potentially lacking proper hydration, nutrition and rest, they undergo physiological processes that contribute to poorer decision-making, decreased productivity, emotional exhaustion, and burnout; all of which have been identified as antecedents to CWRs (Guidroz et al., 2012; Oyeleye, Hanson, O'Connor, & Dunn, 2013).

The hospital's organizational structure is defined by the organization's formal policies and procedures regarding its operations, including how nursing work is to be conducted. Nevertheless, the presence of dysfunctional relationships between RN peers also allows the conditions for these policies and procedures to be interpreted in different ways. For example, some nurses who were accused of bullying were able to successfully defend their behaviours as *not bullying* by referencing legitimate organizational processes such as mentoring or providing constructive criticism (Hutchinson et al., 2006; Walrafen,

Brewer, & Mulvenon, 2012). Other times, behaviours perceived by some nurses as a CWR behaviours were argued as being a part of a nurses' professional responsibility to ensure patient safety, and/or to mitigate problems with co-workers that management failed to address (Katrinli, Atabay, Gunay, & Cangarli, 2010; Walrafen et al., 2012).

Other examples in the literature included how nurses could excuse their behaviours by reframing the circumstances that caused them to behave in that manner, including that it was part of the culture of nursing or that they were "sadly caught up in the moment" (Walrafen et al., 2012, p. 9). On the other end, many nurses who were at the receiving side of perceived bullying behaviours sometimes did not view themselves as victims of bullying for the same reasons as noted above. A Canadian study investigating psychological harassment of nurses found a considerable discrepancy between a nurse's exposure to negative behaviours (20.4%) and the nurse's perception of victimization (3.8%) (Fornés, Cardoso, Castelló, & Gili, 2011). Although nurses recognized that they had been exposed to negative behaviours, they did not perceive themselves as victims of harassment because exposure to these behaviours was accepted as part of their stressful and demanding nursing job (Duffy, 1995; Fornés et al., 2011; Hutchinson, 2009).

Some research has indicated that between 28.4% and 77% of nurses have witnessed CWRs between peers, yet between 50% and 80% of the incidents go unreported (Cleary et al., 2010; Ditmer, 2010; Walrafen et al., 2012). One of the reasons suggested for underreporting has been the bully's ability to mask their bullying behaviours by referencing legitimate organizational processes, like those described above (Hutchinson, Vickers, Jackson, & Wilkes, 2006; Lewis, 2004). In other studies that questioned nurses about underreporting, nurses conveyed feelings of uncertainty about

their interpretation of events, with expressions such as *Was that intentional? Am I misinterpreting that?* (Walrafen et al., 2012). Other RNs cited fear of retaliation as their reason for not reporting CWRs (Hutchinson et al., 2006; Vessey et al., 2009). Similarly, bystanders who witnessed CWRs cited how they failed to report the conflict because they felt ashamed or guilty for not intervening to stop it, fearing they would become the next recipient (Cleary et al., 2010; Hutchinson et al., 2006). Another kind of explanation suggests that the emphasis on caring and collegiality in nursing influences why some nurses are reluctant to appear confrontational and fail to challenge bullies or report episodes of CWR events (Padgett, 2013).

In conducting this literature review it became apparent to me that personal and interpersonal explanations for the development of CWRs were insufficient. These types of explanations did not give enough attention to the broader systemic (extra-local) influences permeating ruling relations of nursing practice in hospital settings, beyond the boundaries of nurses' everyday experiences (Campbell & Gregor, 2006; Hutchinson, Vickers, Jackson, & Wilkes, 2006). For this reason, I engaged in a search for these extra-local influences, beginning with the organization of health care in Canada.

2.4 Acute-Care Hospital Services in Canada: Extra-Local Influences

A significant extra-local influence on the organization of the hospital setting and nursing practice is Canada's publicly funded health care system (Government of Canada, 2019; Martin, Miller, Quesnel-Vallée, Caron, Visssandjée & Marchilon, 2018). Under this system, all Canadian residents are expected to be provided with reasonable access to medically necessary hospital and physician services without having to directly pay for

these services (Armstrong & Armstrong, 2010; Martin et al., 2018). The expectations for the delivery of health care in Canada are defined in federal legislation known as the *Canada Health Act* (1984). This act lists the conditions that provincial/territorial health insurance plans must respect to receive federal cash contributions (CNA, 2000; Government of Canada, 2019). The five conditions listed are public administration, comprehensiveness, universality, portability, and accessibility (CNA, 2000; Government of Canada, 2019). However, within the boundaries of these five pillars, each provincial/territorial government is responsible for organization, management, and distribution of health care services (Dixon, 2013). Still, not every Canadian has equal access to health care services, and for those who have access, there are long wait times and a shortage of care providers (Armstrong & Armstrong, 2010; Martin et al., 2018). Additionally, there are many expenses in accessing care, such as transportation and childcare, which are still out-of-pocket.

Due to the evolving nature of health care, changes to and reforms of the delivery of health care services have been required. Based on a neoliberal worldview, some more recent health care reforms have generally included embracing the principles of a market economy and cost cutting for efficiency (McGregor, 2001). As well, the increasing austerity measures in the field of health care have stemmed from the neoliberal fiscal and public policy agendas introduced in the early 2000s (Martin et al., 2018). These measures are most widely applied in hospital setting, where both, patients and health care providers are impacted by these policies that are comprised of government decisions affecting cost, delivery, quality, accessibility, and evaluation. Nursing practice is also affected by government decisions and in the next subsections I explore relevant broader, systemic

pressures or extra-local influences related to the hospital setting and the acute-care organizational structure, specifically looking at those ruling relations directly influencing nursing practice.

2.4.1 The Hospital Setting and Organization of Acute-Care Services

The World Health Organization (WHO) (2013) define acute services as "all promotive, preventive, rehabilitative, or palliative actions, whether oriented towards individuals, or populations whose primary purpose is to improve health and whose effectiveness largely depends on time-sensitive and, frequently rapid intervention (p. 2). Considered to be the most time-sensitive, acute-care serves as an access point to health care for persons with emergent and urgent conditions, encompassing emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care, and short-term inpatient stabilization; playing a vital role in the prevention of death and disability (WHO, 2013). Many acute-care services take place within the acute care hospital setting.

Within the acute care hospital setting, the organization of services continues to be highly influenced by the biomedical model of health and its underpinning philosophies (Mazzotta, 2016). The theoretical assumptions underpinning the biomedical model of health have been highly influential in the development of modern medical practice and subsequently, in the organization of the hospital setting to meet the requirements for the delivery of acute care services (Day, 2013; McEwen & Wills, 2014). As a result, delivery of services is framed to support medical specialization, which has as its main focus the physical aspects of the disease, including bodily management, monitoring, and the

treatment of specific disease(s) (Armstrong & Armstrong, 2003; Farre & Rapley, 2017; Wade & Halligan, 2004). Therefore, health care providers working within most acute care institutions are required to be highly specialized in the knowledge and skills required to fulfil this goal. As bodies are the objects of care, this often results in limited attention given to the psychological, social, and spiritual processes of care within the hospital setting despite rhetoric that suggests these aspects of health care are addressed (Armstrong & Armstrong, 2003; Day, 2013; Farre & Rapley, 2017; Wade & Halligan, 2004).

While recognizing the relevance and useful aspects of the biomedical model, in the period between 1960 and 1980, George Engel (1977) proposed a biopsychosocial approach as a more inclusive model, emphasizing the role of the social, political, economic, and cultural contexts in mediating the experience, diagnosis, and treatment of illness and disease (Engel, 1977; Farre & Rapley, 2017; Russell, 2014). The biopsychosocial model of health has gone on to influence core aspects of medical and nursing practice, education, and research (Farre & Rapley, 2017). For example, RNs are educated on the importance of this model of health as necessary to providing holistic nursing care. Thus, RNs are taught to evaluate all the factors contributing to the patient's disease and illness experiences, rather than focusing on physical factors alone (Farre & Rapley, 2017).

Biopsychosocial aspects of providing care, however, are subjugated in the hospital setting because a greater emphasis and accountability is still on disease treatment and cure, which can be scientifically tested and proven to be cost-effective and efficient (Armstrong & Armstrong, 2003; Rankin & Campbell, 2006; Wade & Halligan, 2004).

Additionally, the biopsychosocial model also has limitations, as it provides little direction to physicians and nurses on how to operationalize it beyond referring patients for services outside of the hospital setting. Although there have been recognized efforts to implement some of the principles of a biopsychosocial model, such as patient-centered care, this model does not have much influence on the larger scale organization, funding, or commissioning of health care services within the Canadian health care system (Farre & Rapley, 2017).

2.4.2 Health Care Changes and Influence on Professional Nursing Practice

Health care reforms have been mainly introduced to address sustainability issues associated with Canada's publicly funded health care system as adopted to varying extents in the different provinces and territories. It involves the delivery of health care services in a more efficient and effective manner, while reducing costs. Some of the factors driving health care costs/changes include an aging population, a rise in chronic disease, treatment and management, and a greater use of sophisticated medical technology (Clarke, Shim, Mamo, Fosket, & Fishman, 2003; Dixon, 2013; Mazzotta, 2016; Salmond & Echevarria, 2017). As a result, the way in which nurses conduct their work has also been reshaped and transformed (Armstrong & Braedley, 2013; Armstrong & Armstrong, 2010; Hartrick, 2002; Rankin & Campbell, 2006; Zboril-Benson, 2002).

Transformations include organizational changes resulting from medical specialization, the addition of multi-skilled workers for direct patient care, and workload measurement tools (Armstrong & Braedley, 2013; Armstrong & Armstrong, 2010; Rankin & Campbell, 2006; Salmond & Echevarria, 2017; Zboril-Benson, 2002). For

example, medical specialization has resulted in hospital units (commonly referred to as *floors or wards*) being organized according to the diseased body part/organ/system and staffed by health care providers with the skills and expertise specific to the care/treatment for that disease (Armstrong & Armstrong, 2010). In addition to this, nursing work in the hospital setting has become fragmented, which is described as a process of breaking nursing care into specific tasks that can be handled quickly by multi-skilled workers who require little training and who can easily be replaced (Armstrong & Braedley, 2013; Armstrong & Armstrong, 2010; Zboril-Benson, 2002). Tasks may include taking vital signs, bathing, feeding, providing medications, and wound care. Fragmentation of nursing care into tasks has been noted to be effective for cost containment in the hospital setting as it allows for the measuring and counting of nursing work with instruments such as workload measurement tools (Armstrong & Armstrong, 2010; Hutchinson & Jackson, 2014; Rankin & Campbell, 2006; Zboril-Benson, 2002). Workload measurement tools have been used in nursing for many years. The purpose of the tool is to allocate a nurse's work based on the assumed time it takes to complete each nursing task. Each nursing task is given a value equivalent to minutes, indicating the total number of personnel minutes required on average to complete each task and the data is used to determine areas where efficiency can be improved (Armstrong & Armstrong, 2010).

Some nurses initially supported the implementation of the workload measurement tool because it was presented to them as a reliable, quantitative way to validate how overworked they were, thus providing evidence to support hiring more nurses (Rankin & Campbell, 2006). However, as reported by Rankin and Campbell, time-based lists of tasks are used as a form of management technology that codified and dictates how nursing

work is completed. Therefore, when the numbers showed nurses were working at a 120 percent capacity during a shift, instead of hiring more nurses to decrease the workload, the workload measurement tool was amended to produce more suitable numbers. This left nurses with feelings of powerlessness to change their working conditions (Rankin & Campbell, 2006).

2.4.3 Nurses Location in the Hierarchy of Medical Dominance

Struggles with powerlessness, autonomy, and accountability of the profession have been noted in the literature for over the past thirty years, resulting in frequent discussions of nurses as being members of an oppressed group (Duffy, 1999; Giddings, 2005; Croft & Cash, 2012; Taylor, 2016). The feelings of oppression experienced by nurses have been recognized in the literature as being related to an organizational imbalance of power within the health professions, a lack of empowerment of nurses, and uncooperative workplace cultures (Embree & White, 2010; Taylor, 2016). While these factors extend beyond interpersonal experiences between RNs, the result of those feelings of oppression have been noted as an antecedent to CWRs between RN peers. For example, nurses who bully have been described as responding to feelings of powerlessness and oppression by manifesting them into aggression, inter-group rivalry, and hostility towards other nurses (Duffy, 1995; Farrell, 2001; Matheson & Bobay, 2007; Randle, 2003; Woelfle, & McCaffrey, 2007; Weaver, 2013). Additionally, oppressed individuals/groups have been known to internalize and perpetuate the norms and attitudes of the dominant group to try to gain a sense of power and control (Duffy, 1995), thus indicating the need for a deeper analysis into the settings in which nurses work and on

those that have conditions favourable to the perpetuation of oppression. Critics, however, argue that oppressed group behaviours within nursing cannot be validated because there is no valid tool to measure oppression, resulting in oppression in nursing being inconsistently and inadequately reported (Farrell, 2001; Matheson & Bombay, 2007).

In this respect, Hutchinson, Vickers, Jackson, and Wilkes (2006) presented a more critical organizational perspective of workplace bullying in nursing. They discussed how oppressed group behaviour theory has fostered only a partial understanding of bullying in nursing and used the work of *Foucault and Clegg's Circuits of Power Model* to present an alternate understanding of how power operates within organizations and its relationship to bullying in nursing. Hutchinson et al. (2006) concluded that a finer-grained analysis is needed regarding the operations of a nurse's workplace to uncover "hidden" processes of power, how these processes are considered routine and self-evident, and how they are used in the act of bullying (p. 123). They emphasized the need to further examine how relationships between RN peers are influenced and justified by rules and power relations within organizations (Hutchinson et al., 2006). The following section highlights the importance of exploring power relations within nursing teams given the significant negative impact that CWRs have on nurses, the health care system, and on the public.

2.5 The Impact of CWRs for Nurses, the Health Care System, and the Public

All the literature reviewed on conflict between nurses reported that it had significant negative consequences on the health and well-being of RNs (Berry et al., 2012; Cleary et al., 2010; Embree & White, 2010; Hutchinson, 2009; Hutchinson et al., 2010; Katrinli et al., 2010; Taylor, 2016; Wilson et al., 2011). When working in settings

where the conflict between nurse peers occurred, nurses reported experiencing high levels of anxiety and stress that negatively affected their physiological, psychological, and social well-being (Ditmer, 2010; Guidroz et al., 2012; Hutchinson, 2010; Roberts, 2015; Yildirim, 2009). The severity of physiological problems varied from weight loss or gain, headaches, and insomnia to more severe symptoms including chronic fatigue, gastrointestinal problems, hypertension, and cardiac arrhythmias (Woelfle & McCaffrey, 2007). Psychologically, nurses reported feelings of decreased self-worth, decreased professional competence, helplessness, and discouragement (Wilson et al., 2011; Yildirim, 2009). After their experience with a CWR, some nurses reported being diagnosed with illnesses such as depression, acute anxiety, and Post-Traumatic Stress Disorder (PTSD) (Hutchinson, 2010; Hutchinson & Jackson, 2014; Myers et al., 2016; Allen, Holland, & Reynolds, 2015; Woelfle & McCaffrey, 2007; Yildirim, 2009). Anger, substance abuse, and suicidal ideations were also commonly reported (Weinand, 2010; Wilson et al., 2011). Socially, CWRs left some nurses experiencing isolation, social stigmatization, and disturbances such as impaired communication both inside and outside the workplace (Lewis, 2006; Yildirim, 2009).

The impact of CWRs on nurses often remains with the nurse even after leaving the setting where the conflict occurred. Hutchison et al. (2010) reported that nurses who left their nursing units because of bullying, despite being successful in their new work, still carried significant legacies of trauma from their bullying experiences. In a survey conducted by Dumont et al. (2012) with 955 nurses on their experiences with HV; 14 of the nurses wrote letters that were not part of the original study design. They felt the need to express how their experiences with HV negatively impacted and continued to affect

their lives. The authors did not include specific statements from the letters in the results of their survey findings, but they did note that the letters were significant because they represented the enormous impact and the strong and enduring emotions that the experience of HV had on nurses (Dumont et al., 2012).

Known to have a detrimental impact on the health and well-being of nurses, some researchers have also explored how CWRs affect the functioning of the health care system by contributing to a toxic (hostile) work environment (Allen, Holland, & Reynolds, 2015; Cleary et al., 2010; McNamara, 2012; Pfeifer & Vessey, 2017). Within toxic work environments nurses were reported to experience increased frustration, stress and anxiety, higher rates of absenteeism, decreased productivity, and decreased personal satisfaction with the job and the profession (Cleary et al., 2010; Hutchinson et al., 2010; Katrinli et al., 2010; McNamara, 2012; Weinand, 2010; Yildirim, 2009). Burnout is one primary symptom noticed in nurses working in a toxic environment (Chachula, Myrick, & Yonge, 2015; McNamara, 2012). Allen et al. (2015) defined burnout to be "a state of physical, emotional, and psychological exhaustion that occurs due to prolonged engagement in work situations that are emotionally exacting" (p. 382). They further characterized burnout as having three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. In this study, emotional exhaustion was recognized as being the most central to understanding burnout from one's work, which is significant considering the caring work associated with nursing practice.

CWRs between RNs is also detrimental to the organization as it has been found to contribute to increased amounts of sick leave usage and increased rates of attrition (Allen et al, 2015; Hutchinson et al., 2010; Layne, Anderson & Henderson, 2019). Frustration,

disillusionment, and burnout were found as the primary reasons for seasoned nurses to abandon their careers with 14% of nurses reporting HV as a deciding factor (Cleary et al., 2010). It is costly for organizations to replace nurses on sick leave and even more expensive to recruit, orient, and replace RNs who leave the profession altogether (Stagg, Sheridan, Jones, & Speroni, 2011). In 2010, the American Nurses Association reported that 53% of nurses considered leaving the profession of nursing altogether because of co-worker conflict. In the United States burnout, job dissatisfaction, and turnover within nursing cost between $32,000 - $64,000 per nurse, or $23.8 billion U.S (Laschinger et al., 2013; Layne, Anderson, & Henderson, 2019). Other studies reported the financial cost to be between $30,000 - $100,000 per year per individual who experienced HV, with the loss of one specialty nurse averaging $145,000 (Becher & Visovsky, 2012). In Canada, retention and recruitment of nurses are important as the Canadian Nurses Association predicts the nursing shortage will rise to approximately 60,000 by the year 2022 (CNA, 2013). With nurses leaving the profession because of CWRs and with a looming nursing shortage, recruitment of new nurses is imperative. However, recruitment and retention of new or novice nurses has been difficult because nurses within this group were also exposed to unethical and unprofessional behaviours from their peers (Read & Laschinger, 2013; Vessey et al., 2009; Woelfle & McCaffrey, 2007).

Up to 60% of novice nurses who experienced CWR were found to leave their first position within six months; 50% of nurses left the job immediately, and 34% of nurses considered leaving nursing altogether (Ditmer, 2010; Flateau-Lux & Gravel, 2014). Having a reputation as a toxic practice environment was noted as making recruiting and retaining nurses in the United States difficult (Cleary et al., 2010; Embree & White, 2010;

Hippeli, 2009). Ditmer (2010) reported that 90% of nursing students voiced their intentions to avoid specific facilities, nursing units, and specialty areas based on their observed or personal encounters with HV. Furthermore, Armmer and Ball (2015) found a positive correlation between HV and intent to leave nursing. Novice nurses were found more willing to leave their positions than more senior nurses. For novice nurses the experience of being bullied was a stronger motivator to part from an organization than was dissatisfaction with salary (Simons & Mawn, 2010). Additionally, the relationship between toxic work environments and RN attrition has significant financial ramifications for health care organizations. These financial burdens, directly and indirectly, have a negative impact on patient care.

Experiencing the adverse effects of working within a toxic work environment compromises a nurse's ability to provide quality patient care. Physiologically and psychologically stressful working environments are linked to an increase in nursing professional error rates, patient falls, adverse patient events, and incomplete nursing tasks (Ditmer, 2010; McNamara, 2012). CWRs between RN peers have been shown to create disruptions in effective communications and working relationships, translating into declines in safe, effective, and quality patient care and poorer patient outcomes (Ditmer, 2010; Flateau-Lux & Gravel, 2014; Katrinli et al., 2010; Weinand, 2010; Yildirim, 2009). In her commentary on HV, Ditmer (2010) reported that 24% of the recorded events that resulted in patient death, injury, or permanent loss of function as being attributed to a lack of, or a fear of, communication. Nurses who had experienced a CWR were either too afraid or too anxious in the workplace to ask the questions needed to provide the best

patient care. The adverse fiscal and patient outcomes reported in this section have prompted concerns about finding ways to address CWRs.

2.6 Strategies Proposed to Address CWRs

Considering the negative impact that CWRs have on the entire health care system, it is important to determine the types of strategies that have been effective and to identify the areas that may not have been addressed. Primarily, two main approaches to address CWRs are described in the research literature. Hutchinson (2009) captured the essence of the approaches in what she termed remedial/corrective strategies and regulatory/restorative strategies.

2.6.1 Remedial/Corrective Strategies

Remedial/corrective strategies rely on the individual experiencing the CWR to identify and address the behaviours (Hutchinson, 2009). Examples of personal actions include exhibiting assertive behaviours, seeking out counseling, and participating in education programs.

Personal Actions

The most acceptable response to co-worker conflict identified in the literature was exhibiting assertive behaviour (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin 2012; Taylor et al., 2016). Assertive behaviours, also referred to as *speaking up* or *whistleblowing*, have been described as the immediate and direct disclosure about the inappropriate behaviour to the aggressor or immediate supervisor, as soon as the incident was recognized (Hutchinson, 2009; Gaffney, DeMarco, Hofmeyer, Vessey, & Budin 2012; Taylor et al., 2016). Immediate disclosure was considered an effective response because it allowed the recipient to regain control over the situation and showed the

aggressor that the behaviours toward them were unacceptable (Leiper, 2005; Broome, 2008). However, Gaffney et al. (2012) criticized assertive behaviours as being problem or emotion focused and found that nurses who used assertive behaviours felt that it minimized the conflict and the negative emotional consequences it had for them.

Other personal actions included participating in counseling on how to maintain a healthy self-view, journaling their experiences, assuming all nurses are bullies and/or avoiding bullies, and not engaging in ingratiating behaviours during a CWR (Broome, 2008; Becher, & Visovsky, 2012). Keeping detailed and factual notes (dates, times, witnesses, etc.) and reporting all incidences of conflict through the proper, established channels were frequently recommended (Broome, 2008; Becher, & Visovsky, 2012), as well as to participate in education and training programs on how to deal with conflict.

Staff Education and Training

The application of staff education and training programs were often noted as a strategy to address conflict between nurse co-workers in the literature. Many different types and levels of training have been implemented, including de-escalation training, conflict management, and crucial conversation training (Cleary, Hunt, & Horsfall, 2010; Dewitty, Osborne, Friesen, & Rosenkranz, 2009; Embree & White, 2010; Laschinger et al., 2013; Weinland, 2010). Initially, the education and training programs consisted of how to cope with adverse effects of conflict between nurses, while more recent research has been conducted evaluating the effectiveness of education and training (Stagg, Sheridan, Jones, & Speroni, 2011).

Resiliency training and cognitive rehearsal training were also frequently referenced in the research literature on conflict between nurses. Sergeant and Laws-

Chapman (2012) described resiliency training as a personal responsibility to develop emotional resilience to achieve success and long-term emotional, physical, and mental wellbeing in the workplace. The expectation is that by developing emotional resilience, individuals would ultimately learn what triggers their stress, how to control it, and how to become more resilient to its effects. Emotional resiliency training emphasized shifting focus away from *avoiding* stress towards *understanding* one's emotional and physical responses to stress. Laschinger et al. (2013) supported the use of resiliency training to help control the adverse personal effects that conflict in the workplace had on students' mental health. The findings from their research revealed the impact of incivility on mental health was lower for those students who had received resiliency training than those who did not. They further discussed how, with time and education, emotional resilience could be a tool to combat conflict in the workplace because it could be taught and developed in nursing students who would incorporate it into their practice as RNs after they graduated.

Cognitive rehearsal training was described (Embree & White, 2010; Stagg, Sheridan, Jones & Speroni, 2011) as a method of preparation that emphasizes stepping away from a moment of potential conflict to process the event, reflect on it, and then respond to it appropriately. Mainly, the training emphasized that rehearsal helps prepare individuals to respond to conflict in ways that could reduce escalation or potentially stop it from happening. This type of training has had some positive feedback from nurses who had taken cognitive rehearsal training workshops. The nurses who participated in the training stated it was beneficial because they felt the knowledge, they received from the training empowered, encouraged, and prepared them to confront conflict (Griffin &

Clarke, 2014). Nurses who took the training thought they were more adequately prepared to handle workplace bullying.

My critique of education and training programs is that, sometimes, they are reactive. Although they may prevent an individual from negatively responding to an event, they still fail to address why the incident had the potential to take place. Many education and training programs only instruct individuals on how to handle a conflict situation when they experience one, with the goal to lessen its adverse effects and limit its potential reoccurrence. Secondly, training such as emotional resiliency endorses the idea of "survival of the fittest" and hardening of the individual as the primary solution to dealing with conflict. Additionally, the term resilience is frequently used without much clarity about what it implies. I believe that it can only be defined in general terms because the ability to become resilient is unique for every person. If one were to assume an individualist conceptualization of resilience, then it would be difficult for any one specific training program to teach different individuals how to actually become resilient. Each nurse would have different personal resources, and unequal amounts of resources, from which they could draw upon to become resilient (Luthar, Cicchetti, & Becker, 2000). As well, within an individualist approach, the broader issues that lead to the development of a CWR are not addressed. Having organizational leaders arrange for education and training is viewed as being representative of the organization's commitment to deal with the issue without really addressing the cause. Current research has indicated that conflict between nurses remains a problem, even when RNs have received formal education about it (Armmer & Ball, 2015).

2.6.2 Regulatory/Restorative Strategies

Hutchinson's (2009) regulatory/restorative strategies referred to actions taken at the organizational level to help lessen the occurrences of CWRs and to have procedures in place to remediate any CWRs that may occur. The most frequently noted regulatory/restorative strategies identified in the research included organizational policies such as zero-tolerance position statements, strong leadership, and promoting a positive workplace culture (Hutchinson, 2009; Walrafen, Brewer, & Mulvenon, 2012).

Organizational Policies Addressing CWRs

Historically, conflict between nurses has not been recognized as the problem that it is today, and it was generally tolerated and accepted as just being part of the job (Duffy, 1995; St. Pierre & Holmes, 2008). The conflict experienced between nurses became a problem for employers in 2008 when the Joint Commission issued a Sentinel Event Alert stating that intimidating and disruptive behaviours in the workplace undermined a culture of safety and that employers needed to address that safety concern (Egues & Leinung, 2013; McNamara, 2012). The Joint Commission is an independent, not-for-profit organization in the United States that provides accreditation and certification to health care organizations regarding the provision of safe and effective, high-quality care (The Joint Commission, 2019). In addition, within jurisdictions in Canada, employers under specific Occupational Health and Safety (OHS) legislation have a general duty to provide all employees with a safe work environment and to provide warnings of any reasonably foreseeable harm (Government of Newfoundland & Labrador, 2014). Employers also must intervene and take reasonable actions to stop or prevent an incident of violence at work (Government of Newfoundland & Labrador, 2014).

However, concerning employee safety, the provincial *Occupational Health and Safety (OHS) Act* (2014) of Newfoundland and Labrador (NL) only broadly addresses employee protection from physical harm and very few directives specifically address co-worker conflict. Despite CWRs causing personal injury, (such as the physical manifestations of stress and anxiety) to nurses in NL, it seemed that only when the conflict between co-workers was connected to the culture of safety and to the effective functioning of health care organizations were formal statements drafted and policies implemented to address the issue. So far, official announcements have been prohibitive statements about violence and bullying, with suggestions for codes of practice and guidelines regarding prevention, early intervention, and management (Hutchinson, 2009). The most frequently noted formal statements were zero-tolerance position statements (Becher & Visovsky, 2012; Egues & Leinung, 2013; McNamara, 2012; Stagg, Sheridan, Jones, & Speroni, 2011). Zero-tolerance position statements have been described as the organization's written commitment not to tolerate any bullying behaviours. They have been used to spur the creation of formal policies and procedures for reporting and mitigating conflict events (Becher & Visovsky, 2012; Egues & Leinung, 2013; McNamara, 2012; Stagg, Sheridan, Jones & Speroni, 2011).

In 2001, the American Nurses Association (ANA) developed position statements regarding workplace violence in the form of checklists, codes of conduct, and a N*urse's Bill of Rights* (ANA, 2001; Ditmer, 2010). Right number four in the nurse's bill of rights states that nurses have the right to work in a safe, respectful and supportive environment, and the right to advocate for themselves without fear of retribution (ANA, 2001; Ditmer, 2010, p. 12). Nurses in the United States have responded favourably to the nurse's bill of

rights and very few updates to the bill have been made throughout the years (ANA, 2018). With the implementation of the bill of rights in the workplace, some nurses reported decreases in nursing errors and turnover, increases in work productivity, and increased quality of care (Ditmer, 2010).

Nurses also have an ethical and legal duty to report conflict according to their code of ethics (CNA, 2017). However, despite nurses being accountable to report incidents of conflict, review of the literature revealed that on numerous occasions, nurses who reported bullying and/or horizontal violence experienced retaliation and/or escalated bullying (Hutchinson, 2009; Croft & Cash, 2012) with little attention being given to investigating how bullying continues to happen.

Formal statements and policies regarding conflict in the workplace have been valuable because they reinforce both the employer's and employee's accountability for their attitudes and behaviours and strengthen leadership responsibility to address conflict events in real-time by instituting corrective actions (Amrein, 2012; Becher & Visovsky, 2012). The employer can fulfill the duty to address occurrences of CWRs through the development of formal statements and policies, but the onus to initiate the policy or procedure is still dependent upon the individual RN. Additionally, the effectiveness of prohibitive policies has been called into question because nurses continue to report increasing levels of exposure to violence and bullying (Hutchinson, 2009; Taylor, 2016). Therefore, robust leadership has been referred to as being necessary for policies to be effective. This includes ensuring that all employees are aware of the policies and that the policies are enforced by all levels of management (Stagg, Sheridan, Jones, & Speroni, 2011).

Strong Leadership

Strong, appropriate leadership has been noted to play a critical role in the effectiveness of strategies to lessen the occurrence of CWRs (Ditmer, 2010; Dumont, Meisinger, Whitacre, & Corbin, 2012; Trepanier, Fernet, & Austin, 2012; Weinland, 2010; Woelfle, & McCaffrey, 2007). Many nurses indicated they failed to report incidents of HV because they felt no action would be taken by management thus making reporting useless or because they were unfamiliar with the procedure for reporting (Cleary, Hunt & Horsfall, 2010). Leaders must demonstrate a sound organizational commitment to interventions for the prevention of conflict while ensuring adequate communication between all staff.

The demands of the clinical environment were also noted to increase the stress and anxiety levels experienced by nurses. High levels of stress and anxiety have been identified as precursors to poor working relationships and the development of CWRs (Chachula, Myrick & Yonge, 2015; Laschinger, Wong, Cummings & Grau, 2014). However, engagement with leaders who used transformational, resonant, and authentic leadership styles was found to offset high levels of stress and anxiety.

A transformational leadership style refers to leaders that adhere to a leadership style that is inspirational and based on motivation (Hartrick & Varcoe, 2015). An authentic leadership style is based on the credibility, respect, and trust of followers by building networks of collaborative relationships, emphasizing strengths, and encouraging diverse viewpoints (Hartrick & Varcoe, 2015; Burns, 1978). A resonant leadership style has been defined as a type of relationally focused leadership that is grounded in emotional intelligence (Laschinger, Wong, Cummings & Grau, 2014). In addition to leadership

style, continuing education for nurse leaders was found to be important. Education aimed at increasing leaders' knowledge and skills concerning leadership styles, as well as knowledge about conflict management and resolution were found to contribute to a workplace culture that did not support or foster conflict (Dewitty, Osborne, Friesen, & Rosenkranz, 2009).

Cultivating a Positive Workplace Culture

Cultivating a positive workplace culture was universally presented in the research literature as being a viable method to address CWRs between nurses (Bowen, Privitera & Bowie 2011; Scott, Mannion, Davies & Marshall, 2003). As some organizational cultures are thought to perpetuate CWRs (Myers et al., 2016), culture change has been described as a requirement for a successful reduction in CWRs (Bowen, et al., 2011; Laschinger, Wong, Cummings, & Grau, 2014; Myers et al., 2016; Scott, et al., 2003). For example, group affiliation, teamwork, and cooperation were associated with greater success in implementing organizational change to reflect a culture that will not tolerate bullying (Scott, et al., 2003).

In 2011, Bowen, Privitera, and Bowie highlighted models and methods for best practice that could be used to prevent and manage workplace incivility (WPI) and workplace violence (WPV). Positive behavioural supports, formal policies, procedure reviews, and staff input, in addition to strong leadership, also helped staff move from a toxic work culture to a beneficial work culture, which meant a physical, emotional, and psychologically safe environment. Improvements to the immediate practice environment of nurses have been found to have positive effects on reducing staff nurse absenteeism, improving patient and staff satisfaction, improving nursing quality indicators, and

reducing occurrences of staff conflict (Nayback-Beebe et al., 2013). Nayback-Beebe et al. found that adequate support from leadership was essential for the successful implementation of positive work environment initiatives.

2.7 An Alternative Way to Investigate CWRs

The literature review allowed me to critically evaluate the many aspects of CWRs explored and to identity that there is limited research examining the organization of nursing practice and how that organization might contribute to the co-creation of toxic environments conducive to the development of CWRs. It is important to understand the way this dynamic has contributed to the development of a profession where CWRs have become acceptable, normalized, and often unrecognized by RNs (Croft & Cash, 2012; Hutchinson, Vickers, Jackson, & Wilkes, 2006). There is a need to comprehend how conflicting relationships are generated, interpreted, and embedded within power structures arising from interaction with local and extra-local contextual influences. To gain a fuller picture of CWRs between nurse peers we need to supplement existing research and shift attention away from *why* conflict between nurses occurs to investigating *how* it occurs. Specifically, I am using IE to research how nursing practice is organized and identify what aspects in the organization are more likely to generate CWRs.

2.8 Chapter Summary

In this chapter, I provided a critical appraisal of the research literature on CWRs. This appraisal began by looking at the research attributing the development of CWRs primarily to individual and interpersonal factors. I then reviewed the research that

extended beyond individual factors to examine the organizational culture of the hospital setting. This included examining the literature about the Canadian/provincial health care system and the way that acute care and hospital services are organized, to identify key influences having an impact on nursing practice. To provide a more comprehensive review of the literature, I examined the negative outcomes of CWRs for nurses, the health care organization, and the public. I then summarized the strengths and limitations of strategies used to address CWRs. I concluded the chapter my rationale for using IE as the most appropriate method of inquiry to explore this topic.

Chapter Three - Institutional Ethnography

In the opening paragraph of her book, *Institutional Ethnography as Practice* (2006, p. 1), Canadian sociologist Dorothy Smith explained the method of inquiry that she developed:

> Institutional Ethnography is committed to exploration and discovery. It takes for granted that the social happens and is happening and that we can know it in much the same way as it is known among those who are right in there doing it. With this difference: institutional ethnography is committed to discovering beyond any one individual's experience including the researcher's own and putting into words supplemented in some instances by diagrams or maps what she or he discovers about how people's activities are coordinated.

In this chapter, I introduce institutional ethnography (IE) as a method of inquiry and provide information that is essential to understanding this type of research inquiry. I begin with a description of the theoretical foundation underpinning IE including its epistemological and ontological assumptions. This is followed by a clarification of IE's unique key terms. Then, I describe IE's two main points of departure, and my position as a researcher, followed by a description of the research methods I used. I conclude this chapter with a description of the measures that I took to guarantee quality in this qualitative research.

3.1 Introduction to IE

As briefly defined in chapter one, IE is a method of inquiry located within the theoretical approach known as the social organization of knowledge (Campbell, 2006, p. 91). The social organization of knowledge stems from an ontological assumption that all knowledge is socially produced, coordinated, and negotiated by social beings engaged in ongoing social relations (Campbell & Gregor, 2008, Rankin, 2017a). Used in this context,

"social relations" refer to the decisions and actions that people make and take in everyday life and how they are coordinated with other events taking place across multiple settings and with multiple participants, who are not necessarily or always present or known to each other (Campbell & Gregor, 2008, p. 27; Smith, 1995). Social organization, therefore, refers to the "interplay of these social relations" (Campbell & Gregor, 2008, p. 27).

At the core of an IE study is an epistemology that insists on empirical descriptions of a social world being coordinated to occur in a certain way. Therefore, any reference to *reality* is supported by the data collection and findings that are used to describe a coordinated "world empirically in common" that can be agreed upon by multiple participants in various locations (Rankin, 2017b, p. 2). IE is not designed to focus on an individual's experience; instead, the IE focuses on institutional processes with the purpose of revealing the ruling relations (connotation clarified in the next section) that shape experiences (DeVault & McCoy, 2006; Smith, 1990a). IE is therefore used to unveil the social and ideological processes that produce experiences of subordination. Unveiling these processes for those who live these experiences increases their knowledge about the processes organizing their decisions and actions, creating room for further contemplation or action (Campbell, 2006; DeVault & McCoy, 2006; Rankin, 2017b).

Those reading the research outcomes of IE investigations must have a clear understanding of the theoretical foundation and conceptual framework of IE, as well as the technical terms used to communicate the research process.

3.2 Theoretical Underpinnings of IE

In developing IE, Smith was influenced by the theoretical underpinnings of Feminism, in particular feminist standpoint theory, and Marxism. She also drew upon Foucauldian discourse analysis, Ethnomethodology, and symbolic interactionism. Originally, Smith developed IE as a sociology *for* instead of *about* women (Campbell, 2003; DeVault & McCoy, 2006; Smith, 1990a, 2005). As a feminist scholar and a professor of women's studies, Smith noticed how male dominance within contemporary society was sustained by conditions that deprived women of an active voice in literature, research, and other cultural productions, reinforcing women's oppressive relations (Campbell, 2003; Smith, 2005). Therefore, she introduced IE into the scholarly discourse to make women's invisible work more visible and to give voice to the oppressed (Campbell & Gregor, 2008). Smith was interested in examining how things worked, from the standpoint of people, as they conducted the activities of their daily lives. As Smith continued her transformation of sociology, she determined that IE was not only a sociology for women, but that it was also useful in addressing oppressions of all kinds (race, class, gender, etc.) (Campbell & Gregor; Smith, 2005; 1990a).

Consistent with Marxism, Smith viewed the patriarchal ideology of society as keeping women and men in traditional gender roles to maintain male dominance. The male domination of the means of production and economic power in society was the motive behind all social and political activities. Women would represent the oppressed class where their contributions to the material and intellectual forces of society were inadequately or incorrectly recognized, keeping men in positions of power and ruling (Campbell, 2003; Smith, 2005). Although Smith's concept of ruling relations originated

in Marxism, she explained how practices of domination and subordination in contemporary times were vastly different from class oppression in the nineteenth century. Today, methods of ruling relations are expressed using technologies such as texts, language, and expert knowledge (Campbell & Gregor, 2008).

IE was developed to examine and make explicit the connections between the use of these technologies and domination, echoing Foucault's argument that institutions overtly regulated and controlled social life in ways that made people conform to social norms (Smith, 1987; 2006). Foucault maintained that discourses usually informed the dominant ideological ways of thinking which governed social life (Foucault, 1995; St. Pierre & Holmes, 2008). In IE, institutions as ruling relations are not theoretical; instead, they function as part of a documentary society, where the members of the society design, circulate, handle, and inscribe documents and texts (Smith, 1987; Smith, 2006). As I will explain in sub-section 3.3.2, Smith (1999) referred to this as textually mediated social organization. She discussed how individuals are involved in their ruling because they are the ones who handle and activate the texts as the instruments of their ruling. Smith, unlike Foucault, goes one step further and examines the interrelationship between the actions of individuals and the part that individuals played in their own ruling.

