Organizational Culture in Home Health Nursing Practice and Day to Day Care of Older South Asians

by

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B.N., University of Victoria, 2006

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Abstract

The objective of this study is to describe and understand the organizational culture and context in Home Health Nursing (HHNsg) practice. Participants consisted of a Licensed Practical Nurse (LPN), three Registered Nurses (RNs) and three Registered Nurse leaders. Using the methodology of ethnography, data collection methods included participant-observation, documenting fieldnotes, writing reflective memos, conducting individual interviews and examining organizational priorities. Home Health Nurses (HHNs) were observed and subsequently interviewed to illustrate routine practices and discourses that influence everyday HHNsg practice. Nurse leaders shared their perspectives of everyday contexts underpinning HHNsg practice, particularly professional claims of culturally-competent care. Geertz's theoretical concepts of "thick descriptions and "texts" were applied to the analysis. My concluding discussion demonstrates how participants enacted cost-effective and efficient philosophies of organizing care despite claiming the importance of culturally-competent care with South Asian clients (India, Punjab).

Keywords: Home Health Nursing, Ethnography, Organizational Context

Table of Contents

Supervisory Committee....ii
Abstract....iii
Table of Contents....iv
List of Tables....vii
List of Figures....viii
Acknowledgements....ix
Dedication....x

Chapter One
Introduction....1
Culturally Diverse Aging Population....2
Research Question and Problem....5
Contextual Background....5
Professional Mandate for Culturally Appropriate Care....6
Organizational Strategies Promoting Culturally Appropriate Care....7
Organizational Discourses and Practices....11
Theoretical Concepts and Approaches....18
Research Format....19

Chapter Two
Literature Review: Conceptual and Theoretical Influences....20
The Concept of Organizational Culture (OC)....20
Historical Overview of OC....20
Attributes of OC....21
OC and the Older Adult Patient....22
Research Approaches to OC....23
Clifford Geertz's Concept of Culture....25
Major Concepts, Assumptions and Relationships....26

Chapter Three
Methodology....30
History of Ethnography....30
The "Texts" of Ethnography....31
Fieldwork and Ethnography....33
Reflexivity and Ethnography....35
Methods....36
Objectives and Significance of the Study....36
Access to the Field....36
Sampling and Recruitment....37
Consent....38
Ethical Procedures....39
Confidentiality, Anonymity, Inconveniences and Withdrawal....39

Data Collection.....40
Participant-observation, Fieldnotes and Interviews.....40
Analysis.....42
Rigor & Triangulation.....43

Chapter Four
Four Stories of Nursing Practices in Home Health.....45
Story 1: Mrs. Mohan's Wound Care 46
Story 2: Mr. Sohan's Chronic Diabetes and Wound Care.....49
Story 3: Anita's Chronic Heart Condition.....51
Story 4: Mr. Raj's Foot Care & Diabetes.....53

Chapter Five
Interviews with Four Home Health Nurses.....55
5.1 Interview with Nurse Sunita.....55
5.2 Interview with LPN Jane.....59
5.3 Interview with Nurse Jackie.....62
5.4 Interview with Nurse Cathy.....66

Chapter Six
Interviews with Three Nurse Leaders.....70
Profile of the Manager.....70
Profile of the Nurse Educator.....70
Profile of the Clinical Coordinator.....71
Daily Tasks in Home Health Nursing Practice.....73
Daily Challenges of Home Health Nursing.....76
Workload Constraints.....78
Ergonomic Constraints.....79
Characteristics of South Asian (SA) Clients and Families.....79
Communication with SA Families.....81
Communicative approaches with SA clients.....83

Chapter Seven
Analysis and Discussion.....84
Discourse of the Organization (Leaders' discourse).....84
Providing the Best Care.....85
The Best Care: Reduce Unnecessary Variation by Using Evidence-Based Approaches (HHNs'discourse).....92
The Best Care: Build an Integrated Electronic Health Record.....95
Develop the Best Workforce (Leaders' discourse).....97
Develop the Best Workforce: Maximise Staff Potential (HHNs'discourse).....98
Innovate for Sustainability (Leaders' discourse).....100
Innovate for Sustainability: Apply LEAN Thinking (HHNs' discourse).....101

Chapter Eight

Implications & Conclusions…….....104
Contributions……...105
Limitations……...106
Implications……..107
Conclusions……..109
Future Research……...111

References.....113

Appendices

Appendix A: Information and Approval Letter to Home Care Manager…….....124
Appendix B: Consent Form to Collect Anonymized Documentary Evidence……...128
Appendix C: Recruitment Poster for Home Health Nurses and Nurse Leaders…….....130
Appendix D: Third-party Scripts and Email Notices for Home Health Nurses.....131
Appendix E: Third-party Scripts and Email Notices for nurse leaders…….....132
Appendix F: Script for Home Health Nurse……...133
Appendix G: Telephone-Script for Third-Party…….134
Appendix H: Electronic and Paper Consent Forms for Home Health Nurse…….135
Appendix I: Older SA Client Invitation/Consent form…….....139
Appendix J: Punjabi Translated Consent Form.....143
Appendix K: Information Letter for SA Client's Family Member.....146
Appendix L: Electronic and Paper Consent Form for Nurse Leader Participant.....149
Appendix M: Fieldnote Template.....152
Appendix N: Interview guide for Home Health Nurses.....153
Appendix O: Interview guide for Nurse Leaders.....154
Appendix P: Transcriptionist Contract.....155
Appendix Q: Fieldnotes and Memos.....156

List of Tables

Table 1: Organizational and Leaders' Discourse versus HHNs' Practice.....92
Table 2: Organizational and Leaders' Discourse versus HHNs' Practice.....100
Table 3: Organizational and Leaders' Discourse versus HHNs' Practice.....102

List of Figures

Figure 1: Diagram of Organizational Priorities.....12
Figure 2: Organization of Thesis.....29

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Dedication

I dedicate my thesis to my family: Antony Francis, Bella Francis and Annabel Francis. Thank you for the opportunities and the possibilities to aim higher than I could have ever imagined.

Chapter 1

Introduction

In British Columbia (BC), Community Nursing or the Home Health Nursing (HHNsg) service is one among many community services that is designed to "maintain health, well-being, [and] personal independence" of the older adult population, primarily (Canadian Home Care Association (CHCA), 2013, p.1). The Canadian Nurses Association (CNA) (2011a) has pointed to some key trends that raise the importance and benefits of HHNsg services. As noted by the CNA, an important determinant of demand for HHNsg services is an aging population. Thus people are living longer often with more than one chronic disease (CHCA, 2012; Canadian Institute for Health Information (CIHI), 2011).

The majority of older adults age 65 and older live independently in their homes and a growing number require ongoing supportive care (CNA, 2011a; CHCA, 2012). "Terms such as senior, older adult and older person" refer to Canadians age 65 and over (Public Health Agency of Canada (PHAC), 2014). The classification of older adults indicates that age groups vary: 65-75, 75-85 and 85 and over (Center of Addiction and Mental Health (CAMH), 2009). The senior's fall prevention guidelines are aimed at older adults age 65 and over while the CAMH guidelines are aimed at older adults age 55 and over. In the case of the latter, health promoting activities and services are generally targeted or available to adults prior to their retirement, to improve the quality of life of the aging population. In spite of older Canadians' preference for home care services, expansion of HHNsg services remains inadequate (CNA, 2011a).

Current policy informs the public that HHNsg services are meant to supplement "rather than replace" care from family members, an indication that services are meant to be limited (Bjornsdottir, 2009; British Columbia Ministry of Health (BCMH), 2013, p.2). The mandate of

HHNsg services is to address the physical needs (e.g. activities of daily living and signs and symptoms of chronic diseases) of clients and manage acute, chronic, palliative and rehabilitative health care needs. It is well established that HHNsg services reduce hospital admissions, lengthy hospital stays, and long term care placements; however, the availability of public financing of HHNsg services remains inadequate even as demand is growing (CNA, 2009; Romanow, 2002; Hollander & Chappell, 2002). Development of technology to support independence and expansion of electronic health records are expected to improve the efficiency of HHNsg services (Romanow, 2002). Increasingly, Home Health older adult clients are encouraged to access private-pay community resources or programs such as adult day care centers, caregiver-respite services, meals on wheels, house-cleaning, life-line, and shop by phone, supplementary services that meet a range of psycho-social and domestic needs (BCMH, 2013, Chapter 2). These alternate resources help fill the gaps in the public system of HHNsg services (Allen, Griffiths & Lyne, 2004). As noted above, in the current health care climate, home health nurses (HHNs) may face unique challenges in their everyday nursing practice, in meeting professional standards and fulfilling organizational policies, while also responding to the unique psycho-socio-cultural needs of a diverse older population.

Culturally Diverse Aging Population

Canadian statistics point to a markedly changing cultural landscape of seniors living in Vancouver, British Columbia (BC). The demography of the older adult population points to an opportunity to expand and improve a variety of social and health care services so that aspects such as gender, language and cultural background are incorporated in the delivery of care (Romanow, 2002, p. 155). This opportunity reflects the assumption that culturally sensitive care

and culturally competent approaches improve health care outcomes and the well-being of older adults (CNA, 2011a; CNA, 2011b; Provincial Health Services Association (PHSA), 2011).

The Kloppenborg (2010) report describes the shifting demographics of aging in the Vancouver population. Between 1950 and 2009, the proportion of older adults (i.e. age 65 and older) rose from 8 % to 13.1 % of the population. By 2031, older adults will comprise 21% of the total population (Kloppenborg, 2010). At the same time, the cultural diversity of the older adult population is also increasing. As a result "both government and community services need to understand the situation of many different groups of seniors and provide enhanced supports to address language and cultural barriers" (Kloppenborg, 2010, p.17). For instance, visible minority older adults make up 25.9 % of the total older adult population and represent "any persons, other than Aboriginal...who are non-Caucasian..." (Kloppenborg, 2010, p.11). According to Koehn and Gregg as cited in Kloppenborg, the older adult population has become culturally diverse; the two largest visible minority senior groups are from China and South Asia. The Chinese make up 60 % whereas South Asians (SAs) make up 21 % of the total visible minority older adult population. Although the statistics suggest that the Chinese older adult population is larger than the SA older adult population, the latter reside and receive services in and around the recruitment site of this study which shaped my interest to investigate how HHNsg services are targeted to SAs. For this research, SAs refer to the Punjabi speaking community living in Vancouver.

Similar to various ethnocultural groups (e.g. Filipino, Chinese, Vietnamese), SAs develop type 2 diabetes and cardiovascular disease more often than compared to Canadians of European descent (Fikree & Pasha, 2004; Gupta, Singh, & Verma, 2006; Raymond et al., 2009; Oliffe, Grewal, Bottorff, Luke and Toor, 2007). Public Health Agency of Canada (2011) issued a report

on the trends, impact and effects of diabetes in Canada. In this document, statistics suggest that "people of South Asian, Hispanic American, Chinese and African ancestry are at higher risk of developing type 2 diabetes than those of European descent..." (p. 69). Multiple risk factors such as genetics, lifestyle (e.g. physical inactivity) choices, life circumstances as well as socio-economical reasons influence the rates of diabetes among SAs (PHAC, 2011). In addition, health literacy and language barriers create barriers to accessing health services. As a result, SA older adults living at home are increasingly likely to need the support of HHNsg services in managing diabetes and other related health issues. This raises the question as demands for HHNsg services grows by an increasingly diverse older adult population, will the design and delivery of these services change to reflect culturally sensitive and competent approaches?

Kloppenborg's report acknowledges the "lack of culturally appropriate care and translation services" (Kloppenborg, 2010, p. 14). The, Provincial Health Services Association (PHSA) (2011) has also acknowledged that the cultural diversity of the aging population is an important characteristic to consider in planning, organizing and implementing health services. PHSA cites language, social customs and ways of living as aspects that significantly impact seniors' ability to participate in decision making regarding their health (CNA, 2011a; PHSA, 2011).

In summary, my reading of extant research and commentary on HHNsg services and the cultural landscape of the aging population led me to initially question how HHNsg services are delivered to meet the needs of the older South Asian clients who live at home. This question, in turn, prompted me to review the professional and organizational goals guiding HHNsg practice. The following review of the professional and organizational goals of HHNsg practice further directed me to refine my initial question.

Research Problem and Question

The current scope of the literature conceives of the problem of cultural competence as one located in the nurses themselves and portrays educational endeavors as a way of rectifying those individual problems. Contrary to this approach, my interest is in studying the ways in which organizational practices influence and shape – and perhaps create barriers to nurses' abilities to enact specific practices that may be the topic of these educational efforts (Allen, 2007; Gerrish, 1999; personal communications, M. E. Purkis, April, 2, 2012).

The research question underpinning this thesis is: How does organizational culture in HHNsg influence HHNs as they provide care to older SA clients who live at home? My research interest also stems from empirical evidence that indicates gaps between the actual realities of nursing practice on the one hand and professional and organizational priorities that guide practice.

In the following pages, I briefly discuss the contextual background of HHNs' practice including a critical review of a variety of professional and organizational expectations of HHNs. Although these different levels of expectations promote quality care for seniors and support cost-effective health care services, in the everyday context of their practice, HHNs may experience challenges in meeting the specific cultural needs of the older SA client.

Contextual Background

In the last decade, a number of key published reports and documents suggest the growing importance of culturally competent approaches to everyday health care (College of Nurses of Ontario, 2009; CNA, 2010). For example the report *A Health System Approach to Chronic Disease Prevention* (PHSA, 2011) is a collaboration of key stakeholders from different health authorities in British Columbia. This report addresses the nature of health inequities and how

these inequities ought to be addressed by the health system. In addition, the stakeholders of the report stress the "acceptability of services," which entails meeting the holistic needs of diverse cultural, linguistic, and social groups (PHSA, 2011, p.26). Moreover, this report emphasizes the need for health organizations to develop mechanisms at all levels: policies, leadership, programs, and resources in order to foster the individual practice of cultural competency with patients. Given these indicators, the need for culturally appropriate care cannot be overemphasized.

Professional Mandate Promoting Culturally Appropriate Care

At a professional level, evidence-based standards and competencies guide HHNs' professional practice in a variety of clinical contexts with diverse populations (Community Health Nurses of Canada (CHNC), 2010). These professional goals are divided into "foundational approaches" and skills guiding everyday HHNsg practice. For instance, the foundational approaches are comprised of "illness prevention, health promotion and protection" (CHNC, 2010, p.2). These approaches are accomplished either by specialized or generalist approaches to care (Warren, Heale, Haughe & Yiu, 2012). For instance, some nurses may specialize in becoming resource experts in distinct areas of clinical nursing such as wound, ostomy, diabetic, continence and pain management (Warren, Heale, Haughe & Yiu, 2012). At a more general level, HHNs typically promote and improve population health by educating, communicating, building relationships, enabling access and equity, and building capacity for clients, families and their communities. The specialized and generalist approaches indicate that addressing the physical and holistic needs of patients is vital.

A specific element, noted in the professional guidelines, is the notion of supporting and promoting "access and equity" (CHNC, 2010, p. 6). HHNs are expected to "apply culturally relevant and appropriate approaches with people of diverse, socioeconomic, and educational

backgrounds and persons of all ages, genders, health status, sexual orientations, and abilities" (CHNC, 2010, p. 6). These professional recommendations are an acknowledgement of the cultural diversity of older adults living in Vancouver and the importance of culturally appropriate care approaches. However, self-reports from managers, data from researchers and my own personal experiences with colleagues reveal that there are differences between the expectations of the mandate and the practice on the ground. My experience as a HHN between the years of 2008-2013, coincides with Accreditation Canada's (2011) "required organizational practices" that primarily focus on safety, communication, risk assessments and medication best practices to improve the quality of client care (p.2).

Organizational Strategies Promoting Culturally Appropriate Care

At an organizational level, health authorities (e.g. Fraser, Providence and Vancouver Coastal Health Authorities) and senior managers overseeing the delivery of HHNsg services have responded to cultural diversity of the aging population in two domains: education and research. In the area of education, there have been two noteworthy contributions, namely an online education learning module and an educational resource book. The former was created for faculty, students and health providers, offering information about cultural and religious diversity and showing how to integrate these aspects into daily care planning and decision making with clients and their families. For instance, this online learning module developed by Fraser Health Authority guides learners on aspects like culturally-sensitive communication, and clients' values and belief systems. Moreover, it provides learners with an understanding of the tenets of the Sikh faith and its influence on the client's daily life. Although this educational effort demonstrates the organization's awareness of culturally specific information that may aid daily

care, the module is optional and unfortunately, no organizational attempts have been made to measure the efficacy or outcomes of such online learning on nursing practice.

A second organizational educational resource is an educational book, entitled: *Huddle for Diversity: Health care Tips for Raising Cultural and Religious Awareness* (Providence Health Care Diversity Services (PHC), 2007). This resource was published in response to "...caregiver and leader requests for more information about the possible health care expectations and values of [an] increasingly diverse patient population" (PHC, 2007, p. 1). It is a summary of specific cultural and religious practices and has the potential to build capacity to provide culturally competent care among home health care providers (PHC, 2007). The authors claim that the resource helps health care providers deal with "cultural speed bumps," by informing health care providers about the unique religious and cultural characteristics of clients that may not be anticipated or previously known (PHC, 2007, p. 1). Unfortunately, it is not widely used in daily practice. Although, HHNs have access to this valuable resource on the company intranet, I have yet to witness educators and resource clinicians apply this knowledge in everyday discussions about clients' diverse needs and perceptions of health. Although well intentioned, it is unclear whether this resource has made a noticeable difference in raising awareness among staff of cultural issues that affect health care delivery.

Research by health care organizations has included a public health research project targeting South Asians (older adults from Punjab, India) and East Asians (Chinese, Vietnamese and Filipino), groups known to have a higher risk for diabetes compared to the Caucasian population (VCH, 2013b; Papineau & Fong, 2011). The project tested the use of a diabetes screening tool, increased an awareness of diabetes and its risk factors, and promoted lifestyle changes among members of the South Asian and East Asian populations living in Vancouver,

BC (Papineau & Fong, 2011). The screening tool identified high risk individuals who subsequently underwent lab tests and language specific education to arrest the progression of type 2 diabetes and promote self-management of their pre-diabetic condition. Such research projects raise the level of awareness about population-specific diseases, focus attention on prevention and health promotion and improve clients' health-seeking behaviors and attitudes to their health. It is worth noting that although this research project aims to promote health; its objectives are disease-oriented and have an underlying risk-based framework.

Another example of organizational research is a recent three-year research study undertaken by a local health authority. Two of the four study objectives, included a cultural focus: 1) health care providers' response to patients' current religious and spiritual practices; and 2) the examination "in which health care contexts shape the negotiation of religious and spiritual plurality" (Reimer-Kirkham, Sharma, Pesut, Sawatzky, Meyerhoff & Cochrane, 2012, p.204). Critical ethnography was employed to investigate, describe and analyze the study's results. This study was implemented in a variety of health care settings such as acute, community and hospice care. The analyses uncovered a primary theme referred to as "sacred" (Reimer-Kirkham et al., 2012, p. 205) which was further categorized at various levels: spatial, individual, interpersonal and organizational. This last level is relevant to this research project. Organizational practices of "biomedicine and managerialism" were seen to depersonalize patients' spiritual values and beliefs (p.207). The health care context and interactions between health care providers and patients were "laden with curative discourses of biomedicine, impersonal uses of technology and fiscally oriented agendas. The stress on bio-medical and efficient aspects of health inhibited patients' opportunities to express spiritual beliefs and practices (p. 207). This finding reveals the actual realities of practice, that is, nurses primarily focus on the "black and white" (technical and

rational) aspects of care even though their Canadian patients' hold unique religious and spiritual belief systems that influence their needs and expectations (p.207). In addition, despite a nod to the importance of holistic approaches to patients' healing, organizations ignore the importance of the "sacred" (p. 205). For example, administrators who face fiscal pressures deemed spiritual services as a non-essential service. Their practices influence other health care providers to ignore holistic approaches to patients' healing process and furthermore to ignore patients' spiritual identity. In brief, Reimer-Kirkham et al.'s study raises an awareness of the dominant organizational practices for everyday health care for a heterogeneous Canadian society.

As noted above, organizational measures to promote culturally-appropriate care in the domains of education and research are inadequate because empirical evidence shows that education and research alone is not sufficient to change individual practice (PHSA, 2011). In other words, dominant organizational discourses and practices influence the organizational culture and context of everyday nursing practice. Organizational context and culture affect nurses' day-day conversations and practices and have negative consequences for the patient. (Ceci 2008; Latimer, 1999; Varcoe, Rodney & McCormick, 2003) More importantly, the problem is that "nurses functioned to reproduce, rather than challenge, the existing system and helped sustain existing [organizational discourses and practices]" (Varcoe, Rodney & McCormick, 2003, p. 967).

In the following paragraphs, I introduce the existing dominant organizational discourses and practices at one of the local health authorities. Dominant organizational discourses have primarily focussed on technical, rational and cost-effective aspects of care but regrettably ignored culturally competent care. Let me put forward the organizational goals and priorities of

the local health authority to demonstrate the potential impact of everyday HHNsg care on the older adult population, of particular focus in this project, the older SA client.

Organizational Discourses and Practices

Efficiency and effectiveness are aspects that are generally referred to as the economics of health care or rationing of services (Bjornsdottir, 2009). "A dominant focus on cost-efficiency in home-based care is criticized because economic rationality is not necessarily compatible with [the nursing profession's values]" (Tonnessen, Nortvedt, Forde, 2011, p. 387). By using the example of the organizational priorities of Vancouver Coastal Health (VCH) (2013a), I will explain how the language in these priorities puts a strong emphasis on economics as in efficiency and cost-effectiveness. These organizational priorities may hinder everyday nursing care, thereby diminishing the capacity of HHNs to incorporate the cultural diversity of the older adult population and their various needs in daily encounters of HHNsg care.

The VCH (2013a) organizational priorities are depicted in a diagram for the public and highlight four overarching goals, listed as:

(i) to provide the best care

(ii) to promote better health for our communities

(iii) to develop the best workforce

(iv) to innovate for sustainability

(See diagram on next page)

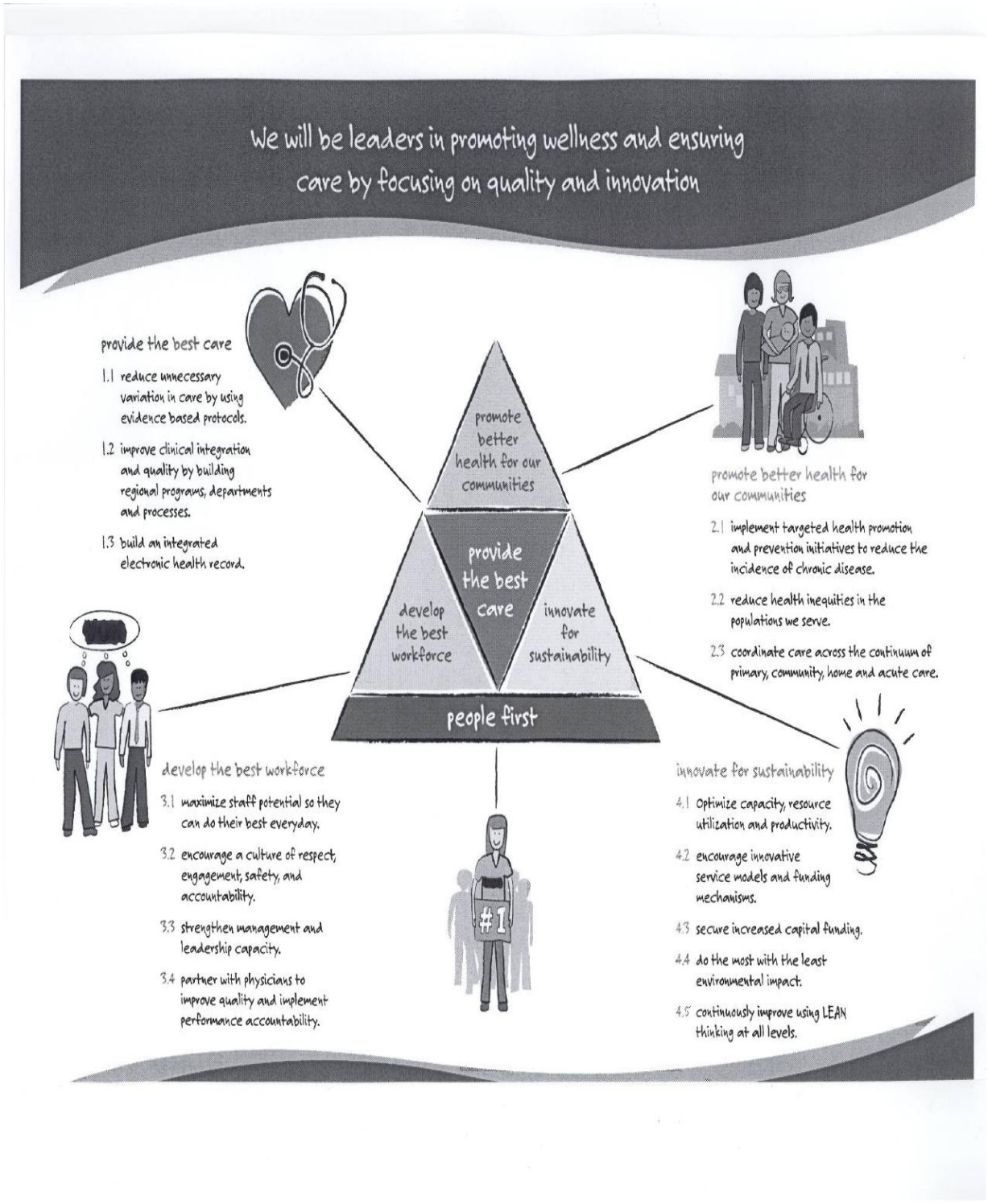

Figure 1: Diagram of Organizational Priorities (VCH, 2013a)

Each goal targets three or four performance objectives that emphasize most efficiency-centered rather than patient-centered care.

1) Reduce unnecessary variation in care through standardization and evidence-based protocols.
2) Build an integrated electronic health record
3) Recurrently apply LEAN processes at all levels

The foregoing list of organizational goals guides day-to-day HHNsg practice, a mechanism that shapes their daily priorities. "Reinforced by other influences, such as corporate ideologies, these values tend to keep nurses' attention on the physical aspects of patient care, away from a focus on patients' and families' emotional experiences..."(Varcoe, Rodney & McCormick, p. 963).

1) Reduce unnecessary variation in care

The organization's goal to reduce variations in care through standardization and evidence based protocols signifies a very mechanical approach to care which stems from fiscal agendas. Watts (2012b) provides an historical overview of care pathways: "Care pathway methodologies were first applied in manufacturing production. Here manufacturing processes and their timings were standardized in an attempt to reduce variation, the time to complete processes and decrease costs while maintaining a quality standard" (p. 24). Watts' discussion about care pathways indicates how care has become rigid, consistent and streamlined very much characteristic of an assembly-line approach to care. Allen, Griffiths & Lyne (2004) discuss the limitations of standard pathways that fail to capture the broader context of clients' circumstances. For instance, nursing staff apply a hospital guideline to discharge a client despite a shortage of community resources and private supports (e.g. rehab or bathroom equipment and nursing services) that would aid the client's recovery at home. Although standard processes guarantee equality of

services for different types of cases or clients, equality-based services do not always address individual needs or situations that may not fit into established guidelines and processes (Allen, Griffiths & Lyne, 2004). For instance, in the case of HHNsg care, "standardization" and "reducing variations" indicates that HHNsg services will be accomplished generically (VCH, 2013a). In other words, within Home Health, all disciplines use standard assessments to assess clients and have standard ways of documenting care to communicate daily client care. Thus, standard documentation and communication, "reduces variations," thereby reducing the clinician's assessment to an objective framework of assessing clients' needs (VCH, 2013a). Although, front-line clinicians gather and summarize information about their clients' religious, cultural and spiritual aspects of care in assessment forms, they choose not to incorporate these holistic aspects of care in the client's care because of daily pressures. In their discussion about rationing services, Allen, Griffiths & Lyne found that front-line clinicians make "judgements" about balancing professional ideals and the daily realities of limited time and resources to meet the distinct needs of clients. Furthermore, my concern is that this approach of "reducing variations" and "standardizing care" reduces the client to standard physical needs which does not take into account my earlier discussion about the cultural and demographic profiles.

In the context of health care, care pathways promote the uptake of best practices, which may include how to conduct an assessment, implement interventions, and consult with other providers. Standardization of care and use of evidence based protocols strengthens clinical aspects of care and promotes client safety. Despite these benefits, such approaches to care do not take into account individual clients' experiences of health and illness. Care pathways prioritize clinical approaches over holistic approaches to care. For example, one of the results from a study about the use of end-of-life care pathways in district nurses' practice demonstrates that symptom

control was prioritized over emotional, psychosocial and spiritual care outcomes, equally important outcomes in end-of-life care (Pooler, McCrory, Steadman, Westwell & Peers, 2002). Even though standardization of care can strengthen the use of best practices and promote quality care, such approaches are associated with fiscal agendas or "managerial agenda" rather than clients' expectations (Watt, 2011, p. 21).

2) Build an integrated electronic health record

The development of electronic records, another organizational priority is also relevant to improving efficiency and cost-savings. Using electronic records has its advantages and disadvantages. In 2002, it was noted that paper charts contained inconsistent information and were not accessible to the patient and other health care providers overseeing patients' care (Romanov, 2002). As such, electronic records were thought to be a hugely technological advancement that could prioritize and organize patient data in one accessible spot. In this way, patient data could be used by decision makers, researchers, and clinicians for their discipline-specific purposes that ultimately could benefit the system and the patient. However, evidence suggests that nurses spend a considerable amount of their time updating and maintaining the electronic health record rather than focusing on the client's needs (Allen, 2007). In the view of the organization, record maintenance is efficient; however, this comes at the cost of responsiveness to the uniqueness of clients' circumstances.

3) Recurrently apply LEAN processes at all levels of thinking

The organization has prioritized LEAN processes as a guide for health care providers to eliminate wasteful activities on a daily basis. Healthcare adopted the idea of LEAN philosophy from Toyota Inc. The British Columbia Ministry of Health (2010-11) has provided a number of examples of health care sites where LEAN thinking has been applied. One example occurred in

the Northern Health Home and Community Care (NHHC). The NHHC team recognized there were inconsistent intake processes that delayed access to long-term home support services. From the time of referral, on an average, a client had to wait 68 days for services. Applying the LEAN approach, a trainer supported the NHHC team to map the referral process step-by-step. In this way, they were able to see the big picture of all the steps employed and were able to eliminate unnecessary steps and inefficiencies. The team identified 46 distinct practices to process a client referral. As a result of the changes made, they were able to create a standard referral process along with another process that could address exceptional referral cases. Consequently, they drastically cut down the steps to the intake referral process. This example of applying LEAN thinking to community setting demonstrates how it can maximize value for the client by minimizing delays and inefficiencies, thereby making the process efficient and cost-effective. LEAN thinking is meant to provide value for both the provider and customer-the client. LEAN thinking focuses on technical and administrative aspects of care. This type of approach can improve the quality of care in some respects. However, in daily practice, health care providers encounter clients who demonstrate complex needs--needs that require culturally sensitive or competent approaches to care. There is no research to gauge the effects of LEAN thinking among health care providers. Although one can assume that LEAN thinking leads health care providers to think about care in terms of scheduling, time allotments, and elimination of delays, it is not beneficial in instances where health care providers have to employ complex and unique approaches to deliver culturally-sensitive care.

As noted above, organizational priorities and professional expectations can homogenize care and thus may create conflicts for nurses seeking to provide culturally sensitive care. Homogenization of care is a characteristic approach in a climate of cost-containment and fiscal

pressures and may tend to categorize clients' diverse needs as being the same even though they are quite different (Ceci, 2008). For instance, care pathways (e.g. end-of-life pathways) aid front line clinicians in making professionally and sound evidence-based decisions, a beneficial approach to improving the quality of client care. These documents integrate clinical and managerial agendas in clinical environments with limited resources (Allen, 2010a). Care pathway approaches are formalized structures that organize everyday processes to be efficient (Watts, 2012b). Thus, in daily practice care pathways are prescriptive, rigid, fit for mass production of services and not exemplary of how front-line clinicians make complex decisions (Watts, 2012b). More importantly, it eliminates the possibility of individualized care. As a result increasing numbers of patients are recipients of standard automatic processes (Watts, 2012b). In reality, clients from diverse backgrounds present with an array of health needs and circumstances. Empirical evidence indicates that dominant economic discourses permeate everyday nursing practice and reframe daily care. The provision of softer aspects of care known to the nursing profession, are gradually diminishing (Allen, 2007; Allen, Griffiths & Lyne, 2004; Tonnessen, Nortvedt & Forde, 2011). Thus, cost-containment practices, policies, and discourses are reframing nursing practice (Latimer, 1999). Furthermore, nurses cope and manage the organizational context, e.g. structural, social, and administrative constraints by further perpetuating efficient and cost-effective practices (Rankin, 2009). Cost-effective approaches to care supersede culturally-specific approaches to care. A growing body of nursing research indicates that culturally competent care is lacking, in particular with the older SA population (Gerrish, 2001; Grewal, Bottorff, & Hilton, 2005; Hilton, Grewal, Popatia, Bottorff, Johnson, Clarke et al., 200; Peckover, & Chidlaw, 2007). In short there is a discrepancy between what

actually happens in practice with patients and what the profession and organizations claim they provide to patients, areas of concern that shaped my research question.

Theoretical Concepts and Approaches

My research question provokes a cultural analysis of HHNsg practice, and thus my investigation is grounded in cultural theory and ethnography. The cultural theory of Clifford Geertz guided my cultural analysis to provide an understanding through "thick description" and "texts" (fieldnotes and interview accounts) that provide descriptive and interpretive work (Koning, 2010, p. 45 & 49). In this way a cultural analysis provides understanding and meaning of daily talk and routine practices. Culture is embedded in stories and can only be understood within a context that conveys the wider influences, structures, discourses, meanings that influence individual agency (Wolf, 2008). .

Using the methodology of ethnography, I provide short stories of four home visits with HHNs and their interviews. I also provide excerpts from nurse leaders' practice accounts of HHNsg practice. These practice accounts provide rich text, an understanding of the culture in HHNsg practice as it relates to HHNsg practice with the older SA population. The organizational context will be derived from the dominant discourses that influence everyday HHNsg practice.

In 2011, I participated in a self-study course with my supervisor Dr. Mary Ellen Purkis. This self-study course was a time for me to focus my research interests on a particular topic. To guide me, shaping my research question through self-reflection, Dr. Purkis selected an array of ethnographic literature. An exposure to this literature helped me to develop an initial understanding of the methodological approach of ethnography. In addition, I became aware of the concept of organizational culture and its influence for daily nursing practice.

Research Format

In Chapter 1, I provide the contextual background of HHNsg practice, the professional and organizational goals that support and inhibit the individual practice of cultural competency with older SA clients. In Chapter 2, I summarize a literature review of organizational culture, a key concept in my research question and describe Clifford Geertz's theoretical view of culture. In Chapter 3, I draw on the scholarship of contemporary ethnographers to inform my methods section. In Chapter's 4, 5, and 6, I present my findings: four stories of nursing practices in Home Health; HHNs' interview accounts about their practice; and three nurse leaders' interviews about HHNsg practice. Chapter 7 details the analysis and offers a discussion with consideration of the implications and conclusions for the future.

Chapter 2

Literature Review: Conceptual and Theoretical influences

The Concept of Organizational Culture (OC)

In current nursing literature, there is a growing interest in the term "organizational culture" (OC), as this concept is known to affect and shape efficiency, quality of care and practitioner's practices (Scott-Findlay & Estabrooks, 2006). Based on my historical overview of the concept of OC, I discovered its complexity, its inherent features and corresponding approaches to organizational studies. My analysis of OC in the nursing literature is in line with how I perceive and understand this concept and ultimately how I apply it to my research question and design.

Historical Overview of OC

In the 1960s, there was a growing interest in research about work environments, specifically the organizational climate. Much of this research was motivated by the dominating positivist paradigm in which practices are based on objective truths. However, positivist views of organizations were insufficient because organizations are complex structures (Bellot, 2011). In order to understand complex organizations and their workings, in the mid seventies, researchers turned to anthropological views to examine the softer aspects of OC--the manifestation of cultural elements such as values, beliefs and intangible assumptions which are evident in discourses and practices (Bellot, 2011; Hewison, 1996; Scott-Findlay & Estabrooks, 2006). There was, additionally, an interface between the three disciplines--psychology, sociology and anthropology-- informing the study of OC because of its complex and holistic nature (Bellot, 2011). Therefore, from the time of its inception into the literature, the application

of the concept of OC required a method that would facilitate meaning and understanding of complex organizations.

In 1979, Thomas Pettigrew, a sociologist, was the first scholar to employ the term of OC in a study of leadership practices, its influence on students and professors and the way they accomplished their work in a British boarding school (Bellot, 2011, Scott, Mannion, Davies, & Marshall 2003). Pettigrew's study is an exemplar of the relationship between OC and the daily performance of employees or everyday practices.

Many disciplines contributed to the development of OC studies and this has made the term less clear (Hewison, 1996; Scott-Findlay & Estabrooks, 2006). Researchers like me face challenges because scholars have linked the term OC with other similar concepts such as work or practice environment (Scott-Findlay & Estabrooks, 2006). As a response to the gaps in the literature, Bellot (2011) and Hewison (1996) have developed a conceptual framework portraying inherent features of OC. The purpose of attributing key features is to facilitate an appreciation of the use of OC in nursing research (Hewison, 1996). From my review of the literature, it was clear that there is a paucity of literature on the topic of OC in HHNsg practice.

Attributes of OC

Synthesizing Bellot's (2011) and Hewison's (1996) work, some key features emerge about the notion of OC. The primary aspect of OC is that it is a product of social interactions and shared experiences (Bellot, 2011; Hewison, 1996). A second point to note is that organizations have distinct cultures whereby members derive meaning in the context of their social networks (Bellot, 2011). A third significant trait is the fluctuating and evolving nature of OC due to its dependence on social contexts and circumstances (Bellot, 2011).

Hewison (1996) applies three distinct perspectives -- cognitive, instrumental and interpretive -- to explicate the concept of OC. At this point, I will refer to instrumental approach and will discuss the interpretive approach at a later point in this Chapter. Hewison's (1996) instrumental approach pertains to organizational leaders who can actively or passively foster specific "organizational values and beliefs, legends and myths, stories, rites and ceremonies to meet the organization's mission" (p. 6). Thus, organizational and leadership discourses inform each other and affect everyday practices. Hewison's instrumental view of organizations has implications for leaders who are highly influential in shaping OC and ultimately, daily performance and processes in health care settings.

Bellot and Hewison's work offers a perfunctory and technical understanding of OC (personal communications, M.E Purkis, May 2014) and provided me a reference point. However, I considered it necessary to summarize and synthesize other literature that portrays the effects of organizational discourses in hospital culture on nursing practices and on the older adult patient.

OC and the Older Adult Patient

Several studies provide evidence of the effects of hospital culture on the care of older adult patients whose experience has been dramatically diminished due to flawed discourses and practices that effectively marginalize the older adult and their ability to access comprehensive care (Chatterji, 1998; Rankin, 2003; Latimer, 1999). The social order of efficient and bio-medical processes defines nursing care and legitimizes the older adult patient and their care needs, especially in hospital institutions and culture. One example is the Rankin (2003) study, in which a patient satisfaction survey is framed within organizational or corporate language which in turn reframes and categorizes the actual patient and family experience. In fact, the survey essentially meets the needs and interests of the hospital.

Hospital culture engages in medical processes like the use of bio-medical terminology to classify and stereotype older adults' needs which includes the need for a bed, a financial and limited commodity. Non-medical needs and experiences are "excluded" as these do not fit within the medical and efficient systems of care (Latimer, 1999, p. 205). These systems of discourse and practices characterize the conduct of nursing and how the needs of older adult patients are defined in practice. A further conclusion is that nurses participate in the efficient processing of patients and their older adult patients' non-medical or non-essential needs are compromised in order to be acknowledged and considered worthy of medical and nurses' attention (Latimer, 1999).

Similarly, in the context of this inquiry, within the area of HHNsg practice, bio-medical, cost-effective and electronic-health record technology overrides attention to the cultural, emotional and spiritual concerns of SA clients. The former is aligned with the efficiency discourses and practices noted in the organizational mission and statement as identified in Chapter 1. The consequence is that the client becomes defined within the confines of organizational thought and system processes.

Research Approaches to OC

Scott-Findlay and Estabrooks's explore how organizational cultural studies have been attempted within the nursing discipline. The results of their review show a need for qualitative methods to studying OC.

Using Hatch's framework, Scott-Findlay and Estabrooks (2006) categorize twenty- nine nursing studies as exemplary of modern, symbolic-interpretive and postmodern approaches. Hatch's framework demonstrates the variety of approaches to studying OC which is also based on the researcher's specific goals, epistemological, and methodological position.

Of more significance, the results of the Scott-Findlay and Estabrooks's review show that modernist approaches to understanding OC are still dominant. However because of the complex nature of organizations and the need to understand the values, beliefs and assumptions of members in the organization, Scott-Findlay and Estabrooks found that six of their twenty nine studies applied symbolic-interpretive methodologies, which, even though they are time consuming and expensive suggest that these methods are necessary. The benefits for researchers who employ them is based on the assumption that "cultures are socially constructed realities;" and that "organizations are cultures and therefore cultures are contexts;" and their aim is "to understand the particular organizational culture from [its members]" (Scott-Findlay & Estabrooks, p. 505).

Hewison's concept analysis of OC reveals similar findings to Scott-Findlay's and Estabrooks's (2006) review in that an interpretive approach to studying organizations is highly valuable especially given that organizations are complex structures with a long history of practices and discourses that have evolved and provide the "glue" that holds members together. Hewison refers to the interpretive approach as a methodological approach to understanding organizations (Hewison, 1996). In order to understand an organization, a researcher must interpret the social relationships in the organization and make sense of the meaning of these relationships. Thus, Hewison refers to Geertz's interpretive approach to understanding culture. "Man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis…an interpretive one in search of meaning" (Hewison, 1996, p. 8). In the context of my project, "webs of significance" refer to the organization's use of language (organizational goals and performance objectives), routine practices and the effects of context for everyday practice (Hewison, 1996).

A researcher can study "familiar activities and procedures and interpreting or reinterpreting them new insights and improvements in practice can occur" (Hewison, p. 8). In line with this thinking, Hewison advocates Geertz's interpretive approach whereby social networks and the organizational context are construed to provide meaning and understanding of the culture. Thus, at this point, I will explore Geertz's view of culture and how it applies to my research design and analysis.

Clifford Geertz's Concept of Culture

Having a wide view of the social sciences and humanities, Clifford Geertz's multidisciplinary experiences or educational background shaped a dynamic and revolutionary view of culture that I could adopt and employ to design my ethnographic research study. His comprehensive and multi-layered view of culture became influential in other disciplines: humanities, political science, sociology, psychology, philosophy, social history, religious studies, and literary studies and subsequently in nursing (Koning, 2010). In this Chapter, I provide an overview of Geertz's anthropological view of culture as it offers a theoretical approach to understanding the organizational culture in HHNsg practice.

The concept of culture he espoused...is essentially a semiotic one" (Koning, 2010, p. 37). He established a unique view of culture that defined it as "...an historically transmitted pattern of meanings embodied in symbols, a system of inherited conception expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life" (Geertz, 1973, p. 89). Applying this view, a health care organization is comprised of members who take part in distinct, repetitive discourses and practices that are handed down or shared among members. Using this definition alone, Geertz incorporates the cultural and social processes of life to derive meaning. Meaning is not isolated to an individual

but rather it can be social and consist of a system of routine practices and linguistic exchanges among individuals of a particular group (Paley, 2002). In this regard, meaning is public (Paley, 2002). A number of nursing theorists such as Patricia Benner and Trudy Rudge have espoused Geertz's view of culture (Paley, 2002, Rudge, 1996).

Major Concepts, Assumptions and Relationships

Geertz's theory of culture consists of three major components: "local knowledge", "thick description" and culture to be like "text" (Koning, 2010, p. 41-49). Applying Geertz's conceptual framework of culture, I chose methods that will facilitate an understanding of nursing practice from a cultural perspective. My analysis will be firmly rooted in these two components of Geertz's conceptualization of culture: thick description and texts (Koning).

The first component of culture is "local knowledge," which refers to the particular social expressions and actions of a group of individuals. In this way, Geertz claims that a researcher can gain an understanding of a group's specific practices by observing their daily actions and words. To add, "local knowledge" is based on the context in which they occur (Koning, 2010, p. 43). I will refer to an example of Geertz's work to provide further clarity. Geertz observed two Islamic groups, one from Indonesia and another from Morocco. By describing the daily actions and expressions along with its surrounding context, each group was characterized differently. Even though both groups were Islamic, their practices differed based on their specific contexts. Likewise, nursing practice is situated within different contexts which make unit culture unique from another (Kaminski, 2006, p. 18). In summary, when a researcher uncovers "local knowledge" he or she observes a group's distinct practices as in their language and actions along with the "actual social contexts" surrounding them (Koning, 2010, p. 42).

The second and equally important concept of his theory of culture is "thick description" (Koning, 2010, p.45). By using Geertz's "thick description," I will produce narrative accounts or "stories" of HHNsg practice, to reveal participants' understandings and how they organize their everyday practice (Martin, 1998; Wolf, 2008, p.324). Narratives usually include agents or actors, their individual actions, the order of interpersonal interactions and the overarching context (Martin, 1998, Wolf, 2008). These type of thick descriptive accounts provide fuller details and "what is being" said by actions of the actors (Koning, 2010, p. 47). Using Geertz's method of thick description, I describe the events, conversations and practice of participants in my study according to their viewpoints. Thick description facilitates meaning and understanding of the culture under study. Examining the context of a group's social actions and expressions, the researcher's understanding his or hers study group is enhanced. Geertz claims that there are two forms of understanding, one that entails providing a description along with the context which demonstrates the whole structure of meaning to enhance understanding (Koning, 2010, p. 49).

Geertz also developed a third concept, this time a metaphorical one-that culture is like a "text" (Koning, 2010, p. 49). Putting this in the context of my own project, the various texts in my research will include fieldnotes and interview transcripts annotated from observing daily actions and words. These texts will require interpretation to provide further meaning of the previously described events that occurred in my fieldwork observations and one-to-one interviews. Interpretation will be the final level of analysis in my research project.

When a researcher observes social expressions and actions of a culture, compared to others, his or her observations are distinct; therefore, in providing a cultural analysis, the researcher is only able to provide a partial understanding. Using Geertz's theory of culture and

its key concepts, the goals of this study is to provide an understanding of the organizational culture in HHNsg as it relates to HHNs' practice with older SA clients who live at home. I conceive of the HHNs as a social group that exhibits distinct cultural practices highly influenced and shaped by the organizational system. A system can take the form of an institution, organizational language, action or document media through which individuals develop an understanding or meaning. In this way, individuals make sense of their roles, responsibilities and positions--their everyday realities. Using Geertz's notion of local knowledge, I observed and listened to the flow of social and interpersonal interactions of HHNs. In addition, I drew upon their personal understandings of daily HHNsg practice. My observations and their practice accounts provide "thick descriptions"- narratives or stories (Koning, 2010, p. 45). In addition, I interviewed the nurse leaders and reviewed a key organizational documents to explore the context of HHNsg culture, wider social values and beliefs in the organization that guide individual and daily practice. All of the preceding sources of data make up the "texts" that are interpreted in Chapter 7 to understand the culture in HHNsg practice.

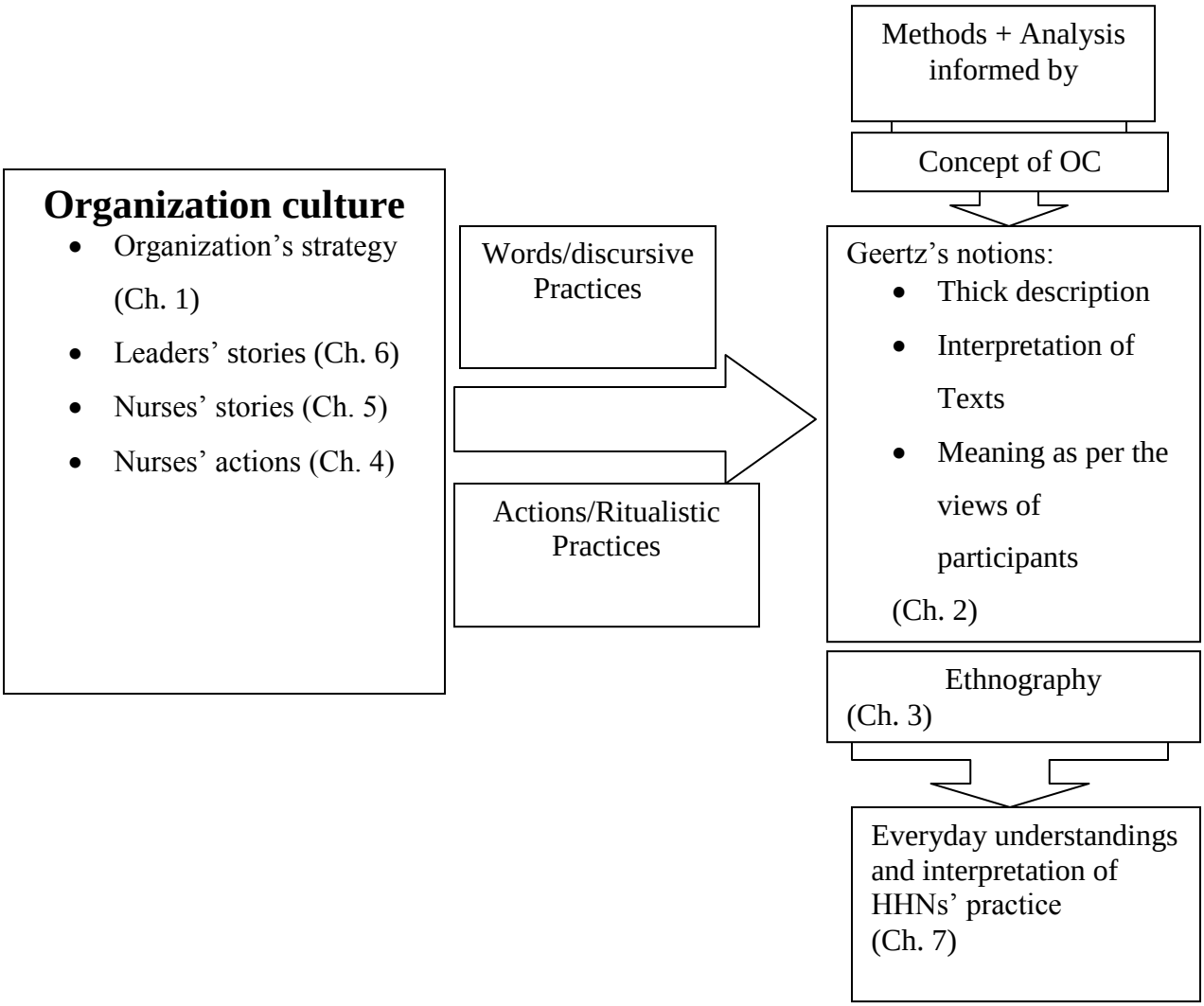

Figure 2: Organization of Thesis

In this thesis, the organization's mission or strategy statement provides the backdrop of the goals and priorities that inform the leaders' stories, and nurses' stories (VCH, 2013a). The stories convey the predominant discursive and ritualistic practices to HHNsg practice. Using, the concept of organizational culture, Geertz's thick description and interpretation of texts, and the methodology of ethnography, I organized my data and presented it to inform my understanding of the organization's culture in HHNsg practice in relation to daily care of older SA clients.

Chapter 3

Methodology

Nursing researchers who employ ethnography, a qualitative form of inquiry, do so in order to understand and change nursing practice from a cultural perspective (Allen, 2004a; Borbasi, Jackson, Wilkes, 2005; Holland, 1993; Polit & Beck, 2008; Holloway & Todres, 2010). Using observation, interviews, and listening, the ethnographer describes participants' everyday life as they engage in social relationships within unique contexts (Borbasi, Jackson, Wilkes, 2005; Holloway & Todres, 2010).). In keeping with my research question "How does the organizational culture in Home Health nursing (HHNsg) influence the day to day practice of home health nurses (HHNs) as they provide care to older South Asian (SA) clients who live at home?" Ethnography offers a methodology to explore and gain an understanding of the culture in HHNsg practice. In the following section, I provide a brief historical overview of ethnography and highlight key methodological assumptions underpinning ethnography.

History of Ethnography

Historically, the study of ethnography took place in the 1920s when the social anthropologist Bronislaw Malinowski travelled to Australia where he conducted fieldwork-observations of the daily life of Trobriand Islanders, an indigenous culture (Bruni, 1995). Like most anthropologists, Malinowski conducted ethnography of non-western cultures (Allen, 2004a; Holland, 1993). Malinowski, as cited in Holland (1993), claimed that the goal of ethnography was to describe the 'whole' cultural scene…and "the native's point of view," the social life of inhabitants, their daily language, rituals and traditions (Holland, 1993, p. 1461).

By the late 1960s, ethnography began to be increasingly adopted by the disciplines of sociology, medicine, law and psychology (Rudge, 1996). In the mid-1980s, positivist approaches

dominated with ethnographers providing objectified and colonialist descriptions of non-Western cultures (Borbasi, Jackson, Wilkes, 2005). On the one hand, detached observation raised the scientific worth of ethnography while on the other this technique perpetuated depersonalized and stereotypical representations of non-indigenous cultures (Rudge, 1996; Borbasi, Jackson, Wilkes, 2005).

Contemporary nurse ethnographers such as Allen (2007) and Rudge (1996) examine every day nursing activities as they occur in practice. Ethnographic methods capture the various influential contexts for nursing practice: the political, social and technological influences that make certain aspects of nursing work visible and invisible (Allen, 2004a; Purkis, 1999). Using this methodology, there is an understanding that human experience is subjective and contextual (Borbasi, Jackson, Wilkes, 2005; Bruni, 1995). Thus, human experience is not "casual" or predictive; it is constantly being constructed and re-framed (Borbasi, Jackson, Wilkes, 2005; Bruni, 1995, p. 46). Offering a broader perspective of influences on individual agency or nursing practices, these approaches seem promising.