As in ethnomethodology, IE investigations begin with the embodied experiences of people. Smith asserted that an investigation should start from the standpoint of the subject as expert, to illustrate something *troubling* or a disjuncture occurring within his/her life. In this way, researchers can compare the differences between a person's own embodied and intuitive ways of negotiating life's demands with how these experiences are written in traditional sociological accounts and other documentary conceptual

practices of power. Unlike ethnomethodology, investigators using IE view people and their talk not as the objects of analysis, but as the entry points into exploring extra-local forms of power organizing knowledge. Influenced by symbolic interactionalism, IEers explore people's experiences of being ruled by examining how language and texts are activated and interpreted within a set of social relations that results in socially appropriate responses.

3.3 Terms Fundamental to Understanding IE

To fully grasp IE as an approach to research, it is necessary to have a thorough understanding of the specific meaning behind the technical terms used to describe the research process. In the following sections, I provide an overview of the terms foundational to IE including standpoint, work, and work knowledge, texts, text-mediation, ruling relations, disjuncture and problematic.

3.3.1 Standpoint, Work and Work Knowledge

To begin an inquiry, researchers using IE commit to taking the "standpoint of those who know their everyday world and showing them how that everyday world is socially organized" (Smith, 2005; Smith, 2006; Townsend, 1996, p.181). *Standpoint* is a critical element in IE because, where one stands determines what one experiences, and therefore, shapes what can be known, and consequently, what remains unknown (Campbell, 2006; Rankin, 2017b). Standpoint does not mean a person's physical location within a specific setting. It is meant to refer to a person's unique position within a complex of ruling relations that are intertwined and interrelated to other standpoints. Individual participant standpoints are different because they have varied embodied

experiences with subordination and ruling stemming from their unique position within the institution. The terms *institutional* and *institution* refers to a complex set of relations forming part of the ruling apparatus – organized around a specific function, which in the case of my research is professional nursing practice (Smith, 1987).

Researchers study and use what the participants can tell them about their everyday actions to discover how power is operating and coordinating their daily lives (Campbell & Gregor, 2008; Smith, 2006). The interest in the participant's standpoint is empirical, meaning that the experience as told by the participant is used as the foundation to build an account of how things are being organized and coordinated (Rankin, 2017b).

The concepts of *work* and *work knowledge* are viewed as the fundamental grounding of social life and are what the researcher draws upon when talking to participants (DeVault, 2006). *Work* in IE refers to what people do (taking time and effort) under certain conditions, and with definite resources; it does not necessarily apply to paid employment (Smith, 2005; 2006). Smith (2005) defined *work knowledge* as what people can tell others about their everyday work practices and how they are connected to the work of others, active in the same process. Researchers analyze the participant's experience (and associated work processes) as a point of entry to investigate which of the participant's activities are recognized and accounted institutionally and which are not. To find out how things work and happen the way that they do, researchers must listen for and ask about texts and text-based knowledge forms used and/or referred to in the construction of the experience. Texts are identified through exploratory interviews, through preparatory work and/or through the researcher's prior expertise with the topic explored (DeVault & McCoy, 2006).

3.3.2 Texts, Text-Mediation, and Ideology

Texts in IE are words, images, representations, or sounds that are set in a reproducible material form (Smith, 2006). Once a text is read, heard, seen, watched, or otherwise activated, the same message is delivered to different individuals engaged with the same text (Smith, 2006). Texts are examined because they are thought to insert institutional interests and values into the local setting to coordinate work and control how work is supposed to happen (DeVault & McCoy, 2006). Smith coined the term "textually-mediated social organization" to express how engagement with texts can organize the activities/work of people and the role they play in the management of people's lives (Smith, 1999; Campbell & Gregor, 2008, p. 29). Smith further refers to texts as an "occurrence" in an ongoing activity (Smith, 2006, p. 67).

IE is meant to expose the organizing power of texts, which has often been taken for granted by those who use them (DeVault, 2006; Smith, 1999). The idea is to make visible how activities in local settings are coordinated and managed extra-locally by using texts (Campbell & Gregor, 2008). Individuals within the local setting, without much conscious thought, instinctively seek out and activate texts and text-based knowledge forms, unaware of how their activities are being coordinated from beyond the local setting (DeVault, 2006; Rankin & Campbell, 2009; Smith, 1999). By using common texts, people who do not know each other, working across different geographical sites, are coordinated to act in the same way (Campbell & Gregor, 2008).

Additionally, people who interact face-to-face may not recognize how their knowing and interactions have been informed and shaped by texts and it is this form of text-mediated discourse that institutional ethnographers (IEers) are interested in exposing

(DeVault & McCoy, 2006). IEers are interested in exposing how text-mediated discourse can frame ideas and issues and establish terms, concepts, and ideologies, which individuals will consistently draw upon when describing their work, legitimizing how it *should* be conducted/completed (DeVault & McCoy, 2006; Townsend, 1998).

How people know what they know, and how it is disseminated and reproduced represents ideologies. Following the tradition of Marx and Engels, ideologies have been defined as the prevailing ideas of an era, associated with the dominant ideas/values/beliefs of the ruling class. Ideologies reflect a way of thinking by individuals, groups and/or cultures that represents an undisputed knowledge and acceptance of the "natural" way things are (Taylor, 1997; Townsend, 1998; van Dijk, 1998). As previously explained, Smith borrows from Marx the notion of ideology and that the dominant ideas are those of the ruling class. Further, Smith also investigates how ideologies are perpetuated by the ruling class through texts and text-mediated discourse. Therefore, texts are implicated in ruling.

Through the analysis of texts and text-mediated discourse, researchers can make explicit how people and their activities are related to each other in predetermined ways through their social organization (Campbell & Gregor, 2008). Texts, and the concepts, values, and ideologies they represent (text-mediated discourse) have the power to dominate and coordinate the actions of others involved in the same processes, and this is what Smith refers to as *ruling relations* (Hart & McKinnon, 2010; Smith, 2005).

3.3.3 Ruling Relations

Smith (2005) defined ruling relations as the "extraordinary yet ordinary complex of relations that are textually mediated that connect us across time and space and organize our everyday lives" (p. 10). Smith uses the notion of ruling as "a way of understanding how power is exercised in the local setting to accomplish extra-local interests" (Campbell & Gregor, 2008, p. 36). The person's embodied knowledge of the everyday world provides the point-of-entry into exploring ruling relations, as these ruling relations coordinate what people know about what is happening and how work is accomplished (Rankin, 2017b). People's knowledge and experience reveal threads of information that can be tracked to illuminate what happens in the process of ruling, with the underlying assumption that we are all organized to participate in and maintain ruling relations (Rankin, 2017b). The researcher will encounter many instances of hidden ruling relations that can be made visible to those participating in the research, thereby providing a valuable knowledge source for people whose everyday activities are being organized against their interests (Rankin, 2017b).

Those taking part in the research inquiry and other individuals working in the same organizational space do not have the same standpoint, as they might be located in different positions within the complex networks of local and extra-local ruling relations. Therefore, aspects of the ruling relations are not visible to all those who occupy different standpoints within the institution. Instead, RNs conduct their activities routinely as part of a situated context (e.g., the nursing unit), which is further organized within the hospital setting, as located within the context of the provincial health care system and broader socio-political influences. How one's actions in their immediate (local) setting are

informed appears hidden from view, because the coordination of the activities occurs outside their immediate setting (extra-locally) (Smith, 1987). Nurses might not give much conscious thought to how their work has been coordinated through texts for purposes beyond their individual involvement.

3.3.4 Disjunctures and the Problematic

Smith (1990) described *disjuncture* as knowledge of practices or processes constructed from ruling relations, which conflict with knowledge of practices or processes stemming from an embodied or experiential perspective. The interview process allows the researcher to gain knowledge of the practice or process from the person living the experience. The researcher is then able to reveal and describe how accounts differ or are disjointed from the abstracted account of the experience (Rankin, 2017a; 2017b). A disjuncture may be obvious, such as working past end of shift, when you are not supposed to be working after the shift ends. Other times, disjunctures will not be recognized by those experiencing them; instead they may state that they feel that something is not happening the way it is supposed to, even though they are experiencing it, they cannot name it – a "recognition that something chafes" (Campbell & Gregor, 2008, p. 48).

Problematic is a disjuncture that may not always be recognized by those directly involved. Smith (1987) used the word *problematic* to refer to "a set of questions that may not have been posed or a set of puzzles that do not yet exist in the form of puzzles but are "latent" in the actualities of the experienced work" (Smith, 1987, p. 91). The problematic identifies how the researcher will navigate the research, from the standpoint of those who

need to know what is happening and answering the question “how does it happen to us as it does?” (Smith, 1987, p. 154).

3.4 Institutional Ethnography Points of Departure

Being driven to discover *how things happen*, IE assumes two main points of departure. Firstly, IE assumes that *social happenings* consist of the concerted (coordinated) activities of people. Therefore, the researcher must position themselves from the standpoint of a group of people. To do this, the researcher first actively listens to and/or observes (through interviews, focus groups or participant observation) the descriptions of accounts of daily/nightly work, this is called first-level data generation. The experiences generated are the ground zero of analysis; an analysis begins with the experience and returns to it, having explicated how it was coordinated to happen the way that it did (Rankin, 2017b).

Next, the researcher shifts attention away from the particular experience recounted and focuses on the institutional practices used to coordinate the work. This component of the investigation generates second-level data. Here the researcher takes what those participating in the research have expressed about what they know and uses it to gather further data on how that knowing was generated (Campbell & Gregor, 2008; Rankin, 2017a). As expressed previously, IE assumes that in contemporary society, local practices and experiences are tied to extended social relations or chains of action mediated by documentary forms of knowledge and text-mediated discourses (Rankin, 2017a). Therefore, the researcher pays careful attention to how texts were referenced and activated, tracing how those texts and text-mediated discourses organized activities to

accomplish institutional goals (Campbell & Gregor, 2008; Rankin, 2017a). Before referring to the process of data generation, I will first position myself as a researcher using IE.

3.5 Positioning Myself as a Researcher

The researcher using IE also acknowledges how she/he/them are immersed in ruling relations, and therefore actively practices personal reflexivity to recognize how their knowledge and perspectives have been both influenced and influential throughout the research process (Finlay & Gough, 2003).

Reflexivity refers to the continuous process of critical self-reflection in which qualitative researchers engage to generate a personal awareness of their actions, feelings, and perceptions and how they influence the research process (Darawsheh, 2014; Finlay & Gough, 2003). Used as a tool, reflexivity helps researchers to explore their experiential knowledge and assumptions about the research topic; to identify and make transparent the perspective that they bring to the research (Finlay & Gough, 2003; Liberati, Gorli, Moja, Galuppo, Ripamonti, & Scaratti, 2015; Maxwell, 2005). Through their reflexive accounts, the significance of the researcher's presence and impact on the collection, selection, and analysis of data are examined and made transparent (Finlay & Gough, 2003). One of the strengths of IE is that the researcher, through their reflexive accounts, can add to data generation by incorporating their standpoint regarding the research topic into the standpoints of others and to explicate how events were constructed (Campbell & Gregor, 2008). This process aligns with a social constructionism epistemological stance. While the term epistemology involves "the study of the nature of knowledge and justification"

(Carter & Little, 2007, p. 1317), social constructionism regards knowledge as being relative to one's location within a set of social norms and views all claims to *truth* or *reality* as socially constructed expressions of power (Cruickshank, 2012: Derher, 2016). Although social constructionism was the rational choice for me to conduct this research, it was only through the research process, with all the stumbling blocks, did I come to appreciate and adopt that stance.

A researcher's questions and epistemological stance influences their selection of how best to proceed with any research. IE was chosen as my method of inquiry because IE accounts for social relations and how they are related to power (Campbell & Gregor, 2008). A method of inquiry guides how the research will be conducted, including the relationship between the researcher and the other taking part in the research, as well as the method for data generation and analysis (Carter & Little, 2007). IE, like other qualitative methods, assumes that all knowledge is socially organized and constructed, and that knowledge carries with it interests that are embedded within its construction (Rankin, 2017b). Therefore, as previously stated, the task of a researcher using IE is not to uncover truths about reality or knowledge, instead, researchers using IE insist on empirical descriptions of a social world happening and refers to *reality* as the descriptions of an empirical world in common (Rankin, 2017b). The IE method of inquiry does not rely on notions of objectivity to produce "validity." It does, however, strive to produce accounts that are accurate representations of how things actually work, going beyond the lived experience of people to explicate how that experience happened as it did (Webster, Bhattacharyya, Davis, Glazier, Katz et al., 2015).

Being an RN who has worked in the hospital setting and who has experienced CWRs, I am an *embodied knower*. As such, I am accustomed to speaking within the ruling discourse and trained to use the very concepts and categories that IE researchers wish to unpack. I had to recognize that I too was enmeshed within the social organization of the work of nurses and the ruling ideas of that organization, referred to by Smith (2005) as *institutional capture*. Therefore, to avoid institutional capture as I conducted the research, I needed a method to examine my prior assumptions and judgments. To accomplish this, I wrote two reflexive accounts, a previous draft at the onset of this research and the one that I shared as part of the introduction to this dissertation. In the shared account, I was able to comment on the insights I gained during my reflexivity practice and how those insights transformed my thinking and were helpful in shaping the research process.

I have had many years to reflect on my experiences with CWRs. During this time, I have worked hard to move beyond my experiences and learn from them. My past experiences undoubtedly have shaped how I relate to people (at work), as I do not want anyone to experience any CWR when working with me. However, it was not until I started this research process that I came to realize that I was experiencing institutional capture, where I accepted the ruling ideas of the individualist paradigm and enacted the role of victim versus bully. I faced many obstacles in the research process because of my mindset and although I wanted to adopt a social constructionist epistemological stance, it took me some additional time, self-reflection, and guided learning to shift my thinking towards a more critical self-reflexive mindset.

3.6 Description of the Research Process

After obtaining ethics approval from both the Human Research Ethics Authority (HREA) of Memorial University and the Research Proposal Approval Committee (RPAC) within the Eastern Regional Integrated Health Authority, I began the research process. Participant selection was predetermined by the course of inquiry as I put out a call for RNs who have experienced CWRs in their practice using recruitment flyers (Appendix A). The recruitment flyers provided information about my research aim and participant involvement. My contact information was provided for nurses to use to volunteer to participate. Snowballing was also used as a recruitment strategy, as many RNs who volunteered knew of other nurses who may have wanted to participate.

Many nurses were already aware of my research interests in CWRs between nurse co-workers. They have heard about my research through my oral presentation at Eastern Health's Nursing Research Symposium (NERC); from my research proposal presentation at the Newfoundland Labrador Centre for Applied Health Research (NLCAHR) Bullying Exchange Group meeting; and my poster presentation at Conference on Workplace Harassment and Violence Research, Policy and Practice hosted by NLCAHR. Over the years, many nurses have approached me after such presentations and unofficially told me tidbits of their tales of conflict. Additionally, going through a Doctor of Philosophy (PhD) program at Memorial University of Newfoundland (MUN), I had presented my research interests four times during the People's Health Matters Seminars as part of my seminar series course. In total, of the seventeen nurses I interviewed, only five nurses had no prior knowledge of who I was, or what my research interests were. My acquaintance with the

participants was recognized as a potential bias in the research process that will be discussed further in Chapter five, section 5.4.1.

3.6.1 Formal, Semi-Structured Interviews

Entering the research from the standpoint of nurses and as a nurse myself, I became aware of the disquiet involved in a CWR. During the interviews, I did not focus primarily on individual nurses or their experiences. Instead, I focused on the social organization and/or the structures/forms of ruling of the work of nurses in relation to CWRs and how different nurses accounted for these relations. The first set of interviews (1-12) took place over three months (November 2, 2016 to February 2, 2017). I conducted a second set of interviews (13-17) from June to September 2018. I used formal interviews to make an ethnographic account of the nurses' knowledge and experience; what they did every day, and how they expressed this knowing and doing in their terms (Appendix B). Formal, semi-structured interviews were essential to anchor the research from their standpoint and to preserve the presence of those taking part in the research as the subject matter expert (DeVault & McCoy, 2006; Smith, 2005).

I used an interview guide only to prompt me to explore more fully the data generated. Through the stories and descriptions generated, I was able to identify some of the trans-local (connecting) relations, discourses and institutional work processes that were shaping their experience with the CWR. After each interview, I reflected on the information provided in the accounts and my reaction to what was said. After the first 12 interviews, it came to my attention how my previous personal experience with CWRs was still influencing the way I asked the questions and how the interviews were conducted. I

began to see how my experiences and preconceptions of CWRs hampered the research process as I remained embedded within the institutional discourse of nursing and sometimes failed to seek clarification about some topics or threads of information. As a result, I had to revisit my first 12 interviews and recruit five additional nurses, for a total of seventeen nurses taking part in my research. Limitations experienced in the interview process are further discussed in 5, section 5.5.1.

The interviews lasted between 40 and 120 minutes and began with me thanking the RN for volunteering to participate and reviewing the consent to participate form, followed with an explanation of the purpose of my research and the type of questions I would be asking. I then asked a series of open-ended questions. I began the interview by asking about professional background, perceptions of the work of nurses and thoughts on the relationships between nurses. I followed those questions with questions regarding their specific CWR experiences and their thoughts on the establishment of more positive working relationships between RNs. Interviews were recorded and transcribed. These procedures were essential to developing detailed and systematic interpretations of the data generated, and it allowed for a more rigorous approach to data generation and analysis.

Throughout the interview process I was mindful to make note of the social and ruling relations shaping the CWR experience and peer relationships that were not wholly known to them. I did not use interviews to gain access to these extra-local processes and second level data. Instead, I followed the descriptions of institutional work processes, noting how texts and textual discourse coordinated activities and behaviours across time and place within institutional relations. I then conducted a detailed text analysis to gain a

more complete understanding of the textual forms and practices of knowledge organizing those work processes and working relationships between RN peers.

3.6.2 Text Analysis

Text analysis as a method of data generation assumes that the ideas, plans, and activities of individuals do not happen haphazardly, but instead are coordinated to occur as they do through the use of mediating or governing texts (Campbell & Gregor, 2008, Rankin, 2017a; Smith, 2001; Smith, 2006, Turner, 2006). Asking about texts and listening for the use of texts as the nurses described the details of their work at the time of their CWRs experience enabled me to map the construction of their experience beyond the local level and illustrate the extra-local social organization and ruling practices governing the work of nurses and influencing their experiences.

As I have already mentioned, ruling practices are accomplished through the use and activation of texts by people. It is through the activation of texts that an individual (or individuals) knowingly (or unknowingly) use a text to guide or influence their work (Smith, 2005). In this way, texts can coordinate actions to achieve outcomes in specific ways and as such, establishes rules, routines and/or practices/cultures that groups of people within the same institution are expected to follow. For example, texts are used to coordinate the activities of nurses in the hospital setting (local) to satisfy the agenda of others (e.g., government decision makers) outside of the hospital setting (extra-local). The coordination of activities of people across multiple settings is usually unseen from the standpoints of those within the local setting (Campbell & Gregor, 2008; Smith, 2006; Turner, 2006). This does not mean that a nurse does not have any autonomy in their

decision-making; it only refers to the way nurses are expected to perform. An example of one such text would be the Association of Registered Nursing of Newfoundland Labradors (ARNNL) *Standards of Practice for Registered Nurses* (2013).

As an RN, I already had knowledge about documents governing the expectations for nurses. For example, I began my text analysis with broad governance documents such as the ARNNL's St*andards of Practice for Registered Nurses* (ARNNL, 2013a) and the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* (CNA, 2017). I started with these two documents because they outline the expectations required for professional nursing practice in all practice settings including the expectations for collegial working relationships. Although I began my text analysis at this time, all descriptions of my text analysis will be presented in chapter four.

During the interview process, I noted many additional texts that could be implicated in ruling relations as the nurses described the details of their workday/night when they experienced a CWR. These texts included models of care and numerous employer-specific policies. I made a list of all the texts identified during the interviews (Appendix C) to demonstrate the complexity of the social organization of knowledge pertaining to nursing work. This is important for data analysis because nurses are governed by employer agency policies and are held accountable to meet the expectations of their regulatory body, professional association, and union. However, only those texts and the subsequent text-mediated discourse related to the social organization of nursing practices and CWRs were analyzed. These were identified by bolding in the list of texts. I then drew a visual representation of the connections in the process called mapping.

3.6.3 The Process of Mapping

Mapping is a process where first-level data gathered through the interview is combined with second-level data gained through analysis of texts (and other institutional practices) to construct a visual representation (or map) of the social organization of the phenomenon explored (Campbell & Gregor, 2008; Rankin, 2017a; Turner, 2006). The IE method of inquiry guides the researcher to move analytically from the ethnographic description of the local environment to the explication of the ruling relations that coordinate people's knowledge and activities (Rankin & Campbell, 2009). By using IE, the researcher makes links empirically, not theoretically, about how things are happening (Rankin & Campbell, 2009).

By mapping connections and making them visible, the researcher gains access to ruling relations (Campbell & Gregor, 2008). Rankin (2017a) states the "expressed purpose of IE is to generate potentially useful knowledge for people whose everyday activities are being organized against their own interests" (p. 1). The ruling relations identified through the nurses' accounts of how they conducted their work, including their colleague relationships, is traced back to the source of that information and the ideologies they created. The goal of tracking is to display what is happening and to describe the features of the social practices and their respective material forms and relationships (Rankin, 2017a). Through mapping, the implicit knowledge and ruling practices taken up and used by RNs are made explicit, bringing awareness to RNs of where these ideologies come from and how they influence their behaviours and interactions with peers. By establishing an objective account of how CWRs experiences between nurses may be generated through the conditions of their work and institutional practices, nurses can use

this information to stimulate a new type of dialogue about the working conditions needed to help support more positive relationships between nurse peers.

3.7 Measures to Ensure Rigour, Trustworthiness, and Authenticity

Rigour in IE relies on its social ontology, the belief that the world is "invariably social and that the only way we can be in the world is as social beings" (Campbell & Gregor, 2008, p. 27; Rankin, 2017). Therefore, transparency in the research began with the acknowledgment of my epistemological stance, which is expected to create an audit trail so that other researchers could follow how and why I conducted the data analysis and discussions the way I did.

My attention to data generation started with my first self-reflection on my experiences with a CWR, followed by my more critical reflexivity account. Reflexivity is another strategy that enables the researcher to meet the criteria of rigour in qualitative research with respect to credibility, dependability, and confirmability (Korstjens & Moser, 2018). I used the methods of reflexivity, field notes, interviews, text analysis, and mapping to meet the criteria for methodological triangulation.

Fieldwork and interviewing in IE are driven by faithfulness to the actual work processes that connect individuals and activities in various parts of the institutional complex (DeVault & McCoy, 2006). As such, generalizability has been argued as a fundamental feature of IE. Even though each nurse's experience of a CWR was unique to them, there were aspects of the CWR experiences that were generalizable to all those participating. The analysis in IE helps make visible the broad generalized social relations that contributed to the development of the CWR within the context of nursing. These are

considered “generalizing relations” (Smith, 2005, p. 39) because despite local differences (the unit, the hospital, what the conflict was about), the analysis of the social relations that contributed to the development of the CWR to some extent will resonate for all those who have faced similar tensions and contradictions in their everyday work (Rankin, 2017a). Generalizability in IE relies on the discovery and demonstration of how ruling relations exist in and across many local settings, organizing the experiences informants talked about (Campbell & Gregor, 2008).

The analysis process in IE is based on an empirical account of the actual activities of people in real practice situations. Assumptions about power and the social organization of everyday life are made explicit as criteria necessary for judging the *truth* of the experience from the standpoint of the nurse. This version of the truth could be sustained by the analytic account of IE by presenting evidence that can be traced back to actual people and the methods of data collection (dependability and confirmability audits). Rigor comes not from technique, such as sampling or thematic analysis, but from the potential to depict the social relations of what actually happens in the developing map (DeVault & McCoy, 2006).

3.7.1 Ethical Integrity

I obtained ethical approval for my study from the Human Research Ethics Authority (HREA) Memorial University, St. John’s, Newfoundland (NL) (Appendix E) and the Research Proposal Approval Committee (RPAC) with the Eastern Regional Integrated Health Authority (Appendix F). I used the Tri-Council Policy Statement 1 (1998) for research involving humans in the planning and implementation of my study.

Written informed consent, including consent to tape the interviews, was obtained from those participating in the research (Appendix D). On this consent form, all were informed individually and in writing that they could withdraw from the study at any time, without having to give a reason, and without any repercussions.

Each person in the research was assigned a number and I was the only one to know the connection between the two. Care was taken to ensure that there were no identifiable features linking the research results to a particular nursing unit. As approved by HREA, I collected data on age, highest level of education, and years of employment as an RN to provide an overview of the types of nurses being interviewed. All material related to the research project, including field notes and research data (both recorded and written), was stored in a secure filing cabinet in a locked office where only the principal investigator (PI) had the keys. All electronic documentation and communication, including a USB drive, were password protected. I hired a transcriptionist, not associated with nursing or any regional health authority, to transcribe the interviews. The transcriptionist also signed a pledge of confidentiality before beginning the transcriptions. Transcriptions were stored separately from the consent forms as an additional measure to maintain confidentiality.

Additionally, as previously explained, data generation included the collection and analysis of texts used to govern nursing practice, for example, nursing protocol documents indicating the tasks nurses are required to complete on specific patients. However, all texts were analyzed effectively in a blank form, thereby eliminating potential breaches of confidentiality for an individual nurse or area in which they were employed.

3.8 Chapter Summary

In this chapter, I presented the theoretical underpinnings of IE and defined its key terms. I also presented IE's main points of departure and my position as researcher, followed by a description of the research process and methods used. I concluded the chapter with measures I used to ensure rigour and trustworthiness in the research process along with other ethical considerations.

Chapter Four - Data Analysis and Findings

Analysis in institutional ethnography (IE) is an iterative process that involves moving back and forth between the data generated by interviews and the context that produced the experience (Campbell & Gregor, 2008; Rankin, 2017a). My analytical work focused on identifying, tracing, and describing the social relations in which nurses were involved in when they experienced conflicting working relationships (CWRs). I then extended those social relations beyond any one particular nurse's experience, noting how trans-local and discursively organized relations permeated their understanding, talk, activities, and behaviours. I did this in conjunction with a textual analysis linking the threads connecting them all (Campbell & Gregor, 2008; Rankin, 2017a).

Being new to the process of data analysis, I referred to two articles published by Janet Rankin (2017 a & b) to help support the beginning institutional ethnographer and fill in the knowledge gap on *how to* complete an analysis using IE. She recommended three tools be used to support data analysis: writing accounts, indexing, and mapping. These data analysis tools compliment the traditional methods used to conduct an IE investigation, with mapping being the most similar. According to Rankin, mapping is used to assist the institutional ethnographer in recognizing "the features of the social practices and their respective material forms and relationships" (p. 5). Mapping also provides a visual display of what is happening. The three analytical tools, as described by Rankin could be used separately and/or simultaneously to make sense of the data generated while keeping social organization at the heart of analysis.

As I presented in my reflexivity account (chapter one, introduction), initially I remained emotionally attached to the subject of CWRs and I maintained a narrow

position on the topic. At the onset of my interviews, I was emotionally invested in this research because I experienced the same things as the nurses in my research reported and, as a result, I was institutionally captured by their stories of a CWR experience. I focused on the subjective interpretations of CWR events experienced and failed to probe into the broader social organization of those events. Stepping back and taking time to reflect on my initial interviews, and after reading more of Dorothy Smith's foundational work on IE, I was able to revisit the interviews with a more critical stance. Once immersed in the data generated, and with the help of Rankin's analytical tools, I was able to move beyond what I was told about an individual CWR experience and begin to understand the broader social organization of those experiences. In the following section, I present a description of the nurses participating in my research and their reactions to being interviewed. Following this, I present the data analysis organized under the names of the tools I used in the data analysis process. These are writing accounts, indexing, and mapping the connections found. I also describe the IE method, analysis of texts relevant to professional nursing practice.

4.1 Description of the Participants

In this research I use the term participant to refer to the nurses who agreed to take part in my research. Although the term "informant" has traditionally been used to describe individuals involved in ethnographic studies, because I was part of the culture being studied, I did not believe that I was being *informed* about a culture, but rather that these nurses were participating in the research process and assisting me with data generation on how CWRs develop.

Seventeen nurses were interviewed. Four had a Diploma of Nursing; six had a Bachelor of Nursing (BN); and seven had a Master of Nursing (MN). Two of the BN-prepared nurses were originally diploma-prepared and later attained their BN. The participants were between 29 and 55 years of age. The number of years employed as an RN (in all roles) ranged from 8 to 28 years. One of the 17 nurses interviewed self-identified as male. Four of the nurses worked outside of St. John's but still within Newfoundland and Labrador. Five participants had worked in other provinces within Canada. Two had worked both in the United States and across Canada and one had worked as a nurse in another foreign country.

At the time of the interviews, twelve nurses were employed in acute care in a hospital setting in various roles. Four worked on a surgery or medicine unit; three worked in acute-care specialty units; three worked as patient care coordinators (PCC); one worked as a program coordinator and one was employed in acute-care management. Of the remaining five nurses not working in acute care at the time of the interview, three were nurse educators, and two were nurse instructors. Despite not all being employed as a staff nurse in the hospital setting at the time of the interview, all described their past experiences (witnessed or experienced) with CWRs as happening while they were employed as a staff nurse in an acute care hospital setting.

Of the 17 participants, one participant had only witnessed CWRs between their RN peers and was not directly involved. Two other participants described both what they experienced and what they had witnessed. I felt it necessary to include the standpoints of RN witnesses in my analysis, as they were able to observe the CWR event from a unique standpoint and provide information about the context surrounding the event that was less

emotionally charged. Additionally, I wanted to include these nurses because, in the research literature, it is highlighted that witnesses/bystanders also experienced distress from this kind of event (Cleary et al., 2010; Hutchinson et al., 2006).

The variety of nurses added to the richness of data generated from the interviews. During the interviews, I questioned the participants about their experiences with CWRs in different provinces and countries, noting the similarities and differences. I also asked the participants about when they experienced (or did not experience) CWRs. The responses provided by these participants helped me to gain insight into working conditions that RNs felt would promote more positive peer relationships.

All participants reported that their experience with or observation of CWRs was with an RN peer. Note that although the RN peer may have been a "charge nurse," a more "senior nurse," or a "specialty RN" at the time of the event; they were not "management" per se. For example, patient care coordinators and nurses assigned to be in charge during night shifts, despite being in positions of power, are still technically a RN peer because they are a member of the nurses' union. As members of the union, the number of years of employment as an RN is the basis for seniority. However, many times in the hospital setting, a nurse with low seniority may be placed temporarily "in charge;" that is, in a more supervisory role. Similarly, seniority may be only one factor taken under consideration by those in administrative positions (i.e., human resources) when nursing positions (jobs) are "awarded." In practice, seniority was not necessarily associated with higher education, levels of experience, or competence. Later, I will describe how various hierarchies among RN peers and within the nursing profession may create tension.

All participants emphasized how they experienced or witnessed more than one incident of CWRs in their careers. In this research, CWRs were described differently than what is found in the research literature on bullying, where it is usually defined as repeated behaviours by a perpetrator to a recipient over an extended time frame (Bennett & Sawatzky, 2013; Berry, Gillespie, Gates, & Schafer, 2012; Cleary, Hunt, & Horsfall, 2010; Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012; Hutchinson, 2009; Hutchinson, Vickers, Wilkes, & Jackson, 2010; Katrinli, Atabay, Gunay, & Cangarli, 2010; Lewis, 2006; Randle, 2003; and Yildirim, 2009). In contrast to the bullying literature, the participants in this study noted how CWRs did not necessarily involve a single nurse repeatedly starting a conflict with a specific peer. Instead, participants expressed CWRs as being a part of the atmosphere of nursing practice, and as such, were widespread within their professional work experiences.

Participants' accounts also identified significant differences in the timing of the CWRs. Some participants described their experiences as having occurred when they were newly graduated and thus occurred a number of years ago, while other participants depicted experiences that happened later in their career. Cognizant of how professional nursing practice has evolved over time, I discuss, the changes made to the documents governing the expectations for nursing practice in section 5.5.1.

After the first set of interviews were completed and I had time to review the transcripts, I followed up with some of the participants to ask clarifying questions and to verify what I thought they were saying. Most of these member checks occurred over the telephone or via email. I made field notes of any clarifications. I also made field notes on

the different reaction's participants had with their CWR experience as well as the process of being interviewed.

4.2 Participants' Reactions to Being Interviewed and to their CWR Experiences

Interview dynamics varied by participant. Some participants were nervous about being recorded, while others were calm and spoke casually and without any apparent reservation. Some participants were emotional and passionate as they spoke about their experiences, while others remained "professional" and reserved. A few participants, after the interview was over and the recorder was turned off, breathed a sigh of relief and then proceeded to tell me their "real" feelings about their CWR experience.

After the interview, I noted these post-recording revelations of how they "really felt" in my field journal. These field notes were only used as a reminder of the strong impact that CWRs had on the personal and professional lives of the interview participants. Below, I provided some excerpts from the interview transcripts to emphasize some of the varying reactions of participants to their CWR experience.

> My first couple of months at [names hospital] was [*sic*] the most horrible group of nurses I have ever had the pleasure of working with. They were trolls. They were nasty. It was most uncomfortable (Participant #4).

> I said I was never going back; I have never gone back in any capacity … it was such a horrible experience … I can't even, I, I can't even imagine, I think I would have anxiety and a panic attack if I had to work in that hospital (Participant #1).

> Yeah, it's, it is a life-changing experience actually, a perspective-changing experience and one that I chose myself to personally grow from, you could take that and just be totally hardened by it … I was quiet for a while or whatever, but eventually change came and the way I look at it is that all change comes at a cost to somebody (Participant #7).

> Um, they always say, you are where you need to be ... and right now I am where I need to be ... I will become a part of the union and become really vocal. Because I feel they [the Registered Nurses Union of Newfoundland and Labrador] are after

> losing so much respect from me and other nurses and I think that's where I will start, and I will start there, and I said . . . "I'd love to do, do a workshop on how to cope" (Participant #5).

I singled out the examples above to highlight the significance of subjective interpretations of events. Although participants' reactions to CWR events in which they were personally involved differed, in some respects, they were also similar. Participant reactions were similar with respect to the strong and enduring impact of their experiences on their personal and professional lives and with respect to how each participant felt troubled that such behaviours could be demonstrated by their peers. The first analytical tool I used to further explore the CWR experiences of the participants was writing accounts. However, before delving into the participants' accounts, it is important to understand how I looked for the participant's use of institutional language as a means to provide insight into how their nursing practice was organized and to further explore how it was related to their CWR experiences.

4.3 How Institutional Language Provides Insight into How Nursing Practice is Organized

Institutional ethnographers (IEers) are interested in discovering the processes involved with the transmission of knowledge to people regarding how they understand the way they complete their work. Part of this discovery is listening for the participants' use of institutional language. Institutional language refers to how the particular use of words, language, and text build versions of what people say, do, or know within a specific setting (Campbell & Gregor, 2008). Listening for and highlighting the participants use of institutional language provides the IEers with insight into the organization of knowledge in that setting.

To capture how the organization of nursing practice was related to the development of CWRs, I focused on the construction of the CWRs, from the participants' standpoint instead of focusing specifically on the individual stories of conflict being told. I began this process by noting how participants used institutional language (e.g., floors, specialty RNs, admission, etc.) when describing the organization of their nursing practice as related to the development of their CWR experience. I included how their work was organized through texts and text-mediated discourses and examined these discourses to help gain a broader picture of how their CWR experiences happened.

A simple example of the nurses' use of institutional language was found when participants' spoke about their "side of the schedule." The side of the schedule referred to how in the hospital setting, nurses work around the clock by rotating 12-hour shifts. This meant that if a nurse was scheduled to work three, 12-hour shifts over the weekend (Friday, Saturday, and Sunday), they had Monday and Tuesday off. Then they would be working Wednesday and Thursday, and not scheduled to work the following weekend. If a group of nurses were working three shifts on a weekend, it meant that the nurses who were off that weekend were on the "other side of the schedule." Not all nurses followed this schedule, but most nurses would understand the pattern; using the phrase other side of the schedule was commonplace for them.

Other examples of specific language used by nurses (as well as other health care professionals), included words like "floor" to refer to a hospital unit, "emerg" to refer to the emergency department, "admission," "transfer," and "kardex" among many others. Although seemingly common terms for RNs, members outside of the health care setting would only have a limited understanding of the meaning of these terms as used by RNs.

However, when RNs used such specific language, they understood it to represent the process they were required to follow as part of their nursing practice. For example, participants understood the word “admission” to refer to a textual process, a series of steps to be completed, that directed the organization of the nursing work required to be completed to admit a patient to the hospital, but that got activated in different ways.

The use of institutional language by RNs is important for three reasons. Firstly, it demonstrates how nurses (as well as other professionals) are organized to work in a specific manner. Secondly, it demonstrates how that organization becomes so commonplace that it is reflected in their everyday language, where the use of that language generally requires no further explanation for those working within the same context. Lastly, it highlights how the organization of that work is rarely questioned by those doing it. Using the side of the schedule as an example, the words “side of the schedule” was related to how the hospital setting was organized, and further, how RNs organized their own activities and relationships (both inside and outside the hospital setting) around a shared understanding of this scheduling.

As a nurse myself, in conducting this research, I found it challenging to recognize all instances when institutional language was being used because I was also accustomed to speaking that language and was captured by the discourse. As I read and re-read the interview transcriptions, it became more apparent how the work of nurses was embedded within ruling relations, as organized within the hospital setting and more broadly organized within the evolving health care context. These ruling relations influenced how nurses came to understand how their nursing practice was to be completed within the hospital setting, provincially, and nationally. At times, this organization was at odds with

their experiential knowledge regarding how their nursing practice was organized. I summarized this information in writing accounts of the participants' CWR experiences.

4.4 Writing Accounts of the Participants' CWR Experiences

Writing accounts is a method of analysis whereby the researcher selects an instance of activity from the interview data and writes down and describes how the activity was socially organized (Rankin, 2017a). In this research, I focused on the details of the participant's work day and the organization of their nursing practice surrounding their CWR experience. With writing accounts, the researcher can notice occasions where the knowledge generated in a participant's everyday work was subordinated by, or was in tension with, other abstract knowledge that was used, or was *supposed to* be used, to decide and act. I then examined how these tensions were related to the development of the CWR experience.

When I began using the writing accounts method, I needed to keep the idea of the social organization of nursing practice and its relationship to CWRs in mind. To accomplish this task, I asked myself a series of orienting questions:

- What is the work to which this nurse is describing or referring? What does it involve for them?
- How are nurses' experiences worked up into authorized facts (meaning how do they know what they know)? And how are these facts related to the ruling relations and the social organization of their work?
- How is this social organization related to or contributory to CWRs?

To be consistent with IE method of inquiry, in the writing of accounts, it was necessary for me to demonstrate how time, effort, and resources (e.g., text, peer support) were used. To do this, I used quotes from the interviews. I also noted when the

participants talked about the specific texts, text-mediated discourses, and ideologies they used to organize their nursing practice. I then reviewed each account numerous times to try and discover how differing accounts were linked into the same generalizing relations by reference to the overarching texts, text-mediated discourses, and ideologies that ruled how their experiences proceeded (Rankin, 2017a). As I wrote the participants' accounts, I concurrently used the strategies of indexing and mapping, which will be further explained later in this chapter.

As each participant communicated their experience(s) with CWRs, I took note of how these experiences were coordinated to unfold in the manner that it/they did. Specifically, I paid attention to the texts and ruling practices (referring to how the participants understood the correct way to conduct their work) that may have influenced or supported the development of their CWR experiences. Many of the participants described their CWRs as occurring during times when they felt a sense of powerlessness. Participants #1, #2, and #12 described their initial experiences with CWRs as happening when they were newly graduated and novice nurses. Participants #1, #5, #8, and #9 portrayed their experiences as casual and/or float nurses (novice to the unit) and their perceptions of having to prove themselves as competent nurses. Participants #7 and #12 recalled how they felt they were "set-up" to fail.

4.4.1 Participants' Accounts Arising from Novice Nurses Practice

Consistent with the literature reviewed in chapter two, participant definitions of what constituted a novice nurse also varied. Notwithstanding the inconsistencies in defining the term novice (sometimes less than a year after graduating from nursing

school, sometimes up to two years after), participants' experiences were similar. Some participants explained how upon entering the profession as a newly graduated RN, they required guidance and mentorship from their more senior nurse colleagues. However, instead of receiving the support and guidance as they expected, many participants experienced the phenomenon of "nurses eating their young" (Hippeli, 2009; Woelfle & McCaffrey, 2007). Participant #1 described:

> I was still being mentored by a nurse who was a young nurse herself, only out [of a nursing education program] a couple of years, and trying to, I guess, feel your way and gain your confidence as a nurse – there was an issue, where she perceived an issue with blood and blood products, although everything was done as it should have been, she perceived it that it was not done her way and perceived and proceeded to call me out, and completely [put me] down to the dirt at the [patient's] bedside.

Participant #1 described how she[2] and her mentor[3] interpreted blood and blood-products policies differently. Although the policy was written to be completed a certain way, the procedure for administering blood and blood products varied a little differently on that unit. Participant #1 stated how she would have expected her mentor to explain to her how the procedure was done differently, along with the reasons for it, instead of reprimanding her in front of the patient. She further expressed how she felt this experience undermined her confidence as a nurse. She went on to explain that, in her experience, she often saw senior (and more experienced) RNs treat novice RNs poorly, and how she could not reconcile how senior nurses could behave in that way towards new nurses because they "have been there before… ." After referring to how every nurse was

[2] She will be used to refer to all nurse participants, regardless if they were female, male, or non-binary to avoid identification of a participant.
[3] A mentor is still an RN peer; although they have more experience than the novice RN, they may not be very experienced themselves

a new graduate transitioning from academia into employment, at one point in time, she emphasized that senior nurses should be "very open to supporting new grads, new staff, and, making you [novice nurses] feel welcome."

Participant #1 further commented on the importance of strong mentorship for newly graduated nurses.

> Um, I think when you find your role as nurses, you, um, it actually comes from yourself, you have to have mentors when you first start out, nurses who are willing to support. You kinda know your role from nursing school in terms of care of patients but in terms of being a leader, a mentor, an educator, a researcher, all the things are known for, take a strong, dedicated nurse to mentor to help find your way.

Participants #1, #5, #8, #9, and #16 all voiced that their theoretical knowledge and psychomotor skills (such as with blood and blood products, sterile field set-up, using care maps) as acquired in nursing school, were vital in their preparation for employment as an RN. However, once becoming employed, they experienced disagreements regarding the appropriate application of their knowledge and skills in the hospital setting. Disagreements commonly centred on procedures, how they were "taught" in academia and how they were "actually" performed in the hospital setting. The phrases "supposed to know," "you should know that," and you are "supposed to do it like this," or you "should do it like this" were frequent in many of the participants' accounts of their CWRs, especially among new graduates but also by experienced nurses who were novice to a unit. On this regard, participant #4 stated:

> I am a nurse and I am proud to say I am a nurse, spent, you know 25 years of my life to become a nurse and work as a nurse. So, it disappoints me to see people react the way that they do. I mean it's the negativity within a floor itself because you always have the senior group. So, the senior group do stuff different, right? They have been there for years and then you have the newer group, the younger staff that come in that are ideologic [idealist], and you [pauses] just went through

> nursing school and nursing school teaches you all this stuff and you are happy and you are proud to be a nurse and whatever and then you go out to the real world and it slaps you in the face.

The reasons for the disconnect between academia and the hospital setting was commonly referred to by participants as the *reality of nursing*. Although there has been a lot of research on the transition from nursing school to working as a professional nurse (Rankin, 2006; Rainbow & Steege, 2019), I identified a disconnect between academia and the workplace as one of many sources of frustration for RNs that contributed to the development of CWRs between RNs. Furthermore, participants with extensive nursing experience reported that when assigned to a different unit and placed in the novice role again, they also experienced CWRs with their more knowledgeable colleagues.

4.4.1.1 Accounts of CWRs from RNs Working on a "New" Nursing Unit

Participant #1 recalled another CWR she experienced when she accepted a new nursing position in a different unit. The participant described how the nurses in her new unit were "not fond of new people" as evidenced by how they "would not make eye contact with you, would not speak to you . . . if there were two nurses in the room and you were free to [help] get this nurse something, she would always ask the other nurse, she would not ask me, so it makes for tension." She then explained the work that was involved in completing a sterile nursing skill. Although she had performed this skill competently numerous times on other units, on this new unit, another RN felt she was completing the skill inappropriately. However, participant #1 highlighted how the nurse could not provide her with any objective account of what she had done wrong such as breaking sterile technique. The nurse instead stated that she did "not like" how the

participant folded the edges of the sterile field and because of this, she discarded the participant's sterile set-up. The participant described how her peer proceeded to "strip, to strip, the entire set down."

She felt that her co-worker was "making a point" in having her start the procedure all over again. Being new to the unit, the participant submitted to her co-worker's behaviour and started the wound care procedure over again. She stated that she had to "just smile and nod at it [the behaviour from her colleague] because at the end of the day you [she] had to get through it." Later, the same co-worker reviewed her documentation, which was unnecessary because the participant stated she was a "competent nurse" who was competent to document independently, and that there was no requirement for her peer to look at her documentation. The participant stated, however, that her relationship with this peer and other peers on the unit improved eventually. The participant attributed the improvement to the amount of time she acquired on the new unit and by her ability to "prove myself." However, she continued to witness similar CWR behaviours with other nurses new to the unit. She described how many new nurses came to her "crying because certain nurses were making their work life miserable." Examples of things that made their work life miserable included "complaining about things that they (novice RNs) didn't do and writing them up [referring to reporting]," instead of showing them what to do and mentoring them. The participant advocated on behalf of the other new nurses by reporting her concerns to their manager, but she stated that no action was taken.

Participant #13 perceived that reporting concerns was the precipitating factor that instigated her CWR experience. As a nurse with years of experience, but a novice to a practice setting, she described how, after voicing concern about the delivery of care to a

more senior nurse, this senior nurse became outwardly hostile and aggressive towards her. Participant #13 then presented the details of a three-week period where the senior nurse slammed doors, refused to talk with her, and refused to answer her questions or provide her with advice. She asserted that this CWR event was harmful because of the break in effective communication between them, which was needed to complete the work safely. She explained how she had "to struggle to get through things that I would normally have been able to ask a simple question and get answers to get things done quickly." Participant #13 felt that the behaviour of the more senior nurse made "novice nurses look like idiots." She felt disgruntled because she believed that RNs had an important service to deliver and, instead of just getting on with the task she knew well, she was being forced to deliver care "with two hands tied behind my back as opposed to being a part of a thriving team."

Participant #16 described her experience of being a novice and having to prove herself to her RN peers after being "awarded a position" on a specialty unit. As job postings for RNs are referred to by a competition number, RNs who are successful in a competition are said to have been "awarded the position." The participant explained how she "lucked into it [the job]" because most often this type of position was given to senior nurses at the end of their careers. She clarified in the interview that the term "senior" referred to RNs with many years of nursing experience and was equated with "seniority" in the nurses' professional union.

Participant #16 illustrated the tension she experienced with one of the nurses who worked on the specialty unit. While completing her nursing duties, one of the more senior nurses reported to the manager that the participant "did not like to ask for help." The

participant felt “blindsided” when her manager approached her regarding the complaint. She defended herself by stating that she was “constantly asking questions,” but if she felt confident in completing a skill, then she did not need to ask for help.

The work of this RN in proving her competence was connected to the work of her co-worker (with whom she needed to prove herself), which in turn was connected to management. Management was obligated by the health care institution to act once a complaint was made. Even though the manager addressed the complaint with the participant, it was not disclosed to the participant immediately what the complaint was about or who made the complaint. Instead, the manager questioned the participant on how to complete certain nursing duties. The participant quickly made the connection between the interaction she had with her co-worker previously and her manager’s line of questioning. At the end of the conversation, the participant explained her position to her manager and the manager apologized to the participant for having her attend the meeting.

The participant felt that the more senior nurse was “not very nice” and how she expected her co-worker to speak to her first so that she could explain herself before making a complaint to management. She recalled how the experience made their working relationship “tense” and how she “never feel [felt] the same way again” about her peer. The participant felt she was reported because her peer thought she had “never paid her dues” and was given the specialty position prematurely. The experience left the participant feeling distressed and “paranoid” about completing her skills independently. Incidentally, participants #5, #8 and #9 explained how their perceived inability to complete their assigned nursing duties independently was often a precursor to a CWR. This was especially true for casual RNs or RNs in float positions.

4.4.1.2 Accounts of CWRs from Casual and Float Nurses

RNs hired in casual and float positions often felt like novice nurses when they were required to work on a unit where they were "new" and unfamiliar. Participant #9 described her experiences as a float nurse.

> I did not like that very much at all [floating] . . . mostly because um I guess, it was the staffing, it never really felt like you could fit in anywhere. People are always a bit more hesitant to float, they think, especially as a new grad, they [meaning the staff] . . . look down on you a bit.

Floating happens when the staff-to-patient ratio is exceeded on a unit. If there are more nurses than required for the number of patients admitted to a unit, then the extra nurse is required to *float* to another unit where there are insufficient numbers of staff (O'Connor & Dugan, 2017). Participant #9 stated "everyone hates floating because it is not your norm." She further elaborated on the term "not your norm" to mean being unfamiliar with the "routine of the floor [unit]" to which float nurses were required to go. She acknowledged how as a float nurse, she often had to ask questions and request help from the nurses who normally worked on the unit and were familiar with the unit's routine. She felt, as evidenced from the behaviours of the other nurses, her requests for assistance were regarded as burdensome and, as such, her requests for help were usually denied or provided reluctantly. She explained how, as a float nurse, belittling comments were made to her all the time. Specifically, she recalled how her peers referred to her as "more trouble than she was worth." As a result, she chose to work independently throughout the shift, leaving her feeling isolated and undervalued.

Participant #5 spoke about how, as a casual nurse, she was often left to complete complex patient assignments on her own. An RN who is hired in a casual position does

not have a fixed employment schedule or number of hours to work. Instead, the RN is called in on an intermittent basis by the employer (RNUNL, 2016). Therefore, a casual nurse is expected to work on different units in the hospital; there may not be a single unit to which they are assigned. Consequently, a casual RN is often unfamiliar with a specific unit's layout and routines. This makes it more difficult for her to build up expertise because she does not spend a lot of time on a single unit. As such, a casual RN often needs more assistance from peers than an RN who is permanently assigned to a unit. In addition, if a casual RN is assigned to a single unit, she may be required to work on both sides of the schedule. As most nurses working in the hospital setting work 12-hour shifts, there are two different nursing teams assigned to each unit to cover a 24-hour period. Unlike other nurses, the casual nurse must work with different teams of nurses depending on the shift she gets assigned to work. As a result, she may not work closely with any one team perhaps hindering the development of strong peer relationships.

Participant #5 described how she was "lost" when she was scheduled to work on a unit to which she was unfamiliar. She expressed feeling lost because she was not as organized as she normally would have been and that she was behind on her assigned nursing duties. She explained how her co-workers, although they could see that she was struggling [lost], would not freely offer her assistance.

> Lost, but not only that, they have not helped you. Nobody has gone to check on your patients, nobody has gone to probably administer something that should have been given at 8:00 - 8:30. They are just … they are going to do their own work. You can "sink or swim."

Similarly, participant # 8, although she did not use the specific phrase "sink or swim," also had experiences where she felt she was being left to prove herself to her

nurse peers. She described a busy and complex shift where her co-workers did not offer her any assistance. Instead, after they completed their own work, they just watched her struggling to complete her assigned duties. Whenever the participant asked her co-workers for assistance, her co-workers responded slowly. The participant stated how she feared for the safety of her patients:

> I felt at that time [a busy, complex shift], guys [referring to her co-workers] I need a hand here and they [her co-workers] were very slow to respond, I was stressed to the max because I thought "my god I hope nobody codes [referring to the Code Blue-cardiac arrest] right here" . . . it was really to me a safety issue.

Participant #8 further elaborated how her co-workers waited until she specifically requested assistance and how they would not freely offer to help:

> But it wasn't [referring to the unit being busy], and if they [her co-workers] could see you running around, they would just kind of hang back and wait for you to say "guys," because they wanted to see, they wanted you to admit [that you needed help].

Both participants #5 and #8 identified that they did not appreciate being left to manage their busy workloads independently. Rather, it left them feeling frustrated, anxious, and stressed. In addition to these feelings, there was also a fear that something in their nursing work would be missed and it could potentially cause harm to their patients. Participant #8 further discussed how being successful in her "rite of passage," referring to when she felt she was deemed competent by her nurse peers in her nursing practice, did not leave her with feelings of accomplishment or empowerment. Instead she recalled being left with feelings of bitterness and resentment:

> . . . she [her co-worker] actually said this to me, I just about dropped on the floor. She said, "you're actually useful." That is what she said to me. And I was just like thank you very much, like this [motioning to interviewer] and I walked away from her . . . yeah, thanks for the insult. Did I not pass the test yet or what [referring to her rite of passage]?

Although the practices of nurses eating their young and sink or swim (André, 2018, Egues & Leinung, 2013; Flateau-Lux & Gravel, 2014; Hippeli, 2009; Meissner, 1986; Woelfle & McCaffrey, 2007) was not specifically referenced by all participants, a common thread that emerged was that some nurses (especially novice RNs) underwent a rite of passage or initiation into the nursing profession or into a new position within nursing. From the participants' accounts, it appears that successful transition of the rite of passage from student nurse into the profession of nursing, or into a new practice setting within nursing, involved proving oneself as a competent nurse. Two other participants, who were not novice RNs, expressed how they not only experienced the phenomenon of nurses eat their young and/or sink or swim, but also how they felt they were "set up to fail."

4.4.1.3 Being Set-Up to Fail

Some participants believed that the circumstances leading to their CWR was related to their peers failing to advise them that they were completing their nursing work differently than what was usual on a unit. Participant #12 described how, at the end of a shift, she was called into a back room by her manager. Participant #12 was presented with a written list of all the things that her peers perceived that she had done inappropriately over the last number of shifts she had worked. Prior to being approached by her manager, the participant had no idea that her peers perceived her as completing her duties incorrectly. She went on to explain how she was surprised by some of the comments made about her on the list. Her peers reported that she had connected a piece of equipment incorrectly. She clarified how this was a common and insignificant mistake by

many RNs when rushed. However, she stated how her peers made a "huge deal" about it when she made the mistake. Her peers submitted an occurrence report on the participant that included the statement, "the patient could have been killed for it," which the participant asserted as not true.

The occurrence reporting system, also called the clinical safety reporting system (CSRS) (the terms are used interchangeably), refers to a process to facilitate the identification and monitoring of adverse events or incidents that may occur during health care treatment/service in health care facilities (Elliott, Martin & Neville, 2014). The reporting system is meant to capture patient falls, safety and security issues, medication errors, treatment and procedural mishaps, malfunctions with medical equipment, and/or the potential for any of these occurrences. The potential for a possible occurrence is called a "close call" (Elliott, et al., 2014, p.1). The individual who is involved in the occurrence or witnesses it, completes the report, and submits it to management for follow-up. The purpose of the occurrence reporting system is to track occurrences and identify trends. This data is then used to make improvements in clinical safety for patients and employees (Elliott, et al., 2014).

The manager who received the occurrence report on participant #12, as part of her follow-up on the report, disclosed to the participant that she held a staff meeting about her to discuss the perceived mistakes she was making. However, the participant was not included in the staff meeting and was unaware that this meeting had taken place. From then on, the participant recalled feeling "humiliated" and under "immense amounts of pressure" at work. She felt as though she was *set up* because no one ever approached her about her nursing practice. She stated that working with her peers afterward made her feel

"really incompetent . . . like an idiot." She found the environment stressful and she continually questioned her ability to be practicing as a nurse. She explained how she developed physical symptoms of anxiety when she was required to go to work. She stated: "your breath gets really fast and shallow and I actually felt intimidated." She also feared "getting into trouble." She went on to describe how the behaviours demonstrated by her peers were commonplace and part of the "culture" of the unit she worked on.

Participant #7 described a similar experience where her nursing practice was appraised by her peers as inappropriate, but how it was not brought to her attention until she was approached by management. Participant #7 explained how she arrived at work for a night shift where she was assigned to provide care for a seriously ill client. Numerous times throughout the evening, the participant requested assistance from her peers. Although some superficial help was provided (she received some help with paperwork), when she was presented with obstacles to providing the best patient care, the participant was left to navigate these obstacles on her own. For example, the participant explained how she was unable to reach the physician to prescribe a stronger pain medication for the patient, and how it would have been helpful if her co-workers would continue attempting to contact the physician for her.

Throughout the night, the participant kept the charge nurse informed of the patient's deteriorating condition. She stated, "I was just frustrated because nobody was really forthcoming with their help and they were just too busy with their own things…not patient care...." The participant described that when the patient died, her peers acted "surprised" as if they were unaware of what the participant had been communicating all

night. Later, the participant was reported to management by her peers for what they interpreted as “inappropriate care.”

While maintaining that their care was appropriate, both participants #7 and #12 felt that if their care was inappropriate, then their RN peers should have notified them immediately or intervened appropriately for the safety of the patient(s). Instead, their peers decided, in the case of Participant #12, to keep notes on her practice over several shifts before reporting her to management, or in the case of Participant #7, let the participant provide care independently the entire night waiting until the shift was completed to report her “inappropriate care” to management.

4.4.1.4 Summary of the CWR Experiences from Novice RNs, RNs New to a Unit, and Casual/Float RNs

Despite nurses entering the profession with similar amounts of training and certified knowledge and experience, CWRs were noted to have occurred when the individuals involved occupied different positions of power within a local context. All nurses, once they pass the registration exam, are given the professional designation of Registered Nurse (RN). When RNs enter the workplace setting, power differentials between nurses become expressed. It is considered normal and expected in this setting for nurses who have more experience, knowledge, and expertise to have greater authority than those nurses who do not. But it is also a professional expectation for more experienced nurses to be mentors and share their knowledge and expertise with the less experienced for the betterment of the patients. Yet, it is evident from the above participants’ accounts that sometimes there is a misuse of power (e.g., more knowledge and experience in nursing practice) between RNs that results in unhealthy and damaging

peer relationships. This was especially evident in participants' accounts of being set up to fail, where it seemed patient care was deemed less important than making a peer feel incapable (not fit to do the job) and powerless.

Common behaviours and attitudes noted in the above participants' accounts included yelling, belittling, denial of assistance, ignoring, withholding information, and the phenomena of nurses eating their young. These hostile behaviours echo the previous research literature on bullying and horizontal violence, as well as a variety of other labels. However, most of the participants did not use the terminology specific to bullying or horizontal violence. Instead, most of the participants described how these behaviours from their peers were unexpected; how they impaired their working relationships, and how they made them second-guess their understanding of nursing. Participant #2 illustrated how as a novice nurse, similar behaviours from her co-workers affected her health and well-being:

> I have worked through it [bullying] as a younger nurse actually, the bullying got to a point that I found myself in my manager's office crying for a full hour one day and told her she could write me in sick every shift, that I wasn't coming back because I had migraines and diarrhea all the time and that every single thing I did was wrong and there was always somebody there to criticize me, no one ever wanted to help me, and I didn't want to come back.

In addition to the work of caring for patients, novice nurses had extra additional/unaccounted work they needed to complete. Some of this work involved navigating differences between the layouts of different nursing units, different unit routines, and unit cultures/values. In addition, novice nurses had the extra work of "balancing the independence line," such that a novice nurse could be neither too independent (for example, not asking enough questions) nor too dependent (for example,

asking too many questions or for too much assistance). Therefore, extra communication work was also involved. Further, novice nurses were also required to figure out what was being said to them and the intention behind this (for example, when management addressed a complaint against them), as well as to learn how and why direct communication with them was often not used, but instead occurrence reports were made.

The culmination of additional work created a lot of "smiling and nodding" (Participant #1) work, where novice nurses had to put their personal feelings aside as they recognized that they needed to work at gaining acceptance into nursing practice (either as a new graduate, or new to a unit), and it was best to "just agree." The "smiling and nodding" work was needed to either successfully acclimate into the profession of nursing, or to successfully transition into a new unit or department. Participants also noted the work of proving yourself as a "good nurse" (Participant #11), which was often linked to the nurse's ability to independently manage and accurately complete all their assigned nursing tasks, including documentation, especially when the work at the unit was considered busy or heavy.

4.4.2 Participants' Accounts of CWRs Related to Working in the Hospital Setting: Documentation, Text, and Text-Mediated Discourse

The previous research literature supports the idea that the majority of CWRs happen within acute-care units of the hospital (Dewitty, 2009; Guidroz, Wang, & Perez, 2012; Taylor, 2016). Therefore, it was necessary to explore the organization of nursing practice in the hospital and how it contributes to the development of CWRs between RN peers. Stemming from the participants' accounts, I began this review by examining the texts used by nurses. Recalling chapter three, texts are more than documents; they can be

videos, sounds, or images that are reproducible and used by many individuals. Text-mediated discourse refers to how ideas and practices, once they become framed in a certain context, establish the terms, concepts, and ideologies on which nurses will consistently draw on when describing their work. The activation of texts refers to how nurses pick up, read, and follow a text and/or a text-mediated discourse when they are planning the organization of their work. The use of the text (or text-mediated discourse) and the completion of texts, such as documentation, influence how nurses approach their work and the ideas/beliefs/values they adhere to in the hospital setting. Participants described many different texts that they used throughout their shift to document the nursing care they provided.

4.4.2.1 The Use of Documents and Documentation

Throughout the interviews, I noticed how some participants adopted a labelling attitude as they commonly referred to their patients by their medical diagnosis (e.g., "a lot of diabetics,"), by the nursing task (e.g., the PICC dressing in room 6125), or by the documentation they were required to complete (e.g., surveillance record), instead of referring to the patient by name or by saying "the person with diabetes." For example, participant #9 explained how she organized her nursing care for an "epidural patient" by using the epidural protocol text. An epidural catheter is a means to provide pain medication for post-operative patients. When providing care for a patient with an epidural catheter, a nurse is required to follow the epidural protocol, which is a text that organizes nursing work because it instructs the nurse to complete and document a focused physical assessment on the patient every hour or every four hours.

> A lot of times [a patient] has an epidural or a PCA [patient-controlled analgesia] so you have to check those [patients] either every hour or every 4 hours depending on what [surgery] they have.

Additionally, participant #9 provided another example of how the work of nurses was organized, not by a specific text, but this time by following text-mediated discourse. She described what she had come to know about the care of patients who were admitted with a medical history of diabetes mellitus (DM):

> We have quite a bit of diabetics [patients with diabetes] lately, so you are responsible to check their glucometers, give them their insulin, and in-between all that at some point in time, get them washed up.

In this quote, participant #9 presented how she came to understand the work she must complete to care for a patient with diabetes mellitus. In her statement she described, in priority, the steps involved. First, she noted that she must check the patient's glucometer reading [meaning sugar level in their blood], then based on the blood sugar level, she was expected to administer the appropriate dose of insulin, and, lastly, there was an expectation for her to assist the patient with their personal hygiene. I provided these examples to bring attention to the concept of social organization. I am not saying that these nursing practices are incorrect. Policy stipulates it is a priority to correct a high or low blood-glucose reading before helping a patient with their personal hygiene (if required) and nurses use their professional judgement on how to do this work. However, I am illuminating how nursing work, as organized via the use of text/procedure/documentation has become commonplace and accepted as the only correct way to complete nursing care from an institutional perspective, which may be interpreted differently by different RNs in different contexts.

Through talking with participants about caring for "diabetics," "epidurals," or patients on surveillance, it became apparent that RNs learned how to care for these patients by activating a text. Texts and text-mediated discourses may have originated from many sources, including nursing curricula, employer policy, or from another RN who passed on what she understood about a specific nursing practice. The important point to note is that by adhering to a text, the RN may perceive that she has appropriately completed the nursing procedure, and she could use the text as evidence that appropriate care occurred. In the following account, participant #8 described how, in the hospital setting, the precise completion of procedures as stated in texts was valued by some nurses more than others, and how discrepancy in the completion of a text could lead one RN to pass judgment on another RN.

Participant #8 described being vigilant about completing the surveillance record text and how other nurses were not as vigilant. The participant spoke about a patient being "under surveillance every hour" referring to the surveillance record (a text) that must be initialed by the RN every hour. This record shows that the RN had provided care for the patient by visiting them and conducting the focused assessment.

> And actually, and I remember, if somebody had to be under surveillance every hour say for vitals, I found that some nurses were very laid back about that, yeah, I'll get to it in a minute, maybe an hour and a half later, but see I am not like that.

Although the participant did not elaborate further on any CWR that arose from the perceived incomplete documentation, during this segment of the Participant #8's interview she indicated that she compared her nursing practice against that of her peers. The surveillance text was the tool that she used (and all RNs could use) to legitimize the comparisons of the two RNs. The RN who initialed the surveillance text every thirty

minutes as required may be perceived as providing "better care" than another RN who was not as prompt with the surveillance checks.

Other times, text-mediated discourse, or the ingrained belief by some nurses about how things should be completed, also fostered comparisons between nurse peers. As demonstrated in the example below, some nurses believed that giving patients a bed bath *should* come first before completing assessments and medications, although there was no text to support the exact time required to give a bed bath; the discourse surrounding how it *should* be done and the reversal of priorities created the potential for conflict.

Participant #3 recalled how she felt frustrated when told that she should stop completing physical assessments and administering medications on her assigned patients, so she could start their morning care (personal hygiene). She explained how her peers noted that it was 9:30 a.m. and that her patients' baths *should* be started (or perhaps medication administration should be completed by 9:30). The emphasis on *should* indicates the value placed on task completion in the organization of the nurse's work. Participant #3 replied to her peers by stating, "nobody died from being dirty and it is certainly more important to get assessments done." The participant went on to explain how this interaction seemed insignificant to her at first; however, instead of being perceived as just a disagreement between peers related to priorities of nursing care, it manifested into rumours about the participant not wanting to complete bed baths for her patients.

Participant #3 was upset when she heard rumours were being spread about the quality of her nursing care. This created a tense working relationship with her peers that she eventually had to address. However, at the same time, participant #3 did not perceive

how her response to her peers might have also been perceived as inappropriate, and how this response also played a role in the CWR that transpired. The participant's response that it was "certainly more important to get assessments done" was also socially constructed. In other words, at some point when participant #3 was learning the role of an RN, the idea that patient assessments *should* be completed before baths was reinforced. Like participant #9 above (surveillance record), personal hygiene for participant #3 was also the lowest priority on her list of tasks to complete. Ultimately, the organization of assessments versus bed baths, or the nurse's assessment of the requirement for frequent surveillance and their relative importance, was dependent upon the needs of patients. Therefore, the organization of nursing work can be fluid and interchangeable day-to-day, shift-to-shift, and there is no requirement to stick to a rigid schedule if patient safety and care are not being compromised. However, the texts that nurses are required to complete to document the care they provide to their patients does not reflect the same level of fluidity.

Participant #2 provided her perception of how documentation (or the absence of documentation) was used to legitimize uncivil behaviours between nurses and how documentation was needed to protect nurses from legal liability.

> If you don't chart it, you didn't do it. If you don't chart it, you, nursing is very much a profession that is about covering your own ass, about looking out for yourself, and even though like in the union we use words like solidarity . . . when you go to work and there are people there that look for things that you have missed, they look for your mistakes as they see them, they look for ways to trip you up or knock you down and somehow elevate themselves by saying look how crappy she is, you know, look what she missed, look what she did.

Here participant #2 is referring to how texts used to standardize nursing practice in the hospital setting can be activated differently by different nurses. More so she clearly notes

how failure to complete a text or varied interpretations of texts can contribute to the development of conflict. Many participants noted that the amount of documentation required for nursing practice contributed to the busyness of nursing shifts.

4.4.2.2 Hitting the Ground Running

Some participants noted that the organization of the acute care hospital setting rarely allowed the time for nurses to reflect upon or plan the activities for their upcoming shift. Participant #2 used the phrase "hitting the ground running" to set the stage for the night shift in which her most recent CWR event took place. She described how there had been two patient admissions to the unit at change of shift. Change of shift was the period between when the day shift ended, and the night shift began. Usually a nurse shows up before the beginning of her shift so that she can speak to the nurse she is relieving. Therefore, when the participant arrived to begin her assigned shift, the work of receiving two patient admissions was still to be completed by the day-shift nurse. She said the work of a nurse receiving an admission included following the doctor's written instructions (or the "doctor's orders"). She clarified that the doctor's orders included what the doctor wanted done as part of the patient's plan of care. The participant further explained the doctor's orders as "…medications and…like diet and activity and bloodwork that kind of stuff." However, for these two admissions, the doctor's orders had not yet been written. Participant #2 described how she needed the doctor's orders so that she could know what medical interventions were needed and, therefore, how she might organize her shift. The text of the doctor's orders was important for her to have as they organized the nursing interventions she needed to implement.

Participant #2 elaborated that the admission paperwork was not done because both admissions happened at the change of the shift and there was no time. The ability of the day-shift nurses to accomplish their tasks was also dependent on how busy they were. She stated:

> So, that day had been very busy, they had a number of discharges and admissions during the day shift. So, there is no rule saying leave things for the nightshift…it is just she ran out of time. The charge nurse ran out of time to get those things done.

Participant #2 clarified that because of the new admissions at the change of the shift, she was required to accomplish additional tasks, which created a "busy" night for her:

> I had paperwork to tackle for three separate patients. I know patients were sick and we had another patient that wasn't unstable, but she needed things . . . like we couldn't get IVs on her [the patient] so we couldn't run her medications. So, I was having to call residents [doctors on call] and make arrangements to have central lines put in so we could have IV access, on top of two unstable patients and all the paperwork, so it was just a very—there was a lot of activity.

To further complicate the evening, participant #2 was assigned as the nurse in charge. She described her role as the charge nurse to include completing the nurse-to-patient assignment, appropriately delegating nursing tasks, and providing support and direction to the other nurses. She further referred to the "model of care" used in the hospital where she worked as evidence to support her understanding of her charge-nurse role. Two other nurses on the unit, however, did not perceive her as following the model of care; instead, they perceived her behaviour as not "very interested in what was happening" and "uncooperative." In contrast, the participant felt that she successfully navigated a busy night because all the required nursing tasks were completed and "nothing happened." She stated that she:

> …didn't feel great about it [the shift], having said that, nothing happened, all the patients were looked after, everything that needed to be done was done. I don't know how to describe but part of the reason I didn't feel good about it, is because I could sense that some of my co-workers were not happy with me.

She further went on to describe the two nurses' "lack of socialization [*sic*]" was the indicator that made her feel that they were unhappy with her.

> Their lack of social talking with me for the rest of the shift — you have to be social and there was a real lack of that from probably three of the nurses on the shift. Yep, so I knew there was like a tension there.

The next night she recalled how two of the same co-workers were "snippy" when they interacted with her, how they excluded her from conversations, and made her feel as if they were talking about her in their private conversations by glancing her way. She said that while this tension did not affect the quality of the care she was providing to her patient, it did affect her personally, as she felt like crying and had difficulty sleeping the next day.

As the participant had previous experiences with what she referred to as being "bullied" as a younger nurse, she stated that from her experience it was best to just confront the situation. Therefore, the participant explained how she confronted the nurses at the end of the shift and asked if there was something that they would like to discuss with her. The nurses replied that they perceived that she was uninterested in helping them on a busy shift. The participant defended her actions during the night shift by referencing the demands on her time in her role as the charge nurse and the busyness of the unit.

Reflecting on her role in the CWR with her co-workers, the participant argued that if her co-workers had an issue with her, they should have approached her, instead of choosing to "pick" on her.

> I said, on top of that, you knew that I wasn't feeling well. I said… if in your opinion I wasn't on top of my game as you felt I should be I said, I don't know why you felt the need to pick on me for that, instead of being supportive toward me…

Participant #8 also described being "chronically short [-staffed], "on the rocks," and "always on bust" as the backdrop for many of the CWR experiences she encountered. She explained how she arrived for a night shift knowing that she was "in trouble" because there were two "traumas" in the emergency department and chest pain in another room and they were already "down one nurse."

Participant #7 also confirmed the shared meaning of being busy (also called "heavy" by participants). She described how being busy meant that she had many nursing tasks that she was required to complete before the end of her shift:

> Yep, um, busy meant that when you received a patient, an unstable patient come in, usually we have a lot to do when they are first admitted, meaning we have to make sure the patient is hooked up to the monitor, all our IV transfusions are appropriate and then usually we have to carry about, a whole bunch of interventions that are requested by the physician. So, it is busy because we have a lot of tasks to do.

Participant #12 recalled how when she first graduated, she "lost 20 lbs" because "it was nonstop." Nonstop was clarified to mean that her job as an RN was very physically heavy (demanding) and there were a lot of things that needed to be completed, so she tried to stay "ahead of it." Like participant #1, she also highlighted how, as a novice RN, she "hated to ask [for help] because everybody would like [gasps] and they'd roll their eyes." These types of interactions with her peers created a stressful and tense working environment for participant #12. However, for participant #12, being busy did not automatically translate into having a poor day. Instead, she described the conditions she felt contributed to her experiencing a "good day." For her, a good day meant being able to

“predict your schedule, you could actually get things done on time, your patients didn’t get sick unexpectedly, and staff helped each other.”

Additionally, as participant #2 noted in her account, RNs were required to complete paperwork during their 12-hour shift to document the care provided to each patient. This documentation contributed to the busyness of a shift. As well, the completion or incompletion of paperwork, in this case, linked two different nursing units together, each affecting the busyness of the other unit. As noted by participant #2, the incomplete admission paperwork of the day shift on another unit impacted the work for the RNs on a different unit on the following night shift.

It came through in many of the participants’ accounts (#2, #4, #10, #11, #13, #17) that there was a strong desire by nurses to see their nursing leaders, such as nurse in charge or nurse manager, more involved in the functioning of the hospital unit. Recalling participant #2’s account, her peers were upset with her because, from their standpoint, as the nurse in charge that night, she (participant #2) did not appear to be interested in what was happening on the unit. Other participant comments directed towards leaders included how leaders needed to “come out of their offices” (Participant #17), “be totally engaged with staff” (Participant #4), and how RNs become “disgruntled with management. . .when they were not adequately staffed or adequately supplied with the things they needed” (Participant #13).

Like the unaccounted/additional work required for novice nurses, the organization of the hospital setting also appeared to create unaccounted/additional work for nurses. For example, participant #2 described how she was unable to begin the work required for her shift because she was first required to complete work that was unfinished by the previous

shift nurses of a different unit. The work required on the two different units being linked together by the admission paperwork. Then her work was further delayed because she had to wait for the doctor to write the admission orders for the new patients. The additional work of completing the day-shift paperwork, and the waiting work for doctor's orders, stalled how she normally would have started and organized her shift. These circumstances created additional demands and time constraints for her. Many participants described situations of this type of additional work as commonplace within the hospital setting. These descriptions highlight how nursing practice within the hospital setting may sometimes be constrained by the organization of the setting. It seems that when deviations from the routine organization occur, nurses were required to change and adapt their practice to meet these changing needs, creating increased workload and stress for them. As noted previously, the busyness of a unit was noted as a contributing factor in the development of CWRs between nurses. However, participants' accounts indicated that although nurses were aware that the difficulty they had in managing their workload was related to the increased busyness of the unit, nurses still regarded the incompletion of tasks as a flaw of the RN as a person, which was further conceptualized as incompetence.

4.4.2.3 Being Left to Your Own Devices: Demonstrating Competence in the Hospital Setting

Participant #5 provided another example of how being busy contributed to poor collegial relationships between nurses, and how busyness was interrelated with the notion of competence as a nurse and the completion of texts. She described her experience as a casual nurse and being unfamiliar with a "care map" used on the unit where she was assigned. Care maps are formally called integrated care pathways or anticipated recovery

pathways (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998; Rankin & Campbell, 2009). They are a task-orientated piece of documentation that details the steps required in the nursing care of patients with specific clinical problems. Once the nursing care steps are completed, a description of the expected progress of the patient, measured in days, is provided on the document (Campbell, et al., 1998). The care maps were designed with the purpose of providing a structured means of developing and implementing local protocols, improving multidisciplinary communications, decreasing unwanted variations in practice, decreasing length of hospital stay, and improving patient outcomes (Campbell, et al., 1998).

Participant #5, being unfamiliar with the unit and having no previous experience using a care map, requested assistance. The nurses on the unit were reluctant to help her. They claimed that they were "busy ourselves" and that "the care map was self-explanatory." This left the participant feeling isolated and uncertain regarding the safety of the patient to whom she was responsible for providing care. Participant #5 reflected on how this incident contributed to her having a "difficult day":

> I went to [unit name] and they had started on that unit [referring to care maps], and I was always one to really try my best, so if I was sent there, I felt that they knew what they were doing, and you know, I am a casual. I am, and I remember going there and asking, they had this new protocol where day one, the [type of illness] patient had to do this, day two they had to do that — the care map. I asked for help and no one helped me — I thought, oh my god, like you know, this is going to be a difficult day."

Further, participant #5 elaborated:

> [B]ecause I didn't understand the [type of illness] map, you know, what would have been expected of me, everybody else was busy. I always understood their position, but I felt…the way units operate, you know, they kind of leave you to your own devices, you go figure it out, right? Which is dangerous for the patients.

Participant #5's statement that she "understood their position" speaks to the strong influence on RNs of the social organization of nursing. In this case, Participant #5 understood and accepted the work of being a busy nurse. She empathized with her peers being too busy completing their own work to take the additional time to explain the care map. However, participant #5 was still perceived by some of her peers as incompetent due to her unfamiliarity with the care map. Her perceived incompetence by her peers reinforced the notion of task-completion-as-competence in nursing practice. In participant #5's account, competence was valued by her peers because it meant that she could complete her work independently, which in turn would not increase her peer's workload, making the workload of the shift more manageable.

Participant #9 verified the shared perception of competence within the nursing profession:

> I was a good worker, I…like had good knowledge…skill set…and, so when, that's on your floor now [unit], that's quite a busy floor…you have to have really good skills and…you have to be up on pretty much everything.

She used the phrase "good worker" to describe how she was able to effectively manage to work on a busy unit and how she had a good "skill set." Thus, competence was also related to a skill set, which translated into the concept of a good worker (nurse). In addition to being able to work independently, having a good skill set, and being competent, another quality of the good nurse included having knowledge of a unit's routine; that is, what doctor to call, where things were located and so on.

Participant #17 described her CWR experience as occurring on a unit that had a "culture of being catty and backbiting." She explained how it was commonplace for nurses on her unit to gossip about their peers, especially when there was any level of

perceived incompetence. She recalled a time when she failed to document on her patient's medication administration record. Her peers did not contact her to clarify if the medication was given to the patient or not, instead, they chose to report her documentation omission by submitting an occurrence report. Participant #17 clarified that the writing of the occurrence report per se did not offend her. However, she was offended that her peers did not contact her first about the omission and that there was no conversation or clarification regarding the well-being of the patient. She went on to explain that after this incident, her peers monitored her work. She described how shortly afterward, another one of her peers purposefully went through her day shift documentation, checking for accuracy. As previously noted by participant #1 (section 4.4.1.1), there are no requirements for RN peers to check one another's documentation. Participant #17 emphasized the impact these experiences had on her personally and professionally. She expressed how she had to "haul myself up out of bed and get the motivation to go to work. I did not sleep well the night before and I always felt like I was walking on eggshells. I was always afraid."

Many of the RNs I interviewed described how they evaluated themselves and their peers by their ability to manage their workload successfully and competently. Those peers who were new at a unit and/or struggled with their workload, lacked a certain skill set, or required a lot of assistance, were frequently labeled as "incompetent." As noted previously, the organization of the hospital setting required nurses to complete their work, such as accepting an admission, within the assigned shift. The incompletion of work by one shift created stress for nurses on the next shift because in the hospital setting there was no additional time allotted (within their scheduled shift) to complete extra duties. The

reluctance to provide help by perceived competent RNs to their perceived incompetent peers reinforced power differentials and the misuse of power between RNs.

In the preceding participants' accounts, the hospital setting appears organized in ways that include additional work for RNs. More so, this additional work is not openly acknowledged or consistently accounted for in the organization of nursing practice. For example, participant #5 had the extra work of explaining to her peers that although the care map was easy to read and follow, she still needed reassurance from her peers when completing the skills outlined in the care map for the first time. She noted the additional work of obtaining competence in a skill as opposed to simply being able to complete a skill, especially when client safety could be compromised if the skill were done incorrectly. Participant #17 also reported the additional work to obtain the motivation to go to work. It was evident from participants' accounts that RNs must work at using their professional knowledge and judgement to determine how to best navigate their nursing practice. This may include work on how strictly to follow texts such as care maps, to meet the needs of their clients while also operating within the constraints of the organization. Most of the time, RNs unconsciously and successfully managed their additional/unaccounted work. However, when work was compounded with the additional stressors found in the hospital setting and sustained over a prolonged amount of time, some nurses had the potential to experience burnout.