The "Texts" of Ethnography

In ethnography, several "texts" provide meaning and understanding (Borbasi, Jackson, Wilkes, 2005; p. 495; Rudge, 1996, p. 149). "Texts" construct the reality of nursing practice and are fluid, dynamic and informed by wider influences such as social and historical conditions (Cheek & Rudge, 1994). Geertz also uses this analogy of "text" to represent culture. It is always changing and dependent on social context (Koning, 2010, p. 49). "Texts" may include: (i) observational fieldnotes (descriptions of everyday language and routines as these occur in unique settings); (ii) interview transcripts; and (iii) key documents (e.g. organizational policies). An analysis of these previously mentioned "textual records" identifies (the researcher's and the

participants') "voices," and "positions" as situated in various contexts, thereby showing how and why meaning is generated and attributed in daily practice (Rudge, 1996, p. 149; Cheek & Rudge, 1994). For instance, in her 1996 study, Rudge's fieldnotes represent the "textual record" that depicts multiple voices, her knowledge of wound care and her knowledge needs as a researcher. Rudge is thus cognizant and transparent about the representation of the text and its influences as her primary goal is to present the perspectives of her study's participants as authentically as possible.

"Texts" such as observational fieldnotes are the outcome of observational-fieldwork, a primary method of ethnography in which "Data is gathered by direct observation" (Bruni, 1995, p. 45). During observational-field work, the researcher provides an understanding of what is actually happening "in situ" (Allen, 2004b, p. 271). These first-hand observations provide visible data of participants' actions--on the spot evidence--as it occurs, in comparison to participants' reflective accounts or claims of every day work (Allen, 2007; Watson, Booth, & Whyte, 2010). Some observational-fieldwork researchers have recorded conversations between health care providers and their patients; and among interdisciplinary members at case rounds (Arber, 2007 & Chatterji, 1998). These records are rich "texts" that indicate the values, beliefs and taken-for-granted assumptions within the health system's culture in different contexts (Rudge, 1996).

During observational-fieldwork, the ethnographer takes hand-written fieldnotes and keeps these as a separate record or integrates it as part of the analysis (Holloway & Todres, 2010). Allen (2004a) maintains that the ethnographer is always managing his or her role in keeping authentic fieldnotes, the construction of these texts (Bruni, 1995). Like Rudge (1996), I represented my fieldnotes in narrative or story format (see Chapter 4). Rudge critically reflects

on her biases by asking herself whose voice is present in her fieldnotes: “Is it nurse, researcher or nurse-researcher?” (p. 149). These personal biases can also be kept in a separate record and openly reflected upon in the analysis of the data (Holloway & Todres, 2010). Additional “texts” can be generated from fieldwork interviews and transcripts. Face-to-face individual or focus-group interviews provide participants’ inside perspectives of their everyday life. Their elaborate descriptions of practice enable the ethnographer to probe deeper into patterns of discourses and compare these to daily routines that are observed in fieldwork. In summary, “texts” play a crucial role in understanding nursing practice and influential political, economic and historical contexts (Cheek & Rudge, 1994).

Fieldwork and Ethnography

While engaging in fieldwork, it cannot be overemphasized that ethnographic “texts” (as discussed above) are based on the social conduct of the fieldwork role. From the point of entry, the field worker or the ethnographer has to manage access to the field (the research setting), and develop and foster authentic relationships with participants in order to obtain and represent their viewpoints (Allen, 2004a). Initially, the fieldworker enters their participants’ social setting “cold” (Borbasi, Jackson, Wilkes, 2005, p.496). Upon entering the field for the first time, Watson, Booth & Whyte (2010) recommends that the fieldworker spends the initial time building rapport with participants (Allen, 2010a). For example in her 2010a study, Allen employed different rapport building strategies with the various participants in her study: physicians, nurses and health care assistants. In the same way, I will have to build professional and trustworthy relationships with participants in my study.

During observational fieldwork, the researcher is a participant-observer--observing, listening and making notes of routine discourses and patterns of actions among participants in the

field (Borbasi, Jackson, Wilkes, 2005; Bruni, 1995; Baumbusch, 2011; Chatterji, 1998, Spilsbury & Meyer, 2005; Wolf, 1988; Wolf, 2007). Allen (2010b) suggests that researchers avoid taking part in superficial tasks such as "[making beds], attending to patient comfort, emptying urinals and bedpans and replenishing water jugs…." (p. 359). She witnesses that by performing these tasks she was not able to capture the data that she set out to gather which was to record the contributions of family members to daily care. While, Rudge (1996) explains further that the "researcher's presence" is always being "positioned by the researched and the research" (p. 148). Thus, it is important to note the responses of participants to the researcher and vice-versa. For example, Rudge observed that some of the nurses in her study "worked hard to ignore" her while "others [provided] information about the science of wound care" and still others positioned her as a fellow colleague (p. 150)

Within nursing literature, scholars have identified the two primary positions known to affect the ethnographer's role: insider or outsider status in the field (Allen, 2004a, p. 16; Bonner & Tolhurst, 2002, Watson, Booth & Whyte, 2010). For example, in the Bonner and Tolhurst study, Bonner's inside knowledge helped her readily negotiate access to the site, identity key sources of data, and have an understanding of existing nursing practices. Therefore, in these instances, participants may feel comfortable with a fellow member of their profession who is conducting research of them. In addition, an insider view may allow the researcher to adapt more easily to the "spatial, social and temporal surroundings," in a way that is respectful of the participants' daily life and knowledge (Borbasi, Jackson, Wilkes, 2005, p. 497). Even though an "insider" view leads to a representative account of daily practice, taken-for-granted practices can be overlooked (Allen, 2004a, Rudge, 1996).

In contrast, Tolhurst claims that her "outsider status" enabled her to record the actions of participants more objectively, absent of social bias (Bonner &Tolhurst, 2002). Yet she feels that it was difficult to determine the impact of her presence in the field and to foster relationships with participants, which would have been helpful in producing an authentic account of participants' understandings and ways of deriving meaning. One further point is that the insider-outsider role shifts if the nurse-researcher is interacting with different groups or disciplines in the field-work (Allen, 2010b).

In brief, nurse ethnographers' insider or outsider status depends on their relationship to their research and the participants in the field and influences the rigor and outcome of the research process. In response to the insider-outsider status and its impact on the research process, Allen (2004a) suggests a reflexive approach.

Reflexivity and Ethnography

A reflexive approach is necessary for accomplishing authentic, non-biased and rigorous field work (Borbasi, Jackson & Wilkes, 2005). Latimer as cited in Toffoli and Rudge (2006) cautions nurse-researchers who conduct ethnography of their own health agencies, to be aware that their existing knowledge and how this influences their understanding of participants in the field. Using a reflexive approach, ethnographers openly demonstrate how their personal interests, stories, theoretical views influence their understanding of observations in the field and accounts of everyday practice in the field (Allen 2004a; Allen, 2010b, Borbasi, Jackson, Wilkes, 2005; Rudge, 1996). Thus Allen as cited in Borbasi, Jackson and Wilkes (2005) emphasizes that "researcher accounts are reflective rather than reflexive, separating the narrative of the field from the narrative of self when in fact the two should be integrated" (p. 497). In the end, reflexivity is

a complex but methodical process in reproducing the social dialogue (e.g. voices) of self, the field and the participants, as one coherent product (Allen, 2004a).

Methods

Objectives and Significance of the Study

In my ethics submission and introductory conversations with the recruitment site's manager and participants, I clearly articulated the purpose of my study in all my recruitment and consent materials which was essentially i) to describe the organizational culture in HHNsg practice; and ii) to develop an understanding of how organizational culture in HHNsg practice influences the day to day practice of HHNs seeking to improve the health and well-being of older SA clients living at home, in Vancouver.

Access to the Field

In November 2012, I was granted ethics approval from the University of Victoria (UVIC) and Vancouver Coastal Health Research Institute (VCHRI) respectively (Appendix R & S). Prior to both ethics submissions, I met with and submitted a letter of invitation to the recruitment site manager (Appendix A). The manager asked me to introduce myself and to present my research project at a staff meeting. At this meeting I introduced myself as a HHN who was completing a research project as part of my graduate studies at UVIC. I followed up with a brief power point presentation of my research study. Subsequently, the HHNs suggested that I translate the consent materials for Punjabi speaking SA clients (Appendix J). Using the previously noted relational strategies and the Allen (2010b) guidelines, I accessed the field and initiated rapport with participants.

Sampling and Recruitment

Similar to Bonner in the Bonner and Tolhurst (2002) study, my HHNsg experience helped me to choose an HHNsg unit that is situated in a geographic location with a dense population of Punjabi speaking home-based SA clients. The "key informants" or participants were front line HHNs and nurse leaders (Rudge, 1996, p. 149). I chose the recruitment site and established participants' eligibility criteria based on the aims of my study. The recruitment criteria for the HHNs, their SA clients, and Nurse Leaders are identified below.

The HHNs had to have been employed by the health authority for at least three months and currently be taking care of an older SA client who is above the age of 55 and receiving HHNsg services for wound care, chronic disease management and intravenous care (Appendix C & D). The clients had to be speaking English or Punjabi and also had to have an English-speaking family member who would assist with translation, if needed. The term SA specifically refers to the Punjabi speaking community and this was clarified in recruitment and consent materials (Appendices I, J and K). This community was chosen because they represent the majority of the SA population living in Vancouver and around the recruitment site. Nurse leaders had to have had three years of leadership experience in the organization and held a managerial, educator, clinical nurse specialist or team leader position (Appendix L).

With the aid of a neutral third-party staff member who was not in a supervisory role to the HHNs and was not involved in any client care, I was able to recruit and protect the dignity and privacy of these parties. The third-party posted recruitment posters at the nursing station and staff bulletin-boards and emailed invitation notices to all potential HHNs and nurse leaders at the recruitment site. In addition, the third-party also promoted the study (word-of-mouth) at staff

and leadership meetings. Thus, recruitment materials comprised of a poster, scripts and invitation/consent forms (Appendices C, D & E).

With permission from the UVIC ethics committee and the privacy officer at VCH, participating HHNs informed SA clients about my study (see Appendix F). After interested clients volunteered their contact details, the third-party recruited them via telephone using a recruitment script (Appendix G). The third-party spoke fluent English and Punjabi.

Consent

I obtained the consent of the HHNs, their SA clients, and nurse leaders by setting a time and place where I communicated the details of the consent forms, giving them an opportunity to voice any concerns and allowing me to address their concerns.

When HHNs contacted me to express interest in participating in my study, at the time of phone or email contact, I introduced myself as a UVIC Masters in Nursing student who is required to complete a research project under the supervision of an academic supervisor. Of primary importance, I explained that my main aim was to observe and take notes of their day to day activities and not to judge or evaluate their practice with their older SA clients (Appendix H). Each HHN was informed that my observation of their care would take thirty to sixty minutes and my face-to-face audio-recorded interview would take forty-five to sixty minutes.

When I introduced the consent process to the various SA clients, I emphasized that I would not be providing or observing any of their personal hygiene. Rather, I made them aware that I would observe wound care, intravenous or chronic disease supportive care during the thirty to sixty minute home visit (Appendix I). The main point that I conveyed was that their HHNsg services would not be affected whether they took part or not. I also encouraged the presence of a

family member to whom I would provide a letter with information about my study (Appendix K).

With the Nurse Leaders, I emphasized my Advanced Practice Nursing (APN) educational background with the objective of obtaining their leadership perspectives during our one-to-one audio-taped forty-five to sixty-minute interview that I would transcribe (Appendix L).

Ethical Procedures

Confidentiality, Anonymity, Inconveniences and Withdrawal

I requested HHNs and clients to protect each other's identity to maintain confidentiality. All participants were assured and the nurse leaders that their real names would not be identified in my fieldnotes, transcripts or in my final research thesis. In addition, I conveyed that hard copies of fieldnotes and transcripts would be stored in a locked cabinet and electronic files would be password protected. After I transcribed audio-recorded interviews, these would be deleted. I prepared a confidentiality agreement for a transcriptionist, services that I did not require or use for this study (Appendix P).

To minimize scheduling inconveniences for participants, they were encouraged to select a preferred day and time for home observations and interviews. The recruitment site manager was asked to allow HHNs to participate in my study during working hours (Appendix A). The manager allowed me to use documentary evidence of organizational policies or guidelines that might be applicable to my study (Appendix B).

Participating HHNs, SA clients and nurse leaders had the option to withdraw at any time without any explanation. If any of the participants withdrew at any time, their data would not be used in my analysis. In particular, I informed clients, that should they decide to withdraw, their HHNsg services would not be discontinued (Appendix I). I maintained a master list of

participants' actual names and their contact details, along with their pseudonyms. I assured participants that this list would be used only for the purpose of communicating with them and in the event they withdraw from the study.

There were no risks associated with participating in this study. Based on my personal experiences of HHNsg practice, I knew experienced HHNs and nurse leaders were used to being observed and interviewed by their peers and clients' family members in their daily practice. However, if a risk occurred, I would immediately stop a home observation or interview, give the participant a break, and offer support as per their preferences. In the case of a medical emergency, I would call 911 (Appendices H, I, L).

Data Collection

Participant-observation, Fieldnotes and Interviews

During my fieldwork from January to November 2013, I adopted the role of participant-observer. I remained overtly visible as I shadowed individual HHNs in each of their clients' homes. The nurses comprised of three registered nurses and an LPN. As for the clients, who allowed me to observe their care, they consisted of two older men and women. While observing, I did not partake in the HHNs' day to day activities even though I was known to have a professional background in HHNsg practice from 2008-current. My rationale for this decision was to observe and document accurate fieldnotes of the HHNs' actual conversations and activities with their older SA clients (Allen 2010b).

I documented my observations in a personal fieldnote template (Appendix M). I recorded the roles and responsibilities of the participant HHNs, their actions and everyday language. In my fieldnotes, I will demonstrate "how [the HHNs] perform their actions and the descriptions of [their] activities [with the client]," a means of gaining particular cultural knowledge for my study

(Wolf, 2007, p.304). I entered my hand written fieldnotes into an electronic file for the sake of keeping neatly documented fieldnotes. I added my personal comments and insights in a memo and journal entry at the bottom of my field note entries (Appendix Q). In the case of my study, I was able to also identify in my fieldnotes not only my observations of patients and nurses but also discourses and claims of nursing practice. At the end of each field note from the observed home visit, I raised questions which encompassed how my research aims and theoretical stance informed my understanding of the data (a form of reflexivity). These questions have been noted at the end of each story and interview account in Chapters 4 and 5. In treating my fieldnotes as "texts," as in the Rudge (1996, p. 148) study, I asked myself: "what is being said by the actions in this social action" (Koning, 2010, p. 52).

I used a semi-structured interview guide to interview the HHNs that I observed (see Appendix N). A semi-structured guide allowed me to stay on topic as well as respond to participants' queries and extended descriptions of their practice. Following transcription of the HHNs' audio-taped interviews, I developed their interviews into a four narrative accounts (Allen 2004a). At the end of each account, I raised questions (a form of reflexivity), framed based on my understanding of the concept of organizational culture and the aims of my research question.

With nurse leaders, my aim was to get a sense of how the organizational culture (leadership talk and actions) in HHNsg influences daily practice. The nurse leaders, a manager, an educator and a clinical coordinator participated in interviews with me after I had observed and interviewed the HHNs. Again I used the semi-structured interview guide to interview them (Appendix O). Later, I transcribed audio taped interviews and summarized their perspectives on daily practice.

During the various interviews, I observed individuals' body language and tone of voice as cues to probe participants for further information, relevant to this inquiry (Tod, 2010). In regard to interview transcripts, I highlighted segments of the transcripts and attached these to electronic comments which comprised of my thoughts about the data, patterns and gaps in routine discourses and activities of HHNs and nurse leaders.

Analysis

As Lathlean (2010) commented, qualitative analysis is a "complex, creative process that is ongoing, interactive…and reflexive," aspects that I applied at every stage of the analysis (p. 435). Using Geertz's model of thick descriptions I use a narrative or story format in Chapters 4, 5 and 6. My "presentation is more narrative in style and concerned with …viewing nursing work rather than painstaking accuracy" (Allen, 2004a, p. 272). Using thick description, I sought to capture the patterns or order of actions and talk that reoccurred in my observations and interviews. In an attempt to apply a reflexive approach, I posed questions at the end of each story and interview account in Chapters 4 and 5. Subsequently, I undertake "textual analysis" to discuss, analyze, and interpret the discourses of the organization, leaders, and HHNs and ultimately the impact of these discourses for the older SA clients in my study (Koning, 2010; Rankin, 2009, p. 281). While interpreting these discourses, I reflect on the social positions of the clients, and how their social positions impact their voices in everyday nursing care (Rankin, 2009; Rudge, 1996).

In the final Chapter, using Geertz's (1973) metaphor of culture as "text," I interpret and synthesize multiple discursive practices by looking at the meaning behind discursive practices in light of wider organizational goals and strategies, particularly the results of these discourses whereby the client's care is de-personalized their needs considered to be invalid in practice

(p. 448). This is where my approach had to be interactive and creative. I compared and contrasted both my fieldnotes and interviews for similarities and differences. Due to the large amounts of qualitative data, I color-coded emerging themes and corresponding examples which also aided organization. Thus, I was able to organize the data into the pre-identified categories that were taken from the organizational mission and strategy statement (see Figure 1).

Rigor & Triangulation

For purposes of rigor, I used a standard field note template which enabled me to systematically record my observations of four home visits (see Appendix M). On the same day as the observation, I recorded and transferred my hand-written fieldnotes to an electronic format. This format also helped to keep a legible record of the data for the duration of my research inquiry. I took note of how the HHNs coped with my presence as I observed their practice, and how they interacted with me during the interview, as this is known to affect the way participants present themselves (Watson, Booth & Whyte, 2010). By raising questions at the end of each field note, I exposed my thoughts and feelings and verified personal impressions in subsequent interviews with HHNs and nurse leaders.

During the course of my field-work, my insider-outsider status shifted depending on the professional designation of participants (Allen, 2010b). All the HHNs were comfortable with my presence because they knew that I continued to practice as a HHN and was familiar with the order of activities on any given day. Prior to the observations and interviews, I advised them to go about their day as they normally would.

I also felt like an outsider as I did not have prior relationships with participants at the recruitment site. Particularly, I felt like an outsider with nurse leaders who knew I was a HHN and a graduate nursing student with no leadership experience. These leaders were very open in

their interviews with me. As well, the clients knew that I was an "outsider" by my status as a student. This role as student made them feel comfortable in my presence. Thus, I paid close attention to participants' interaction and response to my presence in the field and documented these aspects in the margins of my fieldnotes and interview transcripts (Allen 2004; Rudge, 2007).

After transcription, again by raising questions at the end of each interview, I show transparency. I summarized the essence of each interview in one page summary to familiarize myself with the data and grasp the big picture of each interview in comparison to the other.

Each phase of data collection that is my fieldwork and one-to-one interviews with HHNs and nurse leaders helped me to corroborate that data. Having worked as a HHN in the years prior to this study, also helped me verify the data. For example, one of the early conclusions that became apparent to me during the home visits was that the nurses were very task-focused and focused on clients' physical problems. This finding was further confirmed by the nurse leaders' who gave the reasons for a physical oriented approach in contrast to a holistic approach. Both HHNs and leaders claimed that they believed in applying a holistic approach which was not evident in everyday practice.

Chapter 4

Four Stories of Nursing Practices in Home Health

My academic interest in this study was to understand how organizational practices in HHNsg services influence the everyday face-to-face interactions among the home health nurses (HHNs) and their clients. In the last two decades, researchers studying the organizational culture of health organizations have shown how employees inherit and take part in organizational practices to order their daily practices (Latimer, 1999; Rankin 2003). Using the same methodology, this Chapter will relate four descriptive and distinct stories about nursing practices delivered to the older SA population living in their homes in Vancouver. In the same fashion Wolf (2008) suggests that "stories [are] …transmitters of nursing culture" … [and facilitate understanding about the everyday work of nurses]" (p. 324). My intent is that by observing the stories that provide cultural descriptions of home health nursing practice and by depicting the physical and social context of each of the home visits, I will provide the cultural lens for understanding nursing practice. These stories are based on my fieldnotes taken while I observed each nurse's interactions individual SA clients. All HHNs and clients involved consented to participate in my study. To protect the anonymity of the HHNs and clients, I have used fictitious names. At this stage, I will not be integrating any analysis or discussion about these stories. More details will emerge in the later Chapters that deal with my interviews with the nurses and nurse leaders, thus providing a more holistic understanding. At this time, however, the following four stories are "texts" which provide an understanding of how the nurses go about doing their everyday work, a micro snapshot of what is important to them and the organizational culture of Home Health. In addition, the "stories impart beliefs, values, customs, norms, rituals and skills" which my study hopes to uncover (Wolf, 2008, p. 325).

Each story follows the same order: a description of the client, their medical history, the physical setting of the home, the social and verbal exchanges between the HHN and the patient and the conclusion of the visit. I end each story with self- reflective questions about my observations.

Story 1: Mrs. Mohan's Wound Care

Mrs. Mohan is a SA woman in her mid to late fifties. She has just been diagnosed with a tumor on her right lower back. After surgical removal of the tumor, a drain or tube was inserted to remove discharge from the surgical site. She also has a wound at the site of the surgery. The HHNs visit her at home to do the dressing and check the amount of discharge in the tube to determine when it can be removed. When the discharge from the tube is about thirty millimeters, the HHNs will remove the tube.

As per the appointment time made by Nurse Sunita, on July 10, 2013 09:30 am, we met in front of the Mrs. Mohan's house. We made our way into the front yard, where Mrs. Mohan's husband was watering the garden plants, and who also waved us inside the home. From the open front door we climbed up the staircase to top where Mrs. Mohan stood, anticipating our arrival. Upon our entry into the living room, Mrs. Mohan greeted both Nurse Sunita and I. As Nurse Sunita started to unpack her brown paper bag for wound supplies, Mrs. Mohan asked her, "what about shoe covers?" Nurse Sunita responded that she did not have any shoe covers that day but that she could pack some for next time. Soon after this exchange between Nurse Sunita and Mrs. Mohan, Sunita wanted to know information about the situation of her tube. Mrs. Mohan did not respond verbally, however, she walked over to the dining table and shared the daily data from her log book. She added that her husband was very "picky" about keeping track of the drainage. After checking the logbook, Nurse Sunita asked Mrs. Mohan about her visit to the doctor.

Nurse Sunita specifically asked the name of the doctor. Mrs. Mohan could not remember the name of the doctor so she got the medication that the doctor ordered. Nurse Sunita identified the doctor's name on the medication bottle that was ordered by the doctor and Nurse Sunita recorded the information on the paper chart.

In preparation for dressing the wound, Nurse Sunita opened a white dressing tray from its plastic wrap and laid all the wound products on it. The following items were set aside on the coffee table: pink bottles of normal saline, silver metal scissors, and different sizes of packaged gauze. She tore off strands of white tape and applied it to the table. For the dressing change, Nurse Sunita knelt on the floor behind Mrs. Mohan and extended her arm to reach her lower back where the drain was located. When Nurse Sunita cleansed Mrs. Mohan's skin and wound thoroughly for a full minute, Mrs. Mohan remarked that in the previous two home visits the dressing came undone. Nurse Sunita told Mrs. Mohan that she would use a different cover dressing for the wound. Throughout the wound dressing, Nurse Sunita walked Mrs. Mohan through the process. According to Mrs. Mohan, nurses who had visited her usually took only 7-8 minutes to change her dressing. Nurse Sunita did not respond and continued on with the dressing change. She applied the gauze to the part of the skin where the drain was inserted. Then she applied the cover dressing and reinforced the edges of the cover dressing with tape.

Again, after few moments of brief silence, the client shared that she used to walk with her husband every day. She mentioned how they liked walking early in the morning and enjoyed the beauty of nature. Nurse Sunita did not respond to Mrs. Mohan's comments. Nurse Sunita finished dressing the wound, counted the number of supplies in the home, organized the supplies for the next visit, and reduced the number of brown bags which contained supplies that had accumulated over a number of home visits in the home. She assured Mrs. Mohan that there were

extra dressings to use in the event that the dressing falls off. She told Mrs. Mohan that as per the schedule, the next home visit was due in three days. Mrs. Mohan, with a smile on her face, thanked Nurse Sunita who then exited the living room down the staircase.

As I mentioned in the introduction to this Chapter, I will pose some self-reflective questions that emerged as a result of my observations of Nurse Sunita and Mrs. Mohan. Vis-à-vis Mrs. Mohan, the following questions came to mind and relate to my research question at the focus of this project:

1. What is the significance of the client saying that her husband is very "picky" about tracking the drainage? What does this suggest about the impact of the previous and current HHNsg care of the drain?
2. Based on the client's concerns (duration of home visits, the dressing coming off, and the loss of physical activity) what do these concerns suggest about the client as an individual experiencing illness in the context of home health?
3. Why did the client self-disclose her difficulties about her level of physical activity? What was the client trying to achieve when she voiced her wish to be physically active?
4. Why did Nurse Sunita ask about Mrs. Mohan's visit to the doctor? What was important about that doctor's visit and thus suggests what is important to the organizational culture in HHNsg practice?
5. How did Nurse Sunita plan to address Mrs. Mohan's concerns? Were there any follow up questions Nurse Sunita could have asked Mrs. Mohan?
6. Were there any cultural aspects that might have impacted the communication between Nurse Sunita and Mrs. Mohan?

I will pose these questions in the following interview Chapter to Nurse Sunita whose answers will increase my understanding the issues involved in HHNsg nursing practice.

Story 2: Mr. Sohan's Chronic Diabetes and Wound Care

Mr. Sohan is an older South Asian gentleman who is 75 years old and appeared to have neurological hand tremors or shaky hands. I noted that he has two superficial open wounds on either side of his right shin and above his ankle. During the home visit, the client mentioned that a vascular specialist had been treating him for the reoccurring lower leg wounds.

On June 10, 2013, at about 0930 am, LPN Jane and I met in front of Mr. Sohan's house. We had access by means of an unlocked door that nurse Jane was aware of and we made our way up the winding staircase and upon entering the living room saw Mr. Sohan seated on a living room couch facing a window that overlooks the street. By his side, I noticed there were wet bandages left on the floor. The surrounding living room was very clean. A clean meal table, a coffee table and an empty chair were beside him obviously intended for Nurse Jane. As she entered the living room, she laid the brown paper bag filled with wound care supplies on the coffee table.

LPN Jane asked Mr. Sohan how he was doing. In a soft voice, he replied saying that he was fine. Expressing her need to wash her hands, she made her way to the washroom while carrying a plastic bag with brown paper towels and a small bottle of soap. When she returned to the living room, she inquired about his pain and his blood sugars. Upon revealing that he took Tylenol every day, he then added that, that day his blood sugars were "nothing over six."

LPN Jane opened her white dressing styrofoam sterile dressing tray, soaked the cotton gauzes in the tray with normal saline. She knelt down so that she could reach his lower legs and cleansed the wounds. Then she informed Mr. Sohan that she would take pictures of both his leg

wounds. He seemed comfortable with this. Before taking the photograph, LPN Jane measured the wound with a paper ruler. Subsequently, she made a note of the measurements and compared it to the previous measurements and communicated this to Mr. Sohan. Following this, she covered the wound, lifted his leg on a stool and wrapped his leg with cotton kling. Subsequently, Mr. Sohan put on a white stocking net to hold the cotton bandage or kling in place. Then together LPN Jane and Mr. Sohan applied a black Velcro compression wrap starting from the ankle up to the calf.

Mr. Sohan helped LPN Jane to clean up as he put the old dressing into the white plastic garbage bag. Then LPN Jane counted the number of wound care supplies in the home. Consequently, she organized the supplies in brown paper bags and noted which supplies to bring for the next visit.

After the session of wound care with Mr. Sohan, LPN Jane made an inquiry and a few comments about his current condition. She inquired about his recent neurologist appointment. In response to this, the client went to the kitchen to retrieve his blister pack which contained his medication. LPN Jane studied this medication blister pack, organized according to the days of the week. She made some notes in her paper chart. After checking his medication, LPN Jane told Mr. Sohan that his hands did not shake as they used to. She thanked Mr. Sohan and exited via the staircase. The next visit was in three days and this was already known to Mr. Sohan as this had been his usual routine.