4.4.2.4 Workload, Workplace Atmosphere, the Development of Burnout, and the Relationship to CWRs

"Workload, workload" was the answer to my question: Why do nurses experience burnout? Participant #7, #10 and #11 noted how being too busy created stress for nurses and when the stress levels became unmanageable, nurses became "burned out."

Participant #11 described how in her experience, many nurses who were "good nurses" were often the ones who experienced burnout:

> …what you notice…really good nurses…I notice excellent nurses that I would want to be taken care of…them to take care of me or my family…but personalities quite change, and I could see it and I've said to them, a few people, you know they [referring to the nurses experiencing burnout] were angry….

Participant #11 recalled a time when her unit was experiencing a change in management that subsequently led to changes in the unit routine, that further contributed to the development of CWRs and to nurse burnout. She described the atmosphere in her unit as one where there was "a lot of anger and disrespect and hostility, and like her and [names another RN] would be like at each other's throats pretty much." She used the words "a lot of upheavals" and "stress" when she described the impact the changes had on the overall atmosphere of her unit and how it resulted in a lot of nurses becoming angry and experiencing burnout. Stressful and tense working environments have been identified as contributing to nurse burnout (Oyeleye, Hanson, O'Conner, & Dunn, 2013).

Participant #9 perceived that nurses who experienced burnout were no longer able to handle their workload. As previously described, nursing practice has been organized in a way where there is either little or no additional time for extra work. Therefore, when one nurse is having difficulty completing their workload, it affects the workflow of the entire unit. The disruption in the workflow was unappreciated by other nurses working on

the unit because it was an additional source of stress for them. Further, it was the nurse experiencing burnout who was perceived as the problem. Participant #9 stated:

> …I would say that the biggest…, the issue probably is when people become burnt out [sic]. You can notice that [nurses who experience burnout] in their attitude towards others (co-workers), I guess kind of expecting them [co-workers] to do more because they (nurses who experience burnout) can't handle it but can't really admit that, and [as a result] there was one time there was quite a bit of conflict going on….

On this point, participant #9 and participant #11 (respectively) went on to say:

> I don't see that they [nurses who experience burnout] really seek help…they, it seems like they get burnout, eventually find a new job and move on, but that period between becoming burnt out [sic] and moving on is, I would gather about a six-month period, which is um, a terrible period to have to work with those people [nurses who experience burnout] I think, which is unfortunate but….

> …I think one [contributing factor to burnout] was a lot of stress was, like I say, a lot of, people here a long time too, so I am thinking nurse burnout had a little bit to do with it, but the unit, I mean, the unit has always been heavy.

Participant #10 (who worked on the same unit as participant #11) described how changes in management and the routines of the unit as creating "staff discontent." From her perspective, there was a lack of consultation with frontline RNs about the changes to the unit, which led to "infighting" between the RNs. The lack of RN input regarding the changes to the unit created an atmosphere where there was "a lot of animosity and hostility to the floor [unit] and like you could feel the tension" (Participant #11).

Participant #10 described how the tension being experienced in the unit affected RN relationships. She noted how there was a lack of tolerance between RNs where "everything was an issue…." To illustrate this, she provided an example of the fluid balance sheet not being filled out properly.

> …everything was an issue…little things that normally people wouldn't care about, …like fluid balance not being done [referring to the intake and output

> documentation record], receiving another email [referring to the complaint received by email] and can't you address that amongst yourselves [feeling that the nurses should have been able to address this particular issue among themselves]?

In this example, she described how one nurse did not fully complete the intake and output record at the end of her day shift. The RN relieving her for the night shift noticed that the intake and output record was not fully completed. Instead of taking the time to complete the fluid balance sheet herself (by doing the mathematics associated with it) or approaching the RN on the next change of shift to inform her of the omission, the night shift nurse emailed a complaint to the unit manager about her co-worker. Participant #11 confirmed a shared understanding of tension. She described the tension as "not infighting but like backbiting behind each other's backs and people filling out occurrences on people."

Both participants #10 and #11 noted how changes to the unit's routine added to the stress of the nurses working on that unit, to the point where it became unmanageable. As the stress levels increased, nurses' tolerance for the perceived downfalls of their peers decreased, which in turn contributed to poor working relationships and conflict escalation. For example, without the additional stressors, if an omission on the intake and output record was noted, the observing RN would contact the RN assigned to the patient to have the missing information completed without reporting it to management or completing an occurrence report. Further, both participants #10 and #11 stated that they expected minor oversights and/or disagreements to be resolved between colleagues, without the need to fill out an occurrence report. However, as previously explained, if the reporting nurse was questioned about her reasons for filing out the occurrence report

(instead of speaking with her peer first), she could defend her action by citing that it was a requirement of the employment setting and, therefore, necessary to ensure patient safety.

Participant #11 felt that nurses choose to fill out occurrence reports instead of confronting their peers because they are too busy and frustrated to take the additional time and energy needed to address issues with their peers themselves. Completing an occurrence report was easier, took less time, and was less stressful for the reporter. Although the occurrence report requested only objective information regarding what the RN did or did not complete correctly, it is still perceived by some RNs as a personal attack. Participant #10 stated, "People take it very personally when you fill out an occurrence report." When nurses received notice from management that "they had been reported" by their RN peers (meaning that their peer had completed an occurrence report on them), feelings of hostility and anger were created. This compounded the stress and tension being experienced and sometimes fostered burnout.

4.4.2.5 The Politics of Nursing Practice: Participants' Accounts of CWRs Related to Expectations for Equality in the Workplace

A sense of injustice related to inconsistencies in nursing practice was frequently noted by some participants as a contributing factor in the development of CWRs. Participant #5 commented on her experience with job postings. She described two experiences where the employment criteria listed for two job postings were inconsistent. She explained how the human resources department may "twist it [the job-posting criteria] sometimes to suit what they want it to suit." She provided an example of how two part-time nursing positions were posted but they were awarded to one RN as a full-time position. Participant #5 felt disgruntled regarding this. From her standpoint, she felt

it was unfair because many more RNs, with more seniority and higher qualifications may have applied for the positions if it was known that they might be combined to create a full-time position.

In her second example, she recalled a situation where the criterion of "2-years' experience" in a specific setting was listed as a requirement to apply for a certain position. This was frustrating for the participant because although she had many years of experience [and hence seniority] she was unable to apply to the position because of that "2-years' experience" proviso. The position was awarded to a novice RN who had the specific experience requested but had *only* worked as a nurse for two years in total. The participant felt that because of her many years of experience she could have easily transitioned to working in that setting and how she would have appreciated the new learning opportunity. However, there was no opportunity for her to even apply for that position. This job posting was especially frustrating for her because she noted how other times, when she was the RN with the experience working in a specific setting, she was still not awarded the position because it was given to RNs with more seniority (and no experience in the specific setting). She expressed that "making all these side deals, it is not fair, and it is frustrating…."

Participant #5 described another situation regarding inconsistency in decision-making practices and employment decisions where seniority was involved.

> I have got 25-years seniority, but it was wiped out when I went casual and why? I don't know. I would love to know why that has to happen because there is no reason. If you are senior you are senior, whether you resigned your position [to accept a casual position] or not. But I heard there is a nurse over in emerg [emergency department] that they are allowing to keep her seniority.

In the above account, participant #5 noted how once she accepted a casual position, her 25 years of employment experience were considered null and void by the employer. The participant, by accepting a casual position, had her seniority "wiped out." This put her in a vulnerable position because it meant that she would be low in the application pool for any new seniority-based nursing positions. More so, participant #5 felt a sense of injustice when she learned about another RN, who had made a similar employment decision who kept her seniority. Ultimately, she felt, it was up to the employer whether they chose to nullify a nurse's seniority or allowed them to keep it.

Participant #4 and #5 also emphasized how RNs sometimes felt powerless because of inconsistencies in hiring practices, and how this translated into CWRs between RNs. The following excerpt highlights some of the most prominent issues regarding inconsistencies with formal employment processes and their influence on CWRs. Concerning this, participant #4 asserted:

> I think there is still disgruntlement between [diploma prepared] RNs and BNs, even after close to 20 years of it [BN as entry-to-practice as an RN]. I still hear that thrown around. I think in some ways it has been demoralizing to RNs because they are forever being now overlooked for positions because they don't have degrees. And they don't have Masters.

Participant #4 was speaking about nursing positions in management and education. RNs with diplomas were sometimes overlooked for management and educator positions because they did not have an undergraduate or graduate degree in nursing, despite having years of clinical experience and experiential knowledge. The Registered Nurses Union of Newfoundland and Labrador (RNUNL) supported diploma-prepared nurses in applying for management and education positions, but it is ultimately the

employer's decision regarding who to hire. The employer valued the educational credentials over the years of nursing experience.

On the opposite side of the spectrum, participant #14 described tense working relationships with her peers because she was awarded a position that she felt more qualified for, but she had less seniority than another RN. The other RNs filed three union grievances against her because they felt the position should have been awarded to the RN with the most seniority. Participant #13 discussed why inconsistency with respect to seniority and the employment setting was so frustrating for RNs. She stated that in her understanding, the union collective agreement was meant to establish expectations for equality in the workplace. However, within the workplace, these expectations were frequently not achieved and/or not enforced. She provided the example in the collective agreement that provides RNs with a fifteen-minute break twice for a 12-hour shift; however, depending on where you were employed, the time taken for coffee breaks varied. This inconsistency sometimes led to perceptions of colleagues being "slackers" because the nurses on their unit took longer coffee breaks as compared to the nurses who were the "go-getters" because they kept to the fifteen-minute timeline.

Frustrations associated with inconsistencies in the established ruling practices were noted in the CWR accounts provided by participant #16 and participant #14. Recall the CWR account provided by participant #16 (section 4.4.1.1). She experienced a tense working relationship with her peers because she was perceived as having "lucked into the job" due to her lack of seniority. A few participants discussed how the absence of a union was beneficial for their working relationships. Participant #14 described, for example, the time when she was employed as an RN in the United States. She believed she experienced

fewer incidents of CWRs between RNs. She believed that there was less animosity between RNs employed in the US because in the US, RNs were not unionized. Participant #14 stated:

> You are judged on your merit…what you did as a nurse, your education. So if I applied for critical care, and I did cardiology [worked as a cardiovascular RN], and she [sic] did all these courses, I would have gotten the job over someone who had 30-years' experience in medicine…because "it makes you work hard for what you want to get, and it makes you look to the future instead of staying in one place and saying "well, I'll get it because I have been here so long."

Participants #3, #4 and #15 shared the belief that nurses should also be appraised on the quality of their work as well as their years of experience. Other inconsistencies in labour - management relations that were noted as contributing to CWRs between RN peers included workload, lack of resources, and differences in the number of resources allocated between regions.

Participant #2 summarized her thoughts on liability in nursing and her thoughts on what she called the "politics [of nursing practice."]

> There are a lot of politics in nursing. We have a regulatory body and are bound to standards of practice and maintaining competency. We also have a union to regulate the quality of our work environment. Also, a good thing. Then we have the organization at large, which serves the public. And there is a duty to uphold the face of that organization and its image. These are all good and necessary things, however, sometimes it feels that they don't work for the best interest of everyone and that the processes within and between each are flawed.

In the above statement participant #2 noted the regulatory body, the union, and the hospital (being a part of the health care system but at the same time also influenced by the health care system) as three authorities ruling over professional nursing practice. She went on to describe how while RNs have the necessary knowledge, skills, and judgment to make decisions regarding their nursing practice, a nurse's professional judgement is

frequently suppressed or not fully utilized. She provided an example of how she decided to "hold" nasogastric (NG) loss replacements. The physician had written orders that a patient was to be given an equivalent amount of intravenous fluids to replace the amount of nasogastric fluid lost via suction. Participant #2 assessed the patient's physical status, including the results of blood work to determine that the patient was receiving too much fluid. Therefore, she used her professional judgement and decided to hold (meaning decided not to give) the intravenous-fluid replacement for the NG losses, until she could follow-up with the physician. She explained how she was "questioned and scolded" by her peers for making that decision. Although the participant conducted an accurate physical assessment and had the required knowledge and experience, her professional judgement was not supported because in the hospital setting, the medical aspects of providing patient care require a physician's order. The participant clarified that she did call the physician after she held the fluids. The physician agreed with the participant's assessment and wrote the order to hold fluids.

In another situation, she (Participant #2) described how a physician made a mistake on an order to remove a patient's drainage tube. The RN, who implemented the incorrect physician's order, was also held accountable for the error. The physician cited how there was an expectation that RNs should recognize errors in the physician's order and to question the physician before implementing the order. In contrast to the situation as described above, the physician was now relying on the nurses use of their professional judgement. The point that participant #2 wanted to demonstrate was the inconsistency in the beliefs held about nurses use of professional judgement and, more so, how this inconsistency was proliferated in the hospital setting. Nursing practice appears to be

organized in ways that undermine a nurse's use of professional judgement, limiting their capacity to use their knowledge, experience, and skills to contribute to the patient's health and well-being (Rankin, 2009, 2015). As well, these inconsistencies are also reinforced by RN peers, where a nurse could be "scolded" for using or not using professional judgement depending upon the context of the situation. This was noted to be frustrating for RNs, creating feelings of powerlessness and complacency.

4.4.2.6 Summary of CWRs Related to the Organization of the Hospital Setting

Participants #2, #3, #5, #7, #8, #9, #10, #11, #12 and #17 voiced how the organization of the hospital setting influenced how nurses were expected to practice. These expectations for nursing practice were further reinforced in the hospital setting via texts-in-use. Many of the participants described their experience of disjuncture between the expectations for providing quality care for the patients, while navigating the busyness of the hospital setting.

Despite a trend towards the promotion of patient-centred care, biopsychosocial models of health, and collaborative practice in the last decade (Farre & Rapley, 2017), hospitals have remained organized according to medical specialization of care and specialized services. As previously explained, these services are highly influenced by biomedical practices and market models of health care delivery. This type of organization has been linked to the creation of disjunctures, tensions, and frustrations for nurses (Day, 2013; Hutchinson & Jackson, 2015). Within the hospital, nursing units are divided by the medical specialization. In this way, most of the work that nurses are required to complete is disease specific and is dependent upon curative medical practices/procedures. Medical

specialization of care is highly effective in producing health care providers who are experts in certain disease processes, which is of benefit to the patients. However, it also separates RNs into "pockets" of nursing practice, where RNs might not completely appreciate the specialized work of their peers. Further, where the specialized experience of nurses was recognized (e.g., job application criteria), there were inconsistencies in the value placed upon that experience.

Nursing practice has become fragmented into discrete tasks can be easily counted and measured in terms of efficiency and productivity, ensuring the hospital is organized according to good business practice (Armstrong & Armstrong, 2003; Day, 2013; Rankin & Campbell, 2006). The ability of the RN to independently manage their workload, including the incorporation of their theoretical knowledge and psychomotor skills, sets the criteria for the idealization of a "good nurse" in the acute care hospital setting. Despite acknowledging the busyness of nursing units, nurses still expected their peers to manage their workloads independently. More than that, the participants expressed that any nurse peer may be perceived as incompetent if unable to do so. Furthermore, incompetence was perceived as a fault of the individual nurse, who was then treated poorly by their peers. This dynamic helped constitute the social context for the development of a CWR. The pressures and time constraints associated with increased workload were described by the participants as the perfect backdrop to prompt the development of CWRs.

In keeping with IE as a method of inquiry, it was important to extend the exploration beyond the local hospital setting and consider the extra-local influence of the federal and provincial health care system and the influence on the organization of the hospital setting, nursing practice, and the development of CWRs between RN peers.

4.4.3 Participants' Accounts of CWRs Related to Working Within an Evolving Health Care System

As explained in chapter two, changes and reforms to health care services have been necessary to respond to the changing health care needs of the population and to keep pace with a technologically evolving health care system. Whether working on the same unit, on different units, or in specialty areas, the work of nurses is connected to and influenced by the organization of the hospital setting. Within this setting, RNs are relied upon to ensure the effective flow of patient movement and coordination as part of the larger health care system. Patient movement within the hospital setting must occur to ensure that patients enter the system, receive the full range of services, and exit the system in a timely manner.

The participants' accounts of the hospital setting demonstrate the significant impact that the working environment has upon the relationships between RN peers. The participants emphasized how when working within the hospital setting, any deviation from normal, established routines contributed to an increased workload that was unaccounted for and difficult to manage. For example, when changes were made to the organization of the practice, nurses needed to adapt their practice to align with the new organization, to ensure that their practice was connected with the different units and departments so that there were no interruptions in the flow of patient care. The following participants' accounts demonstrate how the implementation of these models of nursing care created tensions and frustrations in the nursing work environment, influential in the development of CWRs between RN peers.

4.4.3.1 CWR Accounts Related to Organizational Change and Lack of Consultation Regarding Changes to Nursing Practice

Previously, when Participant #2 described a CWR she had with a few co-workers on a night shift (section 4.4.2.2), she justified her decisions that evening by referencing the model of care used to organize nursing practice on that unit. Recalling her CWR account, she described how her co-workers were unhappy with her because she did not seem interested in what was happening on that unit and shift. Participant #2 stated that she was working as the nurse-in-charge according to the model of care being used and further that she was confident that her peers were competent to complete their work without her involvement. She explained:

> According to the [regional health authority] model of care, we are supposed to be responsible for our own patients — right? And contact the doctor yourself. It is the normal practice that nurses obviously communicate with the charge nurse about what is happening because ultimately, I would have to step in and make a decision if a decision needed to be made of some sort, but um, yep, you know, like I said there is no rule about it but some nurses rely more on the charge nurse than other nurses for their involvement of care.

However, her peers did not view her role as a nurse-in-charge in the same way, and the difference between interpretations of the role set the conditions for the CWR event to occur.

Models of care and the documents supporting models of care were mentioned not only by participant #2 but also by participants #4, #7, #9, #10, #11 and #14. However, none of the participants were sure of the name of the model of care they were using, whether it was a specific model adapted to meet the needs of their unit, or even where the model of care text could be found. The two models of nursing care named were the Ottawa Model and the Eastern Health Model; both names were used interchangeably. The

proper and full names were the Ottawa Hospital Model of Nursing Clinical Practice and the Eastern Health Model of Acute Nursing Clinical Practice. The latter model was adapted from the former.

Participants #10, #11, #12 and #14 felt they (the participants used the word "they" to refer to all nurses) were not adequately consulted on or involved with the changes to their nursing practice. Therefore, when the new model of care was being implemented, the nurses experienced feelings of "upheaval" which was an additional source of stress for them. For example, participant #12 spoke about how the implementation of a new nursing care model created a generalized discontent among the nurses working on her unit and how this discontent impacted the effectiveness of the working relationships between nurses:

> And I think because there was so much staff discontent that we had several meetings and went to director level and we talked about why people were so unhappy….Basically every[one] said workload was a big major thing, about who they just can't keep up with it and how sick patients are and stuff, so then, it's basically, director went from that and said let's look at it…and then kind of made decisions without consulting the nurses.

Participant #12 went on to say that:

> …me and [names co-worker] were really upset at the time because it was changing our life and what we did as well. We went from 12-hour shifts, with two days off during the week [to eight-hour days all week].

Participant #11 described her understanding of how her peers felt based on her experiences with them. She voiced how her peers felt that hospital administrators failed to sufficiently ask questions regarding how the implementation of a new model of nursing care would affect nurses. Some of the effects she noted included: reductions in staff numbers, increased scope of practice for other health care providers, reductions in the

number of beds per unit, the addition of new units, different hours of work, and expanded roles for nurses in leadership positions. All these changes directly and profoundly impacted the nurses who worked on the unit, yet little input was requested of them before these changes were implemented.

Participant #12 supported this standpoint and further described:

> . . . without our input, actually is what the crux of it was like that's how it began and when we'd go to meetings with the director….It was a very disrespectful relationship, um, it was basically, she would come in and sit down and say…this is how it is going to be and that's the way it is, she would not listen to people.

These participants felt that the changes implemented in their unit would have been better received by RNs if their opinions had been requested and their concerns discussed prior to the changes being implemented. They felt there needed to be more discussion with RNs about how this new model would work with the overall organization of patient care. By including the RNs in the discussions on how the nursing units were to change and how those changes would impact their nursing practice, perhaps the RNs in the unit would embrace the changes and work together, instead of releasing their frustrations on each other.

Participant #14 described how her experience with CWRs also occurred during a time when there were changes being made to nursing practice. She described how RNs "don't feel that they are a part of it" (meaning the change process). Further, when nurses voiced that they needed additional supports and resources to effectively implement the changes to their practice, they were told it could not be done because of fiscal constraints. Participant #14 summed up by stating that nurses are "working in an environment that is completely frustrating." Also evident from the participant's comments above is the

importance of nursing leadership. Nursing leadership is discussed in chapter five, section 5.2.3.

4.4.3.2 CWR Accounts Related to the Disruption of Routine Nursing Practice

In addition to the Eastern Health Model of Acute Nursing Clinical Practice some participants described how lean process improvements were also implemented in the hospital setting. Originating from Japanese industrial organizations, most notably Toyota, lean methods offer ways to work smarter by creating more value for customers with fewer resources (Lean Enterprise Institute, 2017). To accomplish this, lean process improvement thinking changes the focus of management away from managing individuals towards improving the flow of products and services, thereby increasing efficient management of the entire system (Lean Enterprise Institute, 2017). Many of these innovations/changes had unanticipated consequences for the organization of nursing practice.

In the excerpt below, participant #11 described how the implementation of the lean process improvements was met with resistance because nurses feared this would lead to greater demands on their time and to more work for them in general:

> …we went through the lean process, basically, we sat down [with management], we said okay, it [the lean process implementation] wasn't working for nurses because they were busy as it is…that was the issue, when are we going to have this time?…see we went from 11 o'clock, that didn't work, we were trying to drag the girls in but they were so swamped out there [on the floor], they didn't want to come in to do their round [referring to "bullet round" in the room behind the nurses station] because you know how it goes, the Eastern Model…." [referring to how, as part of the Eastern Health Model of Care, an interdisciplinary collaboration referred to as a "bullet round" at 11 o'clock was introduced]

Participants felt that this top-down approach was ineffective because changes to improve the functioning of the system needed to begin with nurses as the frontline patient care providers. As participant #11 explained:

> So lean is basically where you… solve your problems, but the staff solves your problems, like so we should solve our own problems so you'd go from the staff level up…not like management level down…to try to give, uh, staff, front line staff ownership of their workplaces basically.

Participant #11 further explained how implementation of lean processes did not stem from the nursing staff. Instead, it was a direction given by management, which created frustration and hostility. The participants felt frustrated that management was not addressing their concerns regarding implementation of lean processes adequately. For the lean process implementation and the Eastern Health Model of Acute Nursing Clinical Practice to work, the way that nurses organized their work on the unit needed to change. On the unit where participants #10 and #11 worked, the nurses felt they were already working at their highest capacity and greatest efficiency. Now they felt they were being asked to work harder to improve hospital efficiency, which was equated with better patient outcomes.

Participants #10 and #11 provided another example of how the reorganization of their nursing unit created a problem for nurses when responding to call bells, the devices patients have in their rooms to request a nurse's assistance. When the participant's nursing unit was rearranged, the call-bell system was not updated to reflect the new organization. As a result, a nurse working on that unit might be assigned to patients in rooms at opposite ends of the hallway, meaning they would have to walk from one end of the hallway to the next. It was a small inconvenience, but the nurses felt it took more time

and effort to do the extra walking to respond to their patients requests for assistance. When the nurses asked if the call-bell system was also going to be updated to reflect the new arrangement of the units, they were told no because it would cost too much money to update the system. The participants' voiced how they felt disappointed by this decision. They felt they were doing their part to support the decisions of management/ administration by effectively navigating the changes to the unit organization, yet they also felt that their efforts were unappreciated because when they suggested to update the call bell system, the request was not considered.

Further, participant #10 and #11 asserted that the changes to the organization of their unit were completed "very underhandedly." The participants described how the nursing staff was told by management/administration "that the research showed that smaller units functioned better" and this was one of the reasons given for why their unit was being re-organized. The nurses were also informed by their manager that this *"*was the way that it was going to go." Participant #10 felt that they had "no choice basically." When I questioned the nurses about how this created conflicting working relationships, participant #10 described some nurses were "very hostile and crying and leaving the unit… there was a major upheaval… many people left…"

Participant #10 felt that the above situation happened because decisions about working conditions were being made without first consulting the workers involved. The way that nurses organized their work on the unit needed to change because of decisions to implement processes like lean and because of models of care informing the organization of nursing practice. However, on the unit where participants #10 and #11 worked, the nurses felt they were not adequately consulted about such decisions or the resulting

changes. Instead, they felt that they were just being made to work harder, with fewer resources. Research participants conveyed how they viewed the implementation of models for clinical nursing practice and lean-process improvements as business-minded. The implementation of these models and processes were associated with the development of hospital policies such as the over capacity protocol.

4.4.3.3 CWR Accounts Related to the Use of Over Capacity Protocol

Participant #15 described how she was completing care on her assigned patients when she received a call from a nurse in the emergency department (ED). The caller stated that she had a patient that needed to be admitted to her unit. The participant, having prior knowledge and experience with receiving an admission, knew she needed to complete her current nursing work to dedicate the additional time needed to accept the admission.

Through the participant's descriptions of the admission process, it became apparent how her work to receive the patient was connected to the work of the nurse in the ED, who was responsible for getting the patient admitted. The ED room nurse expected the participant to accept the ED patient within thirty minutes. The participant described her account of the CWR that transpired. When she received the call, she was already in the process of receiving a previous admission and transfusing blood to another patient. From her standpoint, she thought "there was no way I can finish an admission, give blood and take up a new patient [the patient from the ED] within a half an hour." Therefore, participant #15 requested that the ED nurse give her more time to complete her current work to be able to properly receive the new admission from the ED. She described how the ED nurse perceived the participant's request for more time as unreasonable and

called the participant's manager stating that the participant was "refusing an admission," and "giving them a hard time and being difficult." The ED nurse referred to the participant as "being slow" and stated that she would "not accept and that she would not tolerate it [the participant not taking the admission immediately]."

During the interview, the participant spoke as if it was common knowledge for nurses to know that they cannot refuse an admission. The participant stated "I know, and you [referring to me as an RN] know that we can't refuse admission. But we can ask for a little time to get through with what we are doing before we take up a new patient." At no time during the participant's conversations with the ED nurse, did she say that she was refusing the admission; instead she was asking for a little extra time. I asked if there was any specific institutional policy stating that nurses must receive a patient from the ED within thirty minutes? Here, the participant described the Over Capacity Protocol (OCP). In her interpretation of OCP, only if the ED called OCP overhead (the public address [PA] system) are RNs required to receive a patient within thirty minutes. She further clarified that the day of her CWR event, the hospital was not "in OCP," which she understood as meaning that she could request some additional time.

In her recollection of the event, the participant emphasized how nurses can sometimes be "unkind," which she further described as "demonstrating a lack of understanding." From the standpoint of this participant, she felt the ED nurse should have understood her request for some additional time greater than thirty minutes. Further, should there have been some disagreement regarding the amount of time required to complete the admission process, the participant expected that the ED nurse would have called her first to discuss the issue before reporting her immediately to her supervisor. In

participant #15's account, she felt in conflict with her RN peer working in the ED. She felt the ED nurse showed a lack of understanding and professionalism by reporting the incident to her manager before speaking with her in person. This created a strained work environment for the participant for the remainder of her shift. The participant stated that she remained "cautious" in all her future interactions with the ED nurse and experienced a tense working relationship with her peers in the ED thereafter.

Participant #10 also found the OCP to be a contributing factor to increased conflict between RNs. She stated, "um, in-fighting with emerg[ency] is a huge issue for us, or if OCP is called." Participant #10 spoke about how RNs working on different units failed to acknowledge or address the concerns of their peers working on different units. As each unit felt that their concerns were equally important, disagreements regarding hospital policies and priorities resulted, which contributed to CWRs. This was especially true when hospital policy was not being accurately or consistently followed.

Using OCP as an example, participant #10 explained her understanding of the OCP policy. It was her understanding that the OCP bed reserved on the unit was to be used only for ED patients to make room for new emergency patients. However, oftentimes, depending on the needs of the organization, OCP beds were sometimes used by recovery room patients or short-term admissions (STA) patients. The nurses working in the recovery room and the nurses using OCP to admit their short-term admission patients did not have an issue with deviating from the OCP policy, because their needs were being met. However, it did create feelings of frustration, uncertainty, and unfairness for the nurses receiving the admission. To meet the requirements for OCP, one hospital bed is kept empty in case OCP is initiated. This empty bed is normally situated in the unit

hallway (as it was an "extra bed" when there are no rooms available.) If an OCP patient is admitted, it is an extra patient for a nurse to care for, who already has a full patient assignment. Like previously described, any deviation from the normal routine creates additional time constraints for RNs, increasing their stress levels.

To complicate matters, participant #11 explained that the patient who occupied an OCP bed need not be a patient of one of the doctors working on the unit. Recalling chapter two, section 2.4.2, medical specialization refers to the organization of patients within the hospital setting in a way that allows types of medical conditions to be grouped together on one unit so that specific, specialized care can be provided to those patients. The health care professionals working on these units become very skilled at providing care for these specific types of patients. However, patients who are admitted to a unit with a diagnosis that is not within the specialty of the doctors or nurses working on that unit are referred to as "off-service" patients. For example, a patient with a broken leg could be admitted to a cardiology unit. Therefore, because of specialization of care within the hospital setting, the nurse caring for that patient may not be familiar with the type of nursing care required for that patient's diagnosis, creating additional stress for nurses that sometimes contributed to the development of CWRs. As this participant expressed:

> …at the end of the day, they [the patients] are stuck and they [the admission department in the hospital] just put them [patients] in an empty bed that they need to, which is added stress to the nurse…because [she is] unfamiliar. It's a medicine patient normally, so they are not familiar with what doctor they have to call…or even the diagnosis of the patient you [RNs] are treating.

Participant #10 further stated:

> …you are supposed to take a patient from emerg[ency] within a half hour and the problem then becomes that the patient they want to send…sometimes it is an off-service patient who is not appropriate to go off service and shouldn't be coming to

> [names floor]…because they don't care, because their only option or only plan for the day is to place patients…so, this whole thing about the right patient, the right place, right time, right bed, all that stuff means nothing to them…."

In the above statements, participants #11 and #10 were illustrating how some RNs find it stressful to care for "off-service" patients because they are sometimes unfamiliar with the nursing care required in relation to the diagnosis and they are unsure of what physician to call should they need support. Participant #11 also raised a concern about not being able to provide quality nursing care for off-service patients, citing how they "are stuck" on a unit where the best possible nursing care is more difficult to provide. Additionally, there was a perceived lack of support and accountability from the unit and hospital physicians. Participant #11 further explained:

> …and what doctors are there to support us? They [the doctor the RN called to get instructions on the OCP patient] say nope, [sic] that medicine doctor is not on today, you got to call this service [specific units in the hospital setting] and they [the medical doctor the RN called], oh, I don't know him because this is my first week, you know….

In this situation, participant #11 is voicing her frustration about how nurses are held accountable to provide care for OCP patients, while physicians are seen to not hold the same level of accountability. Caring for an OCP patient created similar stressors that the novice, float, or casual nurses described as their precursors to their CWR events. The RNs lack of knowledge of how to care for patients outside of their normal routine was stressful and was a source of added work for the RN.

When participant #10 spoke of the "right patient, the right place, right time and right bed" she was referring to what the patient care facilitator (the title patient care facilitator replaced the previous title charge nurse or nurse in charge) spoke of during "bed rounds." Bed rounds refer to an interdisciplinary team meeting of health care

providers who discuss the needs of the patient and ensure that the patients' needs [caring the right patient is in the right place, at the right time, in the right bed] are being met. In the above account, participant #10 described policies and procedures that ensure high-quality, safe and effective patient-centred care. Frequently, however, patient-centered care has been subjugated to meeting the efficiency needs of the organization. Although participants voiced their concerns about the OCP, including patient safety, increased workload, and the inability to contact the most appropriate physician, they did not feel such concerns were ever adequately addressed.

Participant #10 explained that she understood that the conflict between herself and her peer in the ED was not personal and that she understood that the ED nurse was just following the hospital's OCP policy. However, she was frustrated because in her professional opinion, she felt saying no to an admission was about patient safety. And further, she was not prepared to provide proper care; a situation she expected her RN peer to understand. Instead, her concerns were undermined by the ED RN who then used the occurrence reporting system (emails to management) to vent her own frustrations in an attempt to gain control over the factors impacting her working life.

Participant #4 described how she witnessed many CWRs between nurses. From her standpoint, she concluded that many CWRs could be avoided if the nurses involved could only see the bigger picture:

> Well, geez b'y [*sic*] you know we are busy here on the floors just as much as you are in emerg[ency]. And everyone is busy. Like there is a reality working in the hospital. You are busy, you are supposed to be busy, you are not supposed to be not busy, you are not supposed to be sitting there. Like this is the, you know patients come in through emergency, they get, you know assessed, they get admitted and then they move to the floor.

> But everyone has their blinders on so [the RNs working on the medicine unit] only knows what [medicine unit RNs] are doing. [The RNs working on the surgery unit] only knows what [surgery unit RNs] is doing. Emergency [referring to ED nurses] is only looking at what they [ED nurses] are doing, right? Everything is in play, it is all part of a puzzle, right?

In the above statements, Participant #4 was referring to how nursing units were organized within the hospital setting, and how RNs working on different nursing units were disconnected from one another. This participant used the word "blinders" to metaphorically suggest how some nurses are unable to see how nurses in other units in the hospital are working. Further, nurses are unable to fully appreciate how each unit within the hospital serves a specific purpose within the broader organization of health care in providing health care services to the public. Being obscured of this "big picture" has been noted as leading to feelings of injustice or unfairness and creating animosity and hostility between nurses. The challenge here is that the organization of the hospital setting as influenced by the broader structure of the health care system has created a social organization of professional nursing practice that makes it difficult for nurses to view the big picture of how their practice has been organized.

Not only was the OCP used in the same inconsistent fashion, but participants #10 and #11 also noted how being "in over capacity" was the "new normal" for nurses working in the hospital setting, instead of being used only to alleviate overcrowding in the ED. Participant #10 stated:

> We have been in OCP every single day, the only thing you are supposed to put in an OCP space [bed] is an emerg[ency] patient.

Participant #10 described how she had an OCP patient admitted to her unit every shift for a full week, and how none of the OCP patients met the criteria to initiate the

OCP. On the day of her interview, she described how she received two patients "for OCP," one that was a short-term admission patient and a recovery room patient who needed extra nursing supervision. She described being frustrated with the lack of consistency when the OCP was initiated and especially with the lack of consideration for RNs who had increased workloads with no extra resources.

4.4.3.4 Summary of CWRs as Influenced by the Evolving Health Care System

Participants #2, #10, #11, #15, spoke about how different interpretations of models of nursing care, combined with demands for increased productivity and efficiency contributed to CWRs between RN peers. The implementation of new models for nursing practice changed nursing care from a team-based approach to what was, and still is, called the "direct care" approach. Participants interpreted direct care to mean that they were the primary nurse responsible for the nursing care decisions of their assigned patients (similar to the total patient care approach). For example, if an RN was assigned to care for four patients, that RN would provide all the nursing care required for all those four patients, including the patient's hygiene, nutrition, medication, pain control, wound care, and so on. Practicing in this way meant that the RN generally worked alone, because her peers would also be providing care for their assigned patients at the same time.

Some participants stated that the direct care model as it was implemented in their practice setting implied that they had to work more independently, while they would prefer to practice using a team-based nursing care approach. For the participants, practicing team-based care meant that RNs worked together to complete common procedures on all the patients. For example, the RNs may work together to complete all

the bed baths on the unit, or one RN may complete the blood-glucose checks on all the patients and inform the primary RN of the results. Although the participants who practiced team-based nursing noted that CWRs still occurred, they emphasized that they were less frequent. What appears to have happened was that some of the participants were having difficulty understanding, interpreting, and adapting to the changes brought about by the introduction of the new model of nursing practice, especially when it was combined with all workload issues identified in the hospital setting.

For example, the introduction of the new model of nursing care was meant to alleviate some of the workload issues identified by nurses. It was expected to allow nurses more autonomy over their decision-making, as well as strengthen collaborative practice, and encourage communication between the person most accountable and knowledgeable about the patient's care (The Ottawa Hospital, 2014). However, the data generated from participants' accounts indicate that the implementation of the model did not successfully convey that message. Instead, the model was perceived by some nurses as productivity and efficiency measures that created additional work for nurses, while increasing their individual accountability. Additionally, some participants expressed feelings of moral and ethical distress concerning the use of efficiency models as contradictory to the delivery of quality patient care.

Participants also described how increased control over their practice environment, including a decrease in workload, would reduce the stress experienced by RNs and help promote more positive peer relationships. However, most of the participants voiced how they felt a sense of powerlessness with respect to the changes being made to nursing practice and the quality of their work lives.

4.5 Analysis of Texts Referenced by Participants

All participants expressed that their CWR experience was traumatic because such behaviours from RN peers was unexpected. Therefore, consistent with IE methods, it was important for me to conduct a closer examination of the broad governing texts that set out the expectations for professional nursing practice. Participants frequently referenced the following documents that are well-known in the nursing profession: The *Standards of Practice for Registered Nurses* and the *Canadian Nurses Association Code of Ethics for Registered Nurses*. Participants noted their use of these documents during their nursing education and during their initial nursing-licensure registration. In the following sections, I provide a textual analysis of these two documents, specifically addressing the expectations for professional nursing behaviours between peers and colleagues. I then provide an analysis of the texts used in the hospital setting and how those texts set the expectations for nursing practice.

4.5.1 Setting the Expectations: Analysis of Texts Governing Professional Nursing Practice

Nursing in Canada is a self-regulated profession. The *Registered Nurses (RN) Act* (2008), under the mandate of public protection, grants authority to the College of Registered Nurses of Newfoundland and Labrador (CRNNL)[4] to set the expectations for professional nursing practice in Newfoundland and Labrador (NL) (ARNNL, 2013a). As the practice of nursing has the potential to cause substantial harm to the public if done

[4] On September 1, 2019, the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) officially changed their name to the College of Registered Nurses of Newfoundland and Labrador (CRNNL). There were no other changes to the mandate or function of the CRNNL. The previous documents published as ARNNL remain relevant and accurate.

incorrectly, the primary purpose of the standards of practice document is to provide a standard level of expected performance of RNs in their practice, against which actual performance can be measured (ARNNL, 2013a).

4.5.1.1 The Standards of Practice for RNs[5]

The standards of practice document for RNs contains broad, principle-based, authoritative statements that articulate the conduct or performance required of RNs (ARNNL, 2013a). The standards are sufficiently dynamic to define safe, competent, and ethical practice across all practice settings. All RNs are responsible and accountable for understanding and applying their standards of practice (ARNNL, 2013a). The document outlines four broad standards, each containing several standard-specific indicators. Each of these indicators clarifies concepts central to meeting the standard and provides the criteria against which RN performance is measured by self and others (ARNNL, 2103a). In my analysis of the standards of practice document, I found all four standards articulated the expectations for professionalism including how nurses are expected to relate to each other in the workplace.

Standard one - responsibility and accountability: This standard describes how the RN "is responsible for practicing safely, competently, compassionately, and ethically and is accountable to the client, employer, profession, and the public" (ARNNL, 2013a, p. 7). This standard has nine indicators. There are two indicators under this standard that are related to the expectations for professional nursing behaviours. Indicator 1.3 requires that

[5] In October 2019, the CRNNL council approved a new standards of practice document for registered nurses and nurse practitioners. I did not conduct an analysis on this document because my interviews were conducted before the document was approved and released. Therefore, the revised document could not have influenced the participants at the time of their CWRs.

RNs practice in accordance with the Code of Ethics for Registered Nurses. This document will be analyzed in the next section. Indicator 1.5 states that the RN is answerable for nursing actions, decisions, and professional conduct. This indicator is important because the way professionals interact with each other in the workplace is part of professional conduct, and this indicator states that RNs are answerable for how they conduct themselves professionally.