The questions in my mind after I left Mr. Sohan's appointment concerned nurse LPN Jane's close-ended questions regarding his pain and his blood sugar levels.

1. Why was LPN Jane more task-focused and less communication focused?
2. What was the purpose of asking about his appointment with the neurologist?

3. At the time of the visit, Mr. Sohan appeared to be alone in a big well-kept house. Who were the other members of the household and how do they play a role in Mr. Sohan's care? I will explore answer these questions in my interview with LPN Jane to further understand what happened at Mr. Sohan's visit.

Story 3: Anita's Chronic Heart Condition

Anita is a lady in her early eighties. She lives on the ground floor of her son's house. She appeared to need periodic monitoring for a chronic heart condition. Anita is frail and uses a cane to walk.

On August 10, 2013 at about 11:00 am, Nurse Jackie and I visited the client on the ground floor suite of the house in the presence of the client's son. The ground floor suite consisted of a small living room, a full bathroom, bedroom and kitchen. The son acted as the translator since his mother did not speak English.

Upon entering the client's home, the client was seated in her living room chair by the fireplace. The son took his seat on the opposite couch. By the smiles on their faces, the client and her son appeared to be very happy to see Nurse Jackie. Nurse Jackie checked Anita's blood pressure and made note of it in the paper chart. She listened to her chest using her stethoscope. She asked the son one of several questions: Any problems with home support workers? The son replied "Everything seems to be okay now." Nurse Jackie checked Anita's pulses, and her overall color. Then together, the son and Nurse Jackie accompanied Anita to get her weighed on the digital weighing scale in the bathroom. This took Anita, who seemed frail, a few minutes to walk. As Anita stepped onto the digital weighing scale, while hanging on to a bathroom railing, Nurse Jackie exclaimed, that Anita's weight was "one or two pounds more" and attributed it to her clothes. Nurse Jackie asked the son "Is there anything else?" He handed over the medication

blister pack. She checked the medications against the list of medications that were previously prescribed. Nurse Jackie observed that everything looked okay. Finally she inquired when she could see Anita again. The son requested a home visit in a month and said “hopefully it’s you Jackie.”

My observations of Nurse Jackie’s home visit with Anita raised the following questions:

1. What strategies does Nurse Jackie use to communicate the day to day care planning with the client and the family?
2. What do the son’s actions say about him and how he is responding to Nurse Jackie? What is his role in the client’s care?
3. Is a small amount of talk advisable to facilitate a smoother interaction between Nurse Jackie and Anita? What organizational values and beliefs guide Nurse Jackie’s actions during the home visit?
4. At the end of the visit, the son specifically asked Nurse Jackie to visit. How did the son’s communication reflect on the need for having a consistent nurse who could care for his mother? Does his request speak to the personal relationship that Nurse Jackie fostered with Anita? What does his request imply about Nurse Jackie’s skills, professionalism and shared understanding about what Anita needs for her care? Was it Nurse Jackie’s efficiency or professionalism that impressed the son? How does Nurse Jackie’s approach reflect the organizational culture in home health? Would it be worthwhile to go back to the client and raise these questions about the nurse’s approach, who was sometimes more communication focused and other times being more task focused. Which approach does the client prefer?

Story 4: Mr. Raj's Foot Care & Diabetes

My fourth client visit was with Mr. Raj, a male in his early eighties with chronic diabetes who lives alone at home. He has chronic diabetes. The appointed time for Mr. Raj's visit was about 09:00 hours. We entered through the back door by climbing up a flight of stairs which took us into the kitchen. Mr. Raj was expecting us as he was seated in his usual dining room chair. He waived us in with a warm welcome. Upon entering, I noticed that for the dressing change, he set aside two chairs, one for Nurse Cathy and the other for himself. She placed her brown bag of supplies on the chair. He had his barrier cream, blood pressure cuff, blood sugar machine, and medication blister pack on the kitchen dining room table which overlooked a bright window. There was a lady in the background prepping his lunch in the kitchen. Facing the window I was seated across from Mr. Raj and Nurse Cathy, with my notebook in hand.

Nurse Cathy initiated conversation by asking if there "was anything new?" He responded by saying "nothing is new." She asked, if he had been outside. He answered, "Just out for a coffee with some friends." Nurse Cathy also inquired about his orthotics. Since getting the orthotics have you noticed a difference in your movement? Do you have any pain? Mr. Raj exclaimed that he was doing fine. Then he placed his leg on a foot stool which Nurse Cathy covered with a blue pad. As she prepared the dressing tray, she inquired about his blood sugar when he listed the following numbers: 7.2, 7.4, 4.2, 4.6 and 8.4. Nurse Cathy commented, "Sounds okay." Mr. Raj then removed his old dressing, unwrapped the cotton kling around his leg and then he removed the cover dressing. Nurse Cathy used a face cloth dipped in warm water to wash Mr. Raj's legs. As she washed his leg taking off dead skin and the residue of the old dressing, she asked if he had any doctor's appointments. He replied that he had to visit his family doctor who is located not too far from home. She continued the dressing change. Using the

forceps to hold the gauze, she cleansed the wound bed of the client's leg. She maintained clean technique by making sure nothing on the table touched her white square dressing sheet. On the dressing sheet was the dressing tray, the normal saline, gauze, and sterile scissors. Not too far from the tray, she placed the kling, tape, and barrier cream. It was easy for her to access these supplies on a clean dining room table.

During the dressing change, Mr. Raj mentioned that he preferred it when the home support workers assisted him with bathing prior to his daily visit to the temple. He mentioned that the previous day he attended a funeral at the temple after the home support workers had assisted him with his bath. Nurse Cathy listened intently to his concerns of personal hygiene and daily activities, but she made no comments. To finish off the dressing change, Mr. Raj told Nurse Cathy how to wrap the kling several times around his ankle. He indicated where the tape should be applied to the kling to hold the whole dressing in place.

After a visit that seemed to be uneventful and go by very quickly, I reflected on the visit and felt a need for some answers.

1. Had Mr. Raj been heard in the matter of the home support scheduling?
2. How does daily care planning take place with clients like Mr. Raj?

I hope to find out the answers to these questions in the follow up interview with Nurse Cathy.

Chapter 5

Interviews with Four Home Health Nurses

When I met with the nurses after the home visits, I posed my self-reflective questions and audio-taped our conversations. Later, I made a transcript of these conversations upon which I base my present summary.

At the beginning of each of the following summaries, I will re-present my self- reflective questions about each visit in order to facilitate recall for the reader. I will then provide a brief description of each nurse`s professional background, describe the nurse`s initial contact with the patient and summarize her views in response to my questions. At the end of each summary, I will make a note of some key questions or reflections and will integrate these in my concluding analysis.

5.1 Interview with Nurse Sunita

The following are questions that I had raised after my visit with the client, Mrs. Mohan.

1. What is the significance of the client saying that her husband is very "picky" about tracking the drainage? What does this suggest about the impact of the previous and current HHNsg care of the drain?
2. Based on the client's concerns (duration of home visits, the dressing coming off, and the loss of physical activity) what do these concerns suggest about the client as an individual experiencing illness in the context of home health?
3. Why did the client self-disclose her difficulties about her level of physical activity? What was the client trying to achieve when she voiced her wish to be physically active?

4. Why did Nurse Sunita ask about Mrs. Mohan's visit to the doctor? What was important about that doctor's visit and thus suggest about what is important to the culture of HHNsg practice?

Nurse Sunita has been working as a full time home health nurse for four years. During my interview, she provided an overview of how the health unit functions. According to her, there are four nursing teams that provide care in different geographic areas around the health unit. Every month each team meets to discuss among themselves, sometimes with the family, "exceptional" clients who have specific needs. The team consists not only of nurses but also other health care disciplinary professionals such as a physiotherapists, occupational therapists, dieticians and social workers. In other meetings the professionals discuss the details of the client's care and formulate a care plan. At the end of each meeting, the primary nurse documents the care plan in the electronic documentation system. Despite these meetings, Nurse Sunita is of the opinion that she has not had an occasion to refer clients with extraordinary needs. When asked about how helpful these team meetings are, Nurse Sunita conveyed that she has not had an issue with a client who needed the problem solving skills of a team and a team care plan.

Nurse Sunita's initial contact with Mrs. Mohan happened following her surgery for a sarcoma or tumor. Mrs. Mohan developed a wound at the site of the surgery and required wound and drain care. Housebound and unable to ambulate well, Mrs. Mohan required home health nursing services.

With regard to my first question i.e. what is the significance of the client saying that her husband is very "picky" about tracking the drainage? What does this suggest about the impact of the previous and current HHNsg care of the drain? Nurse Sunita confirmed that Mrs. Mohan and her husband were very particular about recording the daily drainage partly because it ``could

have been the way we taught her `` and partly because Mrs. Mohan was an ``anxious person. `` Mrs. Mohan`s anxiety was not totally unjustified since she had more than one incident when her intravenous (IV) line infusing antibiotics had got blocked. As a result, Mrs. Mohan had to go to the emergency (ER) the experience of waiting in the ER frustrated her. Nurse Sunita`s role involved troubleshooting issues such as infection and the formation of blood clots in the IV by contacting a specialized IV hospital team to meet Mrs. Mohan in ER which to some extent allayed her anxiety. She was grateful to Nurse Sunita and wondered why she had not received the care in the previous two instances. This spurred Mrs. Mohan and her husband to be more responsible for monitoring and tracking Mrs. Mohan`s health. Having previously monitored her IV infusion to prevent complications, Mrs. Mohan was now following equal caution and monitoring the amount of drainage.

With regard to the second question about physical activity, Sunita was aware that Mrs. Mohan wanted to go back to work and be more active. She claimed that the client was also disappointed that the removal of her drain was delayed because the drainage had not subsided.

To the question about the doctor's visit, Sunita wanted to know the doctor's name and if he had recently prescribed any new medications which would need to be documented into the electronic chart. She also claimed that if she does not ask about appointments, clients forget to share this information with her.

Regarding other strategies or resources that would have facilitated Nurse Sunita's work, she wished that the two documentation systems (Pixalere and Paris) were better interlinked so that she could track the client`s progress on a daily basis. As it stands now, retrieving client information is not very efficient. Accessing information from two systems is more time

consuming. With regard to Mrs. Mohan`s case for example, Nurse Sunita preferred to view the amount of drainage in an accessible and easy to view place in the electronic chart.

In addition, Sunita listed several electronic documents that she uses to do wound care. For instance, the Pixalere care plan lists the client's wound care products, the steps on how to do the wound care, the frequency of visits for the wound care, recent pictures of the wound, and periodic recommendations from the wound care nurse or specialist. The current PARIS care plan had some outdated information on it indicating that the nurses had to do IV care even though it had been previously discontinued. Besides the Pixalere electronic care plan, Sunita refers to the paper chart which contains a monthly calendar that indicates the client's visits for the month and if daily supplies are packed. The monthly calendar is a helpful tool as Sunita is able to track the client's medical appointments and follow up regarding recent prescriptions.

Towards the end of the interview, Sunita emphasized the importance of collaborating with other health care team members to deliver fair and quality care to the client. She gave examples of how she and other interdisciplinary members meet monthly to discuss client care and how she communicates with her nurse colleagues to provide good care.

Having provided a summary of Sunita's viewpoint, I would like to list personal self-reflective questions about Sunita's approach during the home visit.

1. Sunita obviously focused on a series of tasks to deliver care to Mrs. Mohan: drain care, wound care and recording drainage, the doctor's name and medication. After the home visit, she reviews, updates and maintains the electronic and paper chart. Considering her tasks, what does this suggest about the organizational culture in home health? What is the organization's mission, strategies and leadership talk say about what is expected of the home health nurses?

2. In my view, Sunita's focus on tasks indicates what's important to the culture in home health nursing practice. Besides the focus on tasks, are there other approaches or strategies that could have been integrated to facilitate "fair and quality care" to the Mrs. Mohan?
3. Did Sunita's interpretation of "fair and quality care" match my interpretation of what I observed?
4. Why are other approaches to care not being implemented with clients like Mrs. Mohan?
5. What are the barriers and strengths of implementing other approaches with Mrs. Mohan's care? How would these impact the nurse and the client?

I will consider these questions noted above in my final analysis Chapter of the four stories and interviews.

5.2 Interview with Licensed Practical Nurse (LPN) Jane

I raised the following questions after visiting Mr. Sohan.

1. Why was LPN Jane more task-focused and less communication focused?
2. What was the purpose of asking about his appointment with the neurologist?
3. At the time of the visit, Mr. Sohan appeared to be alone in a big well-kept house. Who were the other members of the household and how do they play a role in Mr. Sohan's care?

In the two and half years that LPN Jane has worked full time her practice has primarily focused on wound care. Her initial orientation to Home Health care included education about the electronic documentation systems (Pixalere and PARIS). Currently, she updates her knowledge at monthly meetings with the Wound Care Nurse (WCN) and RN colleagues. Periodically, she

relies on the clinical nurse educator, family social worker and clinical coordinator (charge nurse) to make decisions about her clients. In addition, in order to provide wound care, she uses a specialized electronic database library that helps her choose the right product and language to chart the progress of the wound. In addition, she finds the educational pamphlets about hypo and hyperglycemia useful to teach clients about their diabetes. To initiate contact with a variety of clients from diverse ethnic and religious backgrounds, she has learned language-specific phrases from her colleagues who speak other languages. In regard to daily client care, she prioritizes her first visit of the day based on whether or not a client has a medical appointment, is bedbound, needs to get out of bed at a certain time, or has home support workers who assist with personal hygiene or other activities.

LPN Jane came to be involved with Mr. Sohan's case because of his reoccurring leg wounds over three years. Throughout her involvement with Mr. Sohan's care, she has sought the expertise of various interdisciplinary team members such as occupational therapists and physiotherapists, outpatient clinic teams, various specialists and the family physician. Since Mr. Sohan had chronic wounds and diabetes, she referred and consulted with a dietician and the WCN. Since the WCN's had advised that he could remove his own bandages after taking a shower, LPN Jane and her colleagues visit him twice a week on those days.

I understood from LPN Jane's following explanation why she was more task-focused and asked close-ended questions during the home visit. Guidance from wound care policies and experts inform LPN Jane's daily practice. LPN Jane focused her efforts on the usual wound care protocol which included the following: referring to a WCN and or a dietician, charting the progress of the wound, recommending the client to check his blood sugars daily and to make healthy food choices. The family doctor disagreed with the latter aspect of the nursing care plan

as the client's blood sugar levels were stable and his diet was already healthy. Moreover, LPN Jane advised adequate pain control for wound care however Mr. Sohan resisted and was not agreeable to this recommendation. Therefore, LPN Jane was more task-focused because of the previously noted disagreements between family doctor, client and the nursing team.

In regard to question 2, I was given to understand that Mr. Sohan's neurologist was periodically changing his medications for long standing hand tremors which were gradually improving.

With reference to question 3, LPN Jane explained to me that she calls on the client's son-in-law who lives in the home. This was useful to her since the client seemed resistive to her recommendations. LPN Jane elaborated that generally when clients are non-compliant, she and her colleagues set up a plan, continue to monitor the client's condition, educate the client and family, and keep the family physician informed.

In addition to communicating with the client's family members, LPN Jane uses two other resources the medication sheet and the electronic documentation system to aid her daily care of the client. She specifically stated that the medication sheet gives her a "picture" of the client. She uses the medication sheet to track the client's health and collaborate with the family physician for ongoing medication orders. For daily charting and reviewing the client's progress, she finds the two commonly used electronic documentation systems to be redundant (In my study, this was the second nurse whom I received the same feedback about the electronic documentation system). She also relied on the nutritionist to support this client. She likes the fact that she has access to client educational pamphlets regarding the daily management of diabetes.

One other pertinent detail emerged from my conversation with LPN Jane. Being conscious of wastage and the impact this has on the budget, LPN Jane and her colleagues limit the amount of supplies they take to the client's home.

After LPN Jane's interview, I noted a few questions for my following analysis:

1. I observed a gap in LPN Jane's task-focused approach especially at the time that the family doctor and the client disagreed with her suggestions which were based on Home Health protocols. How did these disagreements come about and also what does this suggest about the organizational culture in home health nursing practice?
2. What can be changed about the current approaches with clients in home health?
3. What are the barriers and strengths of new approaches versus the current approach?

5.3 Interview with Nurse Jackie

1 What strategies does Nurse Jackie use to communicate the day to day care planning with the client and the family?

2 What do the son's actions say about him and how he is responding to Nurse Jackie? What is his role in the client's care?

3 Is certain amount of small talk advisable to facilitate a smoother interaction between Nurse Jackie and Anita? What organizational values and beliefs guide Nurse Jackie's actions during the home visit?

4 At the end of the visit, the son specifically asked Nurse Jackie to visit. How did the son's communication reflect on the need for having a consistent nurse who could care for his mother? Does his request speak to the personal relationship that Nurse Jackie fostered with Anita? What does his request imply about Nurse Jackie's skills, professionalism and shared understanding about what Anita needs for her care? Was it Nurse Jackie's

efficiency or professionalism that impressed the son? How does Nurse Jackie's approach reflect the organizational culture in home health? Would it be worthwhile to go back to the client and raise these questions about the nurse's approach, who was sometimes more communication focused and other times being more task focused. Which approach does the client prefer?

Nurse Jackie is a full time registered nurse having worked in home health for at least three years. She is a passionate advocate for holistic care, client safety, trust and respect. Holistic care includes incorporating every aspect of the client, their health care team, their environment and their spirituality. With reference to the client, Nurse Jackie commented that the client spoke only Cantonese and Punjabi. On a daily basis, Nurse Jackie and her case manager colleague have directed the home support workers to assist Anita with her medication, meals and bathing.

Prior to her involvement, Nurse Jackie related the tumultuous history between the home health team and Anita. Historically, the home health team was concerned because Anita had been refusing her medications. At that time she had pneumonia and probably related delirium. She refused medical and personal care from the nurses and the home support workers. She was admitted to hospital as her medical condition deteriorated. Nurse Jackie listed the possible reasons as to why Anita was refusing her medications. Anita had some mild dementia and thus lacked an understanding of her treatment. In addition, she lacked an understanding of the nurse's role in conjunction with her son and the family doctor. She had a poor relationship with her son. These were possible factors that influenced her to be uncooperative. Nurse Jackie wondered if Anita was getting conflicting information from the nurse and the family doctor. "Cultural" aspects may have played a role in her "non compliance." These factors may have led to her

refusal of her medication and the subsequent hospitalization. Upon her discharge home, Nurse Jackie became involved in her care.

The strategies that Nurse Jackie uses to communicate the care plan to the client and the family is simply to tell the client what will happen from visit to visit. Her use of simple language like "goals of care" facilitates better communication between herself and the client. Instead the organization promotes the term "care plan," which can be confusing for clients. Nurse Jackie facilitates daily care planning by addressing concerns that are visible and documenting these needs in the electronic chart so that all the team members are informed about the client's needs.

About the primary caregiver's role, Nurse Jackie observed that he frequently communicates with home care nursing staff, assists his mother to navigate the health care system like visiting the GP, and attends to her needs when home support is not available. He also communicates information between the heart function clinic and family doctor and the home care nursing staff. Nurse Jackie claimed that the son appreciates the nursing and home support care that his mom gets in her home.

With regard to communication, Nurse Jackie had developed a good rapport with the family. For example, right from the start, Nurse Jackie claimed that she talked to them repeatedly about the client's needs which included checking her weight and medication. As a result, the son has been "conditioned" to respond to the nurses' requests for assessment information. Sometimes, he even communicates information spontaneously from the doctor to the nurse. As a result of this collaboration, Nurse Jackie finds it easy to update the electronic chart and track the client's overall condition.

The organization has an electronic charting system and few other important documents that guide Nurse Jackie's interaction with the client. For instance, the most recent case notes

convey daily nursing interventions with the client. Nurse Jackie uses a paper flow sheet to collect information about the client's heart condition: breathing, circulation, blood pressure, sleeping, diet and weight. Based on the client's presentation, she tailors her assessment questions and interventions with the client. She also adjusts her interaction with the client based on orders from the doctor or the heart function clinic. Since the client receives home support, Nurse Jackie checks her voicemail for updates in order to advise the home support about the client's needs.

According to Nurse Jackie, the son specifically asked Nurse Jackie to come back because there had been so much previous conflict between the client and the health care team. Anita and her son took an instant liking to Nurse Jackie for reasons that she could not comprehend. Since Nurse Jackie became involved, Anita has cooperated with Nurse Jackie and the home support. Nurse Jackie persevered in getting Anita to understand what needed to be done each visit: checking weights, blood pressure, circulation and medication. In general Nurse Jackie discussed the specifics of Anita's treatment to the son and vice-versa. Her approach of checking the client's weight, measuring the blood pressure, and checking the client's compliance with medication reflects that this information is important to the organization and daily documentation.

I will reflect on these following questions in my subsequent analysis.

1 Based on Nurse Jackie's approach, is the culture in Home Health to collaborate with the client for the purpose of learning about their health or to merely get information to maintain the electronic chart and keep medication regimes and chronic disease management in order.

2 In this instance, Nurse Jackie continually used a didactic approach. Given the context of Home Health, is it possible to enter into a dialogue with the client to co-create health

goals? What are the barriers? What would be the strengths of using an approach that is conversational? How could this be applied in the instance of Anita's care?

3 What other approaches could Nurse Jackie have employed during the visit other than focusing on retrieving information about weight, blood pressure, and medications?

5.4 Interview with Nurse Cathy

1. Had Mr. Raj been heard in the matter of the home support scheduling?
2. How does daily care planning take place with clients like Mr. Raj?

Nurse Cathy had previously worked seven years in surgical oncology and has currently taken up a one year temporary position in home health nursing. Nurse Cathy came to be involved after Mr. Raj had two toe amputations related to his long standing history of diabetes. Nurse Cathy and her colleagues had been previously provided Mr. Raj intravenous (IV) antibiotic therapy at home to treat an infection. Nurse Cathy currently visits Mr. Raj in the early morning so that he can go out to visit friends or the temple.

Mr. Raj had particular concerns about his home support service. Previous to our visit with him, he expressed that he wanted bathing assistance from the home support workers three times instead of two times a week. Nurse Cathy was aware the surgeon had advised him to keep his foot dry and that Mr. Raj was frustrated with his diabetes which caused him to perspire. He was doing sponge baths in between the biweekly home support worker visits. Therefore, Mr. Raj thought that he could have a better shower with the aid of the home support workers and during the shower he could stick his leg out of the bathtub in order to keep his foot dry. Nurse Cathy was unsure how to address his request for additional home support service for bathing. To increase his hours, Nurse Cathy would have to talk and also make an electronic referral to the case management worker. However, as it turned out, Mr. Raj was not referred to case

management for additional hours for bathing support. Nurse Cathy stated that "we" got it sorted and just offered him home support services for bathing twice a week. She said he was stressed about that for about two or three weeks and then it was no longer an issue.

Nurse Cathy made a few general comments about the electronic documentation system and how it influenced Mr. Raj's care and the care of other clients. Since she had frequently been caring for Mr. Raj, on that day of our visit, she did not require a lot of time to review his electronic chart. Her general routine is to check the electronic wound care plan and updates from the wound care nurse (WCN). However on one occasion, she had to consult with the expert WCN because her colleagues had not charted the wound care plan in a clear manner. Nurse Cathy usually prints a copy of the care plan and takes it for her reference to the client's home. On this paper copy, she makes herself a few notes to check blood sugars, falls, pain, and mobility to guide her overall assessment of Mr. Raj.

During the interview, Nurse Cathy reflected on her approach to Mr. Raj's care. During his dressing change, Nurse Cathy conducts a "basic assessment" which may include asking Mr. Raj about his blood sugars, pain, and orthotics and how these affected his mobility. Throughout her involvement with Mr. Raj's care, unlike her colleagues, she has not done any "teaching" about his diabetes. Although that is standard procedure, she mentioned earlier that Mr. Raj is very independent with checking his blood sugar, adjusting his insulin medication based on his blood sugar readings, and maintaining continuous contact with his family doctor.

Nurse Cathy's overall view point is that that it is important to maintain effective communication with team members and the client in order to foster collaboration and safe care for the client. She gave an instance where she persevered in following up with Mr. Raj's

surgeon. Since Mr. Raj's wound was not healing, Nurse Cathy made several attempts to fax his surgeon to secure an appointment and was finally successful.

Nurse Cathy gave some general information about care planning. She emphasized that the care plan needs to be "client specific." I explored this concept with her in detail. The home health team individualizes the client's care plan by asking the client about their goals for their health. In acute care, the care plan is in the form of a Kardex, a card that lists the medical characteristics of the patient instead of the patient's goals. Nurse Cathy, however, finds the Home Health care plan more informative and helpful. She has had experiences where care plans have not been regularly updated and are thus insufficient. As a result she has had to review several nursing case notes to get a general understanding of the client's needs. When she initially started in home health, her main focus was to learn how to do care planning since this was a new process for her. By reviewing the work of her other colleagues and using template care plans provided by her leadership team, she learned how to make a care plan.

In Mr. Raj's case, his general care plan contained two particular health concerns namely wound and "metabolic" management. For the former, the care plan directs the nurse to review the Pixalere care plan and to liaise with the WCN. For the latter, it was noted that the nurses should assess the client's understanding of his diabetic condition, the signs and symptoms of hypoglycemia and hyperglycemia and the frequency of blood sugar monitoring. Nurse Cathy admitted that Mr. Raj's current knowledge base and preferences were not mentioned in his care plan and added that due to workload reasons; sometimes clients care plans are incomplete.

Nurse Cathy related a few other tasks that impact the care of clients in general. She stressed how important it is to indicate the next home visit in the paper chart's monthly calendar and to pack supplies for the next visit.

After my interview with Nurse Cathy, I raised the following questions:

1. Mr. Raj's care plan seemed general even though Nurse Cathy specified that care planning is "client specific" and "individualized" What does this suggest about the organizational culture in home health (the observed difference between my observation and Nurse Cathy's claim about care planning).
2. What was the gap regarding Nurse Cathy's approach to Mr. Raj's home support needs? Why does this gap exist? What can be done about it? What does this suggest about the organizational culture in home health nursing practice?
3. Are there any commonalities between Nurse Cathy's view point and the view point of her colleagues that participated in my study?

Chapter 6

Interviews with Three Nurse Leaders

In this Chapter, I introduce the perspectives of three Registered Nurse Home Health leaders: 1) a nurse manager, 2) nurse educator and 3) nurse clinical coordinator (team leader). I introduce each leader followed by their varying perspectives about the organizational culture in HHNsg practice. Their viewpoints are unique and specific to the professional roles they fulfill at the home health unit. The three leaders provide a holistic perspective (financial, educational, structural, technological and relational) of organizing daily nursing practice. Their perspectives build off each other and provide the organizational context in HHNsg practice. I hope that the interviews with the leaders will provide more meaning to the previous data I presented in Chapters 4 and 5 (observed home visits and HHNs' interviews).

Profile of the manager

The manager is an advanced practice nurse with seven years of managerial experience in Home Health. Her home health unit is situated in the city where the population is dense and culturally diverse. She manages interdisciplinary practice teams and administrative personnel. As well, she belongs to a leadership team that is comprised of a nurse educator, clinical coordinator, wound clinician, and a social worker. She openly discussed and provided a critical reflection of the day to day practice of Home Health nurses as it applied to my research question.

Profile of the nurse educator

In contrast, the nurse educator has seven years of nurse educator experience. Under her profile, she is responsible for orientating and integrating professional and non-professional staff to the area of Home Health practice. She educates and informs staff about organizational guidelines, policies and best practices. In addition, she supports the nurses with interpersonal

challenges with client and other team members. As a committee member of several organizational projects, she is knowledgeable about current organizational goals and context impacting daily HHNsg practice. She referred to LEAN philosophy and its application to everyday nursing practice. In daily practice HHNs apply LEAN philosophy to be more efficient in daily practice and to eliminate redundancy and wastage. Furthermore, the educator promotes an awareness of cultural diversity of patients, culture-specific educational pamphlets, resources, interpreters, and in regard to challenging and complex situations, she engages team discussions about culture-specific care.

Profile of the clinical coordinator

The clinical coordinator, a senior nurse, has worked for a long time at the home health unit. She coordinates client referrals from hospital to the Home Health unit thereby linking clients to a variety of Home Health services: physiotherapy, occupational therapy, social and nursing services. She values HHNsg services because these services promote the comfort of clients, maintain and support them in their homes. HHNsg services play an important part in the system and in supporting clients' health at home. As part of her coordination role, she ensures that home health nurses regularly update their skills and knowledge so that they are able to provide daily client care. For example, she keeps a list of nurses' names along with their most recent skills, so that she can safely assign nurses to clients. In addition, she strongly encourages the nurses to seek the expertise of interdisciplinary team members and clinical resource experts who have knowledge about intravenous, wound, and palliative care. She expects that the nurses are up-to-date with clinical guidelines and standards. One of the strategies she employs is to be supportive of nurses who want to update their skill set. She encourages the HHNs to speak up

about the skills they lack and to seek out the resources to maintain these skills. In this way, she supports skill development and maintenance.

At an organizational level, she participates on various committees responsible for meeting the organization's mission and objectives. Based on her committee experiences, she claims that the organization or health authority lacks an understanding of and support for Home Health services. She quoted that the system is "hospital driven and focused." The organization's goals at large are "acute driven." Even with the advent of the "Home is best" philosophy, acute care lacks an understanding about Home Health's ability to respond to client care. For instance, the hospital is primarily focused on getting people well enough to be discharged but without proper supports in clients' home, clients routinely have repeat hospitalizations. Given her role at the home health unit and the organizational level, she is a strong advocate for increasing home health resources in terms of more staff, more resources, and supporting staff with a diverse skill set.

In the following section, I present the nurse leader views and expectations of HHNsg practice. Their verbal accounts are based on my interview topics and questions. In response to my first question, the manager, educator and clinical coordinator offered similar and varied perspectives about the role of HHNs.

According to the manager, she believes that "we" are providing a good service. The clients need "us." Getting clients out of hospital and into their homes is a safer and happier place. Compared to other disciplines, HHNs primarily focus on clients' physical needs as this information is provided on referral documentation that comes from the hospital. Physical needs usually pertain to wound, intravenous, catheter care, chronic disease or palliative care. Moreover, HHNs also provide chronic disease support whereby they support clients and their families, their

coping skills and changing lifestyles. The context of our practice is family oriented. We have very cultural families and lot of inter-generational family situations which are quite unique compared to the other health centers. In addition, HHNs are "guests" in clients' homes and are thus respectful of clients' and their families' wishes as applicable to their health care. Moreover, considering clients are culturally diverse and live in inter-generational homes, HHNs are expected to meet cultural and familial needs of clients and their families.

To add to the manager's excerpt above, the nurse educator and the clinical coordinator also shared the benefits of HHNsg services. The educator claims that clients are happier to be at home compared to acute care because HHNs provide more holistic care, develop better relationships and do more teaching with clients and their families. In contrast, the clinical coordinator believes that HHNs play an important role in maintaining clients in their homes and supporting their life and illness trajectory. She adds that there is a need for HHNs who have stronger skills and more resources to support clients in their homes, a comfortable place for clients to obtain HHNsg care.

Daily tasks in Home Health Nursing Practice

Manager. The following is the manager's brief explanation of a regular nurse's working day. They review electronic documentation and consequently "figure" out their day. This includes getting their "stuff," calling clients, attending palliative rounds and home health meetings.

Nurse Educator. Compared to the manager, the nurse educator provided a more detailed explanation of the daily context in HHNsg practice. She listed her "ideal" expectations of HHNs working at the unit. "Ideally" HHNs review PARIS and pixalere (wound care) documentation from the last two visits including any care plan updates that may have occurred in between visits.

In the event that there is a client cancellation, the HHN must notify the clinical coordinator who can then re-assign him or her to a client who needs a visit. In addition, HHNs ought to schedule home visits in the same geographic location to minimize the amount of time spent travelling from home to home. After their daily visits to clients' homes, they chart, contact physicians, family members or outside agencies or attend meetings. In an "ideal" world, HHNs would take a coffee and a lunch break and go home on time.

According to the nurse educator, in reality, HHNs fail to review daily electronic documentation prior to home visits. For example, if there has been a change in a client's care plan, the HHN may not know because he or she has "chosen" not to review the care plan prior to the home visit. This practice is a "reality." In my view, difficulties in navigating the electronic system, the lack of time, and workload prevent the nurses from reviewing up-to-date documentation (for e.g. a care plan) prior to a home visit.

In the past, HHNs made notes in a flow sheet chart as they visited clients. With the advent of electronic charting, the nurse educator states that HHNs do narrative charting which takes a long time. In addition, the educator listed several documentation expectations of HHNs. For example, during an admission process, a HHN has to screen for falls and risks as well as reconcile or obtain an extensive medication history and document advance care wishes. To add to these daily documentation expectations, the educator exclaims that everyone in health care is getting "busier" and nurses have to do more tasks and care under time constraints. Workloads are increasing. Also client care is getting more and more "complex." She shared that it is common for HHNs to miss their lunch and coffee breaks as well as weekly or monthly rounds. Also, they spend a considerable amount of time travelling from one area to another area instead of clustering their home visits in one designated area.

Clinical Coordinator. Unlike the educator, the clinical coordinator provided specific examples of daily occurrences. For instance, when a HHN is assigned a new client, he or she reads the most recent consult report from the hospital. When the client needs intravenous therapy, HHN has to organize the order of home visits to reflect the time-sensitive requirements of that task.

The context of a home health nurses' work is that they travel to five to six clients' homes and then return to the unit where they document their visit and make several phone calls to coordinate the clients' overall care. While travelling, because they do not have quick access to the clients' electronic charts, they carry paper charts which contain the clients' most current care plan, doctor's orders, and consult reports. After their morning home visits, in the afternoon, the HHN may have to write a letter to a family-physician or communicate with another team member regarding the plan of care for the client. In addition, the HHN ensures that the client is assigned their following visit by documenting this information in the electronic record as well as on the daily and weekly assignment sheet. Sometimes, the HHN hands over a verbal report to another colleague especially when a client is experiencing complex symptoms. Every day, the clinical coordinator assigns more than one flex call. A flex call refers to unanticipated calls from clients who may require a home visit. Since clients are more complex, they have more issues that need immediate attention and may occur on the spot. Some examples of urgent calls include a blocked catheter, a pain crisis, or a saturated post-surgical dressing. In some instances, the hospital may not indicate that a client needs to be seen sooner than later. This can result in a call from a family member of a client, not known to the health unit or HHN. Their complaint may be

that the client's pain has risen since discharge. This issue can also lead to unexpected calls from clients not known to the health unit.

Daily Challenges of Home Health Nursing (HHNsg)

Manager. The manager listed several daily challenges for HHNs. These include maintaining communication with outside or contracted home support agencies, family physicians and interdisciplinary team members. Besides these tasks, HHNs are expected to attend various meetings such as wound care rounds, palliative rounds, or intravenous rounds as these meetings keep them up to date with organizational policies and guidelines as it pertains to their various skills.

HHNs are primarily responsible for arranging, changing, and adapting home support service plans. In regard to home support services, HHNs are always troubleshooting issues and coordinating care which can be hard and challenging. They communicate with the home support agency over the phone or via the electronic documentation system because the home support agencies are located outside of the home health unit. In some instances, the HHNs may or may not know the client for whom they are ordering and organizing a home support plan. Thus, the HHN has to navigate through several electronic assessments and documentation to convey the right information to the home support agency. Periodically, the HHNs receive calls from a home support agency representative who requires information about assisting and supporting clients and their families.

HHNs face reoccurring challenges in being able to communicate with family physicians. First, family physicians are not easily accessible and available. Therefore, on a day-to-day basis, HHNs have to communicate by fax or telephone. This form of communication is not at all timely for patient care and not at all helpful for the HHN who needs to take immediate action to

resolve the patient's concerns. Since HHNs experience delays in getting in touch with the family physician, the leadership team provided two solutions. Firstly, the leadership team created a letter template for HHNs to communicate with physicians. Secondly, they educated and advocated the use of a communication tool called SBAR (Subject, Background, Assessment, and Response) as this tool helps HHNs to organize large amounts of client information into a succinct verbal message.

Another challenge for HHNs is for them to maintain interdisciplinary care planning. Even though members of the interdisciplinary team are located in the same office, which enables face to face contact among team members, joint care planning is difficult and fragmented. Increasing caseloads and difficulty in accessing electronic care plans augments the problem of fragmented care planning. From the manager's perspective, HHNs fail to involve the client in daily care planning. This is also evident in cases where the client has poor cognition related to a medical condition.

Nurse Educator. From the educator's perspective, HHNs have different understandings of how to document and maintain a care plan. A care plan is a communication tool, as it communicates and identifies the client's needs and daily care to the nursing and interdisciplinary team. Care plans have some characteristic problems. For instance, some nurses document what to assess versus how to intervene with a client. Care plans are either too general or too detailed. Because of the variance in HHNs' practice with care planning, care plan templates were set up. HHNs copied and pasted these templates instead of adjusting it to fit the client's situation. Thus, care plans are not client-centered and not client specific. In addition, as the client's care progresses, different HHNs have a poor sense of the client's needs. Inevitably, care plans remain

the same even though the client's wishes and logistics of care have changed over a period of time. In addition, some nurses may not have time to update clients' care plans.

Clinical Coordinator. According to the clinical coordinator, she claimed that it is imperative that the HHNs update clients' care plans because there are a number of staff who do not work every day and a number of staff who call in sick. When these issues occur, it is not always possible to schedule the same nurse to visit the same client. Thus if the care plans are not updated, the client receives inconsistent care. These issues were also validated by the manager and the educator.

Workload Constraints

Manager. The manager has found that increasingly clients no longer just require simple post-surgical dressings. Their needs are more complex and acute and therefore they require new procedures and more equipment to live at home. Moreover, clients have behavioral and mental health issues which can make the care more complex. Additionally, in terms of the physical environment of clients' homes, she has concerns about unsafe ergonomic situations and acknowledges that nurses have less control in a home environment and have limited access to resources that are not available in the next room as it is in hospital.

Nurse Educator. The nurse educator also reaffirmed increasing workload issues. "Everyone in health care is getting busier" "The expectation is that the nurses do more with little time." For example, the demands of charting and reviewing electronic documentation clearly reduce the number of clients being seen on a daily basis. Considering HHNs are pressured for time, she has heard clients' report that their care was rushed. As a response to daily workloads and client complexity, the educator advises the HHNs on how to deal with challenging clients and provides recurrent updates of policies and guidelines.

Clinical Coordinator. The clinical coordinator gave several examples of workload issues along with contributing problems. For instance, she claims that it has become increasingly difficult to respond to the increasing numbers of client discharges from hospital. Also home visits take longer because clients have complex needs. Moreover, on a daily basis, it is difficult to replace a sick call. Thus the continuity of the client's care is disrupted. In addition, because of "tight" staffing and sick calls, it makes it challenging to respond to calls that occur on the spot, or calls that have not been prescheduled for the day. She feels uncomfortable when she has to keep deferring client visits because of sick calls and the lack of relief.

Ergonomic Constraints

The manager and educator commented on the implementation of projects aimed at bettering the HHNs' work environment. The manager has supported the nurses in buying a product that will make the work ergonomically safe to wrap lower leg wounds. The clinical coordinator had no comments on the ergonomics of clients' homes.

Characteristics of South Asian (SA) Clients and Families

Manager. According to the manager, with Asian and SA families, there is a huge family component as it relates to understanding cultural values and its impact for health as well as knowing about the roles of family members: how they make decisions, which members are responsible for care and are the primary contacts for the health care team. As per the manager, HHNs are sensitive to families' cultural values, their roles, and decision-making and communication patterns. In regard to communication, when SA clients require translation services, this is a big issue.

The manager notes that HHNs are uncomfortable conversing with clients in terms of "getting the [client] to talk about themselves and their circumstances." She emphasizes that

HHNs should “read the [clients’] walls and environment.” This is more than just attending to the “stoma” or “wound.” The manager has set up educational and research opportunities for HHNs to provide better care to older SA clients. She has hired SA HHNs, arranged mentorship opportunities between non-SA nurses and SA nurses, between younger and more experienced staff, organized in-services about the SA culture, and approved research projects targeted at the SA population.

However in response to her efforts above, she had made a number of challenging observations. First, younger and novice nurses were particularly challenged when they had to take care of SA and Asian clients. She also noticed that SA HHNs experience more demands from SA clients. Despite offering opportunities for staff to debrief on issues related to caring for older SA clients, she found that HHNs were not open to exploring daily challenges with SA clients.

Nurse Educator. In contrast to the manager’s report above, the nurse educator described HHNsg practice within the context of caring for SA clients and their families. Typically, HHNs assume that extended family systems offer adequate support to SA clients who live at home. Sometimes, HHNs assume that just because the family is able to provide the client a hot meal, the client’s health needs are met. However, the educator provided a number of examples that prove this is not the case. Extended family members are busy. In addition, family dynamics play a huge role in daily care. Sometimes, the family expect the daughter-in-law to be the primary caregiver, but she lacks the desire to do so because of immediate familial responsibilities like holding a job and taking care of her children. Despite this known fact, HHNs may engage the daughter-in-law with the client’s care, even though she is resistive. In other instances, multiple family members want to be active participants in the client’s care, however these same family

members are not always present in the home at the time of the HHN's visit. It is time consuming for the HHN to provide ongoing and consistent teaching and communication to family members especially if they are not always present. Also some of these members may not speak English or may speak English but have poor health literacy. In these instances, HHNs make do and then try to arrange for an interpreter when possible. Also it is not possible to arrange a language-specific nurse all the time. Thus, the HHNs routinely inform clients and their families not to expect a language-specific nurse. The above instances make up the daily context of care and is time consuming.

Clinical Coordinator. The clinical coordinator provided her thoughts on other characteristic aspects which are important for the daily care of SA clients. Unlike some of the other client populations, many SA families have an ailing family member living at home which raises the caregiver burden for them. These families expect more home support services and HHNsg visits than allowed. In addition, their demands of SA nurses are very high. Too conclude, in an effort to communicate clearly with SA clients, home health nurses use translated educational material, translators, or family caregivers to facilitate communication between them and their SA clients.

Communication with SA Families

Manager. The manager, educator, and clinical coordinator have used different strategies to support effective communication with SA clients and their families. The manager claimed that some of the senior SA nurses are very skilled in the area of communication and interacting with SA families. Thus, she has advised these nurses to mentor younger nurses who need support to care for SA clients and their families. The manager has particularly given supportive feedback to younger nurses who struggle with communicating with SA clients.

Nurse Educator. The educator exemplified HHNsg communication strategies with SA clients and their families. According to her, HHNs access a variety of language-specific resources like client educational pamphlets, but daily teaching is not tailored to suite cultural lifestyles. For example, in the context of managing clients' dietary habits as it relates to their heart function, the educator claimed that the HHNs do not address culture-specifics like washing chickpeas to reduce the salt content. In other instances, the educator stated that HHNs and other members of the health care team develop a care plan to communicate consistent messages to clients and their families especially about how their health needs will be looked after by the health care team. Thus, team meetings help HHNs discuss different strategies on how to provide good care and how to cope with difficult client behaviors. In addition, when the various team members meet, this strategy reduces conflicting and differing expectations of care between the team and the SA client or their family. One more point In regard to communication is worth mentioning. The nurse educator also confirmed that HHNs do not have opportunities to advance their teaching and communication skills, areas of development that I noted as gaps in my observations and interviews with the various home health nurses.

Clinical Coordinator. In contrast to the educator's claims regarding communication with SA clients and their families, the clinical coordinator provided an illustration of a conflict that had arisen regarding the care of a SA client. She gave the example of a nurse who left the home of a SA client because the family members were demanding more visits and home support services. Consequently, the SA family showed up at the health unit and asked to speak with the clinical coordinator. The clinical coordinator claimed that this family was not argumentative as originally described by the HHN who saw them. They just wanted an explanation of what

services they could access. The clinical coordinator explained the guidelines to the family and they accepted her explanation.

Communicative Approaches with SA clients

The manager believes that HHNs ought to nurture the skill of having personable conversations with the clients which entail asking direct and open questions: “how are things going? What kind of support are you getting? On the other hand, the educator referenced the regional wide education strategy of how to approach advanced care planning with clients and families. Advanced care planning is just one strategy or tool HHNs can use to nurture and foster open conversations about health. Advance care planning prompts questions like “tell me what you think about your health? Tell me what health means and what is important to you?”

The clinical coordinator recommended the hiring of language-designated nurses who get a small stipend. She was also frustrated with the acute care system’s expectations of community services for clients as these services are actually difficult to provide and organize on a daily basis. Therefore, the clinical coordinator hopes that the acute care system provides realistic messages about home health services to clients being discharged home.

Chapter 7

Analysis and Discussion

Ch. 7 offers the analysis and discussion of the data collected in Ch. 4, 5 & 6 to reveal "webs" of "meaning" and an understanding of HHNsg practice (Geertz, 1988, p. 5); in other words, I reveal "patterns, explanations and propositions" within my ethnographic analysis (Lathlean, 2010, p. 435; Wolf, 2008). I aim to explore the differences between the leaders' and HHNs' discourses and the practical realities I observed of HHNsg practice in so far as they apply to an ethnic minority of a specific age group. I attempt to consolidate answers to the question: How does the organizational culture (values, beliefs and the hidden assumptions beneath the various discourses) influence the actual daily practice of HHNs who provide care to older SA clients who live at home and receive HHNsg services? Ultimately, the meanings behind the responses of the nurses and their leaders who participated in this study reflect the values inherent in HHNsg practice and disclose the differences between the stated objectives of the organization, the expectations of the leaders and HHNs on the one hand and my own observations on the other.

Discourse of the organization (Leaders' discourse)

Let me recall the four organizational priorities as established in the current mission statement: to provide the best care; to promote better health for our communities, to develop the best workforce; to innovate for sustainability (VCH, 2013a; see Figure 1).

I found during my interviews that the discourse of the organization was echoed in the leaders' accounts and-- in fact-- has a powerful effect on the way the HHNs interact with their clients in daily practice. "Nursing practice takes place at the point of interchange between everyday life and its textual representations or discourses..."(Bjornsdottir, 2009, p.734). My

observations noted that HHNs acknowledged holistic and family-centered approaches in their private interviews with me; however, they played an active role in the "efficient processing" of patients by [solely] attending to their "physiological concerns…at the expense of nonphysical (emotional, mental, spiritual) concerns" (Varcoe, Rodney & McCormick, 2003, p. 962). Purkis as cited Bjornsdottir (2009) also found that "other issues which for example involved serious existential questions [are]…left unaddressed" (p. 733). As a result, no time was allocated for finding out how the patients perceived their situation and what support they might wish to receive from the governmental sector" (p. 733). In summary, the discourses, expectations of leaders and organizations organize, shape or frame nursing practice in a way that insufficiently addresses the everyday needs of clients.

Providing the Best Care

In this section, I discuss the leaders' interpretation of the organizational discourse regarding "the best care" (VCH, 2013a). All three leaders validated the slogan "home is best" for clients to access their health care. Their view is evident in current public policy whereby "Despite the dearth of evidence, this trend of [Home Health] continues, [is] driven by political motivations, technological advances, and the unchallenged assumption that patients prefer to be treated in the home when possible" (Preto & Mitchell, 2004, p. 10). Ceci (2008) additionally includes other factors--"cost-effectiveness" research, discourses and practices"—that impact the rationale for home care (p. 21). Thus, client expressions of health and living are understood in terms of the "ideas" and "ideologies" that play such crucial roles in determining the shape not only of the Canadian health system, but also Canadian society" (Ceci, 2008, p. 21).

Although the leaders distinguished the "home," to be a "safer" "happier" "comfortable" place for clients to maintain their health, they conceded that the system is "acute driven,"

focussed on quicker discharges and reduction of the length of hospitalizations, and more and more is being expected out of HHNsg services. Ceci (2008) confirms that home care is under "increasing pressure" because of political and economic shift of services from hospital to the home (p. 21). Evidence suggests that health care administrators consider home health and its nursing services to be a "less costly" alternative to hospitalized care (Preto & Mitchell, 2004, p. 5).

Increasing home health client acuity, complexity, and urgency of care has led to "demands for more different acute care, new procedures and equipment..." in clients' homes and thus nursing care tends to focus on clients' "physiological problems" (Interview: Manager). For this reason, HHNs frequently access clinical experts and specialty team meetings where team discussions focus on managing signs and symptoms. In addition, managing "challenging clients" is the emphasis of problem-solving and team talk (Interview: Nurse Educator). According to the nurse educator, "challenging clients" may include those who expect a language-specific nurse and others who wish to leave hospital to heal at home and yet have no desire to participate in managing home equipment like an electronic intravenous pump.

On the topic of challenging clients, as per my previous observations, Mrs. Mohan was labelled as "anxious." I believe her anxiety was mainly due to the actions of the HHNs. She did not feel that she was getting enough attention from the HHNs. On one occasion her dressing fell off because they did not secure it properly (see Story 1). On another occasion, they did not anticipate the blockage of her intravenous line, a preventable issue (see interview 5.1). Despite the real challenges that she faced, the HHNs perceived her as a challenging client. Another illustration comes from Nurse Jackie's interview about Anita's issues with medication. As per my observation and based on Nurse Jackie's interview, Anita would benefit from conversations

that would elicit her own understanding about her health, her medications, and how her culture or spirituality plays a role in her choices around her health. However, this approach was not used with her and this is why she refused to take her medication. Nurse Jackie claimed that "cultural" aspects and the client's "dementia" may have played a role (see interview 5.3). On the contrary, the Home Health team needed to employ more effective communication strategies with the client that met her literacy, language and cultural needs.

Thus, in spite of the benefits of the home as an ideal environment, it was constructed as a central place of economical, structural and political challenges such as: the complexity of care, increasing client caseloads, poor staffing levels, unsafe and unpredictable ergonomic situations, increasing mental health behaviors, limited access to home support resources, poor care planning and "complicated" or poor coordination and communication among nurses, physicians, home support workers, and other disciplines (Interview: Manager). Cost-wise, while home health is an area plagued with limited resources, more and more is being expected of HHNsg services, which help to prevent hospitalizations of elderly population, in an effort to alleviate the pressure on the acute care system (Interview: Nurse Educator and Clinical Coordinator). In light of all the aforementioned challenges, the leaders made the following claims that were not evident in my observations.

According to the manager, a majority of clients treated by the HHNs in this study, come from "cultural families" and "inter-generational family situations." Given this diversity, the leaders professed approaches that were a laudable fit with their clientele namely: holistic, family-oriented, teaching-centered and communicative. According to expert scholars within the nursing field, these approaches are best suited for older South Asian clients (Hilton, Grewal, Popatia, Bottorff, Johnson, Clarke et al., 2001; Oliffe, Grewal, Bottorff, Luke and Toor, 2007). I frame or

categorize the leaders' claims as alternative or *wishful* thinking because the aforementioned approaches were absent for the most part in the four cases I observed.

In regard to holistic care, all three leaders differed in their views, but overall they felt this type of care needed to be applied. For instance, as specified by the manager, the HHNs ought to "read [clients'] walls and environment entailing more than just attending to the "stoma" or "wound" (Interview: Manager). On another occasion, the same nursing manger remarked that daily care requires thinking outside the box, much like big picture thinking. In contrast, the educator exemplified holistic care as "what's important to the client, involving people that are important to the client…." We go into not very nice homes. [For example], we have a client who had a cat infestation…It's important to him to have [the cats] in the home" (Interview: Nurse Educator). In the clinical coordinator's view, however, holistic care was seen as attending to clients' emotional and social state. While the nurse leaders expressed the need for a philosophical approach—not just a physiological approach, the nurses largely focused on the latter.

Given the high volume of clients and the high acuity of their care, it was possible for nurses to attend to clients' "physiological problems," alone. This basis of care originates from the acute care system's referral categories (Interview: Manager). Ceci (2008) refers to this context of care wherein "the needs of the newer, more acute and medically fragile client [is] set against the needs of the traditional clients of home care, the frail elderly and chronically ill" (p. 21). The physical care of clients has thus become the central focus of care. The circumstances surrounding physical care involve increasing workloads and insufficient time. Physiological approach to care has been noted to be insufficient for SA clients, an observation made in wider research and in more than one instance in my fieldwork with the front line HHNs (see interviews

5.1 and 5.2). SA clients' and their families' lifestyles and health are predominantly based upon collectivist thinking, spiritual needs, and dietary traditions (Hilton, Grewal, Popatia, Bottorff, Johnson, Clarke et al., 2001; Oliffe, Grewal, Bottorff, Luke and Toor, 2007). Applying these facets of SA culture to the context of their HHNsg care, HHNs need time and open-conversations to foster SA clients' belief and health systems. However, current predominant medical discourses in the delivery of health care services are not aligned with the delivery of holistic care. The existing discourses perpetuate consistent and streamlined approaches that are intent on promoting efficiency.

In regard to developing family-oriented care—Brotman (2008) notes that family members such as grown up children "become involved in some capacity, either through providing supplementary care or in mediating relations between elders and formal service systems" (p. 33). In Story 1, Mrs. Mohan's husband took on the task of monitoring her drainage quite closely. Even worse, family members "lose out" when they have to engage in "bartering" for elder family members' services (Brotman, 2008, p. 33). My findings are in line with Brotman's study (see interview 5.3 and interview with clinical coordinator). For instance, the clinical coordinator observed that she was asked to intervene in a previous incident where a nurse and a SA family had gotten into an argument about the amount of home support services being provided to them. During this conflict, the nurse had walked off abruptly during the visit. Several cases like these indicate the caregiver strain on family members as well as the limited capacity of HHNs to respond to caregiver concerns.

Approaches to communication too were limited because of the use of scripted tools like care plans and daily documentation that was categorized under physiological needs-based titles. HHNs employed scripted methods of communication to perform nursing tasks like measuring

and keeping track of drainage, weight, blood sugar and pain levels etc. (see interviews 5.1, 5.2, 5.3). In fact, care plans are scripted and task-oriented tools that help nurses organize their work in standard and routine ways. Even though the leaders advocated for sensitive and high level methods of communication with clients and their families by establishing standard template care plans, these templates did not capture the evolving needs of clients. There were several cases in this study where the client's needs were inadequately met as a result of scripted methods of communication either in conversations or documentation. In interview 1, for instance, Nurse Sunita acknowledged that the care plan was inaccurate and outdated. In interview 4, Nurse Cathy acknowledged that the client's care plan did not take into account his advanced knowledge of diabetic care. Thus, similar to the case managers' work in Ceci's (2008) study, the nurses in this study "seem able to pick out only limited range of recognized needs to which to respond and demonstrate a series of responses themselves equally limited" (p.19). In sum, scripted methods of communication leave room for conflict between the HHNs and their clients or families and limit the application of holistic and family-centered models of care.