Standard two – knowledge-based practice: This standard sets the expectation that an "RNs practice using evidence-informed knowledge, skill and judgment" (ARNNL, 2013a, p. 8). This standard also has nine indicators. Indicator 2.7 speaks to how there is an expectation for RNs to support their "colleagues and students by sharing their nursing knowledge and expertise" (ARNNL, 2013a, p. 8). Nurses, as a group of regulated professionals, are required by their standards of practice to support their colleagues, including nursing students. If all nurses in all practice settings are required to adhere to these standards of practice, it is contra-indicatory that the phenomenon of "sink or swim" or "nurses eating their young" exists.

Standard three - client-centered practice: Client-centered practice refers to the expectation that RNs "contribute to and promote measures that optimize positive client health outcomes at the individual, organizational, and system level" (ARNNL, 2013a, p. 9). This standard has seven indicators. Indicator 3.2 sets the expectation that an RN "communicates effectively and respectfully with clients, colleagues and others" (ARNNL, 2013a, p. 9). Effective communication is defined as involving "the application of knowledge and skills related to relationship-building, assertiveness, problem-solving and conflict resolution" (p. 10). Indicator 3.4 speaks to the RN engaging "in

interprofessional and intersectoral collaboration" (p. 9). Additionally, indicator 3.7 sets the expectation that the RN "advocates for and contributes to quality professional practice environments" (p. 9), where quality professional practice environments are further defined to mean "practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care" (p. 13).

Standard four – public trust: This refers to how RNs are expected to uphold the public trust in the profession. This standard also has seven indicators. Indicator 4.1 sets the expectation that a RN "demonstrates a professional presence and models professional behaviours" (ARNNL, 2013a, p. 10). The definition of professional presence is further defined in the 2013 *ARNNL Competencies in the Context of Entry-Level Registered Nurse Practice 2013- 2018* (ARNNL, 2013, p. 5) to mean "the professional behaviour of registered nurses, how they carry themselves and their verbal and non-verbal behaviours; respect, transparency, authenticity, honesty, empathy, integrity, and confidence are some of the characteristics that demonstrate professional presence."

The Standards of Practice for RNs document clearly articulates the expectations for professional conduct and behaviours of nurses. I also examined standard one, indicator 1.3 which related RN practice in accordance to the Code of Ethics for RNs.

4.5.1.2 Code of Ethics for RNs

The *Canadian Nurses Association Code of Ethics for RNs* consists of two parts. Part I, speaks to nursing values and ethical responsibilities articulated through seven primary value and responsibility statements. These statements are grounded in professional nursing relationships including those to whom nurses provide care, as well as, students, nursing colleagues and other health care providers. The seven values are:

- Providing safe, compassionate, competent, and ethical care.
- Promoting health and well-being.
- Promoting and respecting informed decision-making.
- Honouring dignity.
- Maintaining privacy and confidentiality.
- Promoting justice; and
- Being accountable.

There are many statements within the Code of Ethics document that relate specifically to expectations for working relationships and the maintenance of collegial relationships. The Code begins with the statement that, "nurses are expected to work towards adhering to the value of the code at all times, regardless of individual differences" (CNA, 2017, p. 4). As components of ethical nursing practice, nurses are expected to self-reflect and engage in open dialogue with other nurses and other health care providers with respect to differences in opinions and perceptions (CNA, 2017).

The Code of Ethics further directs nurses to reflect upon all components of their practice, including the quality of their interactions with others, and on the resources, they need to maintain their own health and well-being. Beyond interpersonal relationships, nurses and employers have an obligation to advocate for conditions that support ethical nursing practice including the creation of high-quality practice environments, organizational structures, and resources to promote safety, support and respect for all persons in the practice setting.

The standards of practice and code of ethics documents are meant to inform RNs about their individual practice as accountable professionals. RNs expectations with

respect to their work settings are outlined in the collective agreement between the employer and the union.

4.5.1.3 Registered Nurses Union Newfoundland Labrador (RNUNL) Collective Agreement 2014

Several participants referred to the RNUNL collective agreement (RNUNL, 2014)[6] in their CWR accounts. The text of the collective agreement is important to consider because it clearly states the expectations of fairness and equality that RNs come to expect in their workplaces and from their employers. Nurses are introduced to the role and function of the union, as well as their association and involvement with the union in nursing school.

The collective agreement (or contract) of the RNUNL states that the purpose of "the Union" is: "to maintain harmonious and mutually beneficial relationships among the Employer, the employees and the Union and to set forth certain terms and conditions of employment relating to remuneration, hours of work, employee benefits and general working conditions affecting employees covered by this Agreement" (RNUNL, Article 1, 2014, p. 2).[7] The contract begins by defining the meanings of the language that it uses. Articles 3 and 4 of the contract describe the relationship between the employer and "the Union." The Union recognizes "the rights, power, and authority to both operate and manage the hospital is vested exclusively with the Employer" (Article 4.01, p. 5). However, Article 3.04 describes how the provisions of the Agreement *take precedence*

[6] A new Collective Agreement was signed on July 30, 2019. It will expire on June 30th, 2020. I did not complete a text analysis on this new agreement because it was not signed until after my interviews were completed. Therefore, the revised document could not have influenced the participants at the time of their CWRs.

[7] The RNUNL Collective Agreement will for the remainder of this document be referred to as "contract."

over all policies, rules, and regulations made by the Employer concerning wages, benefits or *working conditions*. The stipulations in the agreement about "working conditions" and "take precedence" are important to consider because many of the contextual factors identified by the participants as contributing to the development of CWRs were labour issues.

When reviewing the collective agreement, I specifically looked for statements that were related to the interview data provided by my research participants. Article 8 described hours of work and details on how an eight- and twelve-hour schedule should work. Rest periods were included in this description and employees were entitled to an unpaid forty-five-minute meal period as well as fifteen-minute rest periods during each third of a 12-hour shift. There was a sentence that stated that the meal and rest period(s) may be combined if mutually agreed upon by both the supervisor and employee. Therefore, it is conceivable that perhaps RNs on one unit are unaware of an agreement between the nursing supervisor and employees on a different unit, where breaks have been combined. This may have led to comments such as were made by Participant #13 (section 4.4.2.5), who described how the collective agreement was not being followed consistently by all nurses in all employment settings and this created the potential for the development of CWRs.

Article 23 defined seniority (subject to clause 33.08 and 33.10) to mean the length of continuous service (excluding overtime) with the Employer (p. 56). Article 24 defined the criteria for the awarding of employment positions. Subsection 24.04(a) states that all level 1 positions shall be considered based on seniority, fitness, and qualifications before an appointment is made. Subsection 24.04(b) broadly relates to "all other staff changes"

(meaning anything above level 1) to give primary consideration to qualifications, ability, and fitness to perform the required duties. When the specifications are equal, seniority, as defined in Article 23, shall prevail. Therefore, when considering participants' accounts and their interpretation of hiring, the collective agreement does state that qualifications will take precedence over seniority unless all qualifications are equal. The CWRs that occurred in relation to the awarding of positions are another example of the frustrations and tensions being experienced by RNs and another example of what I call 'double domination' (further explained in chapter five). Some RNs with years of experience and service to the profession are halted while other RNs progress, and this may lead to feelings of tension between both parties, hindering more positive working relationships.

Article 47 addresses workplace violence and sexual and personal harassment. This article sets the expectation that RNs have the "right to work in an environment free from workplace violence, and the Employer shall develop policies in support of this principle which shall be reviewed annually by the Occupational Health and Safety Committee" (p.89). CWRs between RN peers is not specifically addressed, however, it is broadly covered under subsection 47.02 - sexual and personal harassment. Personal harassment is defined as "any behaviour by a person in the workplace that is directed at, or is offensive to, an employee, endangers an employee's job, undermines the performance of that job or threatens the economic livelihood of the employee" (p. 91). The collective agreement also recognizes that personal harassment can stem from the abuse of power or authority, can undermine, sabotage or interfere with the career of an employee, and can be repeated, intentional and deliberate. Further, the agreement sets the expectation that if such incidences occur, "the Union, the employer, and OHS shall investigate alleged

occurrences and the Employer shall take appropriate action to ensure that occurrences cease" (Article 47.01, p. 65).

4.5.1.4 Summary of Texts Broadly Governing Professional Nursing Practice

The analysis of the texts governing nursing practice revealed that there is an expectation for nurses to maintain a level of professionalism in all their interactions, not only with their clients, but also with students, colleagues, and other members of the health care team. Professionalism has been defined by the College of Registered Nurses of Newfoundland and Labrador (2014, p. 6) to mean "adherence in all roles and practice settings, to the ARNNL Standards of Practice; and includes behaviours, qualities, values and attitudes that demonstrate the RN is accountable, knowledgeable, visible and ethical. Therefore, when the participants stated how they did not expect to experience CWRs with each other, they could have supported their expectations for professionalism by referring to the texts governing nursing practice. The expectations for professional nursing practice are important because both the *Standards of Practice for RNs* and the *Code of Ethics for RNs* are legislative requirements under the *RN Act* (2008), under the mandate of public protection. These two documents (among others) represent the minimum expectations for professional nursing practice while providing the criteria against which RNs are held accountable in their practice.

If an RN's practice was deemed inappropriate or unacceptable, the first question to be asked in a court of law would be if the "standard of care" was met and what would another reasonable, prudent RN do in a similar situation? To find the answers to these questions, the director of regulatory services or a lawyer would refer to these documents.

Provided that the *Standards of Practice for RNs* and the *Code of Ethics for RNs* are legislative requirements and must be observed by all nurses in all practice settings, it is reasonable to believe that CWRs should not occur at all. Recall that for this research, CWRs do not represent normal, everyday conflict, a difference of opinion, or a healthy debate. Instead, CWRs represent the escalation of conflict to the point where it is unhealthy and unproductive. In the next section, I analyze texts that govern the expectations for professional nursing practice in the hospital setting.

4.5.2 Analysis of Texts Organizing Nursing Practice in the Hospital Setting

Three specific texts were mentioned during the participant's interviews concerning the organization of nursing practice in the hospital setting, Eastern Health's Model of Acute Clinical Nursing Practice, Lean process implementation, and OCP.

4.5.2.1 Eastern Health Model of Acute Nursing Clinical Practice

A nursing model refers to the ways nursing services should be organized, how they should be delivered, and by whom they should be delivered (Canadian Health Services Research Foundation [CHSRF], 2011). The Eastern Health Model of Acute Nursing Clinical Practice is the official title of the model of care that organizes hospital nursing practice within NL. The Eastern Health model was adapted from The Ottawa Hospital Model of Nursing Clinical Practice (The Ottawa Hospital, 2014) to meet the unique context of nursing practice in NL. This model was mandated and partially funded by the Ministry of Health and Social Services NL and adopted in 2011.

Nurses from all practice domains at The Ottawa Hospital formed a Work Group Committee, which in consultation with patients and academic partners, developed The

Ottawa Model of Nursing Clinical Practice. The model is described as a guide to the organization of nursing care for registered nurses, licensed practical nurses, and personal care attendants that considers nurse competencies and position description as well as the values of the organization (Eastern Health, 2015). The model is based on the theory that "practice environments that promote nurses' autonomy, accountability and strong interdisciplinary teamwork led to better patient outcomes and improved nurse satisfaction" (CHSRF, p. 5). Additionally, the model was developed to be adaptable to the needs of specific nursing units within the hospital: to reduce RN stress, improve nurse well-being, and promote more positive professional-practice environments (CHSRF).

The Eastern Health Pamphlet: *Guiding Principles for Nurses* (2015) summarizes the purpose and meaning behind the adoption of the model as "It's all about providing excellent care by working to the full scope of your practice[8], making the right decisions, and being your patient's advocate and coordinator" (p. 1). The goals of the model include improving the quality of care provided to hospital patients and their families; having nurses work to their full scope of practice, being accountable for their practice and having autonomy to make decisions about direct nursing care/ and the organization of care and the continuity of patient care by reducing number of care providers. Further, the model encourages open communication, access to information and patient and family engagement in decisions regarding care (Eastern Health Pamphlet Guiding Principles for Nurses, 2015, p. 3).

[8] The scope of nursing practice is defined as the range of roles, functions, responsibilities, and activities which registered nurses are educated and authorized to perform (ARNNL, 2006).

The pamphlet includes a list of the principles, including that nurses are assigned specific patients during their shift, have the freedom, within their scope of practice to make decisions about patient care, and work to their full scope of practice and use evidence-based practices and professional collaboration to provide the best care possible, while working collaboratively with patients and families. A key support for the successful implementation of the model included nurse experts to help nurses' transition to using the new model of care, and to ensure that the implementation of the model remained focused on best patient care and not administrative process.

However, as the above participants' accounts suggest, more consultation and/or education with frontline health care providers may have been needed prior to implementation of this model in Newfoundland. Participants' accounts also suggested that the implementation of the model of care had not been carried out correctly for the purposes it was intended, perhaps because it may not have been completely understood by those nurses who were meant to use it. For example, as noted in the participants' accounts, RNs referred to the model of care being used as the "Ottawa Model" and only one participant referred to Eastern Health model by name. Also, a few of the participants' accounts of CWRs indicated that different interpretations of the model of care in use may have been a precursor to poor peer interaction. Further, RNs were being asked to organize their nursing practice according to a model of nursing care that was at odds with the task-based organization of the hospital setting. Initially, after the implementation of the model, nurse experts were available to help RNs navigate issues that arose; however, the participants determined that the length of time that nurse experts were available for support was inadequate and that ongoing support was needed.

4.5.2.2 Lean Process Improvement

The Newfoundland and Labrador Strategic Health Workforce Plan 2015-2018 outlines an approach to addressing priority issues facing the provincial health workforce (Government of Newfoundland and Labrador, 2015). Five strategic directions aimed at improving the quality of the health care workforce include i) building quality workplaces; ii) establishing an appropriate workforce supply; iii) strengthening workforce capacity; iv) enhancing leadership and management, and v) maintaining robust planning and evidence. Lean process improvements are found under strategic direction number three, strengthening workforce capacity, which is described as a means of improving productivity. Improving productivity is necessary to increase the health and community services system's ability to improve services and meet new demands, while remaining sustainable (Government of Newfoundland and Labrador, 2015). Working efficiently is one measure noted to help improve productivity, and efficiency is described as getting the job done well, with the minimum time and resources. The implementation of lean process improvements is given as an example of one approach the government was using to help improve efficiency. For the participants, though, lean process improvements were viewed as management's attempts to reduce the financial burdens associated with the health care system by making nurses work longer and harder and with fewer resources.

4.5.2.3 Over Capacity Protocol (OCP)

I reviewed the OCP document to find that it was a policy implemented by the regional health authority to acknowledge and account for periods of overcrowding in the emergency department (ED) (Eastern Health, 2011). Patients entering the hospital system through the ED were often required to wait in the ED until a bed became available on a

nursing unit where they could be admitted. Waiting patients were referred to as being "boarded" in ED, which increased the risk of impairing the timely delivery of emergency care to new patients arriving. Therefore, as the regional health authority is committed to providing client-centered care, the OCP allowed for the transfer of boarded patients to inpatient units that are already at full capacity.

The policy outlines specific criteria for OCP to go into effect. Specifically, one or more of the five criteria must be met. The five criteria include: when an ambulance is unable to offload a patient; when high priority ED patients in the waiting room cannot be accommodated in the assessment or triage room; when patients (level 3) have been in the waiting room longer than 1.5 hours; when the volume of level 1 or 2 patients exceeds 10% of the stretcher capacity, and when 40% of stretchers in St. John's, and 50% of stretchers in other EDs are occupied with boarded patients. Extenuating circumstances for such a nursing shortage in the ED may also be used as a reason to initiate OCP. The policy then lists 15 steps in the process of initiating OCP. Step #10 states that "boarded patients will be transferred to the assigned inpatient unit within 30 minutes of the announcement of OCP (Eastern Health, 2011, p. 3).

Participants #10, #11 and #15 expressed how they accepted the need for OCP but found it incredibly stressful when they were required to care for a patient with a diagnosis in which they were unfamiliar. This led to disagreements about where the patient would receive the best care. Participants #10 and #11 expressed how as RNs they felt undervalued when their concerns regarding patient safety were, in their opinion, not being heard. Additionally, an OCP admission increased the RNs workload and disrupted their routine for the shift. The participants' accounts provided examples of how professional

nursing practice can sometimes feel chaotic because RNs must frequently adapt their routine work to meet the needs of patient flow in the hospital setting. As the hospital setting is organized into different units, with different sets of nurses working on scheduled shifts, nurses are working within a type of "micro-society." The micro-level social-construction perspective views social norms as being established by only those within a setting, where face-to-face dialogic interaction between individuals and the use of texts, establish the identity of the self and the norms of the social environment (Cruickshank, 2012). Within a micro-level perspective, it is difficult for RNs on different units to envision and appreciate their involvement, and the involvement of others in the "bigger picture." The bigger picture extends beyond their immediate unit to include the other units in the hospital setting. All the units within the hospital setting have been organized to meet the requirements for our evolving health care system, as evidenced through health care change/reforms. As noted in the accounts provided by participants #2, #4, #7, #9, #10, #11, #14 and #15, RNs must sometimes adapt their work to meet the expectations of care as outlined in models of nursing care, in business processes such as the lean process implementation, and in hospital policy.

4.5.3 Hospital Policies on Conflict Resolution

Although not specifically referred to by participants, I also reviewed the hospital policies specific to conflict management. Within the hospital setting, few policies exist that address aspects of conflict and conflict resolution. I reviewed three policies applicable to CWRs between RN peers. The three polices reviewed were: Conflict Management (RHA, 2013), Prevention and Resolution of Harassment in the Work

Environment (RHA, 2017) and Safe Work Practices and Procedures (RHA, 2013). These three policies are not RN specific. They apply to all individuals (and students) employed by the Regional Health Authorities (RHA). Each policy is organized using the same framework. Policies begin with an overview statement, followed by a statement of the policy, the purpose, and scope. Each policy outlined several steps for employees to take to use the policy correctly.

4.5.3.1 Conflict Management

The overview statement on the conflict management policy reads: "Eastern Health is committed to promoting a healthy, respectful work environment in which individuals feel accepted, valued and engaged about their work and work environment" (Eastern Health, 2013, p. 1). The policy statement is as follows:

> All incidents of work environment conflict must be addressed constructively to promote and maintain respectful working relationships. This policy is to be read in conjunction with relevant collective agreements and management support policies (p. 1).

In this excerpt I bolded the words and phrases I considered significant in reading this policy. If an RN were to quickly read through this policy document, they may be under the impression that to constructively address a conflict, reporting the conflict to management is required. Additionally, the policy encourages employees who observe or experience conflict in the workplace to seek guidance from management or from human resources consultants.

The purpose of the policy is provided on page one. It states that the policy is meant to inform employees about the expectations for behaviours of individuals working within that setting. The policy uses the acronym "RESPECT" to refer to the expectations

for employee behaviours: R refers to: recognizing that each individual is different, with a unique set of opinions and values, E refers to: being engaged in and being committed to problem-solving to achieve positive outcomes, S refers to: support for a positive work environment for all, P refers to: promote respectful behaviour in the workplace, E refers to: establish an environment where conflict is dealt with in a timely and effective manner, C refers to: commit to maintain a high standard of professional conduct and T refers to: "think before speaking and be accountable for attitudes and actions" (Eastern Health, 2013, p. 2). This is followed by a list of respectful workplace behaviours, such as being inclusive, eliminating gossip, critical words, and hurtful behaviours, as well as modeling positive interactions with peers. Despite having a formal policy in place, the research participants indicated that expectations for professional behaviours between RNs in the workplace were clearly not being met.

The conflict management policy also contains information regarding the roles and responsibilities of each member involved in the conflict management process. Maintaining the standpoint of the participants, I examined these roles and responsibilities. The policy states that complainants have the "right" (underlined in the document) to have their complaint assessed to determine the appropriate intervention and subsequent follow up. Again, this information was contrary to participant experience, as many of them voiced how follow up was inadequate when their complaints were reported. The policy also indicates that complainants have the "responsibility" (underlined in the document) to make their disapproval or unease known, as soon as possible, and in a reasonable manner, to the person who exhibits the undesirable behaviour. However, no direction, advice or resources are provided to teach or support the complainant on how to complete this

process. Following the responsibilities of each member involved in the conflict was the procedure for the conflict resolution process. The procedure section also begins with a strong statement encouraging employees and students to attempt to resolve the conflict interpersonally. If resolution cannot be obtained between the individuals involved, only then should the formal conflict resolution process be initiated.

Furthermore, the conflict resolution policy only addresses steps to be taken after a conflict has occurred. It does not address any factors leading up to a conflict or provide any direction for nurses on how to proactively mitigate CWRs in the workplace before they happen.

4.5.3.2 Prevention and Resolution of Harassment in the Workplace

The policy on the prevention and resolution of harassment in the workplace is structurally the same as the conflict management policy. The document begins with an overview statement that states the regional health authority is "committed to promoting a healthy workplace in which all individuals are treated with respect and dignity by encouraging acceptance, valuing diversity, promoting equal opportunities and prohibiting any form of harassment" (Eastern Health, 2017, p. 1). This policy is more robust than the conflict management policy because of language used and the legal implications. For example, a definition of harassment as defined by the Human Rights Code of Newfoundland and Labrador was included in the policy.

As well, different from the conflict management policy, the harassment policy states that managers may be *required* or may be *obligated* to act, even in the absence of a complaint. This policy also states that the person who believes they have been the subject of harassment is *not* required to bring the matter to the attention of the person being

accused of harassment; however, the complaint of harassment must be written. Like conflict management, the policy outlines the roles and responsibilities of all members involved in the harassment complaint, but it also outlines the procedural steps required for the formal investigation of the complaint. Again, the policy did not address any contextual factors leading up to the conflict, and the suggestions for promoting a healthy working environment (captured under the heading *guidelines,* sub-heading, *some cultural guidelines*) were directed towards hospital employees to initiate and maintain. In the document it stated that creating a harassment-free workplace was everyone's responsibility and that employees are encouraged to lead by example and demonstrate mutual respect.

4.5.3.4 Summary of Policies on Conflict Resolution

As previously discussed in chapter two, policies on conflict resolution are valuable and necessary as they help reinforce both the employer's and employee's accountability for their behaviours and actions and they assist leadership in making decisions regarding corrective actions (Amrein, 2012; Becher & Visovsky, 2012). Leadership needs to ensure that all employees are aware of policies on conflict resolution and that the policies are enforced by all levels of management. However, the onus to initiate the policy is still dependent upon the individual RN and her/his ability to recognize and report a conflict that has already happened.

4.6 Using the Data Analysis Tool Indexing

At the beginning of chapter four, I introduced writing accounts, indexing, and mapping, as tools that could be used to help support the beginner institutional

ethnographer in the data analysis process. To help maintain a logical flow and sequence of ideas, I have explained the use of these data analysis tools separately. However, I used all three tools concurrently, as I moved back and forth between the accounts provided by the participants and the data generated. In the preceding section, I used the tool writing accounts to detail the participants' experiences with CWRs. In the following sections, I describe the data analysis process of indexing, followed by an explanation of mapping.

Indexing is a tool used in conjunction with the interview transcripts to cross-reference work processes, people, and settings, and organize the data into linked practices to support an analytic view into the institution (Rankin, 2017a). Indexing is oriented to the materiality of the data; consequently, it links work activities in a way that organizes data around empirical happenings (Rankin, 2017a). Because I organized my research participants' accounts using three different headings, I used three similar index headings and three tables to index the CWR accounts related to the ideology of being a good nurse, being a good nurse in the hospital setting and lastly, the broader evolving health care system's influence on nursing practice. Throughout the indexing process, I retained the idea of work (section 3.3.1) as an expression of how nurses understood their nursing practice, as the orienting concept (McCoy, 2006; Rankin, 2017a). I began this process during the interviews as I listened for the use of institutional language, texts, text-mediated discourses in the details of the participants' work day surrounding their CWR experience. I then summarized what the participants described in the participants' accounts.

I created indexing tables to help me organize the details of the participants' nursing practice surrounding their experience with CWRs. I began with what the

participants stated they "knew" was required from them for their nursing practice. This information was generally transmitted via the use of texts and/or text-mediated discourse. I then indexed what the participants described as additional work they needed to complete that was not readily accounted for in their nursing practice. This additional work was often implicated in creating conditions conducive to the development of their CWR.

The indexing tables were a method to bring together and arrange the information provided by the participants' accounts and pull out three threads of knowledge regarding the social organization of professional nursing practice. The first indexing table helped me to organize the phenomenon of having to prove yourself as a good nurse, which led me to the ideological thread which I called *should nursing*. Indexing Table 2 led me to the thread *double domination,* which represented how RNs were accountable both to the hospital and their peers. Lastly, indexing Table 3 led me to the *big picture* thread which brought to the forefront how there are broader, external factors influencing the organization of nursing practice in the hospital setting. All three threads will be discussed in relation to the development of CWRs between RN peers in the following sections. Despite being presented separately, the tables are not mutually exclusive from each other and there are instances of overlapping of information within individual tables and between the three tables.

Table 1
Indexing the Should Nursing Thread – The Additional Work of Proving Yourself as a Good Nurse

Categories of RNs	**In addition of completing the work required of an RN, participants described additional work that was not accounted for in their practice.**		**Participants mentioned texts and text-mediated discourses as they described their conflict.**
Novice RN (New Graduate) Novice RN (New to Unit)	• Transitioning from a student nurse to a fully accountable RN with inadequate mentoring at the workplace. •Navigating differences between how things are taught in school and how things are completed in the hospital.	Dealing with criticism and feelings of powerlessness.	Text-mediated discourse from nursing school. Standards of Practice Code of Ethics Hospital Policy (e.g., blood and blood products, sterile technique)
Casual RN	•Navigating the differences between different nursing unit's physical layout, routines, culture, values.	"Nodding and smiling" at work.	
Float RN Senior RN	•Navigating the differences between how nursing tasks are completed on different units within the hospital. •Understanding different interpretations of how nursing work "should" be completed.	Gaining confidence in yourself.	
	•Navigating how different levels of knowledge and skill are required between different units. •Knowing when to express a difference in opinion and when to just let it go (communication work).	Gaining acceptance/ fitting in.	
	•Navigating the independence line - knowing when to ask questions.	Rite of passage success	
The work described by the participants was linked to the work of their peers working on the same and different units, which was further linked to the routine practices of the units as they were organized within the hospital setting. This led to the *should* nursing thread of knowledge generation			

As shown in indexing Table 1, regarding the development of CWRs, it appeared that regardless of whether the nurse was a new graduate, novice, casual, float, or senior nurse, the overarching thread noted from the participants' accounts, was that there were differences in interpretation between RN peers about how nursing practice *should* be completed within the hospital setting. The idea of should in nursing, referred to, for example, in the completion of tasks, which was one of the criteria used to establish the ideology of the "good" nurse. The good nurse was the one who can complete all the nursing duties required to provide care for patients while fulfilling the requirements of how these duties should be completed in the hospital setting (Day, 2013; Daly, 2013). The participants noted how it took a lot of extra time, resources, and effort to complete nursing work to meet the criteria of being a good nurse. Indexing Table 2 was used to organize what participants understood about how to be a "good" nurse within the hospital setting.

Table 2
Indexing the Double Domination Thread - Being a Good Nurse in the Hospital Setting

Categories of RNs and Hospital Units	**Nursing practice as described by the participants was coordinated to be in line with the organization of the acute care hospital setting. This also resulted in additional work that was not accounted for in their practice.**		**Participants mentioned texts and text-mediated discourses as they described their conflict.**
Unit RN (e.g., medicine and surgery units). Emergency Department RN. Specialty RN (e.g., operating room, intensive care units). Senior RN Nurse in Charge	•Putting work aside to receive an admission. •Navigating being busy/time constraints. •Learning to care for different patients.	Learning how to "hit the ground running." Dealing with moral and ethical distress.	Overcapacity Protocol Care Maps Epidural Protocol RN Collective Agreement
	•Maintaining effective patient flow of the hospital setting. •Knowing how closely to follow hospital policy. •Explaining yourself.	Navigating differences in priority interpretation. Dealing with lack of motivation.	
	•Navigating inconsistencies regarding professional judgement within medical dominance. •Proving yourself as competent. •Dealing with the experience of burnout.	Dealing with feelings of powerlessness. Dealing with criticism. Dealing with peer comparisons.	
	•Navigating how to manage a heavy workload. •Navigating different skill sets among different units.	Competing to be "awarded" a position. Dealing with decreased tolerance.	
	•Navigating time task imperatives and different unit routines.	Knowing who to ask for help or assistance when required.	
The work described by participants was linked to the work of the nurses on different units; dependent upon each other to operate efficiently and effectively within the acute care hospital setting. This led to the *double domination* thread of knowledge generation.			

Indexing Table 2 led me to further investigate the predominance of the biomedical model of health and business models organizing health care and their influence on the organization of the hospital setting and the effects this had on nursing practice. It appears that medical specialization of care has played a role in generating hierarchies within the nursing profession and among nurses. Some participants noted how hierarchies in nursing practices had the potential to create animosity and tension between nurses. Participant #1 stated:

> All nurses want to have a sense of importance, that is only way I can describe it, that you know…, because I work in the ER, well, I am more important than any nurse working on the floor because I am busier, and I can put in these lines and I can do that, instead of looking at… nurses don't look at the whole picture, they don't look at, why it is important to have nurses in the ER just like LTC [long-term care] because they don't do nothing but change out [the undergarments of] patients.

Participants #4, #10, #11 and #15 echoed participant #1's comments as they described CWR experiences that occurred with an RN peer from another unit and specialty department within the hospital. Participant #4 discussed how nursing is hierarchical in nature:

> Everyone thinks that critical care is critical, and emerg [emergency department] thinks they are the best…nursing has siloed ourselves [*sic*] and our profession because down so much that nobody knows what anyone else is doing.

It appears that medical specialization and the subsequent organization of the hospital into different units and departments (surgery, medicine, emergency, intensive care and so on) has created a rift between nurse colleagues and reinforced an ideology of a hierarchy of nursing practice between and within units. Patients admitted to surgical or specialty care units are purposely placed there because those patients have specific needs, that require a specific set of skills, and they potentially have more complex health care

demands. Therefore, nurses working on these units are expected to use their assessment skills to pick up on changes in their patients' conditions and initiate the appropriate measures. From the participants' accounts, it appears that some units are thought of as being busier due to the complexity of care being provided to complex patients. In contrast, other units within the hospital setting admit patients who are less unstable and have more predictable outcomes. For example, a patient admitted to a medicine unit may be newly diagnosed with heart disease or experiencing an exasperation of a chronic illness, both of which require medical intervention. Therefore, the RNs working on these units use a different set of nursing knowledge and skills in caring for these types of patients. Although both types of nurses are equally skilled, and their nursing expertise are equally important, the nurses working on the so-called less task intensive units may be perceived by their peers on the more task intensive units as less busy, less skilled, and less competent. This misperception is due in part because nurses have become accustomed to the nursing work on their specific unit and they have not experienced what it is like to work elsewhere. Nurses, as they have become siloed into specific units, may have fostered an atmosphere of comparison and competition between units and decreased the ability of some nurses to appreciate the health care contributions of all nurses.

The misperception about being less busy, less skilled, equating to being less competent, can also be thought of as being reinforced by the pay scale for nurses. Nurses who have a greater level of knowledge and skills required to care for more complex health issues are paid more than nurses who do not. Within the organization (employer), and in agreement with the Registered Nurses Union of Newfoundland and Labrador (RNUNL) (2014), nurses are designated or ranked according to a scale. All RNs have the

same steps on the pay scale (RNUNL, 2014). An RN classified as a "Nurse I" is described as a nurse who provides care for patients in a hospital setting (Government of Newfoundland, 2017). This nurse is paid on the NS28 pay scale and can progress "6 Steps" based on the number of years of employment in this designation. An RN classified as a "Nurse II" is described as a nurse who provides patient education, and consultation for a specialized service or program. A Nurse II is paid as on the NS30 pay scale; a higher pay scale than NS28. In addition to these classifications, there are others (e.g., Registered Nurse IC, IIC, IID, IIB and Psychiatric Registered Nurse II).

A Registered Nurse IC was described as a nurse who provides care for patients in an area of specialization, typically found in intensive care units (ICU), coronary care units (CCUs), emergency departments, operating rooms, and labour and delivery units. RNs IC are described as performing comprehensive nursing skills at an advanced level of expertise and autonomy (Government of Newfoundland, 2017). RNs who work on the more complex units are paid at a higher level because of the requirement for them to be able to manage the care of more complex patients. This is one example of how hierarchies within nursing have been constructed. RNs who have additional education and advanced knowledge and skills are practicing nursing where they are subject to a greater amount of accountability, and therefore, they are ranked on a different pay scale. These differentiations among RNs are generally not disputed, as it is expected for nurses with enhanced education and training to be paid for their advanced knowledge and skills. Further, the Government of Newfoundland and Labrador introduced a new job evaluation system for unionized positions. The job evaluation is used to determine the relative value of jobs by addressing four standard criteria: skill, effort, responsibility, and working

conditions. Jobs with similar demands were to be recognized in pay equity legislation (Association of Allied Health Professionals, 2019). However, like previously mentioned in section 4.4.2.5, sometimes power and authority among RN peers can be perceived as inconsistently and unfairly distributed and/or ambiguous, which was noted as a source of conflict between RNs. This phenomenon was referred to as the politics of nursing.

The data as presented in Table 2 helped me to recognize that the organization of nursing practice was influenced by the hospital setting which was also influenced by the increasing complexity of the evolving health care context. Indexing Table 3 presents how I organized this data.

Table 3
Indexing the Big Picture Thread - Practicing Nursing Within an Evolving Health Care System

RNs, the local setting, and the broader context.	**Nursing practice as described by the participants as organized to respond to the needs of patients in the acute care hospital setting was also concerted to meet the needs of the evolving health care system. This also resulted in additional work that was not accounted for in their practice.**		**Participants mentioned texts and text-mediated discourses as they described their conflict.**
All RNs (The participants also noted the roles of others in positions of authority).	•Adapting to new models of providing nursing. •Learning how to care for "off-service" patients. •Working with different interpretations of models of nursing care.	Adapting to changes to the work environment and to established routines. Accepting a 'new normal' for practice. Making time to implement change.	Models of Nursing Care Lean Process Improvements Over Capacity Protocol Harassment/ Conflict Policies
	•Navigating biomedical model influences in the hospital setting. •Being left out of bigger conversations. •Navigating changes/reforms to the health care system.	Navigating breaks in communication. Dealing with incident reporting. Navigating feelings of frustration and powerlessness. Dealing with ethical dilemmas concerning providing holistic nursing care.	
	•Incorporating management and efficiency tools/protocols into care. •Working with different hierarchies within nursing/medical dominance.	Doing more with less. Dealing with peer comparisons. Using professional judgement in a medical dominated system.	
	• Being open to different unit routines/practices.	Trying to see other perspectives.	

The work required of the nurses in the hospital setting was organized to meet the evolving needs of the broader health care context. This led to the *big picture* thread of knowledge generation.

Indexing Table 3 helped me to recognize how health care reforms influenced and changed the way nurses' practice. For example, in the past few decades the hospital environment has seen a decrease in the number of beds available to patients, despite an increase in occupancy rates, as well as escalating health care costs. Therefore, there has been the need for unprecedented levels of efficiency and cost containment within hospitals (Yousefi & Maslowski, 2013). As nurses are the front-line care providers in the hospitals these measures directly affect their work.

It is well-known that health care reforms are necessary to ensure the sustainability of the Canadian health care system (Government of Canada, 2019; Martin, Miller, Quesnel-Vallée, Caron, Visssandjée & Marchilon, 2018); therefore, the question now becomes, how can nurses operate within this system in a way that does not obscure their view of the *big picture*, where the *big picture* includes an awareness of where nursing practice is located with the broader, sociopolitical context of Canadian society and the requirements of the evolving health care system. To further explore the data being generated, I constructed a visual representation of the data collected in a process called mapping.

4.7 Mapping the Connections

Recalling chapter three, section 3.6.3, mapping is a process where first-level data gathered through the interview is combined with second-level data gained through analysis of texts (and other institutional practices) to bring visual coherence to research findings (Campbell & Gregor, 2008, Rankin, 2017a, Turner, 2006). I completed the

mapping process in three stages. First, I mapped what I have called the socialization processes influencing the construction of RNs.

4.7.1 Mapping the Socialization Processes of Becoming an RN

Figure 1 is a visual representation of how I started on the road to discovery of the thread of *should nursing*. It illustrates how even before entering the profession of nursing, individuals, guided by their personal experiences and external influences, have preconceived notions regarding nurses and nursing practice. This concept is highlighted by a comment provided by participant #14:

> It is always easy to see if you had a student [student nurse] who didn't really want to be a nurse because immediately it was evident by what they were doing and how they were talking and behaving.

In this comment, the participant spoke very matter-of-factly about how she evaluated the talk and behaviors of her nursing students as being suited for the profession of nursing or not. She had a preconception of how nurses should talk and behave, and if her students were not exhibiting the talk and behaviours she deemed appropriate for the nursing profession, she surmised that the student "didn't really want to be a nurse."

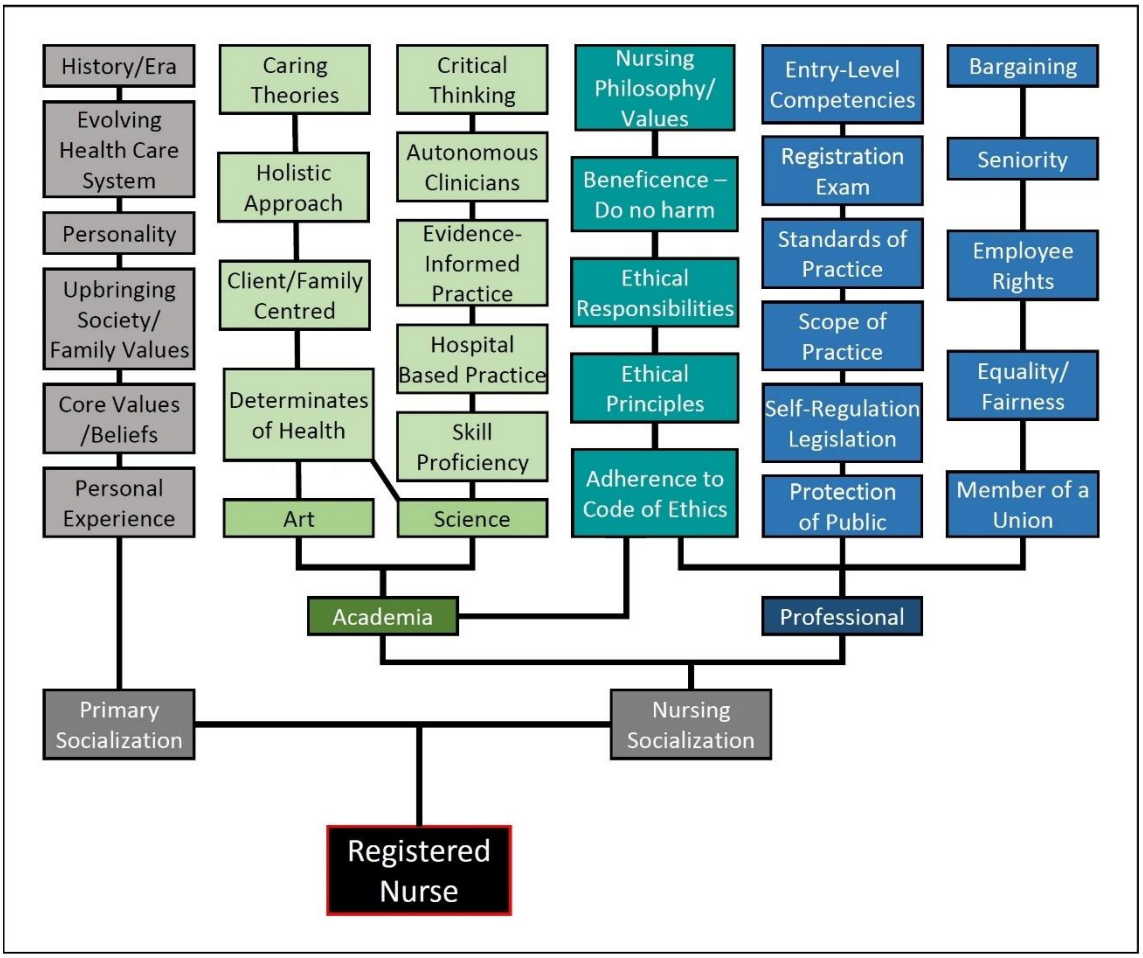

Figure 1. Mapping the socialization processes of becoming an RN.