The leaders reported that all client populations regardless of their culture received the same care. Nevertheless, the leaders made attempts to organize education and mentorship opportunities as well as debriefing meetings for younger nurses who experienced personal conflicts and communication challenges in delivering and explaining services to SA clients and their families. All three leaders recognized that SA clients expected more services out of language-specific nurses. For instance, the nurse manager claimed that senior SA staff, language-specific nurses, had a better understanding of how to handle "this" (Interview: Manager). "This" suggests that either SA clients were challenging or that there is a difference in practice between language-specific nurses and English-speaking nurses. As explained to me by the nurse educator

"this" refers to the well-known fact that SA clients expect more out of language-specific nurses because of language and cultural affinities. "If I went in there with my [lighter skin], they (SA clients) don't bother asking for special favors. But they would say to a SA nurse "You understand our community, please do this for us" (Interview: Nurse Educator). The comment from the educator suggests that SA clients did not feel comfortable because their needs could not be understood by English speaking nurses. Furthermore, does this suggest that nurses need cultural–sensitivity and diversity awareness and training? Do they need more time or to use their time to ask questions "that get at the fundamental beliefs and values that impact how people perceive their health and look after themselves" (Interview: Manager).

In addition, the nurse manager recommended that daily assessments need to provoke broader discussions about what is important to the client in terms of their overall health. My discussion and examples provided above make it amply clear that at the leadership level, implicitly there was a felt need to talk about the importance of culturally-targeted care (e.g. holistic care, family-oriented care, teaching-centered, and communicative). As shown in Table 1, the leaders' discourse differs from everyday HHNsg practices. Table 1 supplements the discussion above.

Table 1

Organizational and Leaders' Discourse versus HHNs' Practice

Organizational Discourse	Nurse Leaders' Discourse	HHNs' Practice
Best Care	Home is best Holistic care Family-oriented care Teaching-centered Communicative approaches	Evidence-based practice Standardization (physiological approaches) Integrating electronic health record in everyday practice

Note. The interpretation of the organization's discourse is reflected in the nurse leaders' discourse or claims underpinning practice. In contrast to their leaders' discourses and expectations, HHNs enacted efficient practices. HHNs = home health nurses

In the following section, I illustrate how HHNs enact the processes listed in Table 1. In addition, I draw on examples from this study's data and integrate comparative findings in the nursing literature to validate my analysis. Although evidence-based, standardization and technological approaches to practice ensure quality, safety and add value to daily workflow processes, from a relational and humanistic perspective, clients may not always benefit from these approaches.

The Best Care: Reduce Unnecessary Variation by Using Evidence-Based Approaches (HHNs' discourse)

Evidence-based practice emphasizes skill development, based on scientific research, and contributes to assessment practices that characterize the patient as a "problem" or in terms of "deficiencies" (Purkis & Bjornsdottir, 2006, p. 249). Typical core nursing activities include

tracking levels of drain output, blood sugars, pain or weight, *standard* inquiries that worked in tandem with *evidence-based guidelines* for *drain care, diabetic care, wound care or congestive heart failure care*. The Bjőrnsdottir (2001) study demonstrates that, "much emphasis was placed on reporting or [asking about] all changes in measurements, the amount of drainage from surgical wounds…" (p. 163). Chatterji (1998) refers to this approach as "systematic classification" especially when nurses interact with clients and discuss the level of bodily functions which in turn quantify the client's value (p. 369). I draw upon the Latimer (1999) study to support my impressions above.

The Latimer (1999) study captures the essence of nursing work in the context of an acute care hospital in England. Dominant ways of practicing nursing included "categorizing as a mode of organizing" (p. 195). Categorizing patients usually occurs in standard and known ways to the nursing team. Interestingly, Latimer observed that nurses conduct physical assessments, take a comprehensive patient history, and perform "ongoing reassessments" to decide the category of the client (195). Nurses categorize with standard terminology: "emergency admission," "cardiac,"...."dependent," "convalescent," "rehabilitating" and "orthopedic" (Latimer, p. 195). Categorization of patients helps the nurses maintain and keep the workflow moving as nurses are able to determine the nature and the amount of nursing services required and the estimated time of discharge (Latimer, 1999). In my own study, HHNs' categories of clients pertained to drain care, wound care, diabetic care, or chronic heart failure. Corresponding actions included tracking measurements such as the size of the wound, the level of the drain output, and the stability of blood sugars, or weight. In other instances, enquiries included following up on medical appointments, names of doctors and medications and patterns of taking medication to treat

medical issues. If the client did not concur with the routine nursing tasks and or expectations, as noted above, they were subsequently labelled and problematized.

Standard problems usually pertained to clients refusing to take their medication. On two different occasions in regard to medication issues, the clients were labelled and reasons for non-compliance was attributed to the client. Although non-compliance is a nursing concern for the general population, factors such as health literacy, language differences, and traditional understandings of health may influence non-compliance among older SA clients. More importantly, these factors create variations in everyday practice that are outside the norm of HHNsg routines and protocols.

For instance, LPN Jane claimed that Mr. Sohan did not "follow through" in taking his pain medication. However, his lack of "follow through" was due to a series of previous incidents. LPN Jane had advised him to track his blood sugars and to obtain nutritional advice from her colleague dietician. Her recommendations were aimed at solving the problem of his slow healing wounds and were also based on the wound care specialist's protocol for managing problematic wounds related to poor diabetic control. At a later point, the family physician revealed that the client's blood sugar values and dietary habits were normal. This discrepancy between LPN Jane's and the family doctor's advice frustrated Mr. Sohan. Subsequently, he refused to accept her advice regarding his pain control. To cope with his lack of "follow through", she formed an alliance with his son-in-law to get Mr. Sohan to take his medication. Her problem-based view of the client led to the lack of "follow through" on his part. Her alliance with the son-in-law is on the one hand strategic but on the other impersonal. Mr. Sohan's health was "articulated by the problem solving mechanism of the [organization]" for no fault of his (Chatterji, 1998, p. 359). If

LPN Jane had not been so protocol-focused and listened or engaged in early discussions with the patient and his family doctor perhaps medication issues would not have occurred.

In another instance, Nurse Jackie commented on medication issues in Anita's case that were caused by the client's poor cognition related to her dementia, inability to communicate in English, and a lack of understanding of the HHN's role. The client refused to take medication. At her refusal, she was categorized as being "non-compliant", resulting in excessive need for problem-solving team meetings. Latimer (1999) and Chatterji (1998) warn that such labelling could lead to clients losing their voice, identity and individuality.

It cannot be overemphasized that standardized and evidence-based approaches may meet organizational demands but are not inclusively cognisant of the SA elderly client's overall needs. This is significant because the same situation may apply to other client populations who have not been studied.

The Best Care: Build an Integrated Electronic Health Record (HHNs' discourse)

Integrating the electronic health record into daily nursing practice is part and parcel of daily nursing care. The electronic health record becomes a document that tells the client's story from a physiologically-based point of view. From my own experience, the system has its advantages. It allows for legibility and continuity of care in terms of tracking measurable indicators of care. For instance, in my visits, the HHNs measured the size of a wound, weight or vital signs. From one visit to the next, a HHN types a note about the client's progress. Each case note outlines current and subsequent tasks that need to be completed. These tasks are categorized under headings such as: wound management, pain management, mobility and so on. Therefore, the electronic record has largely become the lens through which clients' needs are understood.

However, the system also has its disadvantages. The addition of the electronic health record has added to the daily workload which in turn leads the nurses to rush the client's care. Updating and maintaining the electronic health record seems to be a tedious and fragmented process. In the past, nurses documented their clients' care in paper flow sheets whereas now with the electronic record, they chart lengthy narrative notes in a free text electronic document. This mode of documentation has made it difficult for the HHNs to get a quick snapshot of the client's health patterns. This is why the nurse educator claimed that some of the HHNs fail to review documentation prior to a home visit. Previous to narrative charting, the HHNs made hand-written notes in flow sheets which enabled them to view the client's health patterns over a period of time. Since that system has been made obsolete, Nurse Sunita "taught" the client to track the amount of drainage because it was difficult to track this information in the electronic narrative charting system (see interview 5.1). In addition, the task of updating and maintaining the electronic document has limited the number of HHNs' visits and their time with clients. Moreover, the HHNs frame their assessment questions and interact with their clients to fill in the fields of information in the electronic record. Some examples include questions about medications, keeping track of wound care products, pain levels or blood sugars. In interview 5.2, LPN Jane claimed that the medication sheet gives her a "picture" of the client. In conclusion, the electronic documentation system, its information fields, and its categories of nursing tasks shape the nurses' outlook and understandings of the client.

In two sources, nursing scholars have elaborated on the idea that frequently used materials or equipment in hospital settings have become part of the client's identity. The Latimer (1999) study uses Strathern's concept of extension. The concept of extension was applied to dancing. In a ritual dance a "person who is to wear the headdress…his identity is materialized in

the headdress, which is made up by, and of, others. Indeed, there is an implicit notion that were he to make up his own display of identity, some of the efficacy attached to him may be lost" (Latimer, p. 190). As well Wolf (1988) discusses the role of medical objects in identifying and delegating the "patient role" (163). Thus "materials and technologies such as electrocardiograms, uniforms, clothes, the arrangement of space, and other paraphernalia of hospital life" were used by staff to understand "older people's identities as patients" (Latimer, 192). In the case of this study, the technology has become central to client care wherein more emphasis is placed on technology than conversing and exploring the client's deeper concerns. As exemplified in this study, HHNs organized their client assessments in a way that they could maintain the accuracy of the electronic health record's information pertaining to names of doctors and their prescribed medications and dosages, names of wound care products, and effectiveness of various nursing and medical recommendations and treatments (see interviews 5.1, 5.2, 5.4). Can some of this time be spent to converse with the client and provoke deeper conversations about their coping and how their health relates to their cultural and spiritual views of health? This approach was absent in interviews 5.1 and 5.4. For instance, in Story 4, Mr. Raj explicitly stated how helpful it was to be able to access bathing services so that he could visit the temple and attend a funeral.

Develop the Best Workforce (Leaders' discourse)

In my view the three leaders fostered "the best workforce" (VCH, 2013a). There were several strategies they employed to foster a strong workforce. For instance, they emphasized the importance of team meetings where team members co-established and contributed to plans related to difficult clients. The manager engaged in hiring language-specific nurses mainly aimed at reducing costs associated with using interpreters to translate client's concerns. In

addition, all three leaders promoted education and mentorships for novice and younger nurses. In this way, the workforce had a strong foundation of skills.

Despite the efforts to maintain a strong workforce, the manager, educator and clinical coordinator elaborated on the effect of the limited budget for daily practice. For example, staffing shortages, working long hours without a break and increasing numbers of sick calls are daily occurrences. When these occur, employees get frustrated and dissatisfied. (Interview: clinical coordinator). Despite these work environment realities, the leaders expect that HHNs broaden their focus of clients' needs as well as keep client care plans.

The gap between the leaders' expectations of their workforce is illustrated in their interview records where the leaders refer to themselves as "we" and refer to the HHNs as "they." Fernandez as cited in Latimer (1999) calls these pronoun references, "the foci of identity" devices to identify roles that have positive or negative consequences (p. 189). These references are referred to as "extension" (p. 189). Obviously, "they" were not able to meet the leader's expectations, a reflection of the organization's vision for health care. As shown in Table 2, the organization's and leader's discourse was reflected in the practice of HHNs. The outcome of the various discourses is that HHNs' applied a physiological lens of care despite my observations that clients required a holistic model of care.

Develop the Best Workforce: Maximize Staff Potential (HHNs discourse)

There were formal and informal support resources that enabled the HHNs to do their daily work. HHNs had easy access to clinical experts such as the wound resource nurse, intravenous resource nurse, clinical nurse educator, family social and support worker, and hospice experts. The wound resource clinician provides expert advice, monitors the nurses' use of wound supplies and the appropriateness of wound care plans. This was especially the case with LPN Jane who

was heavily reliant on expert clinicians or fellow senior Registered Nurses. She focussed her efforts on using the electronic record and wound-based protocols to get the "picture" of the client's health issues (see interview 5.2).

The HHNs used informal tools to track the client's progress and journey. For instance, Nurse Jackie used a flow sheet to track the client's health: "breathing, circulation, blood pressure, sleeping, diet and weight" (see interview 5.3). However, she had already established rapport with her client who really was quite pleased with her. In addition, Nurse Sunita and Nurse Cathy used the monthly calendar to indicate the date for the next visit and adequacy of supplies (see interviews 5.1 & 5.4). Furthermore, most of the HHNs in this study appreciated the easy access they had to education pamphlets as these resources helped them educate clients about signs and symptoms of various conditions. Thus, the HHNs relied on supports that helped them with maintaining consistent and seamless care. In addition, the HHNs also formed a task force that looked at buying equipment that would enable them to do leg dressings more safely. This was mainly to aid the challenging ergonomic situations HHNs encounter in a variety of clients' homes (Interview: Manager). In the area of wound care, the manager supported the purchase of a product that would prevent injuries to nurses who monitor and care for clients' lower leg wounds. In summary, Table 2 supplements the discussion above and demonstrates the organization's discourse compared to the leader's discourse and everyday HHNs' practice.

Table 2

Organizational and Leaders' Discourse versus HHNs' Practice

Organizational Discourse	Nurse Leaders' Discourse	HHNs' Practice
Develop the best workforce	Team Meetings (e.g. HT) Language-specific nurses (e.g. Punjabi speaking nurses) "Education and mentorships" Ergonomically work safe environments Access to specialist and experts (e.g. WCN & IVE)	Team meetings (e.g. HT) Informal tools (e.g. monthly calendars) Education resources for clients Task force to buy work safe equipment for wound care Access to specialist and experts (e.g. WCN & IVE)

Note. The discourses of the organization, leaders and HHNs effectively support the organization and operation of a workforce that adopts a physiological framework and understanding of clients' needs. HT = hospice team; WCN = wound care nurse; IVE = intravenous educator.

Innovate for Sustainability (Leaders' discourse)

In terms of sustainability, the leaders provided examples of mechanisms that eliminate inefficiency. Some examples include creating awareness about limiting wastage in terms of wound care supplies, clustering visits in the same geographic area, and ensuring that care plans are up-to-date so that the care is consistent, efficient and current among various HHNs.

Innovate for Sustainability: Apply LEAN Thinking (HHNs' discourse)

LEAN thinking applies to eliminating redundant approaches that make care inefficient. In three of the home visits (Story 1, 2 and 4), the HHNs counted wound care supplies to ensure that the next HHN would not bring in unnecessary supplies into the home. Their actions suggest that there was an emphasis on cost-saving. Another example of a LEAN approach to HHNsg practice is the use of a standard communication tool known as SBAR (situation, background, assessment and recommendation), to communicate with physicians (Interviews: Manager and Nurse Educator). This tool was created to support consistent and collaborative communication between health care providers and physicians and to better the quality of client care. The tool helps HHNs to organize communication based on concise facts or assessment findings and to resolve clinical problems of patients with family physicians.

On more than one occasion, the HHNs claimed that they "taught" clients (interviews 1 and 4). The teacher role is based upon meeting organizational policies and guidelines, the advice of wound experts, and the actions of other colleagues. In the instance of my inquiry, the teachers ask standard questions related to standard tasks and information needs. In response to the teacher role, the older SA client performed the role of an "obedient student." In this case, an obedient student refers to being "conditioned" to respond to the nurse's standard requests (see interview 5.3). Being an obedient student referred to either the client or the client's immediate family member. There were several instances of "obedient students," a role that was observed to be adopted by the client or an immediate family member. To recap, Mrs. Mohan's husband became "picky" about tracking the drainage (Story 1). In another instance, Anita's son was "conditioned" to respond and to report her health information (Interview 5. 3). In Mr. Raj's case, there was no opportunity to further discuss his need for additional home support, so he stopped asking about it

(Story 4 & Interview 5.4). Thus, based on these prior illustrations, the HHNs "conditioned" their clients and their family members to track nursing tasks as a form of LEAN or efficient thinking.

Table 3

Organizational and Leaders' Discourse versus HHNs' Practice

Organizational Discourse	Nurse Leaders' Discourse	HHNs' Practice
Innovate for sustainability	Cluster home visits in the same geographical area	Inconsistent organization of home visits in the same geographical location
	Manage and keep skill set Up-to-date (psychomotor skills: wound care, intravenous care, handling equipment).	Consistent learning from expert nurses
	Keep care plans up-to-date	Inconsistent care planning
		Consistent tracking visits and tasks and use of efficient communication tools (e.g. SBAR tool and standard assessment and task-related questions)

Note. SBAR = subject, background, assessment, recommendation.

Although organizational frameworks such as “people first” (VCH 2013a) and professional client-centered philosophies are professed by leaders and nurses, nevertheless in actual practice, the organization’s “practice is filled with schematization and stereotyping...that may objectify the client” and health care providers or HHNs (Chatterji, 1998, p. 358).

Chapter 8

Implications and Conclusions

The preceding chapters offer a description, exploration and interpretation of the organizational culture in the specific instance of HHNs who provide care to older SA clients who live at home in Vancouver BC. The findings and discussion illustrate how HHNs enact or reproduce the organizational context of efficiency and cost-effectiveness and how, despite a high-level of commitment to values for cultural sensitivity and cultural appropriate care, the organizational focus on costs overrides those values that might provide for more person-focussed care.

Key professional experiences shaped my interest in this ethnographic inquiry of HHNsg practice. In my undergraduate nursing degree, between the years of 2002-2006, I participated in a nursing student practicum experience, wherein my colleagues and I worked at a local Sikh temple in Vancouver, BC, and developed an initial understanding of the significance of cultural, social and familial ties for older SA Canadians with regards to their health, wellbeing and quality of life. Subsequently, from 2006-2008, I practiced as a registered nurse in an acute specialty unit at a local hospital where my registered nurse colleagues continued to strive to be caring within a highly technological context of practice as they delivered care to meet the needs of a diverse older adult population. Since 2008, as a practicing HHN, I have been delivering nursing services to a culturally diverse older adult population in Vancouver, BC. Upon my entry into professional HHNsg practice, I discovered that the electronic health record system had been introduced and was to become an integral aspect of HHNsg practice. HHNs were thus positioned and expected to manage the technological charting system as well as the complex physical and holistic needs e.g. culture, language, psycho-social and spiritual aspects of the culturally diverse older adult

population. Thus, my professional nursing experiences with this population created a desire to conduct and contribute research in this area of knowledge development.

Contributions

This ethnographic inquiry provides an empirical explanation of the realities of HHNsg practice and compares everyday nursing practices with organizational and professional discourses influencing practice (Allen, 2007). This study's findings provide a *partial* understanding of individual agency embedded in a complex context of political-economical-technological factors. I emphasize that this ethnographic inquiry represents a partial understanding of HHNsg practice for two reasons. Rudge observes "[An] ethnographic record is constituted as much by the positionality of the researcher as by the research participants" (Rudge, 1996, p. 147). In an ethnographic inquiry, understanding is not an objective but rather a subjective process dependant on the researcher's theoretical, professional, methodological framework. Thus, the presence of the researcher in the fieldwork influences the outcome of the study. In summary, this research has uncovered the actual realities of practice in the *context* of "what people actually do, as opposed to what they say they do," a discovery I could not have made based solely on my own front-line practice (Allen, 2007, p. 42).

Using Geertz's thick description, I contributed first-hand observations in the form of four stories that illustrate how HHNs integrate efficient and cost-effective practices with clients in their homes. These first-hand observations also illustrate "hidden meanings" of HHNsg practice, not always apparent through conversational interviews (Allen, 2007; Holloway & Todres, p. 166). Based on this study's observational findings, Advanced Practice Nurses (APNs) can influence and shape organizational leaders and policies to better address the realities of everyday practice, especially the expressed needs of clients.

Limitations

Prior to my observational fieldwork, I encouraged HHNs to convey a full understanding of how their practice is accomplished in the privacy of clients' homes. It is not possible to capture this context of HHNs' work solely through conversational interviews. By proactively building and fostering trust with participating HHNs, I hoped that my presence would not unduly affect their actions with their clients during my observations of practice. Although HHNs are accustomed to being observed by their fellow colleagues and clients and family members, in the instance of my observations, there is a remote possibility, given the variables of age, personality, experience and the pressures of the day's work, that my observational fieldwork impacted in some measure their practice. For instance, they may have wished to demonstrate their commitment to the organization (e.g. physiological approaches and cost-effective approaches) thus foregoing a holistic model of care. Having worked for a number of years as a HHN, my "insider" status granted intimate knowledge of HHNsg practice has thus further enabled me to confirm my observations of the HHNs' practice in this inquiry. Despite this possible short-coming, there was remarkable consistency in practice noted across the four observations I made of practice. It is not likely that all four HHNs would have made the same adjustments to their practice in response to my presence.

In hindsight, a second limitation of this study is that had I had more time and resources, I could have implemented more than one observation of each the HHN in this study. I would have welcomed the opportunity to observe each HHN, for example, over three home visits to explore their practices comprehensively.

A third limitation is that this study consisted of a small sample of HHNs who participated in this inquiry. Their involvement depended on the participation of a small number

of clients who volunteered to take part in this study. Given the limited scope of this inquiry, only one LPN participated in this study compared to six RNs, and thus the implications of this study are limited.

Implications

Based on the findings of this study, I categorize its implications on the basis of practice and research. With reference to practice, given the current organizational context of HHNsg practice, I raise the first question: What are the benefits of the LPN model of care compared to the RN model within the organizational context of HHNsg practice? Currently, the health system faces significant costs one of which includes maintaining adequate levels of staffing and the right staffing-mix to respond fiscal shortages, and increasing workloads and complexity of clients (CNA, 2004). In response to these fiscal challenges, Canadian health organizations are increasingly hiring LPNs despite a number of factors that play a role in the organizational context of HHNsg practice.

In this study, the organizational context in HHNsg, characteristics of clients and their homes, and professional expectations underpinning HHNsg practice may create a degree of variability, uncertainty, and complexity, a challenging environment for LPN practice, a model of care which is based upon stringent organizational guidelines because of educational background and scope of practice. According to the CHNC (2010), a home health nurse is an independent, autonomous, critical-thinker, problem-solver and collaborative practitioner who adapts to various psycho-social-economic circumstances of clients. These established qualities of a HHN fit the complex organizational context illustrated in this study: increasing client acuity, caseloads, urgency of care and limited human and fiscal resources. “As such, staff mix decision-making

must ...consider patient, provider and organizational factors," --variables that are yet to be taken into consideration in the Canadian context of health care (Harris & McGillis Hall, 2012, p. 19).

The LPN model of care is beneficial in that LPNs implement best practices by taking up protocols and policies from computer databases, organizational policies and specialist nurses. According to Purkis and Bjornsdottir (2006), evidence-based practice is a scientific and logical model of patient care and is acknowledged not only within the nursing discipline but also among other disciplines e.g. medicine. In this study, although the LPN model of care demonstrated excellent best practices in the area of wound and diabetic care, its application was not therapeutic and relational for the client and family, especially the latter who took on an advisory role with the client on behalf of the LPN. "...nursing is at a particularly high risk because economics, like other disciplines which rely on positivist methodologies, leaves no space for many of the subtleties of nursing" (Lawler, 2009, p. 42). Thus, the organization will have to develop better supports and guidelines for practicing LPNs, so that implementation of evidence-based and technologically oriented guidelines are client or person-centered. One prime example of a comprehensive and person-centered guideline is the *"Best practice guideline for accommodating and managing behavioral and psychological symptoms of dementia care in residential care: A person-centered interdisciplinary approach"* (British Columbia Ministry of Health, 2012). Although this guideline is not based in the context of home health, it successfully integrates evidence-based and philosophical approaches, beneficial for adults living with dementia.

The RN model of care too can be improved further to meet the diversified needs of clients receiving HHNsg services. For the purpose of this discussion, I would like to draw attention to Nurse Jackie's practice, an exceptional and personable nurse who responded creatively to her client's previous problems with the health care system. Among the four HHNs

who participated in this study, Nurse Jackie was the only nurse who received positive affirmation from the client and the family. I could not comprehend, in this specific instance, why Nurse Jackie had been able to build rapport, trust, respect and an evidence-based care plan with a client who had encountered several communication and conflicting expectations with the health care system. This observation raises the question: How sustainable is it for an organization to rely on exceptional nurses like Nurse Jackie whose personality and years of experience may have improved the quality of the client experience? This system of relying on individual traits of nurses to sustain the system of care is doubtful. In my view, the RN model of care may require an organizational context (e.g. more time and resources) that supports the sustainability of culturally-competent care. A guideline that directs a client-centered approach (e.g. respecting wishes, dignity, and expectations) alongside the implementation of best practices would be desirable.

With reference to practice, I raise the question: How can we narrow the gap between the various organizational and professional discourses? HHNs continue to be confronted with enacting their practice based on the polar positions of organization and professional discourses. Due to the complicated organizational context, HHNs require an advanced level (e.g. holistic and evidence-based perspective) of practice that helps them meet the conflicting realities of the various discourses.

Conclusions

The dominance of economic discourses "...have seduced [professions] into formalising our knowing of the physical body and nursing care in a form which is more meaningful and useful to economists and managers than it is to practicing nurses, scholars and researchers" (Lawler, 2009, p. 41). For example, in this study, HHNs predominantly adopted evidence-based

protocols, LEAN, team-based and specialist thinking to organize their everyday work, in an effort to cope and meet the objectives of an "acute-driven" organizational context faced with human and fiscal shortages (Interview: clinical coordinator). As observed in the instance of this study, HHNs enacted the objectives of the organization (e.g. standard, cost-effective, evidence based practices) and minimized professional obligations to explore the holistic expectations of SA clients in practice. These differences between organizational and professional obligations exist among various disciplines, and within the discipline of nursing, there is a need to achieve professional status in an organizational context dominated by efficiency (Purkis & Bjornsdottir, 2006, p. 248). However, "aspects of nursing cannot be reduced to, or rendered meaningful as entities that can be measured for productivity, cost effectiveness and efficiency" (Lawler, 2009, p. 41). The HHNs, in this study, provided task-focussed and physiological-based care which limited possibilities for them to open up conversations about their clients' social determinants of health (e.g. culture) and health promoting strategies that are just as equally important in reducing unnecessary costs to the health care system and improving the quality of their care.

Organizational discourses ought to be illustrative of person-centered and cultural-sensitivity approaches. In this study, however, team meetings or team talk focussed on managing signs and symptoms, accounting the investment of resources e.g. wound care products, and managing conflicting expectations of clients and the) services. "However, the biophysical model does not and cannot claim to account for aspects of practice which are contextually dependent or which have their origins within the person-in-the-body and his or her embodied experiences of illness, disease and health care" (Lawler, 2009, p. 46). Thus, organizational leaders ought to focus day to day interdisciplinary team conversations to support the client as a whole person within the context of policies, protocols and availability of resources. Leaders are

charged with the responsibility of narrowing the gap between organizational and professional discourses to fit the everyday realities of practice and expectations of clients (e.g. holistic expectations of SA clients in this study.

Future Research

Several questions have arisen in my mind as a result of this ethnographic inquiry. How can Advanced Practice Nurses influence managers and directors who organize cost-effective front-line care? "...The discourses of the sciences and economics, while they have shaped and continue to shape the way we talk and think about nursing, have silenced important and central concerns for nursing" (Lawler, 2009, p. 49). For myself, I aspire to be a leading member of the Association of Registered Nurses of British Columbia (ARNBC) (2014), an organization that has created safe mechanisms for nurses to discuss organizational issues affecting everyday care like the effects of staffing mix (e.g. LPNs and RNs) for the quality of care. Further, if front-line nurses are immersed in cost-effective and efficiency contexts, how can they articulate the essence of nursing (e.g. humanistic and holistic approaches versus biophysical and scientific approaches) to leaders who are managing and immersed in political and economic contexts? (Lawler, 2009).