This first part of the map represents the standpoint of the individual nurse, which is different from the standpoint of nurses as a group. To become an RN, individuals undergo two socialization processes. The primary socialization process happens before the individual chooses to become an RN. This socialization process consists of the social and familial influences and experiences that may have directed them towards the nursing profession. Some aspects of primary socialization are unique to individuals while other aspects are more generalizable. For example, some participants spoke about their individual/personal values or unique experiences that influenced their decision to pursue a career in nursing (a positive experience they had with a nurse as a patient; a family member who was a nurse, a desire to make positive contributions to the health and well-being of their communities). While other participants spoke more generally about their experiences (either positive or negative) with the care they received within the health care system. As well, all participants belonged to a generation where health care and nursing has been idealized by broader societal influences, to include positive and caring connotations, which also may have influenced their decision to become a nurse. A few participants stated that they entered the nursing profession for strictly financial reasons.

Many other expectations regarding nursing practice are formulated during nursing socialization or socialization into the profession. The first level of nursing socialization begins with postsecondary nursing education. Within academia, students are taught that nursing is both an art and a science that combines scientific, evidence-informed, autonomous practice with a caring, client-centered approach (Daly, 2013). Students are instructed on the profession of nursing in Canada and on the theoretical underpinnings of the nursing practice as set by nursing theorists (Mintz-Binder, 2019; Parker & Smith,

2010). Students are also instructed about the expectations for competent, compassionate, safe, and ethical nursing practice. These expectations are described as the "must-do" expectations as they refer to the *Standards of Practice* and the *Code of Ethics* for RNs.

The second level of nursing socialization is a professional socialization process. Students leave the academic setting knowing they are expected to perform the entry-level competencies (ELCs) required for professional nursing practice (ARNNL, 2013b). These ELCs are formally tested with the National Council Licensure Exam - Registered Nurse (NCLEX-RN©) before formally entering the profession and earning the protected title of RN. Students also leave academia with a strong knowledge of the *Code of Ethics* for RNs including the values and ethical responsibilities expected for all RNs for their service to, and protection of the public. When new graduates enter the workforce, they are informed about their rights as employees by the union. A part of their professional socialization is working for an employer. Once employed, nurses are socialized into their employment setting where they adopt organizational policies and values relevant to their practice setting. As well, throughout their careers, RNs may work in different regions where different collective agreements are enacted. If a nurse changes their practice setting, those employment aspects of the professional socialization process may occur again. In contrast, adherence to the standards of practice and the code of ethics remains constant for all nursing roles and in all practice settings.

The point of mapping how research participants described their entry into the nursing profession was to highlight how even before entering the profession, the participants had preconceived notions regarding the expected behaviours of nurses and nursing practice. These preconceived expectations have been influenced not only by

personal experience but also by the underlying values of modern society concerning health care.

4.7.2 Mapping the Influence of the Hospital Setting on the Development of CWRs between Nurse Peers

Many participants noted how their first experiences with CWRs occurred while completing their clinical rotations as nursing students. It appears that once the students were removed from the academic setting and placed within the context of the hospital environment, they had a greater potential to experience a CWR. In the following section, I make visible some of the factors within the hospital setting, as noted by the participants' accounts, that contributed to the development of CWRs.

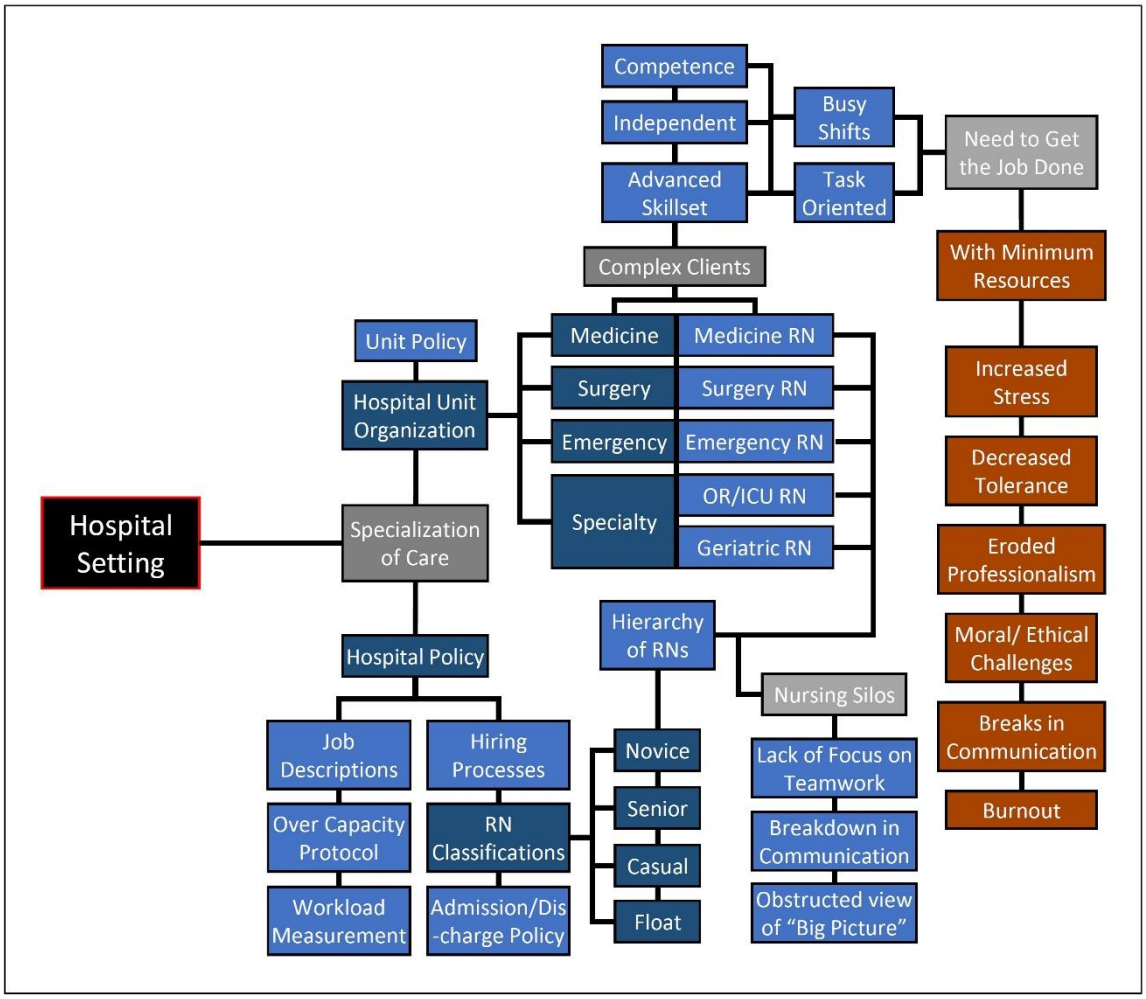

Figure 2. Mapping the influence of the hospital setting on the development of CWRs between nurse peers.

As depicted, the medical specialization of care services has led to the organization of the hospital setting into distinct units, where nurses with different classifications and various skill sets work to meet the needs of multiple types of patients. Nurses working on different units and having different levels of nursing knowledge and skills has led to the creation of hierarchies within and among different nursing practices, fostering comparisons between RN peers. Hierarchies have been further reinforced through the collective agreement, hospital policy, and other texts organizing nursing practices. The complexity of the patient's health care needs, as well as the demands for efficiency, has created a busy work environment where some nurses struggle to provide safe, competent, compassionate, and ethical nursing care. The participants' noted that in stressful working environments they experience increased stress, decreased tolerance, moral/ethical dilemmas, breaks in communication, and eroded professionalism. Some participants described how nurses, who struggled with competing expectations over extended periods of time, experienced burnout. Some participants also expressed how many RNs are exhausted and have no energy left to invest in positive collegial working relationships.

Participants' accounts of their CWRs brings to light a cycle of how nursing practice, as organized within the hospital setting, has the potential to create conditions where nurses routinely experience disjunctures, tensions, and frustrations, producing unhealthy working environments. Additionally, participants indicated, from their experiences working in these environments, that nurses (as a group) have no personal resources left to draw upon to resolve conflicts on their own. So instead, nurses used texts (i.e., occurrence reporting system, etc.) and text-mediated discourses to reinforce and legitimize their discontent. When RN peers stepped outside of the authorized discourse

(*should nursing*), some RNs chose to report their peers using the occurrence reporting system, to ensure compliance with the established discourse (how things should be done). Figure 2 also depicts the beginning of a second thread of knowledge, *double domination*, as it is within the hospital setting that *double domination* frequently occurred. I will elaborate further on this second thread in the next section.

4.7.3 Mapping the Influence of the Evolving Health Care System on the Development of CWRs between Nurse Peers

Figure 3 is the extension of Figure 2, where Figure 2 represents the local hospital setting where nurses work and what can be seen and known from the participants' standpoints. Figure 3 extends that knowing to include how medical specialization of care and hierarchies of nursing practices have been concerted extra-locally, provincially, and federally, within the Canadian health care system. Through the implementation of models of nursing care and business models for efficiency, the participants noted how they experienced disjunctures, tensions, and increased frustrations in their nursing practice environments. Particularly, some participants noted how the model for nursing practice was only partially implemented for the purposes intended. After the implementation of the model nurses still struggled with inconsistencies concerning the use of professional judgement in caring for patients. Further, the increased focus on individual accountability was perceived as being detrimental to true collaborative teamwork. Many participants also noted how the organization of the hospital setting using business-minded initiatives and task-based practices did not support the new model of nursing practice.

With respect to CWRs between RNs, participants' accounts suggested how the efficiency of the health care system was sometimes perceived as being valued above the

quality of the work lives of those that provide care. More so, nurses felt left out of the bigger conversations about changes to health care and how it could affect nursing practice. Figures 2 and 3 as presented represents how I continued to follow the *double domination* thread and started on the *big picture* thread.

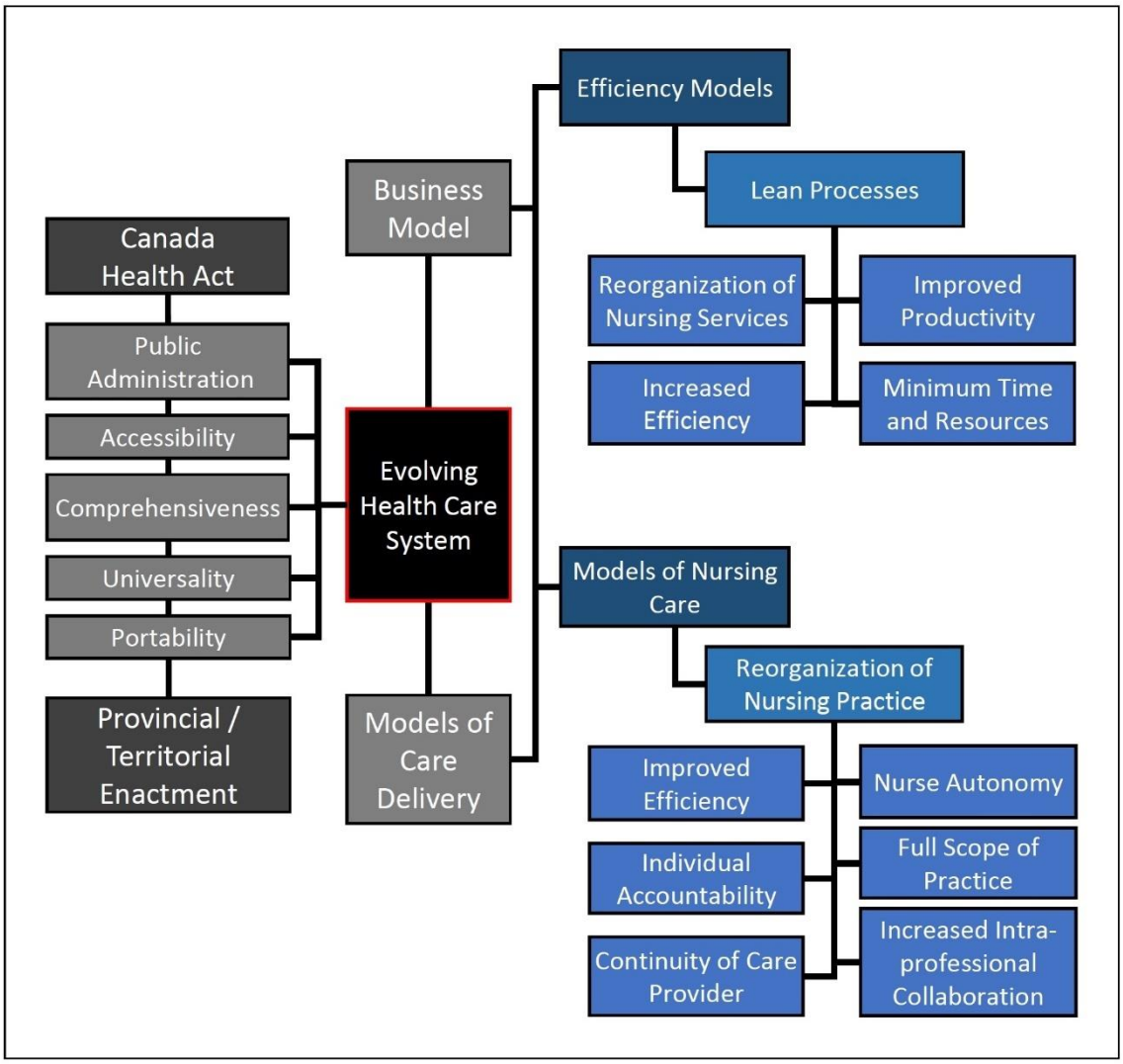

Figure 3. Mapping the influence of the evolving health care system on the development of CWRs between nurse peers.

I created the three previous figures to provide a clearer picture of the many influences (individual, local, and extra-local contexts) surrounding development of CWRs between RNs. There are two sets of broken lines. One set encompasses the evolving health care system and the hospital setting. The other set encompasses the hospital setting and the RN. The broken lines are meant to make apparent how each figure is not independent of the others, instead, they represent an interactional dynamic where they are interconnected and influential to each other existing under the broader social, political, and economic environment. Figure 4 represents this dynamic and the thread of knowledge generation that I call the *big picture*.

In viewing figure 4, it is easy to see the location of the disjunctures nurses experience in their practice. Disjunctures are made visible by the lack of connection between figures 1, 2, and 3. There is a disconnect regarding the socialization processes involved in becoming an RN and the reality of nursing practice as organized in the hospital setting. There are also disconnections noted with respect to patient centred care, teamwork, and the ideology of a good nurse as evidenced through hierarchies of nurses and silos of nursing practice. Coordinated extra-locally to meet the needs of the Canadian health care system, these disconnections are further reinforced and maintained in the hospital setting by using models of nursing care influenced by biomedical practices and business models for efficiency and productivity.

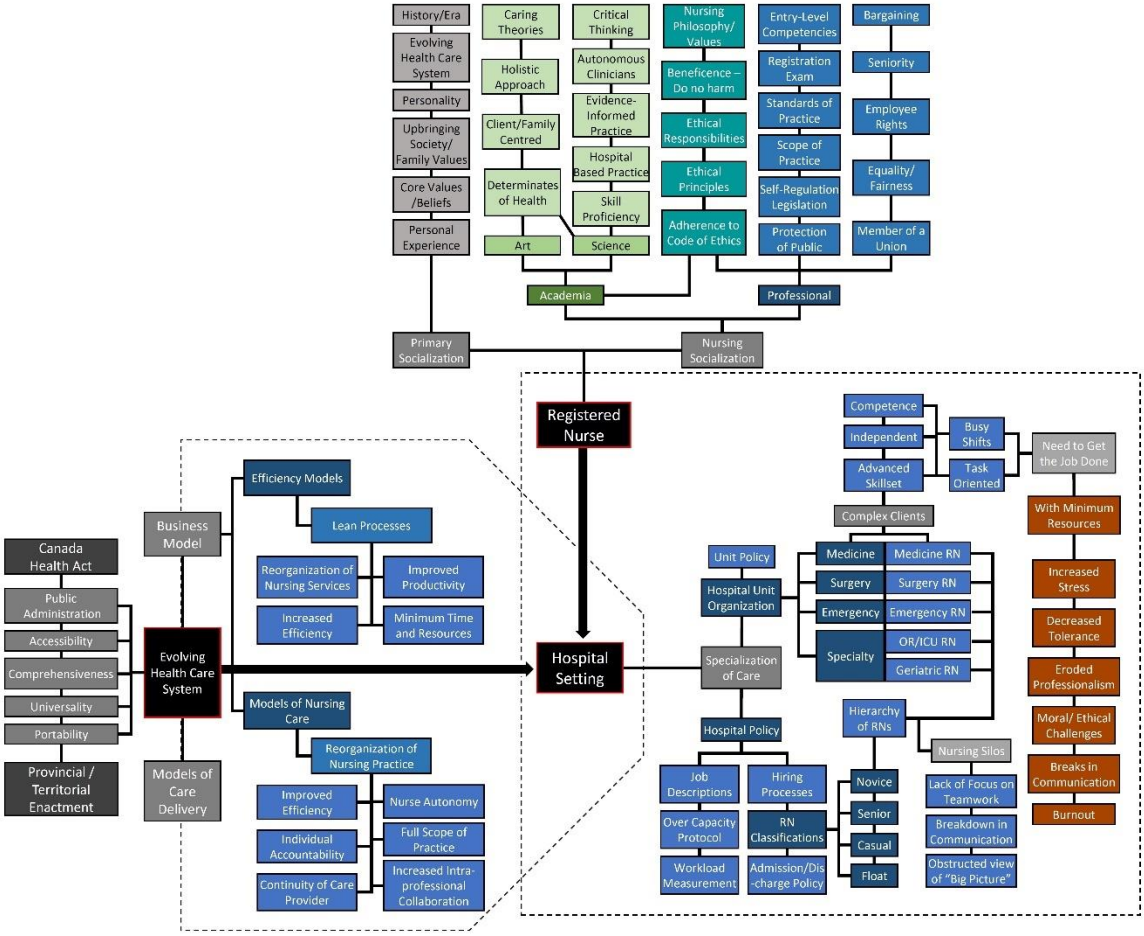

Figure 4. A map of the interconnections and generalizing relations influential to the development of CWRs between nurse peers.

The indexing Tables 1, 2, and 3 helped me to organize the information provided through the participants' accounts. The maps as shown in Figures 1, 2, 3, and 4 helped me to extend that knowledge to illuminate the influences that the local and the extra-local contexts have on the development of CWRs between RN peers. Analyzing this information, I uncovered and followed three threads of knowledge generation. The first thread represents the authorized discourse of nursing practice and I called this thread *should nursing*. The second thread represents how the authorized discourse is legitimized and perpetuated within the hospital setting and I called this thread *double domination*. The third thread represents influence of the broader, extra-local health care context and the acknowledgment that it influences nursing practice in the every day. I called this thread the *big picture*. By making visible how nursing practice is concerted to happen in a certain way shifts the focus of strategies for prevention of CWRs from looking exclusively at individual behaviours to also looking at the broader issues influencing such behaviours, as illustrated by the three thread of knowledge generated and represented in Figure 5.

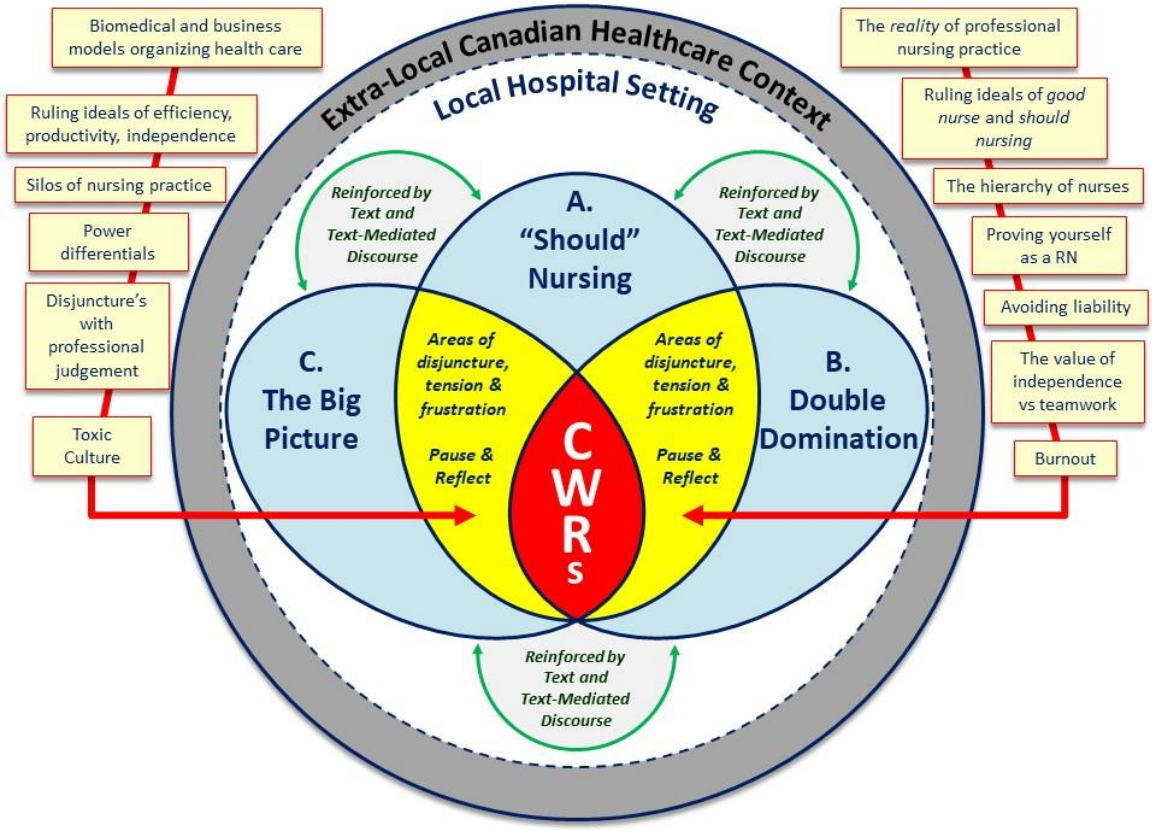

Figure 5. A map of the social organization of nursing practice in the hospital setting and its relationship to the development of CWRs between Registered Nurse (RN) peers.

Figure 5 clearly makes visible that CWRs occur at the intersections of *should nursing, double domination*, and the *big picture*, representing three aspects of the social organization of nursing practice in the hospital setting as located within the broader Canadian healthcare context. As previously discussed, these three threads of knowledge (A, B, and C) were generated through participants' accounts of their nursing work when their experiences with CWRs occurred. CWRs are coloured in red in the centre of the framework. The red colour represents *stop* because once disjunctures, tensions, and frustrations between RN peers escalate and reach the point when a CWR occurs, the damage to the professional working relationship has already occurred. At this critical point, it becomes difficult to re-establish and promote collegial working relationships.

Between each of the three threads of knowledge, there are areas that are coloured in yellow. These areas are meant to make nurses aware of the contextual factors surrounding the disjunctures, tensions, and frustrations they experience in their practice (as well as noting how they arise, and the reasons behind their occurrence) and the influence they have on the development of CWRs. By situating the development of CWRs outside of the individualist paradigm, nurses have an additional knowledge source to inform their responses and behaviours to CWR events. Nurses may potentially change their decision-making and choose different behaviours, which would not contribute to the escalation of a conflict to a CWR.

The interconnections between the A, B, and C threads are further emphasized with double-sided arrows. These arrows explicate how texts and text-mediated discourses reinforce and perpetuate the ruling relations associated with *should nursing, double domination* and obscuring the *big picture*. Each of the three threads are depicted as

happening within the context of the local hospital setting, being further located within the influence of the broader extra-local evolving health care context. The broken line encircling the local context of the hospital setting represents how all components of this framework are interrelated and influenced by each of the other components.

Finally, the framework pulls out the key topics noted to contribute to their experiences of disjunctures, tensions, and frustrations related to *should nursing*, *double domination* and the *big picture*. Listed to the side of the framework, these key topics can be used by leaders to start a dialogue regarding advocating for positive changes in the working environments of nurses and the organization of nursing practices. A more complete discussion of *should nursing, double domination* and the *big picture* as represented in the framework is presented in chapter five.

4.8 Chapter Summary

From the data generated from the interviews, I mapped and made visible the local and extra-local influences and relations of ruling that play a role in the development of CWRs between nurses. I untangled three threads of knowledge: *should nursing, double domination,* and the *big picture*. These threads were woven within the complex web of influences organizing nursing practice in the hospital setting and contributing to the development of CWRs.

Chapter Five - Discussions, Key Contributions, and Future Directions

"*To act intelligibly at all is to participate in relationship*" (Gergen, 2009, p. 39).

Using a variety of different labels, the existing research literature has determined that CWRs are a widespread and prevalent problem that continues to exist within the profession of nursing (Brunt, 2019). CWRs are also known to be a complex problem that is influenced by a variety of multifaceted and intersecting factors. However, there has been little research looking at how professional nursing practice is organized within the hospital setting and how that organization contributes to working conditions favourable for the development of CWRs.

Currently, organizational and management structures have not been extensively considered for the role they have in the development and/or perpetuation of CWRs. This may be partially related to the belief that CWRs are interpreted to be mainly an interpersonal phenomenon and many of the strategies used address CWRs on an interpersonal level. Therefore, to extend our understanding of how CWRs develop, the experiences of nurses needed to be contextualized within the local environment and further, within the broader extra-local health care system.

My IE-based research reveals three aspects of the social organization of nursing practice in the hospital setting - *should nursing*, *double domination*, and the *big picture*, as creating conditions conducive to the development of CWRs. In addition to these findings, in this chapter I discuss the struggles encountered by the participants in their professional nursing practice, the general institutionalization of conflict, and the need for strong leadership. I highlight the key contributions of this research and include suggestions for leaders on how to raise awareness about the complexity of factors

contributing to the development of CWRs. I also propose the need to include nurses and key stakeholders in an open dialogue on how to identify better ways of organizing nursing practice within the hospital setting to strengthen collegial practices between RNs. This chapter concludes with a discussion of some of the strengths of IE as well as some of the limitations I encountered while conducting this research.

5.1 A Discussion of *Should Nursing*, *Double Domination*, and the *Big Picture*

In this section, I discuss the three threads of knowledge, *should nursing*, *double domination* and the *big picture*, as generated from the participants' accounts surrounding their experiences with CWRs.

5.1.1 Discussion of the *Should Nursing* Thread

Recalling chapter four, the first group of participants' accounts were related to the CWR experiences of novice nurses (including new graduates, newly hired nurses, casual nurses, and float nurses). These accounts as told by the participants were described as mainly an interpersonal conflict between two RN peers with different levels of knowledge, experience, and power, and how they felt the more experienced nurse misused this power. The participants described how their CWR experiences were particularly troubling for them because they had preconceived ideas regarding how their peers/mentors were to respond to them. From the participants' standpoint, their ideals/expectations regarding nursing practices were concrete and unquestionable. Therefore, it was important for me to investigate the origin of these ideals/expectations and what purpose(s) they served. This started me on the road of discovery regarding the *should nursing* thread.

Used as a verb, the word *should* is defined by the Oxford English Dictionary Online as "used to indicate obligation, duty, or correctness, typically when criticizing someone's actions; indicating a desirable or expected state; used to ask advice or suggestions, and used to give advice" (Oxford English Dictionary Online, 2019). Many participants used the word *should* to describe how they came to understand the way their nursing work ought to be completed. Specifically, participants would describe their typical day or night shift by listing the activities they were "supposed to" do, what their role was "supposed to" be, how they were "supposed to" act, and how they "should" complete their work. I began to recognize that *should* statements reflected the ruling ideas of those in positions of power and/or authority (Taylor, 1997). As ruling ideas are generally accepted and unquestioned, the participants' use of should statements were important to investigate to better understand where these ruling ideas come from and whose interests they serve and/or support.

The *should nursing* thread does not represent a debate on the importance of conducting high quality, accurate, safe, and effective nursing practices. As I will explain below, the *should nursing* thread represents a dysfunctional power differential between nurse peers with different levels of knowledge and experience, where knowledge and experience is not shared or co-created, but instead can be misused to criticize, demean, and belittle colleagues. Further, the *should nursing* thread highlights how the contextual variables surrounding nursing practice is not considered influential with respect to the behavioural expectations of how nurse peers relate to each other.

Many of the participants learned what they were "supposed to" do as an RN through their nursing education, however, other participants learned what they were

supposed to do from an experienced mentor. Nursing education is designed to provide an important foundation for competent nursing practice; but competence in the *application* of their knowledge and psychomotor skills is only achieved through strong mentorship, time, and experience working within a supportive environment. Hence, mentorship, is an essential way to transition graduate nurses into professional nursing practice. This topic has been extensively investigated in the research literature and data generated from my interviews are consistent with these findings (Rankin, 2006; Rainbow & Steege, 2019). Laschinger et al. (2013) remarked that early in their careers new graduate nurses are known to rely on experienced colleagues for professional and social support. This statement was supported in many of the participants' accounts of their experiences as newly graduated nurses (Section 4.4.1.1).

Should statements also reflect how most nurses adopt biomedical and business attitudes of providing health care and incorporating the ruling ideals of completion of tasks as the only relevant way to demonstrate competence in their nursing practice. The documentation of their completion of tasks and adherence to procedures provide proof of their competence as an RN (Table 1). At the same time, some nurses are co-opted by biomedical and business models of health that are often at odds with how they expect nursing to be practiced, creating an internal conflict regarding the conceptualization of the *good* nurse. The *should nursing* ideology reflected the concept of the *good* nurse as one who can complete all their nursing interventions/tasks but also as one who can complete them independently and in a timely manner, thereby contributing to endeavours that support a fiscally responsible health care system (Day, 2013; Townsend, 1998).

Many of the pressures nurses are experiencing in the hospital setting, and the "shoulds" they have adopted have resulted from the way their nursing practice has been concerted to happen, these ways are consistent with interests of the broader Canadian/provincial health care context, which is often highly influenced by the neoliberal frame of mind (Armstrong & Armstrong, 2010; McGregor, 2001). Nurses implement the care they provide via the activation of hospital texts and text-mediated discourses regarding how nursing care ought to be completed, including the completion of documentation. Further, nurses may be disciplined or have sanctions applied to their practice should they operate outside of this authorized discourse, which reinforces the belief that nursing practice should be completed in this way. Nurses, who are operating within the social organization of nursing practice in the hospital setting, unknowingly perpetuate the *should nursing* ideology as a ruling ideal, thereby ingraining it into the culture of nursing. Interrelated to the idea of *should nursing* was a thread of discovery that I called *double domination.*

5.1.2 Discussion of the *Double Domination* Thread

Participants' accounts highlighted how CWRs are commonplace on some hospital units, so much so that those units became known as a toxic work environment. This finding was consistent with previous research that found CWRs undermined the effective functioning of the health care organization by contributing to negative environments (Allen, Holland, & Reynolds, 2015; Cleary et al., 2010; McNamara, 2012). However, despite the participants' acknowledgment of certain units being conceptualized as toxic, many did not comment on their own role in the continuance, perpetuation, and dominance

of this toxicity through their own established practices. In other words, the participants were unaware of how the organization of their nursing practice (e.g., the creation of the *should* nursing ideology) was likely contributing to the development of toxic work environments. In the following paragraphs, I use the example of RN burnout to better explain what I mean by *double domination*.

Many participants noted how busy and stressful working environments could lead to RN burnout even for those perceived as "good nurses." Burnout was described as a common occurrence and as a precursor for strained working relationships between RN peers. As previously presented in section 4.4.2.4, a participant emphasized how an additional source of stress for RNs were peers who were experiencing burnout. Instead of identifying the source of burnout as being located within the hospital setting and the conditions surrounding the work of nurses, some nurses perceived burnout as the nurse's personal flaw, such as their inability to cope. Although it is true that symptoms of burnout can definitely affect the nurse's performance (Guidroz et al., 2012; Oyeleye, Hanson, O'Connor, & Dunn, 2013), the nurse experiencing burnout was being *double dominated;* first, by the organization of their work, and second, by RN peers who had fully embraced the domineering top-down institutional mindset. This finding is complementary to other studies, which looked at nurses as a group being "doubly oppressed" through gender and medical dominance (Hutchinson, Vickers, Jackson, & Wilkes, 2006, p. 120).

Double domination was also apparent in how participants described their use of texts. Recalling section 4.4.2.4, a participant described how nurses frequently use the occurrence reporting system to resolve conflicts. However, the participant also explained how if working conditions were more manageable, disagreements between RNs still

occurred but were more likely to be resolved between individuals. However, when nurses felt overwhelmed at work (too busy, too stressed, burned out), the occurrence reporting system was also used to vent frustrations.

Escalation of CWRs are further complicated by official organizational texts (e.g., occurrence reports and policies for documentation). Such texts can mistakenly legitimize a nurse's reporting of another nurse for purposes other than intended (e.g., to be non-collegial). The organizing of practices via the written word are often interpreted as "what actually happened" (Smith, 1990a, p. 70). Since the practice is written down to be carried out in a specific way, this "textual reality" can be considered as a more factual account than the "lived actuality" of the person completing the practice (Smith, 1990a, p. 71). So, if disagreement exists regarding what happened versus what was documented, then the documented account is usually perceived as more credible, despite the textual reality being devoid of the contextual variables that were present and influential in the lived actuality.

Furthermore, occurrence reporting is a legitimate process within the hospital setting. Therefore, the actions and the motivations of the reporting RN are rarely questioned. It may be that the reporting RN was just too busy to have a direct conversation with her peer about the perceived error/omission or it may be that the reporting RN wanted to document a near miss, with no intention of creating a conflict with her peer. The point being made is that oftentimes, when the conditions within the workplace are favourable, an occurrence report would not be completed and instead the oversight would just be corrected by the nursing team or communicated between individuals. The participants noted how they preferred and expected that an

error/omission would also be communicated between colleagues as a professional courtesy prior to the completion of the report. When working conditions were "busy," however, and the atmosphere already tense, the occurrence report is more likely to be used. Inconsistency in the use of the occurrence reporting system was also a factor that led to questions about the intent of the written report. Such disjuncture, as created by lack of communication and reporting inconsistencies, created escalating tension in the working relationships between RNs.

Although most of the research participants emphasized the importance of open communication, peer support, and teamwork to safely and successfully practice nursing, the reality for the participants was that nursing practice had become organized in a way that promotes individualism and competition between nurse peers. It became evident that within the hospital setting, RNs unconsciously supported competition among themselves, which has been detrimental to the formation of team-based and supportive practice environments. Recalling Section 4.4.2.5, a participant summed-up how nurses have come to understand protection from legal liability to mean "proving yourself" as better than your peers. Competition among nurses and comparisons of nursing practice was further reinforced in the organization of the hospital setting by the hierarchies in nursing practice. The thread of *double domination* leads to a further investigation of how these hierarchies have created nursing silos, and a trend to generate competitive work environments. In this way, RNs are obscured from "seeing" and acknowledging the valuable contributions of all RNs, working separately but for the common aim of enhancing the health and well-being of the public. I call this thread of knowledge generation the *big picture*.

5.1.3 Discussion of the *Big Picture* Thread

The participants' accounts regarding the circumstances of their work surrounding their CWR experiences generated data that helped me to unravel the *should nursing* and *double domination* threads. I was able to extend that knowledge to reveal how nursing practice has been shaped by the wider social, political, and economic trends influencing the evolving health care system, and health care reforms as implemented at the provincial level. I called this last thread of knowledge, the *big picture*.

Within the Canadian health care context there are pressures associated with accessibility, efficiency, and cost containment. Health care changes/reforms have been implemented to respond to these pressures in the form of management and cost containment processes that are very evident in the hospital setting and highly influential on nursing practice. Recalling chapter two, section 2.4.1, the hospital setting has remained primarily organized according to medical specialization and business management models in the delivery of acute care services. Despite the acknowledgement of the biopsychosocial models of health, the utilization of business models in the delivery of acute care services has contributed to the normalization of fragmented nursing practice.

Efficiency monitoring and outcome measurements organize the hospital setting so that nursing practice (and the practices of other health care providers) can be easily measured and controlled. As well, the coordination of nurses and their everyday practice allows for their nursing practice to be supervised, ensuring conformity and standardization. As a result, nursing practice is continuously monitored, measured, and reported on. Of course, the need to standardize and monitor nursing practice is perceived to ensure that public safety is maintained; yet the findings from this research have posed

questions about how nursing practice may be organized differently. Perhaps, an organization that would allow for deviation from monitoring and standardization if public safety is were ensured while promoting more collegial practices between RNs. One approach highlighted by the participants was to move towards a more horizontal communication process and inclusion of nurses' voices in examining how nursing practice can be organized to decrease the struggles experienced while caring for patients.

Some participants noted how nurses are not well represented in the financial and decision-making forums concerning the organization of nursing practice. Instead, they felt that decisions regarding the implementation of organizing models of nursing care were made at the executive level with only superficial consultations with frontline nurses. Organizing nursing practice in this manner has resulted in nursing practice being judged as appropriate or satisfactory by those in positions of power and under the terms they describe (Hutchinson et al., 2005), which may be at odds with what nurses deem as more appropriate in the context of their everyday professional practice. However, as nurses become accustomed to working within the system, they are coordinated and conditioned to adopt the same fiscal and efficiency attitudes as the correct/most appropriate way to practice nursing. These attitudes are supported and reinforced within the hospital setting by texts directing nursing practices/procedures to ensure conformity (Hutchinson, Vickers, Jackson, & Wilkes, 2005).

The activation of texts by nurses further persuades them to mediate and sometimes overlook the uniqueness of their patients in order to align their work with managerial imperatives (e.g., strictly adhering to time-based tasks). This idea was highlighted when the participants referred to their nursing practice as being comprised of tasks (including

documentation), and it was the completion of those tasks that was used as the criteria to define nursing competence and the characteristics of a good nurse. In this way, nurses are being organized to subordinate their professional knowledge and education, and to rationalize their actions within the institutional relations of ruling (Rankin & Campbell, 2009). At a national and provincial level, the value of care is regarded as a matter of the appropriateness of services being delivered at a manageable cost. The participants' accounts highlighted how nursing work, when conducted in this way, has created struggles for nurses to provide quality care within a task-based, results-focused, continuously evolving, complex health care system (Day, 2013).

Changes to the organization of the hospital setting and acute care services has also influenced changes in the policies directing patient care. Long gone are the days when an otherwise healthy patient would remain in hospital to recover from a routine surgery. Nowadays, the types of patients being admitted to hospital are older, sicker, and have multiple comorbidities requiring more complex and technical nursing care than ever before (Clarke, Shim, Mamo, Fosket, & Fishman, 2003; Dixon, 2013; Orhan & Serin, 2019; Russell, 2014; Salmond &Echevarria, 2017). These are also the patients likely to stay in the hospital for longer periods and are often in need of assistance for everything (e.g., hygiene, turning and positioning, and mobilization). Many of these tasks require more than one nurse to complete. For example, if a patient requires the use of a mechanical lift to ambulate, it is difficult for one nurse to safely use the lift. Therefore, there is an expectation of nurses to work together to complete the task.

For these reasons, a direct care model for professional nursing practice may not be feasible or even physically possible for all patients. Recalling section 4.4.3.4 the

participant equated a direct care model with the total patient care model in which the nurse assumes primary accountability for the nursing care of her assigned patients. Although nurses are individually accountable for their practices, nurses still need to rely on each other to complete their assigned duties and to critically think through complex care situations, while navigating the evolving health care system. Despite the acknowledgement and promotion of team-based, collaborative practice by the organization, the nursing practice environment is not organized in a way that promotes such collaboration. Perhaps, if the hospital setting were organized differently, models for nursing practice that promote a team-based, collaborative approach would be better received and more accurately implemented. Therefore, the organization of the hospital setting needs to enable nurses to partner with each other, and with professionals in other disciplines, for the common goal of providing the population with safe, competent, compassionate, and ethical health care.

Manyazewal and Matlakala (2017) reported on a cross-sectional study about the impact of health care reform on job satisfaction. The researchers found that in many countries, health care professionals who were operating under the constraints imposed by health care reforms struggled with decreased productivity, effectiveness, and morale. Further, those professionals subjected to greater numbers of reengineering initiatives were less satisfied with their jobs, less engaged, more burned out, and more likely to look for new employment. The authors suggest that health care reform efforts need to focus on improving job satisfaction for health care professionals, which in turn will lead to better patient outcomes (Manyazewal & Matlakala, 2017). Health care reforms in Canada and elsewhere have been presented as necessary to contain health care expenditures and

improve access to care. However, some research evidence suggests that the opposite may be true, and that the current organization of the hospital setting may be increasing costs and reducing efficiency (Campbell, 2013). The research literature on CWRs noted earlier and its impact on the retention and recruitment of RNs could be used as evidence to support this claim.

Like the findings from Manyazewal and Matlakala (2017), research participants also indicated that they expect their concerns about working conditions and job satisfaction to be addressed by both management and the health care organization. Recalling section 4.4.3.2, the participants felt that their efforts to meet the expectations of the organization were not appreciated because when the participants requested a change in their practice environment to improve their working conditions their request was denied. This left them with feelings of injustice, inequality, and powerlessness. Other participants voiced how they felt disrespected when they were not included, or included but not heard, in the conversations concerning changes to their working environment and how these changes would impact their nursing practice and hence the quality of their work lives. Feelings of powerlessness within the profession of nursing has been mostly linked to theories of nurses as an oppressed group.

Oppression theorists view the nurse's position within powerful relationships as one that results in marginalization and disempowerment (Croft & Cash, 2012; Duffy, 1999; Farrell, 2001; Giddings, 2005). Duffy (1995), one of the first researchers to recognize the occurrence of intra-staff conflict among nurses, discussed how the marginalization of nurses created feelings of self-hatred and low self-esteem, culminating in submissive-aggressive syndrome and horizontal violence (Duffy, 1995; Farrell, 2001;

Matheson & Bobay, 2007; Woelfle, & McCaffrey, 2007). She noted that nurses would internalize the norms and attitudes of the dominant group to gain power and control. The continued use of the oppressed group model as the primary means of understanding CWRs within nursing, however, generates a perception of CWRs as an intrinsic occupational reality in which nurses are expected to adapt. Using this explanation only, attention is focused on the individual behaviours and reactions of nurses and the processes that promote, condone, or perpetuate conflict. This stance obscures the role of power relations within organizations and inadvertently reinforces the oppression of nurses using disciplinary power (Hutchinson, Vickers, Jackson, & Wilkes, 2005). An example from the participants' accounts was their understanding that there could be legal and/or regulatory ramifications if nursing care was not documented appropriately – not documented, not done.

Using IE, my research offers additional insights to those provided by oppression theorists, by making visible how nursing practice, as it is organized within the hospital setting, plays a role in how nurses relate to each other within that setting. The ways in which nurses have been organized to work obscures their view of the big picture, where the big picture represents the location of nursing practice within the broader sociopolitical context of health care in Canada.

5.2 Discussion of Key Findings

As I listened to each participant telling me the details of their workday surrounding their CWR experiences, I became more aware of their use of institutional language as the starting point into the relations of ruling organizing the participant's work

as a nurse. When I extended the information beyond the standpoint of each participant, I paid attention to the generalizing relations linking the organization of nursing practice in the local hospital setting to extra-local influences beyond the participants' standpoint. By doing this, I outlined and made visible how aspects of the social organization of nursing practice in the hospital setting have created work environments where disjunctures, frustrations, and tensions among nurses create conditions where CWRs are likely to proliferate. This organization is made visible in figure 5, section 4.7.3. Further, I was also able to make visible how the social organization of nursing practice has contributed to work environments where nurses struggle to provide appropriate care, where conflict has become institutionalized, and where there is a need for strong leadership. A relational inquiry approach to nursing practice is discussed as an option for the organization of nursing to support more relational practices between RN peers. I conclude this section with a discussion of key contributions and recommendations for future directions.

5.2.1 When the Organization of Professional Nursing Practice Creates Struggles for Nurses

The word *struggle* was used numerous times by many participants during the interview process. Struggle was used in reference to the difficulties routinely encountered by nurses as they navigated the complexities associated with professional nursing practice. Some of the struggles noted by the participants, as referenced in the indexing tables, included unaccounted work, time constraints, difficulty with communications, as well as stress, and burnout, among others.

Although many of the participants remarked that they enjoyed their work as a nurse, some of them also highlighted that the practice of nursing was difficult. One of the

difficulties encountered by the participants was the amount of unaccounted and additional work they were required to complete on top of caring for patients. Both kinds of work contributed to their struggles. As referenced in the *double domination* thread, RNs were required to complete the work of proving themselves as good nurses, both to their peers and to their employers. To meet the requirements of being a good nurse to the employer, nurses were expected to work efficiently and competently. This work was tied to meeting the efficiency and fiscal expectations of the evolving health care system and requirements of health care reforms.

The nurse's ability to work efficiently and competently was measured by the employer via patient flow within the hospital setting, meeting the requirements of institutional policies (e.g., OCP), and documentation. Similarly, participants spoke about how their peers also expected them to work efficiently and competently but using a different set of criteria (e.g., completion of all tasks, good skill set, working independently, working effectively under stress and not becoming burned out). All this additional work, although required for professional nursing practice, is not routinely recognized, or accounted for in the everyday work life of nurses. The demands imposed by these additional areas of work have created contradictory expectations for nurses, creating the *struggles* they experienced in their nursing practice. In addition, nurses are expected to respond to the increasingly complex health care needs of patients as they adapt to new technology and keep pace with an evolving health care system. As nurses struggle to provide nursing services under these conditions, from the participants' accounts and the experiences they shared, the prevalence of CWRs within the nursing

profession seems to be a strong indicator that the work environment is not conducive to more collegial relationships.

Historically, nursing as a profession developed alongside the expansion of hospital-based health care. Even nursing education was initially located within the hospital setting (Porter-O'Grady, Clark, & Wiggins, 2010). Therefore, many of the characteristics of medical dominance, such as tight hierarchical controls, role subordination, and task-based care, informed and framed the development of the nursing profession (Porter-O'Grady, Clark, & Wiggins, 2010). Efforts to counter these characteristics have included the expansion of nursing roles, the moving of nursing education to the academic setting, and the implementation of biopsychosocial models of health care. However, the influences of medical dominance still prevail within the hospital setting where the majority of nurses are practicing.

With advancements in medical technology, clinical services in the hospital setting have become more complex. These clinical services are technologically based, requiring specialization of nursing practice, a greater depth of nursing knowledge, and critical thinking that includes evidence-based practice, as well as the ability to skillfully and competently perform a large variety of psychomotor skills (Porter-O'Grady, Clark, & Wiggins, 2010). Further, the expectations for the type and level of knowledge and skills required from nurses have been reinforced on many levels including academia, the employer, and the health care system via texts-in-use within the hospital setting. In addition to these requirements and on a broader level, nurses are also expected to coordinate, integrate, and facilitate the continuum of patient care in the hospital setting.

However, patient satisfaction surveys indicate that satisfaction with their health care experiences is directly correlated with their perceptions of nursing *care* as indicated through positive nurse-patient interactions. Conversely, patient dissatisfaction with health care services had corresponded to patient perceptions regarding nurses as being persistently busy (Scott, Matthews, & Kirwan, 2014). As such, nurses must work at balancing the line between operating within a complex, technical, and siloed health care system while still providing quality, wholistic (non-fragmented), patient-centred care (Mazzotta, 2016; Torabeni, 2006).

Another inconsistency in nursing practice addressed by participants, included how nurses are expected to use their professional judgement and to be primarily responsible for the care of their patients, but are also limited in exercising their full professional autonomy because they are subject to bureaucratic rules of medical authority (Rankin & Campbell, 2006; Rankin, 2009). Patient-centered care has been undermined by the objectifying processes of admission, assessment, diagnosis, evaluation, and discharge (Rankin & Campbell, 2006; Rankin, 2009). Participant #2 provided a good example, when she described how despite knowing what care needed to be provided for a patient, her work to care for the patient was delayed because she had to wait for the physician to write admission orders.

Further, collective action by RNs has been narrowed by a focus on individual accountability for nursing practice, coupled with what participants referred to as the realities of nursing practice, which is restricted by a hierarchal decision-making process and relations of ruling. Participants noted that even what appeared to be autonomous nursing practice was distorted by anonymous but interconnected, routine organizational

processes that governed what “could or should” and what “could not or should not” be done (Townsend, 1998). Although idealized as a caring profession, nurses have been limited in their ability to provide holistic care to their patients by the constraints placed upon them by a broader system of authority. Tierney, Bivins, and Seers (2019) assert that compassionate and caring nursing practice requires a facilitative environment to flourish. Within such an environment, nurse leaders would be able to examine cultural and/or organizational factors necessary to support compassionate care. However, the results from this research indicates that working relationships among RN peers within the hospital setting have deteriorated to the point that disagreements cannot be managed on an interpersonal level and the processes for managing conflict has become institutionalized.

5.2.2 The Institutionalization of Conflict

Many of the participants described how they felt caught off-guard by the CWR they experienced with their RN peers. More so, they found it frustrating and disappointing when informed by their managers that a peer(s) had a problem with them or their work because they expected that their colleague would speak with them first. Incidentally, the reporting RNs were also left with feelings of disappointment and frustration because they felt management did not give their concerns adequate attention and/or that the incident was not adequately resolved. The results of this investigation have indicated that for some RNs, despite their preference for the conflict to be resolved directly between the individuals involved, this rarely happened. Some participants noted feeling too professionally and emotionally depleted by other struggles they experienced at

work to address the conflict themselves. Therefore, the default situation has been to report the conflict to management for them to address.

As previously discussed in section 4.5.3.1, within the Regional Health Authority (RHA) there are a few human resources policies that address conflict and harassment in the workplace. Structurally similar, both documents contain a policy statement on the first page of the text. As explained in the analysis of the conflict-management text, if the policy statement was read quickly by an RN seeking support to resolve a conflict, it may be misinterpreted to mean that all conflict must be reported to management. Although the conflict-management policy does direct individuals involved in a CWR to attempt to resolve the conflict between themselves, it is not stated until page six, making it seem less significant than if it were stated on page one.

Additionally, the policies, as written, do not consider the contextual factors of an event or provide adequate support or direction to employees on how to manage the conflict themselves. Many of the suggestions noted in these policies for the promotion of conflict and harassment free work environments relied exclusively upon the individuals involved in the conflict to have the communication skills necessary to professionally resolve the conflict. There is also an implied expectation that the individuals involved in the conflict will be comfortable with confrontation. Incidentally, during the interview process when I asked the participants about such policies, many of them stated that they knew policies existed, but had never referred to them specifically.

Some research has found that efforts to change nursing behaviours that focus only on communication skills and becoming more comfortable with conflict have little effect (Padgett, 2012). According to Padgett, it is easier to use an online reporting system and

the email system because it removes the actual personal connection to the CWR, and the reporting individual feels less accountable. Such a practice is worrisome for the profession because a crucial part of collegiality is taking accountability for one's actions, which is a professional expectation for a self-regulating profession like nursing. The environment in which nurses work needs to assist nurses to switch their thinking away from linear, one-sided thinking to critical, reflexive thinking and away from individual practice to collective practice.

As it is now, when faced with a conflict, nurses are directed to raise questions about the specific practices of their peers with their managers. This leads to a range of problems and recriminations as discussed earlier. In the future, instead of only questioning the practices of our colleagues, nurse leaders need to open an arena for discussion on the ways nursing practices are organized and how it contributes to the development of CWRs.

5.2.3 The Importance of Leadership

Conflict resolution is an important leadership quality that can be remarkably effective in dealing with co-worker conflict when employed correctly (Green, 2019; Grubaugh & Flynn, 2018). However, the results of my research suggest that an equally important quality of leadership is the ability to recognize the conditions that foster the development of conflict in the work setting, and to possess the necessary skills to advocate for positive changes. My research shows that nurse leaders can proactively take measures to enhance the social organization of professional nursing practice to promote "relational practices" among RN peers (Hartrick, 2002, p. 50).

Relational practice refers to "a humanely involved process of respectful, compassionate, and authentically interested inquiry into people's experiences" (p.50). A relational style of leadership emphasizes the use of self-refection, as well as a reflexive practice to acknowledge and appreciate the contextual influences permeating interactional experiences (Hartrick, 2002; Hartrick-Doane & Varcoe, 2015). As such, the relational style of leadership has been noted to be most effective in the implementation of organizational change (Kaiser, 2017).

To promote an organization that supports relational practices, nursing leadership must support an "ecocentric" view of nursing, which calls for a more holistic approach, based on the understanding that everyone and everything is connected to everything else (p. 17). This would allow acknowledging that the different experiences/values/attitudes that nurses bring to their practice influence the way they act in relationships. Therefore, it is imperative for leaders to embrace new ways of thinking about leadership and be mindful about the complexities and challenges of the health care environment (Hutchinson & Jackson, 2013).

Participants' accounts regarding changes to the organization of routine practices (section 4.4.3.2) indicated that they needed to feel more involved in the decision-making processes concerning organizational changes and the conditions surrounding their work. These accounts were consistent with research findings that showed that nurses felt uninvolved when leadership did not explain the "big picture" issues surrounding nursing practice, a practice that negatively impacted nurse relationships (Kaiser, 2017). Furthermore, participants' accounts provided by RNs in novice roles pointed out how new nurses felt more empowered when exposed to nurse mentors who modeled

professional behaviours and supported relational practices. Leaders who empower staff by asking for staff input, make joint decisions based on feedback, and demonstrate a genuine interest in staff development were found to contribute to a more civil work environment (Kaiser, 2017).

The methodology of IE helps support relational leadership approaches because it allows pro-active leaders and RNs to visualize an ecocentric view of professional nursing practice, assisting all to see the big picture. Therefore, it is important that the social organization of professional nursing practice allows room for the development of more collegial workplace culture through relational practices.

5.2.4. Supporting Relational Practices and a More Collegial Workplace Culture

My research shows that the organization of contemporary nursing practice tends to be individualistic and decontextualized. The problem with this organization is that nursing practice becomes focused on individual nurses being primarily responsible and accountable for providing client care, without consideration of the contextual constraints that shape the care they provide and the options available to them (Hartrick-Doane & Varcoe, 2015). Participants' accounts led me to ponder questions about the best way to organize nursing practices in the hospital setting in ways that create and sustain positive working relationships between nurses.

A relational inquiry approach has been proposed as an alternative way to organize nursing practice (Hartrick-Doane & Varcoe 2015). The practice involves an intentional focus on the intrapersonal (what is happening within people), interpersonal (what is happening among and between people), and contextual (the social organization of the

activities of people, including the structures and forces that are influencing what people do, how they do it, and how they think and behave) factors. Part of the relational inquiry approach involves the use of relational consciousness. Relational consciousness is defined as "the action of being mindfully aware of the relational complexities that are at play in a situation and intentionally, and skillfully working in response to those relational complexities" (p. 5). Essentially, a relational inquiry approach to organize nursing practice supports an awareness and recognition of broader contextual influences and the connections with patients, families, communities, and health care systems. Furthermore, there is a recognition that people are shaped by and shape other people's responses, situations, experiences, and contexts. Such a practice would be more effective in creating and maintaining positive, healthy, and respectful work environments for nurses.

The health care environment must be changed to support relational practices. The onus is not on the nurses alone to implement a relational practice or a relational inquiry dynamic. RNs need a practice environment that is organized in a manner that provides the time and resources to allow for relational practices to support a more collegial workplace culture.

5.3 Recommendations for Future Directions

There are varying views regarding how the findings from IE studies can be used (Campbell & Gregor, 2008; Hussy, 2012; Smith, Mykhalovsky, & Weatherbee, 2006; Smith, 1990b). Traditional IE research is meant to unveil the social and ideological processes that produce experiences of subordination. Unveiling these processes for those who live these experiences increases their knowledge about the processes organizing their

decisions and actions, creating room for further contemplation or action (Campbell, 2006; DeVault & McCoy, 2006; Rankin, 2017b). The framework presented as figure 5 highlighted the intersections between *should nursing*, *double domination*, and the *big picture* as caution areas for RNs. These caution areas make nurses aware of the contextual factors surrounding their experience of disjunctures, tensions, and frustrations in their nursing practice that contribute to the development of CWRs with peers. These caution areas provide nurses with additional knowledge regarding the conditions informing their thoughts, actions, and behaviours, creating the space for RNs to potentially choose a different response. These caution areas can be thought of as complementing the existing strategies of emotional resilience and cognitive rehearsal training, which have been shown to decrease occurrences of CWRs (Embree & White, 2010; Stagg, Sheridan, Jones & Speroni, 2011; Sergeant & Laws-Chapman, 2012).

However, some researchers, such as George W. Smith (1990b) have used the results of IE investigations for activism, dubbed political activist ethnography (PAE). As a form of IE, PAE is focused on mapping the social organization of ruling regimes that activists wish to change (Hussey, 2012). In this regard, the same caution areas by RNs can also be used by individuals in leadership positions (senior RNs, managers, RNs in charge, regulators, union leaders, educators, researchers, and government) to begin a dialogue about the development of CWRs as related to the organization of professional nursing practice. Wherever there is a toxic environment, a dialogue must begin by questioning nurses about their work: what works well, what does not work, and where disjunctures, tensions, and frustrations are experienced in the context of their work environments. Nursing leaders could use the information to begin a dialogue about a

common ground for nursing practice, one that meets the expectations for nurses, the public, the organization, and the government.

Government decision-makers may want to re-visit nursing care-delivery models and systems used in the hospital setting to grasp how they are working in every day practice. Officials need to address the issues noted by nurses who have been working with the models of nursing care and support more RN involvement in the decision-making process regarding the organization of their work. There may also be a need to advocate for changes with respect to the hierarchy of nurses within the hospital setting, to reflect a more balanced (horizontal) organizational system of nursing care, making it transparent, fair, and consistent across sites, shifts, and providers. Part of this process may include changing the value of independence as the indicator for the status of the good nurse to mean one who is relational and strives to support a team dynamic. Perhaps rewarding nursing teams and collegial practices, instead of individuals. Another suggestion would be to revise the format/wording of policies concerning conflict resolution to better reflect the importance of relational approaches.

Leaders may also want to participate in and/or support research investigating the prevailing socio-cultural context and organizational culture of the hospital setting, as well as the resources needed to better support more positive nurse peer relationships in that context. Through education and research, frontline nurse leaders need to be provided with increased awareness about the relational inquiry approach to nursing practice. To ensure consistency, such research may be conducted in collaboration with RNs, the employer, the regulatory body, professional association, and the nurse's union. Nursing leaders need to also lead-by-example and advocate for organizational changes to support relational

practices among RNs peers based on consideration of the contextual factors impacting collaboration, empowerment, open dialogue, joint decision-making, and continuous learning.

5.3.1 Complementing Existing Work

The findings from this research and recommendations for future directions may serve to complement and contribute to the work already begun. With respect to the promotion of professional-practice environments and respectful workplaces, consider the *Quality Professional Practice Environment Standards* from the College of Registered Nurses of Newfoundland Labrador (ARNNL, 2013c). This document was created to acknowledge the need for healthy work environments by identifying organizational and workplace factors necessary to create a workplace that benefits nurses. The document outlines six standards that have been shown to influence the quality of professional practice nursing environments. These standards address workload management, nursing leadership, control of practice and work life, professional development, organizational support and communication, and collaboration. The research participants addressed each of these six standards as issues. The document further outlines specific criteria to meet each standard and how nurses can be involved in the process.

The Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU) issued a joint position statement (*Practice Environments: Maximizing Outcomes for Clients, Nurses, and Organizations*) outlining the expectations of quality practice-environments to support the delivery of safe, compassionate, competent, and ethical care while maximizing the health of not only clients but also of nurses (2013).

Eight elements of quality practice-environments were highlighted and included areas where nurses experience respect and are involved in decision-making processes. Also included were areas that promoted responsibility and accountability and the provision of safe and realistic workloads, areas where leadership would be present and there was support for information and knowledge management, professional development, and positive workplace cultures. Positive workplace culture was further defined to mean one that values the well-being of employees.

On July 30, 2019, the Registered Nurses Union of Newfoundland Labrador signed a new Collective Agreement. Article 48 addresses the formation of a professional practice committee. The purpose of the committee is to respond to any RN who judges a work area's patient workload to have exceeded safe patient care levels (RNUNL, 2019, Article 48.01(f), p. 68). The committee is intended to review written concerns relative to patient/resident/client care regarding (but not limited to) the safety of patients/clients/residents and RNs, quality practice environments, professional standards of practice, code of ethics, and workload. The concerns addressed by this committee are reflective of the concerns noted by the research participants as contributing to their CWR experiences.

Regional health authorities have joined nursing regulators and unions in advocating for quality professional practice environments. Eastern Health's (EH) 2017 to 2020 strategic plan highlights EH's commitment to healthy workplaces. Providing healthy workplaces is a new, separate priority that focuses on employee engagement and improving employee wellness (Eastern Health, 2017b). The importance of quality professional-practice environments is well known and supported by research. The next

steps need to be the implementation of these standards, and once implemented, an in-depth evaluation of their effectiveness.

5.4 Contributions and Limitations of Institutional Ethnography

Institutional ethnography (IE) has been credited by many researchers with providing a much-needed alternative approach to the highly abstract and theoretical accounts of the world generated through mainstream sociological research (Hart & McKinnon, 2010). Many researchers consider that IE assists in the recognition of the discursive nature of sociological knowledge without relinquishing the right to speak the truth of social actuality (Hart & McKinnon, 2010). This can be accomplished because the analytic account of IE supersedes any one informant's experiential account, but in a way that does not deny the experience of the research participants (Rankin & Campbell, 2009).

IE also contributes to a broader understanding of the micro and macro-social structures and institutional relations that shape or exclude individual experience. Although not originally designed for activism, the results from IE research can be and have been used to support activists' agendas (Hussy, 2012; Smith, 1990b) and has been used to provide insight on how to approach change. It has been applied to help uncover relations of ruling within organizations, which may be fundamental to policy change allowing for the exploration of, and challenges to, ruling discourses. In my research, the IE methodology helped to reveal the extra-local processes and relations of ruling influencing the development of CWRs between RNs. Further, it supplied an alternate knowledge source from which nurses can draw upon when reflecting on their experiences

with CWRs, as well as insight on where to start the processes for change to support a more relational organization for nursing practice.

However, there are also limitations. Walby (2007) describes three main limitations of IE. The limitations are concerned with ontology and truncation (to shorten or cut off); data collection and constitutive hermeneutic of the interview process, and data analysis and the production of possible subjects (Walby, 2007). With respect to ontology and truncation, Walby argues that IE fails to maintain the presence of the subject because it does not account for the social relations involved in the research process. Although IE is fundamentally designed to explicate ruling practices, when it comes to the examination of its own ontology of the social it becomes less reflexive. Walby debates that IE researchers tend to produce rather than preserve the presence of the subject. With this, he claims that the social ontology framing IE investigations pays attention to and selects only specific social elements truncating other elements that may be equally as important for the investigation. I feel that the risk of ontology and truncation is not unique to IE and that it is a potential limitation for many research methodologies. However, being aware of the potential for this limitation, I ensured that I kept the idea of the social organization of nursing practice and its relationship to the development of CWRs (from each participants standpoint) at the heart of data analysis, thereby preserving their presence.

Walby's second critique of IE research refers to how IEs social ontology is framed in a certain way, and because of this framing, it asks certain questions in a specific language that elicits specific responses. Walby refers to this as the "constitutive hermeneutics of interviewing" (p. 1020). The line of questioning, listening, and asking about texts, corrals what could possibly be said by the participants. By responding to the

questions, participants provide their accounts in a form that satisfies the demands of the ontological claims that philosophically and methodologically guide IE. Being aware of this limitation, I ensured that the interviews with the research participants proceeded like a casual conversation while having a semi-structure to fully explore the CWR. I did not formally direct the flow of the conversation and the participants spoke freely about their experiences with CWRs. In this way, the participants were not corralled to elicit a specific response. However, this interviewing technique did result in long interviews, and as previously discussed, because of the casual organization of the interview, I might have missed the opportunity to ask some clarifying questions.

Data analysis and the production of possible subjects was the last critique by Walby. The data analysis stage of social research is crucial for representing the subject. Editing in IE was also noted as having a potential for misrepresentation. Fortunately, I had the benefit of using Rankin's two articles on (2017a & b) methods for data analysis to help reduce the potential for this last limitation. Using the data analysis tools of writing accounts, indexing, and mapping helped me to be consistent in the data analysis process.

In Smith's (1987) discussion about the limitations of IE, she stated that there can never be a point where you can know everything about the social organization of the *everyday world*, so IE research is never complete. I felt this way as well. I had to set limits on the texts I explored and on the scope of the analysis I was going to complete for the purposes of this research. Fortunately, I can use this current research to embark upon new research endeavours in the future. For instance, there is a need to examine the relationship between CWRs and other forms of oppression such as racism, sexism, classism, and others from within institutions using IE.

5.4.1. Limitations of My Research Using IE

Like Walby, I was also troubled by the language of IE. It was difficult for me to use the language appropriately during interviews and while writing this dissertation. During the interview stage, as I previously mentioned, I intended to listen for the use of institutional language and ask for clarifications of the understandings for that language. However, I found that, as an RN, I was unable to recognize all instances where institutional language was used and often missed important data. In addition, I was caught up in my own personal experiences with CWRs and some of the interviews went off track. I found that clarifying the use of institutional language took time, and it was difficult for the participant to fluidly tell me their CWR experiences. As I did not have previous experience using IE, my interviewing method was poor for some of the interviews and I had to conduct five additional interviews. To ensure better interviews and to ensure I was gathering high quality data, I drafted a more detailed interview guide and was less casual in my interview process.

The absence of interviews with nursing managers and administrators was another limitation. Instead, of interviewing managers and administrators, I used text analysis as my entry point into second level data. My recruitment flyer advertised for RNs who had experienced a CWRs with a peer in the hospital setting. It did not specify if the RN was to be in a particular role such as management or administration. However, some of the participants I interviewed held management or administrative positions at the time of the interview but not at the time of their CWR. Also, as a novice researcher and a new user of IE, I did not want to stray too far off of my initial plan for conducting the research, whereas a researcher with experience using IE would follow the lead of the data

generation and seek out people to interview to generate second level data. Similarly, as I was not an employee of the regional health authority, I did not have access to all the texts that may have been useful for analysis (e.g., the online occurrence reporting system). Instead of analyzing the actual text, I analyzed the purpose of the text as articulated in policy. Again, I feel with more time and experience, I would be more forthright in requesting access to these texts.

The absence of direct participant observation as a method for data generation is another limitation of my research. However, the reflexive account I provided regarding my experiences of CWRs with a peer in the hospital setting, could be considered indirect participant observation. Although I was not present to observe any of my participants' experience of CWRs, I did witness CWRs between RN peers many times during my career. As well, my work experiences as an RN in acute care settings allowed me to have a unique understanding of the context participants spoke about because I have been in that context as an RN. My own knowledge of CWRs as an embodied knower further allowed me to get to the point where I could recognize IE as a method of inquiry to further explore CWRs.

Another potential limitation of my research was acquaintance with some of the participants and the participants' knowledge of my research interests. During my PhD education, I completed several presentations and was involved in working groups and committees related to my research topic. However, keeping in line with an IE, I did not focus on these participants' personal experiences. Instead, I focused on the social organization of their nursing practice and the generalizing relations surrounding the development of CWRs. This information was related to how the participants' understood

how their nursing practice was to be completed, not influenced by their prior relationship with me. However, I did want to emphasize that the nurses I interviewed played in role in the process of discovery regarding how CWRs, Therefore, as discussed previously, I decided to use the word participant to represent the nurses I interviewed instead of the word informant as traditionally used in IE.

Furthermore, as previously noted in section 4.1, some CWR accounts as told by participants took place years prior to the interview date. As such, some participants may have been referring to different versions of the Standards of Practice and Code of Ethics, and perhaps, different sets of expectations for professional behaviours. Therefore, it was necessary to review the previous versions of these texts for any revisions that may have influenced participant experience and/or their expectations on how to behave professionally. Despite revisions and/or updates to the standards of practice and the code of ethics documents, overall, nursing continues to be defined as a caring profession. Hence, the overarching expectation for nurses to have a caring attitude and to act professionally did not significantly change over time.

With respect to dissertation writing, IE presented a difficult new language for me that I embraced to the best of my ability and with the resources available to me, including my standpoint as an experienced RN. However, many of my descriptions of IE are using the words and explanations as contained in the writings of Dorothy Smith. This resulted in the use of frequent quotations and citations from her work, which may be confusing for those readers unfamiliar with IE as a method of inquiry.

5.5 Dissemination of Findings

The findings from this study have been developed as a doctoral dissertation to be submitted in partial fulfillment of the Doctor of Philosophy, Faculty of Medicine, Division of Community Health and Humanities, Degree at Memorial. As part of meeting the doctoral requirements, the completed dissertation will be defended. The dissemination and transferring of knowledge generated from this dissertation will occur in a variety of forms.

I will utilize the teleconference education system offered by the College of Registered Nurses of Newfoundland Labrador to reach the RNs of Newfoundland and Labrador to present my research findings and provide them an opportunity to ask questions. I will seek out opportunities to disseminate my research findings locally, provincially, and nationally. I will seek to publish my research findings in both peer-reviewed and non-peer reviewed journals and present my finding at conferences, research symposiums, and at meetings with key stakeholders and nursing advocacy groups. I also plan to partner with the Faculty of Nursing to do presentations of the research findings to nursing students in all four years of the program. I intend to develop the findings into at least one manuscript for publication in a peer-reviewed academic journal such as the Journal of Advanced Nursing, the Journal of Nursing Management, Nursing Inquiry or the Journal of Nursing Administration.

I hope to be able to offer knowledge resources to nurses, to members of the interdisciplinary health care team, and to health care leaders. By disseminating knowledge to these social actors, they may be better equipped to look at their work environment and think about the contextualized conditions needed to generate healthy

and positive working relationships within them. Making RNs aware of how ruling practices influence their work every day and night, provides them with an additional way-of-thinking — an important resource to draw upon when making decisions regarding on-the-job conflict. Moreover, my work will provide leaders with a platform to begin the process of change in the organization of nursing practice in the hospital setting.

5.6 Conclusion

The aim of this research was to make visible how the social organization of nursing practice in the hospital setting was related to *how* CWRs between RN peers happens. I did not intend to draw conclusions about *why* CWRs occurred. Instead the results of this research were meant to reveal aspects of the social organization of professional nursing practice that were significant in the development of CWRs. Based on my research findings, my knowledge of and familiarity with the subject, and feedback from my supervisors, I am confident that I have accomplished my research aim. This research revealed how *should nursing, double domination*, and the *big picture*, as aspects of the social organization of nursing practice within the hospital setting, are linked to the creation of disjunctures, tensions, and frustrations for nurses that were influential in the development of CWRs.

Although each of the participants experiences were unique to them, at different points of time, under different sets of circumstances, and subject to different interpretations, the results of this research will resonate with all of them, a thread that binds all participants together. This outcome is because IE epistemology insists on empirical descriptions of *reality* that is supported by data collection and analysis to reveal

a “world empirically in common” that can be agreed upon by multiple participants in various locations (Rankin, 2017b, p. 2).

I also wanted to identify steps that could be taken to help promote healthy and productive working relationships between RN peers. The participants’ accounts identified that strong nursing leadership would be beneficial to help RNs successfully navigate the struggles they encounter in their nursing practice and to help them advocate for positive changes to their practice environments. I believe the results of this research can be used to supplement and advance the work that has already been started with respect to quality professional practice environments. A relational inquiry approach to professional nursing practice was also suggested as a potential model to organize nursing practice that would support a more relational approach between RNs.

The current health care context is asking health care providers to provide higher quality care in an increasingly resource-constrained environment. Nurses who are caught in the disjunctures created by this environment need strong leadership to advocate for resources to help them navigate the obstacles encountered in professional nursing practice and to promote more positive nurse-to-nurse relationships. Nursing practice within the hospital setting must be redesigned, changing the context of how nurses’ practice, and aligning it with the health care system that exists today. Nurses who have strong professional relationships in respectful workplace environments are happier, healthier, and are better able to provide safe, competent, and ethically sound care to their patients.

References

Allen, B. C., Holland, P., & Reynolds, R. (2015, February). The effect of bullying on burnout in nurses: the moderating role of psychological detachment. *Journal of Advanced Nursing,* 71 (2), 381-390. doi: 10.1111/jan.12489

Alshehry, A. S., Alquwez, N, Almazon, J., Namis, I. M., & Cruz, J. P. (2019). Influence of workplace incivility on the quality of nursing care. *Journal of Clinical Nursing,* 28(23/24), 4582-4594. doi: 10.1111/jocn.15051

André, S. (2018). Embracing generation diversity: reducing and managing workplace conflict. *Revue de AIISOC*. Retrieved from www.ORNAC.ca

American Nurses Association (ANA) (2001). ANA's Bill of Rights for Registered Nurses. Retrieved from https://www.nursingworld.org/practice-policy/work-environment/health-safety/bill-of-rights-faqs/

Amrein, K. R. (2012, September). Horizontal violence: can anything be done? *Nursing*, 42 (9), 1-2. doi: 10.1097/01.NURSE.0000418620.83970.1c.

Armstrong, P., & Braedley, S. (2013). *Troubling Care: Critical Perspectives on Research and Practices*. Toronto: Canadian Scholars 'Press.

Armstrong, P., & Armstrong, H. (2010). *Wasting Away: The Undermining of Canadian Health Care*, 2nd edition. Toronto New York Oxford, Oxford University Press.

Anderson, L. M., & Pearson, C. M. (1999, July). Tit for Tat? The spiraling effect of incivility in the workplace. *The Academy of Management Review,* 24 (3), 452 – 471. Retrieved from http://www.jstor.org/stable/259136?origin=JSTOR-pdf

Andrew, N. (2012). Professional identity in nursing: are we there yet? *Nurse Education Today*, 32, 846-849. doi: 10.1016/j.nedt.2012.03.014

Armmer, F., & Ball, C. (2015). Perceptions of horizontal violence in staff nurses and intent to leave. *Work,* 51, 91-97. doi: 10.3233/WOR-152015

Association of Allied Health Professionals (AAHP) (2019). Job Evaluation System. Retrieved from https://aahp.ca/membership/job-evaluation-system/

Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2019). *Annual report* 2018-2019. Retrieved from https://crnnl.ca/sites/default/files/ARNNL-anuualreport2018-may2019.pdf

Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2014). *Professionalism and the Registered Nurse.* St. John's: Author.

Association of Registered Nurses of Newfoundland Labrador (ARNNL) (2013a). S*tandards of Practice for Registered Nurses*. St. John's: Author.

Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2013b). *Competencies in the Context of Entry-Level Registered Nurse Practice*. St. John's: Author.

Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2013c). *Quality professional practice environment standards*. St. John's: Author.

Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2006). *Scope of Nursing Practice: Definition, Decision-Making & Delegation*. St. John's: Author.

Becher, J., & Visovsky, C. (2012, July-August). Horizontal violence in nursing. *Medsurg Nursing*, 21 (4), 210-232. Retrieved from https://www.researchgate.net/publication/230831024_Horizontal_violence_in_nursing

Bennett, K, & Sawatzky, J.A. (2013, April – June). Building emotional intelligence: a strategy for emerging nurse leaders to reduce workplace bullying. *Nursing Administration Quarterly,* 37 (2), 144-151. doi:10.1097NAQ.0b013e318286de5f

Berry, P. A., Gillespie, G. L., Gates, D., & Schafer, J. (2012). Novice nurse productivity following workplace bullying. *Journal of Nursing Scholarship,* 44 (1), 80-87. doi: 10.1111/j.1547-5069.2011.01. 01436.x

Bowen, B., Privitera, M. R., & Bowie, V. (2011). Reducing workplace violence by creating healthy workplace environments. *Journal of Aggression, Conflict and Peace Research, 3*(4), 185-198. doi: http://dx.doi.org/10.1108/17596591111187710

Broome, B. A. (2008). Dealing with sharks and bullies in the workplace. *Association of Black Nursing Faculty Journal, 19*(1), 28-30. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,url,uid&db=rzh&AN=2009809103&site=ehost-live&scope=site

Brunt, B. (2019, February March April). Combatting lateral violence. *The Bulletin* [Independent Study]. Retrieved from https://www.ce4nurses.org/combatting-lateral-violence/

Burns, M. M. (1978). *Leadership*. New York: Harper & Row. In Gaudine, A., & Lamb, M. (2015). *Leadership and management: working in Canadian health care organizations.* Toronto: Pearson Canada Inc.

Campbell, A. (2013). Work organization, care, and occupational health and safety. In Armstrong, P., & Braedley, S. (2013). *Troubling Care: Critical Perspectives on Research and Practices*. Toronto: Canadian Scholars' Press. (p.89).

Campbell, H., Hotchkiss, R., Bradshaw, N., & Porteous, M. (1998). Integrated care pathways. *British Medical Journal*, 316 (7125), 133-137. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2665398/

Campbell, M. (2003). Dorothy Smith and knowing the world we live in. *Journal of Sociology & Social Welfare*, 30(1), 3-21. Retrieved from https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=2871&context=jssw

Campbell, M. (2006). Institutional ethnography and experience as data. In D. E. Smith (Ed.), *Institutional ethnography as practice* (pp. 91). Lanham Boulder New York Toronto Oxford: Rowman & Littlefield Publishers, INC.

Campbell, M., & Gregor, F. (2008). *Mapping social relations: A primer in doing institutional ethnography*. Toronto: University of Toronto Press Incorporated.

Canadian Health Services Research Foundation (CHSRF) (2011). *Transforming nursing practices in Canada: a case study of the Ottawa hospital model*. Retrieved from https://www.cfhi-fcass.ca/sf-docs/default-source/reports/OttawaHospitalNursingModel-EN.pdf?sfvrsn=0

Canadian Nurses Association (CNA) (2000). *The Canada health act*. [Fact Sheet]. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/fs01_canada_health_act_june_2000_e.pdf

Canadian Nurses Association (CNA) (2014). *Practice environments: maximizing outcomes for clients, nurses and organizations* [CNA-CFNU Joint Position Statement]. Retrieved from https://cna-aiic.ca/~/media/cna/page-content/pdf-en/Practice-Environments-Maximizing-Outcomes-for-Clients-Nurses-and-Organizations_joint-position-statement.pdf

Canadian Nurses Association (CNA) (2015) *Framework for the practice of registered nurses in Canada*. Retrieved from https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/framework-for-the-pracice-of-registered-nurses-in-canada.pdf?la=en&hash=55716DC66A8C15D13972F9E45BE4AC7AE0461620

Canadian Nurses Association (CNA) (2017). *Code of Ethics for Registered Nurses*. Ottawa: Author. Retrieved from https://cna-aiic.ca/-/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive.pdf?la=en&hash=09C348308C44912AF216656BFA31E33519756387

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316. doi:10.1177/1049732307306327

Chachula, K.M., Myrick, F., & Yonge, O. (2015). Letting go: how newly graduated registered nurses in Western Canada decide to exit the nursing profession. *Nurse Education Today*, 35, 912-918. http://dx.doi.org/10.1016/j.net.2015.02.024

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003, April). Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review*, 68, 161-194. doi: 10.2307/1519765

Cleary, M., Hunt, G. E., & Horsfall, J. (2010). Identifying and addressing bullying in nursing. *Issues in Mental Health Nursing*, 33, 331-335. doi: 10.3109/01612840903308531

Coletti, M, Davis, B., Guessferd, M., Hayes, S., & Skeith, J. (2012, August). Building better health care through evidence – "It's not just a retention problem": A hearing on "bullying" and "lateral violence" in nursing. *Journal of Hospital Librarianship,* 12 (3), 229-257. doi: org/10.1080/15323269.2012.692242

Corney, B. (2008). Aggression in the workplace: a study of horizontal violence utilising Heideggerian hermeneutic phenomenology. *Journal of Health Organization and Management,* 22 (2), 164-167. https://doi.org/10.1108/1477260810876321

Croft, R. K., & Cash, P. A. (2012). Deconstructing contributing factors to bullying and lateral violence in nursing using a postcolonial feminist lens. *Contemporary Nurse*, 42 (2), 226-242. doi: 10.5172/conu.2012.42.2.226

Crowley, M. (2012). Control and dignity in professional, manual and service sector employment. *Organizational Studies*, 33(10), 1383-1406. doi: 10.1177/0170840612453529

Cruickshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: a philosophical orientation. *Nursing Inquiry*, 19 (1), 71-82. doi: 10.1111/j.1440-1800.2011.00558.