Yet another and final question based on the findings of this study bears further consideration: What are the expectations of clients living at home? (Personal communications, M. E. Purkis, August 15, 2014). Do home health professionals resist this question because of the perception that clients' expectations may be too high to meet and sustain with existing organizational resources (e.g. human and financial). These queries are worthwhile further intensive exploration and undertaking for a better understanding of the intricacies of HHNsg and for contributing to the future strength and effectiveness of this important health service for those

members of the community who currently rely on it and for all those in the future who will come to rely on health care delivered in a community context.

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Appendix A: Information and Approval letter to Home Care manager/recruitment site manager

Subject: Graduate Studies Research Project
Dear (name of manager)
Cc (name of director)
Cc (name of charge nurse at health unit)

I am currently completing my last year in the Masters of Nursing (MN), Advanced Practice Leadership (APL) program at University of Victoria.

The purpose of my letter is to invite your work site _____ to be part of my final research project that I will complete as part of my MN studies in the APL program at UVIC. Let me take the opportunity to introduce myself and my project. My project needs to be approved by the UVIC ethics board, Vancouver Coastal Health Authority's Research Institute (VCHRI), and your work site. I would like to review my project with you in person in order to gain your approval to conduct my research project at your worksite _____

I am currently working as a Home health nurse (HHN) for Vancouver Coastal Health (VCH) at Evergreen Community Health Center. Having worked as a HHN for the past seven years and completed my practicum as a Masters student at VCH, I am particularly interested in designing a research study that is based in Home Health nursing (HHNsg). In the following sections, I have provided a detailed description of my project: research question, key definitions, study's sample and procedures, benefits of this study, timelines, and confidentiality and anonymity procedures.

Research question/Project title:
How does the organizational culture in HHNsg influence the day to day practice of HHNs as they provide care to older South Asian (SA) clients who live at home?

The focus of my research project is HHNsg practice in the particular context of HHNs who work with the older SA population that receive nursing services at home. Given that my target population will consist of HHNs who deliver care to older SA clients, I am interested in conducting my project at your work site. In addition, since I am in the APL program at UVIC, I have incorporated a leadership perspective by including the concept of organizational culture in my research question.

Definition of organizational culture
The organizational culture refers to how a group functions to complete their day to day work. The culture of the organization can be interpreted by observing how a group performs their day to day work through their language, actions, values, beliefs, unspoken assumptions and the use of visible organizational artefacts (practice guidelines and or organizational policies) (Bellot, 2011; Scott-Findlay & Estabrooks, 2006; Scott, Mannion, Davies et al., 2003). Several authors have illustrated how the culture in nursing practice influences patient outcomes and care (Davis, 1997; Spilsbury & Meyers, 2005; Wolfe, 1988).

Research design: Ethnography

Ethnographic methods include conducting observational fieldwork, documenting fieldnotes, interviewing key informants, and examining documentary texts or evidence.

Why is this study important?

Among the growing senior population in Vancouver, the older adult SA population is increasingly accessing HHNsg services, an important service that enables seniors to live at home independently and with the support of family members. Successful home care has been demonstrated to prevent costly hospitalization and is therefore becoming increasingly important in terms of Health Authority strategic planning. A key challenge identified by nurses working in this sector relate to language and cultural barriers in meeting the needs of the older SA population.

Participants are invited to participate if they meet the following criteria:

- HHNs practicing as Licensed Practical Nurses (LPNs), registered nurses (RNs), and case manager registered nurses (CMRNs), employed by the health authority for at least three months and are currently taking care of older SA clients who live at home.
- Nurse leaders with three years of leadership experience in the organization and practice as a manager, team leader, clinical nurse specialist, and clinical nurse educator.
- Older SA clients who are 55 years and older, self identify as a SA, speak basic conversational English or have a English speaking family member who assists with translation and are currently receiving HHNsg services for wound, chronic disease and intravenous management.

Data collection methods:

I will observe individual HHNs as they provide care to older SA clients in their homes. During observations, I will document fieldnotes of how the HHN completes her daily work activities with the older SA client. Following observations, I will conduct individual interviews with the HHNs that I observed and as well as with nurse leaders. Furthermore, I would like to include organizational documentary evidence for e.g. organizational policies as part of my data for this study.

Purpose and Objectives

i) To observe and understand the everyday actions of and language used by HHNs as they provide care (wound care, chronic disease management, and intravenous management) to older SA clients who live at home.

What will observations entail? I would like to observe and document personal fieldnotes of how individual HHNs engage in their daily work with the older SA client. This includes the HHN's day to day words, actions and use of organizational artefacts that are observed during the visit. I will not be documenting any sensitive information about the client or their family members. My main focus is the HHN's practice in the context of the organization's culture. I intend to conduct my observational field work in the homes of older SA clients during work hours.

ii) To develop an understanding of the organizational culture in HHNsg through the interview accounts of HHNs and nurse leaders and the examination of organizational documentary evidence.

What will individual interviews involve? I intend to conduct individual interviews with HHNs who were involved in observations in order that I am able to gain insight into the HHNs' perspective of his or her practice and what was accomplished during the visit. In addition, I will also carry out individual interviews with nurse leaders who will be invited to describe the values and beliefs of the organization and how these aspects of the organization manifest in day to day practice of HHNs who provide care to older SA clients that live at home. Interviews will take place after work hours.

If participants choose to be interviewed at the recruitment site, would I be able to book a private space to conduct interviews on the unit's premises? Yes ____ or No _____

Documentary evidence

Documentary evidence is an important aspect of this study and includes particular unit policies or guidelines that inform the day to day practice of HHNs who provide care to older SA clients in their home. Through my observational fieldwork and individual interviews, I will learn of organizational documents that shape HHNs practice with older SA clients. Thus, I will seek your permission/consent for documentary evidence in this project--please see attached consent form. I will need your assistance to print the policy or guideline and to strip off any identifying information that may identify the organization/employees in the document.

What is expected of the site (name of site) _____?

- I will require the assistance of a volunteer third-party who will assist me with recruiting potential participants. I will provide the third-party with the study's recruitment materials which include recruitment posters, email notices and electronic and paper invitation/consent forms. (I can review the recruitment materials in person with you and the third-party).
- I will require the assistance of the recruitment site's manager to print and strip off identifiers of documentary evidence (for e.g. organizational policies or guidelines) that may be relevant for my project.

Number *of* participants required*:* 5 HHNs, 2 nurse leaders and 3-5 clients

Possible Benefits

By participating in this study, participants can personally reflect upon and discuss the implications of current gaps and strengths of the organizational culture in HHNsg for HHNs who practice with older SA clients in their homes. Findings may have implications for future nursing research, education, practice, quality improvement projects and organizational policy as relevant to improving the organizational culture in HHNsg practice especially for HHNs who provide care to the older SA population who live at home**.**

The Time lines for my project are as follows:

Ethics approval: November 2012
VCH, recruitment site's manager and director approval: September-October 2012
VCHRI approval: January 2012
January-February 2013- I will initiate recruitment procedures in collaboration with the recruitment site.
February 2013-I will initiate data collection
November 2013- Closing meeting with manager at recruitment site

Anonymity and Confidentiality:

- The study's data (e.g. observation fieldnotes, audio recordings and interview transcripts) will not contain any personal information like name, age, or place of work. Therefore, I will use pseudonyms for participants' data.
- I will not disclose the identities of participants with anyone.
- If a medical emergency or life threatening circumstance occurs during an observation or interview, I will call emergency services (e.g. police, ambulance or fire department). If the client discloses that they are at risk for harm due to an existing illness, then I will ensure that appropriate medical, crisis or emergency services are offered to the client.
- I will maintain a master list of participant's actual names, their contact details, and their

pseudonym or false name. I will be the only person who accesses this master list. Access will only be in the event that I need to communicate with or withdraw participants' data. This master list will be locked in a filing cabinet stored within my residence.
- Paper copies of the study's data (fieldnotes, interview transcripts, documentary evidence) will be stored in a locked filing cabinet, located in my home.
- Electronic files of the study's data will be stored in password protected files on my laptop which will be protected by anti-virus software and stored within my residence.
- Throughout the course of the study, data will be linked to fictitious names and will be analyzed by my supervisor/co-supervisor and I.
- A transcriptionist will sign a confidentiality agreement to transcribe audio-taped interview data verbatim. Audio tapes will be held by the transcriptionist until transcription is completed. Audio recordings will be deleted / erased by me after transcription is successfully completed. Interview notes will be shredded after transcription has been successfully completed.
- Paper and electronic copies of fieldnotes and interview data will be stored for a period of five years after this study is completed and thereafter will be shredded and deleted/erased.

Research Results may be Used/Disseminated in the following ways:
- Findings will be included in my Master's thesis, a requirement to graduate from the MN Program at UVIC.
- The study's findings will be shared at a scholarly meeting with faculty members and fellow students and posted on the UVIC library website.
- Findings from this study may be published in peer reviewed journals and may be presented at a health conference, professional development or educational workshop.
- Upon completion of the study, upon request, I can provide an executive summary of this study's results to participants or the recruitment site.

Questions or Concerns:
- I have provided my contact information at the top of page 1;
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545 ethics@uvic.ca
- I will be conducting my research project under the supervision of Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria.

By signing below, you _____(name of manager and director)_____ agree the site ____(name of site)_____ is suitable for this research project: How does organizational culture in HHNsg practice influence the day to day practice of HHNs seeking to meet the needs of older SA clients living at home?—An ethnography

Name of manager		*Signature*		*Date*

_____ _____

_____

Name of director		*Signature*		*Date*

Please see attached forms from VCH Research Institute's approval forms and sign where appropriate. I have attached a consent form so that I can collect appropriate documentary evidence for this study- please review and sign if appropriate.

Appendix B: Consent form to collect anonymized documentary evidence

University of Victoria **School of Nursing**	

Project Title: How does the organizational culture in Home Health Nursing (HHNsg) influence the day to day practice of Home Health nurses (HHNs) as they provide care to older SA clients that live at home?—An ethnography

Researcher(s): My name is Jonquil Francis and I am a graduate student in the School of Nursing at the University of Victoria (UVIC) who can be contacted by email or phone (removed for privacy purposes). **Supervisor:** Please contact Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria for more information or concerns.

Please take the time to read this invitation/consent form carefully as you are entitled to have full information about the study.

Purpose of the research study:

The purpose of this study is to gain an understanding of the organizational culture in home care nursing practice especially for home health nurses who provide care to older SA clients who live at home.

What is this study important?

In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

What will happen during the study?

Documentary evidence will supplement the data that I collect in my observations and interviews. I would like to include documentary evidence for e.g. particular organizational policies or guidelines that inform day to day practice for HHNs who provide care to older SA clients in their home. I will require your voluntary consent to include particular organizational policies or guidelines in this study. Post data collection of my observational fieldwork and interviews with participants, I will consult with you in person which policies or guidelines I can include in this study. I will need your assistance to print the policy or guideline and to strip off any identifying information that may identify the organization or its employees on the document.

Possible Benefits

My findings may have implications for nursing research, practice, education, organizational policies and quality improvement in HHNsg in the particular context of HHNs who provide care to the older SA population.

Anonymity and Confidentiality:

- Documentary evidence will not be linked to the organization's name or any other indirect identifiers that would imply the identity of the organization.
- Paper copies of documentary evidence will be stored in a locked filing cabinet, located in my

home.

- Electronic copies of documentary evidence will be stored in a password protected files protected by anti-virus software on my personal laptop.
- Throughout the course of the study, data will be linked to fictitious names and will be analyzed by my supervisor/co-supervisor and I.
- I will destroy (shred or delete) documentary evidence five years after the study's completion.

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by me and that you agree to participate in my research project.

Name of Participant		*Signature*		*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Can I contact you in the future if I wish to use the data from the home observation for secondary analysis _____

University of Victoria

School of Nursing

Appendix C: Recruitment poster for Home Health nurses and nurse leaders

My name is Jonquil Francis and I am a home health nurse and a Masters in Nursing student from the University of Victoria (UVIC) conducting a qualitative research study at _____(name of the recruitment site)

My research question is as follows: How does the organizational culture in home care nursing (HHNsg) influence the day to day practice of home health nurses (HHNs) as they provide care to older South Asian (SA) clients who live at home?—An ethnography

Purpose of the study

To develop an understanding of how organizational culture in HHNsg practice influences the day to day practice of HHNs seeking to improve the health and well being of older SA clients living at home.

Why is the study important?

In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

You are invited to participate if you are:

1) a home health nurses who has worked at least three months in the health authority and are currently providing home care nursing services (wound care, chronic disease management or intravenous therapy) to older SA clients who are age 55 years and older, self-identify as SA from Punjab, speak English or Punjabi, and have an English speaking family member who assists with translation.

2) nurse leader (nurse manager, team leader, clinical nurse specialist, or clinical nurse educator) who has three years of leadership experience in the organization

What is expected of participants?

I would like to observe a home visit with a HHN and an older SA client who lives at home followed by a face to face individual interview with the same HHN who participated in my observation. The home visit will take 30-60 minutes and the interview will take 45-60 minutes.

I invite nurse leaders to participate in an individual interview that will take 45-60 MINUTES.

All participants will sign a consent form which will contain full details about the study: inconveniences, benefits, and confidentiality, anonymity and dissemination procedures.

I can provide you more information about this study, please contact me directly **by** email or phone (removed for privacy purposes).If you volunteer to participate, I will seek your permission for your contact details so that I can schedule a time and place to obtain your written consent.

Thank you,

Jonquil Francis, B. N., RN, MN candidate

Appendix D: Third-party scripts and email notices for HHNs

Hello,

Jonquil Francis is a graduate nursing student from the University of Victoria (UVIC) and will be conducting a qualitative study at _____(name of recruitment site) and would like to invite Home health nurses (HHNs) to participate in her study.

HHNs that practice as Licensed Practical Nurses (LPNs), registered nurses (RNs), case manager registered nurses (CMRNs) and have been employed by the health authority for at least three months are invited to participate especially if you are currently taking care of an older South Asian (SA) client who lives at home.

The study's research question is as follows: How does the organizational culture in home care nursing (HHNsg) influence the day to day practice of HHNs as they provide care to older South Asian (SA) clients who live at home?—An ethnography

Purpose and importance of the study

To develop an understanding of how organizational culture in HHNsg influences the day to day practice of HHNs seeking to improve the health and well being of older SA clients living at home.

In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges of HHNs everyday work as they provide care to older SA clients who live at home.

What is expected of participants?

You are invited to participate in this study if you are currently taking care of an older SA client who is 55 years an older, speaks English or Punjabi and has an English speaking family member and the client receives wound, chronic disease or intravenous care.

The researcher, Jonquil Francis, would like to observe a home care nursing visit with you and an older SA client who lives at home and to interview you about the observed home visit. The home visit will take 30-60 minutes and the interview will take 45-60 minutes.

All participants will sign a consent form which will contain full details about the study: inconveniences, benefits, and confidentiality, anonymity and dissemination procedures.

If you desire to participate, please contact the researcher, **Jonquil Francis**, for more information via email or phone (removed for privacy purposes). If you decide to participate, you may volunteer your contact details so that a convenient time and place can be set up to review the consent process prior to your participation.

On behalf of

Jonquil Francis, B. N., RN, MN candidate

Please refer to the attached electronic invitation/consent form for more details. Paper copies are available at the nursing station.

Appendix E: Third-party scripts and email notices for nurse leaders

Jonquil Francis is a graduate nursing student from the University of Victoria (UVIC) who will be conducting a qualitative study at _____(name of recruitment site).

Nurse leaders who are nurse managers, team leaders, clinical nurse specialists and clinical nurse educators and are currently working in the organization for at least three years are invited to participate in this study.

The study's research question is as follows: How does the organizational culture in Home Health nursing (HHNsg) influence the day to day practice of home health nurses (HHNs) as they provide care to older South Asian clients who live at home?—An ethnography

Purpose and importance of the study

To develop an understanding of how organizational culture in HHNsg influences the day to day practice of HHNs seeking to improve the health and well being of older SA clients living at home.

In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges of HHNs everyday work as they provide care to older SA clients who live at home.

What is expected of participants?

You are invited to participate in an individual interview with the researcher

All participants will sign a consent form which will contain full details about the study: inconveniences, benefits, and confidentiality, anonymity and dissemination procedures.

If you desire to participate, please contact the researcher, **Jonquil Francis**, for more information via email or phone (removed for privacy purposes). If you decide to participate, please volunteer your contact details so that a convenient time and place can be set up to review the consent process prior to your participation.

On behalf of

Jonquil Francis, B. N., RN, MN candidate

Please see attached electronic information/consent form for nurse leaders. Paper copies are available at the nursing station.

Appendix F: Script for Home Health Nurse

A student Jonquil Francis from University of Victoria is doing a study about home health nurses and how they provide day to day care to older South Asian clients. Can I provide some information about this study to you?

Please note your participation in this study is voluntary. You do not have to take part in this study if you do not want to.

Whether you decide to participate or not you will continue to receive your current home care nursing services.

Why is this study important? In Vancouver, the older South Asian (SA) population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

What is involved?

The student would like to observe one home visit with the home health nurse and you. You may choose to have a family member present with you.

Would you like to volunteer your contact information for this study? A third-party assistant to the student will contact you shortly with more information.

For the third-party to contact you, what is the best way to contact you? Please print below. You also have the option of calling the third-party at the health unit phone number

_____

Or contact Jonquil at phone no: xxx-xxx-xxxx

Appendix G: Telephone script for third-party
(When he or she contacts the client after the client gives their contact details to the HHN)

Hello my (third-party) name is_____. I am calling from xxxxx (removed for privacy) on behalf of Masters Student Jonquil Francis.

Jonquil will be conducting a study to graduate from her program. She would like to invite older South Asian clients to be part of her study.

Are you an older adult SA client, age 55 years and older, speak basic conversational level of English or seek assistance from an English speaking family member for translation and are currently receiving home care nursing services for wound care, intravenous care or chronic disease management?

If you are, then you are eligible to participate. **Please note your participation in this study is voluntary.**

Whether you decide to participate or not you will continue to receive your current home care nursing services.

Purpose of the research study:

The purpose of this study is to gain an understanding of the organizational culture in home care nursing especially for home health nurses who provide care to older SA clients who live at home.

Why is this study important? In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

What is involved?

She/Jonquil will observe one home visit with the home health nurse and you. You may choose to have a family member present with you.

During the home visit, Jonquil will observe and take notes of how the home health nurse does/performs her work activities.

Jonquil will not observe any of your personal or intimate care. If you are not comfortable discussing anything in front of her, or having her witness your interaction with your home health nurse, you can ask me to stop observing or to leave your home.

Would you like more information about this study? If yes, I will mail a poster and a consent form to you. Please take time to read the poster and consent form. I will call you back a second time to check if you are interested in participating. If you are not interested, please let me know. If you like, I will book a time and place, at your convenience, for Jonquil to obtain your written consent, prior to doing the home observation with the HHN.
She can be contacted by email or phone (removed for privacy purposes).

Appendix H: Electronic and paper consent forms for Home Health Nurse

University of Victoria **School of Nursing**	***Nurse Participant Consent Form***

Project Title: How does the organizational culture in Home care nursing (HHNsg) influence the day to day practice of home health nurses (HHNs) as they provide care to older South Asian (SA) clients who live at home?—An ethnography

Researcher(s): My name is Jonquil Francis and I am a graduate student in the School of Nursing at the University of Victoria (UVIC) who can be contacted by email or phone (removed for privacy purposes). **Supervisor:** Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria can be contacted for more information or concerns.

Purpose(s) and Objective(s) of the Research:

The purpose of this study is to i) describe the organizational culture in HHNsg practice; and ii) develop an understanding of how organizational culture in HHNsg influences the day to day practice of HHNs seeking to improve the health and well being of older SA clients living at home.

This Research is Important because:

In Vancouver, the older SA population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

You are invited to participate in this study if you are a practicing Licensed Practical Nurse (LPN), registered nurse (RN), or case manager registered nurse (CMRN) and have been employed by the health authority for at least three months and are currently taking care of an older SA client in their home

- Participation in this project is voluntary.

What is involved?
After you volunteer to participate and provide written consent, I invite you to allow me an opportunity to observe one home care nursing visit with you and your SA client in their home followed by an individual interview with you. During the interview, I will invite you to discuss your day to day practice with older SA clients, in particular the home visit that I observed. Observations of home visits will take 30-60 minutes and the interview will take 45-60 minutes.

1. On the day of the home visit, I will verbally seek your approval to conduct the home visit. At the time of the scheduled home visit, i will confirm your consent. During the home visit, if you are agreeable and comfortable, I am interested in observing your daily work activities with older SA clients. As I observe your work, I will record some notes about how you do your daily work during the visit. My goal is to observe, describe and understand the organizational context (collective values, beliefs, practices and structure of the organization that influence the everyday work of HHNs) of your practice and not to judge your practice.
2. I will not observe any personal or intimate care that you do for the client. I will rely on you and your client to let me know if there is anything that I should not know or observe. You can stop or reschedule the observation at any time.
3. Following the observation of the home visit, after work hours, I would like to conduct an

individual 45-60 minute interview with you to gain a better understanding of your daily work activities especially those activities that I observed in your client's home.

4. During the interview, depending on your level of comfort, you are invited to discuss the home visit and your daily work activities in further detail. You can stop or reschedule your interview at any time.
5. After the observation and interview, please do not reveal the identity of the client to anyone outside the research study. I have asked the client and/family member also not to reveal your identity to anyone.

Inconveniences: The main inconvenience associated with your participation is that participation in the observation aspect of this study will take place during work hours. In addition, the interview will take place after hours. As a result, I will do the following:

- I will ensure that the follow-up interview is conducted in an organized and systematic way, as well as I will carry out the interview at a pace that is suitable for you. You have the option to review interview questions prior to the interview and to abstain from answering questions during the interview. During or after your interview, you can also request me to delete specific comments in the audio-recording. I will test audio-equipment ahead of time to avoid delays during the interview process.
- If you have child or personal time commitments, I can schedule your interview at a time and place that is convenient for you. I am open to rescheduling the interview as per your individual needs and preferences.
- I will conduct my observations of the home visit as per the wishes of the HHN and the client.

Compensation:

I will provide a stationary gift worth twenty dollars for your participation in this study.

If you would not participate if the compensation was not offered, then you should decline to participate in this research project.

Possible Benefits:

- By participating in this study, HHNs may reflect upon and share current gaps and strengths of their organization's culture and its effects for daily practice with older SA clients who live at home.

- By participating in this study, findings may have implications for future nursing practice, research, organizational policy, and education in the particular context of HHNs who practice with older SA clients.

- For society, the findings from this study may contribute to quality improvement projects in the field of HHNsg practice.

Withdrawal of Participation:

- You may withdraw at any time, without explanation.
- If you withdraw from the observation, I will not include any data collected from that observation.
- When you withdraw from the study, there will be no consequence or penalty and your data will not be used my research project.
- If you decide to withdraw your data, you will receive the compensation promised at the time of consent.

Anonymity and Confidentiality:

- Throughout the course of the study, my fieldnotes, audio recordings and interview transcripts will not contain any personal information of participants for e.g. your name, age, or place of work. If you participate in a home observation, the client and or family member will know that you volunteered to take part in this study. In this way, your anonymity is not fully guaranteed. However, I have requested the client and or family member not to reveal your identity to anyone. Since the sample size in this study is small, this may be a limitation to your confidentiality. Therefore, I will use pseudonyms to depersonalize direct and indirect identifying information.
- The third-party will not to disclose your identity to anyone nor will I share any of your data with the third-party.
- I will maintain a master list of participant's actual names, their contact details, and their pseudonym or false name. I will be the only person who accesses this master list. Access will only be in the event that I need to communicate with or withdraw participants' data. This master list will be locked in a filing cabinet stored at my residence.
- If a medical emergency or life threatening circumstance occurs during an observation or interview, I will call emergency services (e.g. police, ambulance or fire department). If the client discloses that they are at risk for harm due to an existing illness, and then I will ensure that appropriate medical, crisis or emergency services are offered to the client.
- Paper copies of the study's data (fieldnotes and interview transcripts) will be stored in a locked filing cabinet in my residence.
- Electronic files of this study's data (fieldnotes and interview transcripts) will be stored in password protected files on my laptop that will be protected by anti-virus software and stored within my residence.
- Throughout the course of the study, data will be linked to fictitious names and will be analyzed by my supervisor/co-supervisor and I.
- A transcriptionist will sign a confidentiality agreement to transcribe audio-taped interview data verbatim. Audio tapes will be held by the transcriptionist until transcription is completed.
- Paper and electronic copies of fieldnotes and interview data will be stored for a period of five years after this study is completed.

Disposal of Data:

- Paper copies of the data will be shredded and computer files of observation fieldnotes and interview data will be deleted after five years from the successful completion of my thesis. Audio recordings will be deleted/erased by me after the study is completed. Interview notes will be shredded after I confirm that the notes correspond to the content in transcripts.

Dissemination of Results:

- The information that participants provide is part of my graduate studies.
- The findings from this study may be shared at my thesis presentation with other fellow graduate students and faculty
- The complete report of this study will be posted on the UVIC website.
- The findings from this study may be published in an academic journal.
- Upon completion of the study, upon request, I can provide an executive summary of this study's results to participants or the recruitment site.
- The findings from this study may be shared at a professional conference or professional development workshop
- Your name or any other identifying information will not be in any reporting of the results from this study.

Questions or Concerns:

- I have provided my contact information at the top of page 1;
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545 ethics@uvic.ca

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you agree to participate in this research project.

Name of Participant		*Signature*		*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Can I contact you in the future if I wish to use your data for secondary analysis _____

Appendix I: Older SA Client Invitation/Consent Form

University of Victoria **School of Nursing**	***Client Participant Consent Form***

Project Title: How does the organizational culture in Home Care Nursing (HHNsg) influence the day to day practice of Home health nurses (HHNs) as they provide care to older South Asian (SA) clients who live at home?—An ethnography

Researcher(s): My name is Jonquil Francis and I am a graduate student in the School of Nursing at the University of Victoria (UVIC) who can be contacted by email or phone (removed for privacy purposes). **Supervisor:** Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria can be contacted for more information or concerns.

You are invited to take part in my research project if you consider yourself to be South Asian from Punjab, you are age 55 years and older, speak English or Punjabi and have an English speaking family member who assists with translation, and if you are currently receiving home care nursing services for wound care, intravenous care or chronic disease management.

- **You are not obliged or expected to participate in this study. Your choice to take part in this study is up to you and is voluntary.**
- **You will continue to receive your current home care nursing services even if you decide not to participate**.

Please take the time to read this invitation/consent form carefully as you are entitled to have full information about the study.

Purpose of the research study:

The purpose of this study is to gain an understanding of the organizational culture in home care nursing especially for home health nurses who provide care to older SA clients who live at home.

What is this study important?

In Vancouver, the older SA population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

Please kindly read the flyer and invitation/consent form for my study.

What will happen during the study?

1. If you are interested in participating in the study, you are welcome to contact me at _____ Or

2. If you choose, you have the option of calling __(name of third-party)_____ at the health unit to get more information about my study. The third-party will seek your permission to forward your contact details to me so that I can speak to you directly about my study and so that I may schedule a home visit to obtain your written consent prior to observing the home health nurse in your home.

3. Just because you are already receiving Home Care nursing services from the (name of recruitment site),

you are not obliged or expected to declare your interest to anyone at the health unit. You are welcome to call me directly to take part in the study.

4. On the day of the home visit with the HHN, and at the time of the home visit, i will confirm your consent or agreement to participate in my study**.**

5. During the home visit, I will observe and take notes of how the home health nurse does her work activities with you. The home visit will take 30-60 minutes.