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation, 21*(12), 560-568. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,url,uid&db=rzh&AN=2012808437&site=ehost-live&scope=site

Daly, T. (2013). Imagining an ethos of care within policies, practices, and philosophy. In Armstrong, P., & Braedley, S. (2013). *Troubling Care: Critical Perspectives on Research and Practices*. Toronto: Canadian Scholars' Press. (p.33).

Day, S. (2013). The implications of conceptualizing care. In Armstrong, P., & Braedley, S. (2013). *Troubling Care: Critical Perspectives on Research and Practices*. Toronto: Canadian Scholars' Press. (p.21).

DeVault, M. (2006). Introduction: What is institutional ethnography? *Social Problems*, 53 (3), 294-298. doi: 10.1525/sp.2006.53.3.294

DeVault, M. L., & McCoy, L. (2006, August). Institutional Ethnography: using interviews to investigate ruling relations. In D. E. Smith (Ed.), *Institutional ethnography as practice* (pp. 13). Lanham Boulder New York Toronto Oxford: Rowman & Littlefield Publishers, INC.

Dewitty, V. P., Osborne, J. W., Friesen, M. A., & Rosenkranz, A. (2009). Workforce conflict: What's the problem? *Nursing Management*, 40 (5), 31-37. Retrieved from http://www.nursingmanagement.com

Dickerson, J., & Latina, A. (2017, October). Team nursing: A collaborative approach improves patient care. *Nursing2020*, 47(10), 16-17. doi: 10.1097/01.NURSE.0000524769.41591.fc

Ditmer, D. (2010). A safe environment for nurses and patients: Halting horizontal violence. *Journal of Nursing Regulation*, 1 (3), 9-14. doi: http://dx.doi.org/10.1016/S2155-8256(15)30327-6

Dixon, J. A. (2013). Backgrounder: healthcare reform in Canada. Toward a Canadian Healthcare Strategy. Queen's Health Policy Change. Conference Series. Retrieved from https://smith.queensu.ca/centres/monieson/knowledge_articles/files/Backgrounder-Healthcare_Reform_in_Canada-Final.pdf

Duddle, M. & Boughton, M. (2007). Intraprofessional relations in nursing. *Journal of Advanced Nursing*, 59 (1), 29-37. doi: 10.1111/j.1365-2648.2007. 04302.x

Duffy, E. (1995, April). Horizontal violence: A conundrum for nursing. *Collegian: Journal of the Royal College of Nursing, Australia*, 2 (2), 5-17.

Dumont, C., Meisinger, S., Whitacre, M. J., & Corbin, G. (2012, January). Horizontal violence survey report. *Nursing*, 42, 44-49. doi: 10.1097/01.NURSE.0000408487.95400.92

Eastern Health (2017a). *Prevention and resolution of harassment in the work environment*. St. John's: Author.

Eastern Health (2017b). *Lighting the way navigating together: 2017-2020 strategic plan*. St. John's: Author.

Eastern Health (2013). *Conflict management*. St. John's: Author.

Eastern Health (2011). *Over capacity protocol*. St. John's: Author.

Eastern Health (2015). *Guiding principles for nurses*. St. John's: Author.

Egues, A. L., & Leinung, E. Z. (2013, July-September). The bully within and without: Strategies to address horizontal violence in nursing. *Nursing Forum*, 48 (3), 185-190. doi: 10.1111/nuf.12028

Elliott, P., Martin, D., & Neville, D. (2014). Electronic clinical safety reporting system: a benefits evaluation. *JMIR Medical Informatics*, 2 (1), e12. doi: 10.2196/medinform.3316

Embree, J. L., & White, A. H. (2010, July-September). Concept analysis: Nurse-to-nurse lateral violence. *Nursing Forum*, 45 (3), 166-173. doi: 10.1111/j.1744-6198.2010. 00185.x

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129-136. doi: 10.1126/science.847460

Etienne, D. (2014). Exploring workplace bullying in nursing. Workplace Health & Safety, 62(1), 6-11. doi: 10.1177/216507991406200102

Farre, A., & Rapley, T. (2017). The new old (and old new) medical model: four decades navigating the biomedical and psychosocial understandings of health and illness. *Healthcare*, 5(88). doi:10.3390/healthcare5040088

Farrell, G. A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing*, 35 (1), 26-33. Retrieved from https://onlinelibrary.wiley.com/doi/pdf/10.1046/j.1365-2648.2001.01802.x

Farrell, G. A., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: Findings from an Australian study. *Journal of Advanced Nursing*, 55 (6), 778-787. doi: 10.1111/j.1365-2648.2006. 03956.x

Finlay, L., & Gough, B. (Eds.) (2003). *Reflexivity: A practical guide for researchers in health and social sciences*. Oxford: Blackwell.

Flateau-Lux, L.R., & Gravel, T. (2014, April). Put a stop to bullying new nurses. *Home Health care Nurse,* 32 (4), 225-229. doi: 10.1097/NHH.0000000000000045

Fornés, J., Cardoso, M., Castelló, J. M., & Gili, M. (2011, June). Psychological harassment in the nursing workplace: An observational study. *Archives of Psychiatric Nursing*, 25 (3), 185-194. doi: 10.1016/j.apnu.2010.08.008

Foucault, M. (1995). *Discipline and Punish. The Birth of the Prison*. New York: Vintage Books.

Gaffney, D.A, Demarco, R.F., Hofmeyer, A., Vessey, J.A., & Budin, W.C. (2012 -April). Making things right: nurses ʾexperiences with workplace bullying – a grounded theory. *Nursing Research and Practice.* 2012 (243210), doi: dx.doi.org/10.1155/2012/243210

Gergen, K. J. (2009). *Relational being: beyond self and community*. Oxford: Oxford University Press.

Giddings, L. S. (2005, July – September). A theoretical model of social consciousness. *Advances in Nursing Science*, 28 (3), 224-239. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16106152

Girard, F., Linton, N., & Besner, J. (2005, June). Professional practice in nursing: a framework. *Nursing Leadership.* [On-line Exclusive]. Retrieved from https://pdfs.semanticscholar.org/5f40/c0eb77c0b130acb64e74dd7101ed53e39a74.pdf

Government of Canada (2019). *Canada s health care system*. Retrieved from http://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care/system/canada.html

Government of Newfoundland and Labrador (2008). *Registered Nurses Act*, RSN R-9.1. St. John's: Author. Retrieved from https://assembly.nl.ca/Legislation/sr/statutes/r09-1.htm

Government of Newfoundland and Labrador (2011). *Improving health together: a policy framework for chronic disease prevention and management in Newfoundland and Labrador*. Retrieved from https://www.health.gov.nl.ca/health/chronicdisease/Improving_Health_Together.pdf

Government of Newfoundland & Labrador (2014). *Occupational Health and Safety Act.* St. John's: Author. Retrieved from https://www.assembly.nl.ca/Legislation/sr/statutes/o03.htm

Government of Newfoundland & Labrador (2015). *The provincial Newfoundland and Labrador Strategic Health Workforce Plan 2015-2018*. St. John's: Author.

Green, C.A. (2019 - January). Workplace incivility: nurse leaders as change agents. *Nursing Management*, 51-53. Retrieved from www.nursingmanagement.com

Griffin, M., & Clark, C. M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing, 45*(12), 535-542. doi:10.3928/00220124-20141122-02

Grubaugh, M. L., & Flynn, L. (2018). Relationships among nurse manager leadership skills, conflict management and unit teamwork. *The Journal of Nursing Administration,* 48(7/8), 383-388.

Guidroz, A. M., Wang, M., & Perez. L. (2012). Developing a model of source-specific interpersonal conflict in health care. *Stress and Health,* 28, 69-79. doi: 10.1002/smi.1405

Hartrick, G. (2002). Beyond interpersonal communication: the significance of relationship in health promoting practice. In L.E. Young & V. Hayes (Eds.). *Transforming health promotions practice: concepts issues, and applications* (p. 49-57). Philadelphia, PA: F.A Davis Company.

Hartrick-Doane, G. & Varcoe, C. (2015). *How to nurse: Relational inquiry with individuals and families in change health and health care contexts* (p. 1-35). Philadelphia, PA: Lippincott Williams & Wilkins.

Hippeli, F. (2009, July-September). Nursing: Does it still eat its young, or have we progressed beyond this? *Nursing Forum*, 44 (3), 186-188. doi: 10.1111/j.1744-6198.2009. 00141.x

Hussey, I. (2012). Political activist as ethnographer revisited. *Canadian Journal of Sociology,* 37(1), 1-23. Retrieved from http://www.jstor.org/stable/canajsocicahican.37.1.1

Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2006). Workplace bullying in nursing: Towards a more critical organisational perspective. *Nursing Inquiry,* 13 (2), 118-126. doi: 10.1111/j.1440-1800.2006.00314.x

Hutchinson, M. (2009). Restorative approaches to workplace bullying: Educating Nurses towards shared responsibility. *Contemporary Nurse,* 32, 147-155. Retrieved from http://epubs.scu.edu.au/hahs_pubs/1763/

Hutchinson, M., Vickers, M. H., Wilkes, L., & Jackson, D. (2010). A typology of bullying behaviours: The experiences of Australian nurses. *Journal of Clinical Nursing*, 19, 2319-2328. doi: 10.1111/j.1365-2702.2009. 03160.x

Hutchinson, M., & Jackson, D. (2013). Transformational leadership in nursing: toward a more critical interpretation. *Nursing Inquiry,* 20 (1), 11-22. doi: 10.1111/nin.12006

Hutchinson, M., & Jackson, D. (2015). The construction and legitimation of workplace bullying in the public sector: insight into power dynamics and organizational failure in health and social care. *Nursing Inquiry*, 22(1), 13-26. doi: 10.1111/nin.12077

Kaiser, J.A. (2016). The relationship between leadership style and nurse-to-nurse incivility: turning the lens inward. *Journal of Nursing Management,* 25, 116-118. doi: 10.1111/jonm.12447

Katrinli, A., Atabay, G., Gunay, G., & Cangarli, B. G. (2010). Nurses ʾperceptions of individual and organizational political reasons for horizontal peer bullying. *Nursing Ethics*, 17 (5), 614-627. doi: 10.1177/0969733010368748

King-Jones, M. (2011). Horizontal violence and the socialization of new nurses. *Creative Nursing*, 17 (2), 80 – 86. doi: 10.1891/1078-4535.17.2.80

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: trustworthiness and publishing. *European Journal of General Practice,* 24(1), 120-124. doi: https://doi.org/10.1080/13814788.2017.1375092

Krautscheid, L. C. (2014, January – February). Defining professional nursing accountability: a literature review. *Journal of Professional Nursing,*30(1), 43-47. http://dx.doi.org/10.1016/j.profnurs.2013.06.008

Laschinger, H. K. S, Wong, C., Regan, S., Young-Ritchie, C., & Bushell, P. (2013, July/August). Workplace incivility and new graduated nurses ʾmental health: The protective role of resiliency. *Journal of Nursing Administration (JONA),* 43 (7/8), 415-421. doi: 10.1097/NNA.0b013e31829d61c6

Laschinger, H. K. S, Wong, C., Cummings, G. G, & Grau, A. S. (2014). Resonant leadership and workplace empowerment: the value of positive organizational cultures in reducing workplace incivility. *Nursing Economics$*, 32(1), 5 - 15. Retrieved from https://pubmed.ncbi.nlm.nih.gov/24689153/

Layne, D. M., Anderson, E., & Henderson, S. (2019). Examining the presence and sources of incivility within nursing. *Journal of Nursing Management, 27(7),* 1505-1511. doi: https://doi.org/10.1111/jonm.12836

Leiper, J. (2005). Nurse against nurse: How to stop horizontal violence. *Nursing*, *35* (3), 44. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/15741895

Lewis, M. A. (2006). Nurse bullying: Organizational consideration in the maintenance and perpetration of health care bulling cultures. *Journal of Nursing Management*, 14, 52-58. doi: 10.1111/j.1365-2934.2005. 00535.x

Lewis, D. (2004). Bullying at work: The impact of shame among university and college lecturers. *British Journal of Guidance & Counselling*, *32*(3), 281-299. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,url,uid&db=rzh&AN=2004169792&site=ehost-live&scope=site

Liberati, E. G., Gorli, M., Moja, L., Galuppo, L., Ripamonti, S., & Scaratti, G. (2015). Exploring the practice of patient centered care: the role of ethnography and reflexivity. Social Science & Medicine, 133, 45-52. doi: http://dx.doi.org/10.1016/j.socscimed.2015.03.050

Luthar, S. S., Cicchetti, P., & Becker, B. (2000). The construct of resilience: a critical evaluation and guidelines for future work. *Child Development,* 71(3), 543-562. doi: http://doi.org/10.1111/146-8624.00164.

Maddalena, V., Kearney, A.J., & Adams, L. Quality of work life of novice nurses: a qualitative exploration. *Journal for Nurses in Staff Development*, 28 (2), 74-79. doi: 10.1097/NND.0b013e31824b41a1

Manojlovich, M. (2005, January – February). Predictors of professional nursing practice behaviors in hospital settings. Nursing Research, 54(1), 41-47. doi: 10.1097/00006199-200501000-00006

Manyazewal, T., & Matalakala, M. C. (2017). Beyond patient care: the impact of healthcare reform on job satisfaction the Ethiopian public healthcare sector. *Human Resources for Health,* 15(10), 1-9. doi:10.1186/s12960-017-0188-1

Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N.A., Vissandjée, B., & Marchildon, G. (2018 - April). Canada's universal health-care system: achieving its potential. *The Lancet*, 391, 1718-1738. Retrieved from http://dx.doi.org/10.1016/s0140-6736(18)30181-8

Matheson, L. K., & Bobay, K. (2007, July - August). Validation of oppressed group behaviors. *Journal of Professional Nursing*, 23 (4), 226-234. doi: 10.1016/j.profnurs.2007.01.007

Maxwell, J. A. (2005). Conceptual framework: What do you think is going on? *Qualitative research design: An interactive approach* (2nd ed., pp. 33) Sage Publications, Inc.

Mazzotta, C. P. (2016). Biomedical approaches to care and their influence on point of care nurses: a scoping review. *Journal of Nursing Education and Practice,* 6(8), 93-101. http://dx.doi.org/10.5430/jnep.von8p93

Meissner, J. E. (1986). Nurses: Are we eating our young? *Nursing,* 16(3), 51-53. Retrieved from https://pubmed.ncbi.nlm.nih.gov/3633461/

McEwen, M., & Wills, E. M. (2014). *Theoretical basis for nursing* (4th ed.). Philadelphia, PA: Wolter Kluwer Health.

McGibbon, E., Gallop, E.P., & Gallop R. (2010). An institutional ethnography of nurses ' stress. *Qualitative Health Research*, dXX (X), 1-26. doi: 10.1177/1049732310375435

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies*, 25(2), 82-89. doi: https://doi.org/10.1111/j.1470-6431.2001.00183.x

McNamara, S. A. (2012, April). Incivility in nursing: Unsafe nurse, unsafe patients. *Association of periOperative Registered Nurses (AORN) Journal*, 95(4), 535-540. doi: 10.1016/j.aorn.2012.01.020

McNamee, S. & Gergen, K.J. (1999). *Relational Responsibility: Resource for Sustainable Dialogue*. Thousand Oaks, London, New Delhi: Sage Publications.

Myers, G., Cóté-Arsenault, D., Worral, P., Rolland, R., Deppoliti, D., Duxbury, E., Stoecker, M., & Sellers, K. (2016). A cross-hospital exploration of nurses ' experiences with horizontal violence. *Journal of Nursing Management*, 24, 624-633. doi: 10.1111/jonm.12365

Nayback-Beebe, A. M., Forsythe, T., Funari, T., Mayfield, M., Thomas, W., Smith, K. K., Bradstreet, H., & Scott, P. (2013). Using evidence-based leadership initiatives to create a healthy nursing work environment. *Dimensions of Critical Care Nursing*, 32 (4):166–173 doi: 10.1097/dcc.0b013e3182998121

O'Connor, K., & Dugan, J. L. (2017, February). Addressing floating and patient safety. *Nursing2017,* 47(2), 57-58. Retrieved from www.Nursing2017.com

Oyeleye, O., Hanson, P., O'Conner, N., & Dunn, D. (2013, October). Relationship of workplace incivility, stress, and burnout on nurses 'turnover intentions and psychological empowerment. *Journal of Nursing Administration (JONA),* 43 (10), 536-542. doi: 10.1097/NNA.0b013e3182a3e8c9

Padgett, S.M. (2013, October). Professional collegiality and peer monitoring among nursing staff: an ethnographic study. *International Journal of Nursing Studies,* 50(10), 1407-1415. doi: 10.1016/j.ijnurstu.2012.12.022

Parker, M. E., & Smith, M. C. (2010). *Nursing theories & nursing practice* (3rd ed.). Philadelphia: F.A. Davis Company.

Petrucka, P. L. (2014). The Canadian health care delivery system. In J. C. Ross-Kerr, M. J. Wood, B. J. Astle & W. Duggleby (Eds.), *Canadian fundamentals of nursing.* (5th ed., pp. 15-28). Toronto: Elsevier Canada.

Porter-O'Grady, T., Clark, J. S., & Wiggins, M. S. (2010, February). The case for clinical nurse leaders: guiding nursing practice into the 21st century. *Nurse Leader,* 8(1), 37-41. doi: 10.1016/j.mnl.2009.11.002

Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43 (4), 395-401. doi:10.1046/j.1365-2648.2003. 02728.x

Rankin, J. M., & Campbell, M. L. (2006). *Managing to Nurse: Inside Canada s Health Care Reform.* Toronto Buffalo London: University of Toronto Press.

Rankin, J. M., & Campbell, M. L., (2009). Institutional ethnography (IE), nursing work and hospital reform: IE's cautionary analysis. *Qualitative Social Research*, 10(2), 1-15. Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1258/2720

Rankin, J.M. (2014). The rhetoric of patient and family centred care: an institutional ethnography into what actually happens. *Journal of Advanced Nursing*, 71 (3). 526-534. doi: 10.1111/jan.12575

Rankin, J. M. (2017a) Conducting analysis in institutional ethnography: guidance and cautions. *International Journal of Qualitative Methods*, 16, 1-11. doi: 10.1177/1609406917734472

Rankin, J. M. (2017b). Conducting analysis in institutional ethnography: analytical work prior to commencing data collection. *International Journal of Qualitative Methods,* 16, 1-9. https://doi.org/10.1177/1609406917734484

Read, E., & Laschinger, H. K. (2013). Correlates of new graduate nurses' experiences of workplace mistreatment. *Journal of Nursing Administration, 43*(4), 221-228. doi:10.1097/NNA.0b013e3182895a90

Registered Nurses Union of Newfoundland and Labrador (RNUNL) (2014). *Collective Agreement*. St. John's: Author. Retrieved from http://rnunl.ca/app/uploads/2016/04/NLNU-2012-2016-Provincial-Agreement-1.pdf

Roberts, S. (2015). Lateral violence in nursing: a review of the past three decades. *Nursing Science Quarterly*, 28(1), 36-41.

Rocker, C. F. (2008, August). Addressing nurse-to-nurse bulling to promote nurse retention. *The Online Journal of Nursing Issues,* 13 (3). doi: 10:3912/OJIN.Vol13No03PPT05

Russell, L. (2014). Biomedicine. In Sociology for health professionals (p. 6-22). London: SAGE Publications, Ltd. doi:10.4135/9781526401922.n2

Salmond, S. W., & Echevarria, M. (2017, January - February). Healthcare transformation and changing roles for nursing. *Orthopaedic Nursing,* 36(1), 12-24. doi: 10.1097/NOR.0000000000000308

Scott, T., Mannion, R., Davies, H., & Marshall, M. (2003). The quantitative measurement of organizational culture in health care: A review of the available instruments. *Health Services Research, 38*(3) doi:10.1111/1475-6773.00154

Scott, P. A., Matthews, A., & Kirwan, M. (2013). What is nursing in the 21st century and what does the 21st century health system require of nursing? *Nursing Philosophy,* 15, 23-34. doi: 10.1111/nup.12032

Sergeant, J., & Laws-Chapman, C. (2012). Creating a positive workplace culture. *Nursing Management,* 18 (9), 14-19. doi: 10.7748/nm2012.02.18.9.14.c8889

Simons, S. R., & Mawn, B. (2010). Bulling in the workplace – A qualitative study of newly licensed registered nurses. AAOHN Journal, 58, (7), 305-311. Retrieved from https://pdfs.semanticscholar.org/5c9d/c35e3837e03ec46b7b147942c4f4dbcd8f22.pdf

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Boston: Northeastern University Press.

Smith, D. E. (1990a). *The conceptual practices of power: A feminist sociology of knowledge.* Toronto: University of Toronto Press.

Smith, D. E. (1999). *Writing the Social: Critique, Theory, and Investigations*. Toronto Buffalo London: University of Toronto Press.

Smith, D. E. (2001). Text and the ontology of organizations and institutions. *Studies in Culture, Organizations and Society.* 7, p. 159-198.

Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Oxford, UK: AltaMira Press.

Smith, D. E. (2006). *Institutional ethnography as practice.* Lanham Boulder New York Toronto Oxford: Rowman & Littlefield Publisher, INC.

Smith, G. W. (1990b). Political activist as ethnographer. *Social Problems*, 37 (4), 629-648. http://www.jstor.org/stable/800586

Smith, G. W., Mykhalovsky, E., & Weatherbee, D. (2006). A research proposal. In D. E. Smith (Ed.), *Institutional ethnography as practice* (pp. 165). Lanham Boulder New York Toronto Oxford: Rowman & Littlefield Publisher, INC.

Stagg, S. J., Sheridan, D., Jones, R. A., & Speroni, K.G. (2011). Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting. *The Journal of Continuing Education in Nursing*, 42 (9), 395- 401. doi: 10.3928/00220124-20110823-45

Statistics Canada (2017). *Newfoundland and Labrador [Province] and Canada [Country]* (table). *Census Profile*. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. Retrieved June 21, 2019 from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

St. Pierre, I., & Holmes, D. (2008, April). Managing nurses through disciplinary power: a Foucauldian analysis of workplace violence. *Journal of Nursing Management,* 16 (3), 352-359. doi: 10.1111/j.1365-2834.2007.00812. x.

Taylor, J. S. (1997). Nursing ideology: identification and legitimation. *Journal of Advanced Nursing,* 25, 442-446. doi: https://doi.org/10.1046/j.1365-2648.1997.1997025442.x

Taylor, R. (2016). Nurses' perceptions of horizontal violence. *Global Qualitative Nursing Research*, 3, 1-9. doi: 10.1177/2333393616641002

The Joint Commission (2019). *About the Joint Commission*. Retrieved from https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

The Ottawa Hospital (2014). *The Ottawa hospital (TOH) models to organize nursing and interprofessional care*. Retrieved from https://www.ottawahospital.on.ca/en/documents/2017/01/organizing-nursing-interprof-care-table-of-content-2015-en-2015-12-11_.pdf/

Thompson, V. D. (2016). *Health and health care delivery in Canada.* Toronto, ON: Elsevier Canada.

Tierney, S., Bivins, R., & Seers, K. (2018). Compassion in nursing: solution or stereotype? *Nursing Inquiry*, 26, 1-6. Retrieved from https://doi.org/10.1111/nin.12271

Tornabeni, J. (2006). The evolution of a revolution in nursing. *Journal of Nursing Administration*, 36(1), 3-6. doi: 10.1097/00005110-200601000-00002.

Townsend, E. (1996). Institutional ethnography: A method for showing how the context shapes practice. *The Occupational Therapy Journal of Research*, 16 (3), 179-199. Retrieved from https://www.researchgate.net/publication/234587716_

Townsend, E. (1998). Good Intentions Overrules: *A Critique of Empowerment in the Routine Organization of Mental Health Services*. Toronto, Buffalo, London: University of Toronto Press Incorporated.

Trépanier, S. G., Fernet, C., & Austin, S. (2013). Workplace psychological harassment in Canadian nurses: A descriptive study. *Journal of Health Psychology*, 18 (3), 383-396. doi: 10.1177/1359105312443401

Turner, S.M. (2006). Mapping institutions as work and texts. In D. E. Smith (Ed.), *Institutional ethnography as practice* (pp. 139). Lanham Boulder New York Toronto Oxford: Rowman & Littlefield Publisher, INC.

van Dijk, T. A., (1998). *Ideology: A multidisciplinary approach*. London, Thousand Oakes, New Delhi: Sage Publications. Retrieved from: http://www.discourses.org/OldBooks/Teun%20A%20van%20Dijk%20-%20Ideology.pdf

Vessey, J. A., Demarco, R. F., Gaffney, D. A., & Budin, W. C. (2009, September-October). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25 (5), 299-306. doi: 10.1016/j.profnurs.2009.01.022

Wade, D. T., & Halligan, P. W. (2004). Do biomedical models of illness make for good healthcare system? *British Medical Journal* (Online), 329, 1398-1401. Retrieved from www.bmj.com

Walby, K. (2007). On the social relations of research: a critical assessment of institutional ethnography. *Qualitative Inquiry*, 12(7), 1008-1030. doi: 10.1177/1077800407305809

Walrafen, N., Brewer, M. K., & Mulvenon, C. (2012, January-February). Sadly, caught up in the moment: An exploration of horizontal violence. *Nursing Economic$*, 30 (1), 6-49. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22479958

Weaver, K. B. (2013). The effects of horizontal violence and bullying on new nurse retention. *Journal for Nurses in Professional Development*, 29 (3), 138-142. doi:10.1097/NND.0b013e318291c453

Webster, F., Bhattacharyya, O., Davis, A., Glazier, R., Katz, J., et al. (2015). An Institutional ethnography of chronic pain management in family medicine (COPE) study protocol. *BMC Health Services Research*, 15 (494), 1-8. doi: 10.1186/s12913-015-1078-7

Weinand, M. (2010). Horizontal violence in nursing: History, impact, and solution. *Journal of Chi Eta Phi Sorority*, 54 (1), 22-26.

Wilson, B. L., Diedrich, A., Phelps, C. L., & Choi, M. (2011, November). The impact of horizontal hostility in the hospital setting and intent to leave. *The Journal of Nursing Administration*, 41 (11), 453-458. doi: 10.1097/NNA.0b013e3182346e90

Woelfle, C. Y., & McCaffrey, N. D. (2007, July - September). Nurse-on-nurse. *Nursing Forum*, 42(3), 123-131. doi: 10.1111/j.1744-6198.2007. 00076.x

World Health Organization (WHO) (2013). *Health systems and services: the role of acute care* [Bulletin]. doi: http://dx.doi.org/10.2471/BLT.12.112664

Yildirim, D. (2009). Bullying among nurse and its effects. *International Nursing Review*, 56, 504-511. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1466-7657.2009.00745.x/pdf

Yousefi, V. & Maslowski, R. (2013, June - July). Health system drivers of hospital medicine in Canada: systematic review. *Canadian Family Physician*, 59 (7), 762-767. Retrieved from https://pubmed.ncbi.nlm.nih.gov/23851546/

Zboril-Benson, L. R. (2002). Why nurses are calling in sick: the impact of healthcare restructuring. *Canadian Journal of Nursing Research*, 33(4), 89-107. Retrieved from https://pubmed.ncbi.nlm.nih.gov/11998199/

Appendix A: Recruitment Flyer

Invitation for REGISTERED NURSES (RNs)
who have experienced and/or witnessed a conflict between nurse co-workers during their career.

"Why can't nurses get along?" Taking the standpoint of RNs to more fully explore how conflicting working relationships between nurse co-workers happens.

Your participation would involve a one or two session interview in a location of your choosing.
Each session will be about 45-90 minutes long.

For more information about this research study, or to volunteer to be interviewed, please contact:

Peggy A. Rauman, RN
Faculty of Medicine
Division of Community Health and Humanities
Memorial University of Newfoundland and Labrador

This study has been reviewed and received ethics clearance from the Provincial Health Research Ethics Board (HREB) and Research Proposal Approval Committee (RPAC) for Eastern Health.

Call Peggy 709-728-0082 Or Email: prauman75@gmail.com	Call Peggy 709-728-0082 Or Email: prauman75@gmail.com	Call Peggy 709-728-0082 Or Email: prauman75@gmail.com

Appendix B: Interview Guide

Sequencing:	Questions:	Notes/Probes:
Introductions /warm-up	• Thank the person for participating. • Explain how confidentiality and anonymity will be protected and ask if they have any questions. Obtain a signature for consent. • Inform the participant that some of the questions I ask may seem unnecessary because I am a nurse and I should know the situation but that it is vitally important that I hear his/her interpretation of the question and/or experience. (Note: It is a means to recognize when the individual is using institutional language).	In polite conversation we all become competent at making sense in the accepted ways and we may feel silly asking what seems like obvious questions to clarify things that ordinarily we could be counted on to know. But we need to at ask at every point in the story where stepped are skipped or discourse words substitute for what actually happens.

Introductory Questions:	Nursing Professional Background
	• It would be helpful if you could tell me about your professional background.
	  ○ Why/how did you choose to become a nurse?
	  ○ How long have you been practicing nursing? In what areas did you work?
	  ○ How do you find your work?	

General Questions about Nursing Relationships:	• Can you describe the working relationships between the nurses in your unit? • Tell me about those relationships. How are relationships formed? Or in the past, how were these relationships formed? • What had your working experiences with peers been like at this unit?	

General Questions about CWR.	In our day-to-day work as nurses in a hospital setting, we work closely with other nurse colleagues and I am interested in hearing about your general experiences with conflicting working relationships and how they happened. • Have you witnessed any conflict between other nurse co-workers? • How did you know it was a conflicting working relationship? • What made this experience a conflict? • Can you take me through the context/shift in which one of these conflicts occurred? What was the environment/setting like during the experience?	What characterized the CWR relationship? What made it that way? How did you know it was a negative environment?
Specific Questions about their Personal CWR. Identify the experience.	Can you describe your CWR incident? • How do you think the conflict occurred? What instigated it? When did it happen? What factors do you think contributed to the conflict? • Can you describe the events of the day/shift in which your conflict occurred? What was the environment/setting like during the experience? • What was your expectation for behaviours for that RN? • Where did your expectations come from? • Is there any flexibility in that expectation/interpretation?	Where were you? Explain what happened first? Second? Am I getting this right? Summarize: am I missing anything? If they reference personality traits of other nurses or specific derogatory names, ask what made the person earn that name?

Texts	Many documents and policies govern nursing expectations and relationships in the workplace. • Are you aware of any documents or policies that govern/define relationships in the workplace? • Are you aware of documents related to conflicting working relationships? • Have you referred to them? • Do you think they had any influence on your conflicting experiences? • How did the text inform your thinking?	What one? Can you give me an example? What did you do with the text? Where did the text go next?
Impact of CWR	• How did the conflicting event affect your work life? • Did it affect your home life? • Did the CWR affect your health?	
Reflection of CWR (Reflexive process)	• How do think you contributed to this conflicting relationship? • When did this reflection occur? (at that time or later?) • In retrospect, is there anything that you would have done differently? • What have you done differently since this experience? Did you learn anything? Have you changed your practice in any way? If yes, how?	

Resolution	• What did you (or others) do about this experience when it happened? • What resources were available to you? What resources did you use? • Did you follow a specific procedure? Did you refer to any specific policy? • What one? Was it helpful? • Were you able to resolve the experience? How? If not, why? • How did you feel when doing it? What did it take for you to move beyond that experience?	
Comparison	CWR does not occur between all nurses all the time, in your experiences: • Have you worked in other institutions where CWRs did not occur? If yes, • What made that experience different? • What was similar? • What changed between times when conflict between nurses was present and when it was not present?	How did you know it was a positive environment? What made it that way? What characterized the positive relationship?
Conclusion/ Wrap-up	• Is there anything else that you that you would like to add? • Upon request a summary of the interview transcript can be provided to confirm its accuracy and to provide an opportunity for further input. • Thank participant	After having time to reflect on the interview, you may have had further thoughts they would like to provide, and I may have some additional questions to ask. A second interview is important to capture all the data. As I read the interview transcript, I may find areas in need of further exploration

Appendix C: List of Texts

Governance Documents

- Registered Nurses Act (2008) and Regulations (2013)
- **Association for Registered Nurses of Newfoundland and Labrador (ARNNL) standards of practice,** interpretive documents, regulatory documents, facts sheets, position statements, discussion documents, briefs, and public policy documents.
- **Canadian Nurses Association Code of Ethics for Registered Nurses (2017)**

Union Documents

- **Registered Nurses Union of Newfoundland Labrador (RNUNL) Collective Agreement (2014)**

Employer Polices

- Blood and Blood Products
- **Over Capacity Protocol**
- Chest Pain Protocol
- Cardiac Care Map
- Epidural Infusion Protocol
- Occurrence Reporting System
- Surveillance Record
- **Conflict Management Policy HR-OH-050**
- **Prevention and Resolution of Harassment in the Work Environment HR-OH-100**
- Pre-Operative Checklist

Provincial Policies

- **Eastern Health Model of Acute Nursing Clinical Practice (the official name of the model) was adapted from the Ottawa Model of Nursing Clinical Practice (TOH MoNCP ©) (official name).**
- **Lean process improvements**

Appendix D: Consent to Take Part in Research

TITLE: "Why can't nurses get along?" Taking the standpoint of registered nurses to more fully explore how conflicting working relationships between nurse co-workers happens.

INVESTIGATOR(S): Peggy A. Rauman, RN, BN, MN, Principal Investigator; Dr. Martha Traverso-Yepez, Graduate Supervisor.

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. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

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 and take as much time as you like. Mark anything you do not understand or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

Many different labels have been used to describe the conflict that happens between nurses working together. Labels commonly used in research studies include interpersonal conflict, incivility, workforce conflict, nurse-to-nurse conflict, lateral violence, psychological harassment, horizontal violence, and bullying. Conflict between nurses at work has been noted to have a negative impact on the health of nurses, which affects their ability to provide safe, competent, compassionate and ethical care to the population. Despite the implementation of strategies designed to improve the working relationships between nurses, conflicting working relationships between nurses remains a significant problem.

2. Purpose of study:

The purpose of this study to explore the ways the work of nurses is organized and its impact on the development of conflicting working relationships between nurse co-workers. I will also identify resources to put in place to limit the development of conflicting working relationships and promote relational practices.

3. Description of the study procedures:

Your participation in this research study would involve answering questions during an interview. The interview will be informal and casual, consisting of open-ended questions, focused on the details of the workday/night when the conflict was experienced; factors contributing to the conflict, and any policies referred to during the conflict.

4. Length of time:

You will be expected to participate in one or two interviews, depending on if you feel you have more information to provide after you receive a summary of the first interview transcript, or if the principal investigator has follow-up questions. Each interview will last between 60 and 90 minutes. The interview will take place in a setting of your choice.

5. Possible risks and discomforts:

You may be inconvenienced by the length of the interview or the travelling required to get to the interview.
You may feel emotional distress, recalling experiences with conflicting working relationships.
If you feel distressed, you will be provided the contact information for the Employee Family Assistance Program: Telephone: (709) 777-3153 or Email: Kathy.Taylor-Rogers@easternhealth.ca where a qualified health care professional can be referred to assist you.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However, it cannot be guaranteed. For example, we may be required by law to allow access to research records.
When you sign this consent form you give us permission to:

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

I will be the only one with access to study records that identify you by name. Other people may need to look at the study records without any identifier. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information
The research team will collect and use only the information they need for this research study.

At the beginning of the interview I will be asking demographic questions which will include your

- age
- sex
- level of education
- years of employment as a nurse

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years.

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. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored password protected and secured in a locked cabinet at 23 Palm Drive, St. John's. Peggy A. Rauman is the person responsible for keeping it secure.

Your access to records
You may ask the study Principal investigator Peggy A. Rauman to see the information that has been collected about you.

9. **Questions or problems:**

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study. That person is:

Peggy A. Rauman, RN, BN, MN
Principal Investigator
23 Palm Drive
St. John's, NL
A1H 1C7

Telephone: (709) 728-0082
E-mail: prauman75@gmail.com

Or you can talk to someone who is not involved with the study at all but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office at 709-777-6974
Email at info@hrea.ca

This study has been reviewed and given ethics approval by the Newfoundland and Labrador Health Research Ethics Board.
Once you have signed this document you will be given a copy.

Signature Page

Study title: "Why can't nurses get along?" Taking the standpoint of registered nurses to more fully explore how conflicting working relationships between nurse co-workers happens.

Name of principal investigator: Peggy A. Rauman, RN, BN, MN Principal Investigator; Dr. Martha Traverso-Yepez Graduate Supervisor.

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent.	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I have spoken to Peggy Rauman and she has answered my questions.	Yes { }	No { }
I understand that I am free to withdraw from the study • at any time • without having to give a reason • without affecting my future care [employment, social status].	Yes { }	No { }
I understand that it is my choice to be in the study and that I may not benefit.	Yes { }	No { }
I understand how my privacy is protected and my records kept confidential.	Yes { }	No { }

I agree to be audio taped.	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

_____ _____
_____ Signature of participant Name printed
Year Month Day

_____ _____
_____
Signature of person authorized as *Name printed* *Year Month Day*
*Substitute decision maker, if applicable*_____

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____ _____
Signature of investigator Name printed Year Month Day

Appendix E: HREA Approval Letter

NEWFOUNDLAND AND LABRADOR
HREB
HEALTH RESEARCH ETHICS BOARD

Ethics Office
Suite 200, Eastern Trust Building
95 Bonaventure Avenue
St. John's, NL
A1B 2X5

September 28, 2016

Dear Mrs. Rauman:

Researcher Portal File # 20170717
Reference # 2016.245

RE: "Why can't nurses get along?" Taking the standpoint of registered nurses to more fully explore how conflicting working relationships between nurse co-workers happens."

This will acknowledge receipt of your correspondence.

This correspondence has been reviewed by the Chair under the direction of the Health Research Ethics Board (HREB). ***Full board approval*** of this research study is granted for one year effective **September 15, 2016**.

This is your ethics approval only. Organizational approval may also be required. It is your responsibility to seek the necessary organizational approval from the Regional Health Authority (RHA) or other organization as appropriate. You can refer to the HREA website for further guidance on organizational approvals.

This is to confirm that the HREB reviewed and approved or acknowledged the following documents (as indicated):

- Application, approved
- Revised recruitment flyer, approved
- Revised consent form, approved
- Interview guide, approved

MARK THE DATE

This approval will lapse on September 15, 2017. It is your responsibility to ensure that the Ethics Renewal form is submitted prior to the renewal date; you may not receive a reminder. The Ethics Renewal form can be found on the Researcher Portal as an Event form.

If you do not return the completed Ethics Renewal form prior to date of renewal:

- ***You will no longer have ethics approval***
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Appendix F: RPAC Approval

Department of Research
5th Floor Janeway Hostel
Health Sciences Centre
300 Prince Philip Drive
St. John's, NL A1B 3V6
Tel: (709) 752-4636
Fax: (709) 752-3591

Eastern Health

October 12, 2016

Mrs. Peggy Rauman
23 Palm Drive
St. John's, NL
A1H 1C7

Dear Mrs. Rauman,

Your research proposal *HREB Reference #: 2016.245 "Why can't nurses get along?" Taking the standpoint of registered nurses to more fully explore how conflicting working relationships between nurse co-workers happens"* was reviewed by the Research Proposals Approval Committee (RPAC) of Eastern Health at a meeting dated October 11, 2016 and we are pleased to inform you that the proposal has been granted full approval.

The approval of this project is subject to the following conditions:

- The project is conducted as outlined in the HIC approved protocol;
- Adequate funding is secured to support the project;
- In the case of Health Records, efforts will be made to accommodate requests based upon available resources. If you require access to records that cannot be accommodated, then additional fees may be levied to cover the cost;
- A progress report being provided upon request.

If you have any questions or comments, please contact Sharon Newman, Manager of the Patient Research Centre at 777-7283 or by email at sharon.newman@easternhealth.ca.

Sincerely,

Mike Doyle, PhD
Director of Research
Chair, RPAC

MD/rg