6. During the home visit, you may choose to have a family member present with you. I will provide your family member a copy of an information letter about my study. I will not be gathering any data about your family members who are present in your home.

7. At any time and for any reason, you or your family member can stop or reschedule my observation of the home health nurse doing her work with you.

8. I will not observe any personal or intimate care. If you are not comfortable to discuss your health needs with your HHN in front of me, you are not obliged to do so and you can ask me to leave your home.

9. Considering my observations will take place in your home, I will request you/family member not to disclose to anyone the identity of the home health nurse who took part in my study. In the same way, the home health nurse will also not disclose your identity to anyone.

Inconvenience: The main inconvenience is that your participation requires your time and that I have to visit your home to do my research. Therefore, I will book the home visit on a day and time that is agreeable to you and the HHN and I will reschedule or stop the observation as per your needs and wishes.

Compensation:
In appreciation for your participation in this study, a stationary gift worth 20$ will be offered to you for your contributions to this study.
If you would not participate if the compensation was not offered, then you should decline to participate in my research project.

Possible Benefits:

- By participating in my study, findings may lead home health nurses and nurse leaders to reflect upon and better their practice with the older SA population who receive home care nursing services.
- By older SA clients participating in my study, findings may have implications for future nursing practice, research, education, and organizational policy in the particular context of home health nurses who provide care to older SAs who live at home.
- For society, the information gained from this study may contribute to future quality improvement in the field of HHNsg.

Withdrawal of Participation:

- You may withdraw at any time, without explanation.
- When you withdraw from the study, there will be no consequence or penalty.
- If you or the home health nurse withdraws from the study, your data will not be used in the research project.
- If you decide to withdraw your data, you will receive the compensation promised at the time of consent.

- If you withdraw, you will continue to receive your current nursing services.

Anonymity and Confidentiality:

- Throughout the course of the study, my fieldnotes will not contain any of your personal information. If you participate in a home observation, the home health nurse will know that you volunteered to take part in my study. In this way, your anonymity is not fully guaranteed. However, I have requested the home health nurse not to reveal your identity to anyone.
- Since the sample size is small in this study, this may be a limitation to your confidentiality.
- The third-party will not disclose your identity or contact details to anyone nor will I share any of your data with the third-party.
- I will maintain a master list of participant's actual names, their contact details, and their pseudonym or false name. Access will only be in the event that I need to communicate with you or to withdraw your data. This master list will be locked in filing cabinet stored within my residence.
- If a medical emergency or life threatening circumstance occurs during an observation or interview, I will call emergency services (e.g. the police, ambulance or fire department). If you disclose that you are at risk for harm due to an existing illness, and then I will ensure that appropriate medical, crisis or emergency services are offered to you.
- Paper copies of my fieldnotes will be stored in a locked filing cabinet in my residence.
- Electronic files of my fieldnotes will be stored in password protected files on my laptop which will be stored at within my residence and my laptop will be protected by anti-virus software.
- My immediate academic supervisor/co-supervisor and I will read and analyze my fieldnotes related to the home observations.
- A transcriptionist will sign a confidentiality agreement and transcribe interview data verbatim. Audio tapes will be held by the transcriptionist until transcription is completed. My notes of the interview will be shredded after transcription.
- Paper and electronic copies of fieldnotes and interview data will be stored for a period of five years after my study is completed.

Disposal of Data:

- Paper and electronic copies of my observational fieldnotes will be shredded and erased five years from the successful completion of my thesis.

Dissemination of Results:

- The information that participants provide is part of my graduate studies.
- The findings from this study may be shared at my thesis presentation with other fellow graduate students and faculty
- The complete report of my study will be posted on the UVIC website.
- The findings from this study may be published in an academic journal.
- Upon completion of the study, upon request, I can provide an executive summary of my study's results to participants or the recruitment site.
- The findings from this study may be shared at a professional conference or professional development workshop
- Your name or any other identifying information will not be in any reporting of the results from this study.

Questions or Concerns:

- I have provided my contact information at the top of page 1;
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545 ethics@uvic.ca

Your signature below indicates that you understand the above conditions of participation in my study, that you have had the opportunity to have your questions answered by me and that you agree to participate in my research project.

Name of Participant		*Signature*		*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Can I contact you in the future if I wish to use the data from the home observation for secondary analysis _____

Appendix J: Punjabi translated consent form

ਯੂਨੀਵਰਸਿਟੀ ਆਫ ਵਿਕਟੋਰੀਆ ਸਕੂਲ ਨਰਸਿੰਗ ਸਾਊਥ ਹੈਲਥ ਕਮਿਊਨਿਟੀ ਸੈਂਟਰ	***ਕਲਾਇੰਟ ਸਹਿਮਤੀ (ਕੰਨਸੈਂਟ) ਫਾਰਮ***

ਮੇਰਾ ਨਾਂ ਜੋਕਿਉਅਲ ਫਰਾਂਸਿਸ ਹੈ ਅਤੇ ਮੈਂ ਵਿਕਟੋਰੀਆ ਯੂਨੀਵਰਸਿਟੀ ਤੋਂ ਹਾਂ। ਤੁਸੀਂ ਮੇਰੇ ਨਾਲ ਈਮੇਲ - ਨਾਲ ਸੰਪਰਕ ਕਰ ਸਕਦੇ ਹੋ ਜਾਂ 'ਤੇ ਫੋਨ ਰਾਹੀਂ।

ਮੇਰੀ ਖੋਜ ਅਧਿਅਨ ਦਾ ਸਵਾਲ ਹੈ ਕਿ ਘਰਾਂ ਵਿਚ ਆ ਕੇ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ, ਸਾਊਥ ਏਸ਼ੀਅਨ ਭਾਈਚਾਰੇ ਦੇ ਬਜ਼ੁਰਗ ਕਲਾਇੰਟ ਜੋ ਘਰਾਂ ਵਿਚ ਰਹਿੰਦੇ ਹਨ, ਉਨ੍ਹਾਂ ਦੀ ਦੇਖ ਭਾਲ ਕਿਸ ਤਰ੍ਹਾਂ ਕਰਦੀਆਂ ਹਨ?

ਮੇਰੀ ਪ੍ਰੋਫੈਸਰ ਦਾ ਨਾਂ ਡਾਕਟਰ ਮੈਰੀ ਐਲਨ ਪੁਰਕਿਸ ਹੈ। ਉਨ੍ਹਾਂ ਦਾ ਫੋਨ **250-721-8050** ਹੈ ਤੇ ਈਮੇਲ **hsddean@uvic.ca** ਹੈ।

ਮੇਰੇ ਖੋਜ ਅਧਿਅਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਮੈਂ ਤੁਹਾਡਾ ਸਵਾਗਤ ਕਰਦੀ ਹਾਂ: ਜੇ ਤੁਸੀਂ 55 ਸਾਲ ਜਾਂ ਇਸ ਤੋਂ ਵੱਧ ਉਮਰ ਦੇ ਹੋ ਅਤੇ

* ○ ਤੁਹਾਨੂੰ ਘਰਾਂ 'ਚ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ ਤੋਂ ਸੇਵਾ ਮਿਲ ਰਹੀ ਹੈ
* ○ ਤੁਸੀਂ ਅੰਗ੍ਰੇਜ਼ੀ ਅਤੇ ਜਾਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ
* ○ ਪਰਿਵਾਰ 'ਚ ਕੋਈ ਅੰਗ੍ਰੇਜ਼ੀ ਬੋਲਣ ਵਾਲਾ ਹੈ

ਜੇ ਤੁਸੀਂ ਮੇਰੇ ਖੋਜ ਅਧਿਅਨ ਵਿਚ ਹਿੱਸਾ ਨਹੀਂ ਵੀ ਲੈਂਦੇ ਤਾਂ ਜਿਹੜੀ ਤੁਹਾਨੂੰ ਹੁਣ ਘਰਾਂ 'ਚ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ ਤੋਂ ਸੇਵਾ ਮਿਲ ਰਹੀ ਹੈ ਉਹ ਏਸੇ ਤਰ੍ਹਾਂ ਮਿਲਦੀ ਰਹੇਗੀ। ਮੇਰੇ ਖੋਜ ਅਧਿਆਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣਾ ਤੁਹਾਡੀ ਆਪਣੀ ਮਰਜੀ ਹੈ।

ਮੇਰੀ ਖੋਜ ਅਧਿਅਨ ਦਾ ਮਕਸਦ ਇਹ ਸਮਝਣਾ ਹੈ ਕਿ ਘਰਾਂ ਵਿਚ ਆ ਕੇ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ, ਸਾਊਥ ਏਸ਼ੀਅਨ ਭਾਈਚਾਰੇ ਦੇ ਬਜ਼ੁਰਗ ਕਲਾਇੰਟ ਜੋ ਘਰਾਂ ਵਿਚ ਰਹਿੰਦੇ ਹਨ, ਉਨ੍ਹਾਂ ਨੂੰ ਦੇਖ ਭਾਲ ਦੀਆਂ ਸੇਵਾਵਾਂ ਕਿਸ ਤਰ੍ਹਾਂ ਦਿੰਦੀਆਂ ਹਨ?

ਇਹ ਖੋਜ ਅਧਿਅਨ ਕਿਉਂ ਜ਼ਰੂਰੀ ਹੈ?

ਵੈਨਕੂਵਰ ਵਿਚ ਬਹੁਤ ਸਾਰੇ ਸਾਊਥ ਏਸ਼ੀਅਨ ਕਲਾਇੰਟ ਆਪਣੇ ਘਰ ਰਹਿ ਕੇ ਘਰਾਂ ਵਿਚ ਆ ਕੇ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ ਤੋਂ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਰਹੇ ਹਨ। ਇਹ ਅਧਿਅਨ ਇਸ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਉਪਲੱਬਧ ਕਰਵਾ ਸਕਦਾ ਹੈ ਕਿ ਸਾਊਥ ਏਸ਼ੀਅਨ ਭਾਈਚਾਰੇ ਵਾਸਤੇ ਘਰਾਂ ਵਿਚ ਆ ਕੇ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਨੂੰ ਕਿਸ ਤਰ੍ਹਾਂ ਬੇਹਤਰ ਬਣਾਇਆ ਜਾ ਸਕਦਾ ਹੈ।

ਮੇਰੇ ਅਧਿਅਨ ਸਮੇਂ ਕੀ ਹੋਵੇਗਾ?

ਮੈਂ ਤੁਹਾਨੂੰ ਮਿਲ ਕੇ ਸਹਿਮਤੀ ਫਾਰਮ ਬਾਰੇ ਦੱਸਾਂਗੀ। ਤੁਹਾਡੇ ਇਸ ਉੱਪਰ ਦਸਤਖਤ ਕਰਨ ਬਾਅਦ, ਤੁਹਾਡੇ ਨਾਲ ਮਿਲਣ ਲਈ ਸਮਾਂ ਮਿੱਥਣ ਵਾਸਤੇ ਮੈਂ ਜਾਂ ਤੁਹਾਡੀ ਨਰਸ ਤੁਹਾਨੂੰ ਫੋਨ ਕਰਾਂਗੀਆਂ।

ਜਦੋਂ ਮੈਂ ਤੁਹਾਡੇ ਘਰ ਆਵਾਂ, ਜੇ ਤੁਸੀਂ ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਰਿਵਾਰ ਦੇ ਕਿਸੇ ਮੈਂਬਰ ਨੂੰ ਆਪਣੇ ਨਾਲ ਹੋਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ। ਅਧਿਅਨ ਦੌਰਾਨ ਮੈਂ ਤੁਹਾਡੇ ਕੋਲੋਂ ਜਾਂ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਦੇ ਮੈਂਬਰਾਂ ਕੋਲੋਂ ਕਿਸੇ ਕਿਸਮ ਦੀ ਵੀ ਜਾਤੀ ਜਾਣਕਾਰੀ ਨਹੀਂ ਇਕੱਠੀ ਕਰਾਂਗੀ।

ਜਦੋਂ ਮੈਂ ਤੁਹਾਡੀ ਨਰਸ ਦੇ ਨਾਲ ਤੁਹਾਡੇ ਘਰ ਆਵਾਂ, ਤਾਂ ਮੈਂ ਇਕ ਵਾਰ ਫੇਰ ਤੁਹਾਨੂੰ ਇਸ ਬਾਰੇ ਪੁੱਛਾਂਗੀ ਕਿ ਕੀ ਤੁਸੀਂ ਮੇਰੇ ਖੋਜ ਅਧਿਅਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ।

ਤੁਹਾਡੇ ਘਰ ਹੋਣ ਸਮੇਂ, ਮੈਂ ਲਿਖਤੀ ਨੋਟ ਲਵਾਂਗੀ ਕਿ ਤੁਹਾਡੀ ਨਰਸ ਤੁਹਾਡੀ ਸਾਂਭ ਸੰਭਾਲ ਦਾ ਕੰਮ ਕਿਸ ਤਰ੍ਹਾਂ ਕਰ ਰਹੀ ਜਾਂ ਰਿਹਾ ਹੈ। ਤੁਹਾਡੇ ਘਰ ਮੈਂ 30-60 ਮਿੰਟ ਤੱਕ (ਅੱਧੇ ਘੰਟੇ ਤੋਂ ਘੰਟੇ ਤੱਕ) ਹੋਵਾਂਗੀ।

ਮੈਂ ਤੁਹਾਡੀ ਜਾਤੀ ਸਾਂਭ-ਸੰਭਾਲ ਸਮੇਂ ਕੋਲ ਨਹੀਂ ਹੋਵਾਂਗੀ। ਜੇ ਤੁਸੀਂ ਮੇਰੇ ਹੁੰਦਿਆਂ ਆਪਣੀ ਨਰਸ ਨਾਲ ਗੱਲਬਾਤ ਕਰਨ ਵਿਚ ਸੌਖ ਨਾ ਮਹਿਸੂਸ ਕਰੋ ਤਾਂ ਮੈਂ ਤੁਹਾਡੇ ਘਰੋਂ ਜਾ ਸਕਦੀ ਹਾਂ।

ਮੈਂ ਤੁਹਾਡੇ ਘਰ ਉਸ ਸਮੇਂ ਹੀ ਆਵਾਂਗੀ ਜਿਹੜਾ ਤੁਹਾਨੂੰ ਅਤੇ ਤੁਹਾਡੀ ਨਰਸ ਲਈ ਠੀਕ ਹੋਵੇਗਾ। ਤੁਸੀਂ ਮੇਰਾ ਆਉਣਾ ਕਿਸੇ ਸਮੇਂ ਵੀ ਮੁਲਤਵੀ (ਕੈਂਸਲ) ਕਰ ਸਕਦੇ ਹੋ।

ਜੇ ਤੁਸੀਂ ਮੇਰੇ ਅਧਿਅਨ ਵਿਚ ਹਿੱਸਾ ਲਵੋਗੇ ਤਾਂ ਤੁਹਾਨੂੰ ਇਕ ਸਧਾਰਨ ਜਿਹਾ ਤੋਹਫਾ ਵੀ ਮਿਲੇਗਾ।

<u>ਮੇਰੇ ਅਧਿਅਨ ਦੇ ਫਾਇਦੇ:</u> ਮੇਰਾ ਅਧਿਅਨ ਘਰ ਵਿਚ ਸੰਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਨਰਸਾਂ ਅਤੇ ਉਨ੍ਹਾਂ ਦੇ ਆਗੂਆਂ ਵਾਸਤੇ ਨਰਸ ਸੇਵਾਵਾਂ, ਖੋਜ ਅਤੇ ਵਿਦਿਆ ਨੂੰ ਬੇਹਤਰ ਬਣਾਉਣ ਵਿਚ ਸਹਾਈ ਹੋ ਸਕਦਾ ਹੈ।

<u>ਹਿੱਸਾ ਲੈਣ ਤੋਂ ਨਾਂਹ ਕਰਨੀ:</u>

* * ਤੁਸੀਂ ਕਿਸੇ ਸਮੇਂ ਵੀ ਅਧਿਅਨ ਤੋਂ ਨਾਂਹ ਕਰ ਸਕਦੇ ਹੋ, ਬਿਨਾਂ ਕਿਸੇ ਕਾਰਨ ਦੇ ਅਤੇ ਇਸ ਲਈ ਕੋਈ ਫੀਸ ਵੀ ਨਹੀਂ ਲਈ ਜਾਵੇਗੀ।
* * ਜੇ ਤੁਸੀਂ ਅਧਿਅਨ ਦੌਰਾਨ ਇਸ ਤੋਂ ਨਾਂਹ ਕਰਦੇ ਹੋ ਤਾਂ ਫੇਰ ਵੀ ਤੁਹਾਨੂੰ ਤੋਹਫਾ ਮਿਲੇਗਾ ਅਤੇ ਤੁਹਾਨੂੰ ਮਿਲ ਰਹੀ ਨਰਸ ਸੇਵਾ ਇਸੇ ਤਰ੍ਹਾਂ ਜਾਰੀ ਰਹੇਗੀ।

<u>ਗੁਮਨਾਮੀ ਅਤੇ ਭਰੋਸੇਯੋਗਤਾ (ਅਨੋਨਾਮਿਟੀ ਐਂਡ ਕਾਂਫੇਡੈਂਸ਼ੀਐਲਿਟੀ):</u>

* * ਮੇਰੇ ਲਿਖਤੀ ਨੋਟਾਂ ਵਿਚ ਤੁਹਾਡੀ ਕੋਈ ਵੀ ਜਾਤੀ ਜਾਣਕਾਰੀ ਸ਼ਾਮਲ ਨਹੀਂ ਹੋਵੇਗੀ। ਮੈਂ ਤੁਹਾਡਾ ਨਾਂ ਅਤੇ ਫੋਨ ਨੰਬਰ ਕੋਲ ਰੱਖਾਂਗੀ ਤਾਂਕਿ ਜੇ ਤੁਸੀਂ ਮੈਨੂੰ ਦੱਸਣਾ ਚਾਹੋ ਕਿ ਮੈਂ ਤੁਹਾਡੇ ਘਰ ਹੋਣ ਸਮੇਂ ਲਏ ਨੋਟ ਸੁੱਟ ਦੇਵਾਂ।
* * ਜੇ ਤੁਸੀਂ ਮੈਨੂੰ ਦੱਸੋ ਕਿ ਤੁਹਾਨੂੰ ਕਿਸੇ ਕਿਸਮ ਦੇ ਨੁਕਸਾਨ ਦਾ ਖਤਰਾ ਹੈ ਤਾਂ ਮੈਂ ਇਹ ਗੱਲ ਯਕੀਨੀ ਬਣਾਵਾਂਗੀ ਕਿ ਤੁਹਾਡੀ ਨਰਸ ਤੁਹਾਡੀ ਮਦਦ ਕਰੇ ਜਾਂ 911 'ਤੇ ਫੋਨ ਕਰੇ।

* * ਮੇਰੇ ਲਏ ਲਿਖਤੀ ਨੋਟਾਂ ਦੀਆਂ ਕਾਪੀਆਂ ਵਾਲੇ ਪੇਪਰ ਮੇਰੇ ਘਰ ਜਿੰਦੇ ਵਾਲੇ ਫਾਈਲਿੰਗ ਕੈਬਨਿੱਟ ਵਿਚ ਰੱਖੇ ਜਾਣਗੇ।
* * ਮੇਰੇ ਲਿਖਤੀ ਨੋਟਾਂ ਦੀਆਂ ਕੰਪਿਊਟਰ ਵਿਚਲੀਆਂ ਫਾਈਲਾਂ ਪਾਸਵਰਡ ਵਾਲੀਆਂ ਫਾਈਲਾਂ ਵਿਚ ਰੱਖੀਆਂ ਜਾਣਗੀਆਂ। ਇਹ ਕੰਪਿਊਟਰ ਮੇਰੇ ਘਰ ਵਿਚ ਅਤੇ ਕਿਸੇ ਵੀ ਕਿਸਮ ਦੀ ਵਾਇਰਸ ਤੋਂ ਬਚਾਅ ਵਾਲੀ ਸਾਫਟਵੇਅਰ ਨਾਲ ਸੁਰੱਖਿਅਤ ਰੱਖੇ ਜਾਣਗੇ।
* * ਮੇਰੀ ਪ੍ਰੋਫੈਸਰ ਮੇਰੇ ਇਹ ਨੋਟ ਪੜ੍ਹੇਗੀ।
* * ਮੇਰੇ ਅਧਿਅਨ ਤੋਂ ਪ੍ਰਾਪਤ ਜਾਣਕਾਰੀ ਮੇਰਾ ਅਧਿਅਨ ਖਤਮ ਹੋਣ ਦੇ ਪੰਜ ਸਾਲ ਬਾਅਦ ਤੱਕ ਰੱਖੀ ਜਾਵੇਗੀ।
* * ਆਪਣੇ ਅਧਿਅਨ ਦੇ ਪੰਜ ਸਾਲ ਬਾਅਦ ਮੈਂ ਸਾਰੇ ਪੇਪਰਾਂ ਦਾ ਕੁਤਰਾ ਕਰ ਦੇਵਾਂਗੀ ਅਤੇ ਕੰਪਿਊਟਰ ਵਿਚਲੀਆਂ ਫਾਈਲਾਂ ਵੀ ਮੇਟ ਦਿੱਤੀਆਂ ਜਾਣਗੀਆਂ।

<u>ਨਤੀਜਿਆਂ ਦੀ ਵਰਤੋਂ:</u>

* * ਮੇਰੇ ਇਸ ਅਧਿਅਨ ਤੋਂ ਪ੍ਰਾਪਤ ਕੀਤੀ ਜਾਣਕਾਰੀ ਮੇਰੇ ਥੀਸਸ ਵਾਸਤੇ ਹੈ।
* * ਮੈਂ ਆਪਣੇ ਅਧਿਅਨ ਦੇ ਨਤੀਜੇ ਹੋਰ ਵਿਦਿਆਰਥੀਆਂ ਨਾਲ, ਸਹਿ-ਕਰਮੀਆਂ ਨਾਲ ਅਤੇ ਪੇਸ਼ਾਵਰ ਕਾਂਨਫਰੰਸਾਂ ਵਿਚ ਪ੍ਰੋਫੈਸਰਾਂ ਨਾਲ ਸਾਂਝੇ ਕਰਾਂਗੀ।
* * ਮੇਰਾ ਅਧਿਅਨ ਯੂਨੀਵਰਸਿਟੀ ਦੀ ਲਾਇਬ੍ਰੇਰੀ ਦੀ ਵੈੱਬਸਾਈਟ 'ਤੇ ਲਾਇਆ ਜਾਵੇਗਾ।
* * ਸੰਭਵ ਹੈ ਕਿ ਮੈਂ ਆਪਣੇ ਅਧਿਅਨ ਨੂੰ ਕਿਤਾਬੀ ਰੂਪ ਵਿਚ ਛਪਵਾਵਾਂ।
* * ਮੈਂ ਆਪਣੇ ਅਧਿਅਨ ਦਾ ਸਾਰ-ਅੰਸ਼ ਤੁਹਾਨੂੰ ਦੇ ਸਕਦੀ ਹਾਂ।

<u>ਸਵਾਲ ਜਾਂ ਫਿਕਰ:</u>

* * ਤੁਸੀਂ ਹਿਊਮਨ ਐਥਿਕਸ ਆਫਿਸ, ਯੂਨੀਵਰਸਿਟੀ ਆਫ ਵਿਕਟੋਰੀਆ - 250-472-4545, ethics@uvic.ca ਨਾਲ ਸੰਪਰਕ ਕਰ ਸਕਦੇ ਹੋ।

ਹੇਠਾਂ ਦਸਤਖਤ ਕਰਨ ਨਾਲ, ਤੁਸੀਂ ਇਸ ਗੱਲ ਨੂੰ ਸਮਝਦੇ ਹੋ ਕਿ ਇਹ ਅਧਿਅਨ ਕਾਹਦੇ ਬਾਰੇ ਹੈ ਅਤੇ ਮੈਂ ਇਸ ਅਧਿਅਨ ਬਾਰੇ ਤੁਹਾਡੇ ਸਾਰੇ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇ ਚੁੱਕੀ ਹਾਂ।

ਹਿੱਸਾ ਲੈਣ ਵਾਲੇ/ਵਾਲੀ ਦਾ ਨਾਂ		*ਦਸਤਖਤ*		*ਤਾਰੀਖ*

ਇਸ ਸਹਿਮਤੀ ਫਾਰਮ ਦੀ ਇਕ ਕਾਪੀ ਮੈਂ ਤੁਹਾਨੂੰ ਦੇ ਦੇਵਾਂਗੀ ਅਤੇ ਇਕ ਕਾਪੀ ਮੈਂ ਆਪਣੇ ਕੋਲ ਰੱਖਾਂਗੀ।

ਕੀ ਮੈਂ ਤੁਹਾਡੇ ਨਾਲ ਭਵਿੱਖ ਵਿਚ ਵੀ ਸੰਪਰਕ ਕਰ ਸਕਦੀ ਹਾਂ, ਜੇ ਮੈਂ ਆਪਣੀ ਖੋਜ ਦੌਰਾਨ ਇਕੱਤਰ ਕੀਤੀ ਜਾਣਕਾਰੀ ਨੂੰ ਦੁਬਾਰਾ ਕਿਸੇ ਮਕਸਦ ਲਈ ਵਰਤਣਾ ਚਾਹਵਾਂ?

Appendix K: Information letter for SA client's family member

University of Victoria **School of Nursing**	

Project Title: How does the organizational culture in Home Care Nursing (HHNsg) influence the day to day practice of Home health nurses (HHNs) as they provide care to older South Asian (SA) clients who live at home?—An ethnography

Researcher(s): My name is Jonquil Francis and I am a graduate student in the School of Nursing at the University of Victoria (UVIC) who can be contacted by email or phone (removed for privacy purposes). **Supervisor:** Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria can be contacted for more information or concerns.

Older SA clients may participate in my study if they are age 55 years and older, speak basic conversational level of English or seek assistance from an English speaking family member and if the SA client is currently receiving home care nursing services for wound care, intravenous care or chronic disease management may participate in my study.

- Participation in this study is voluntary.
- Regardless of the client's decision to participate, he or she will still continue to receive home care nursing services

Please take the time to read this form carefully as it includes information about the study: what will happen during the study.

Purpose of the research study:

The purpose of this study is to gain an understanding of the organizational culture in home care nursing especially for home health nurses who provide care to older SA clients who live at home.

What is this study important?

In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work, as they provide care to older SA clients who live at home.

What will happen during the study? Please read the following:

1. I will seek your permission to observe the home health nurse as he or she provides care to the older SA client in their home.
2. You may contact the researcher via phone (removed for privacy purposes) or the third-party representative at the health unit xxx-xxx-xxxx (removed for privacy purposes). The third-party can only provide you information about my study however for the client to voluntarily take part in my study, I must speak with you directly.
3. Upon contact with me or the third-party, please volunteer personal contact details so that I can contact you to book a home visit in order to obtain the client's written consent prior to conducting the home observation of the home health nurse in your home.

4. On the day of the home visit, I will verbally seek the client's consent prior to the home visit. I would like to observe the home health nurse performing her work activities with the older SA client who lives at home.
5. I will not include any family members' data in my study's data. During the home visit, I will observe and take notes of how the home health nurse does her work with the older SA client.
6. I will not observe any personal or intimate care. If the client is not comfortable discussing their health needs with their HHN in front of me, the client or you can ask me to stop the observation and to leave.

Inconvenience: The main inconvenience is your participation requires your time and that I have to visit your home to do the research.

Compensation:
In appreciation for the client's participation in this study, a stationary gift worth 20$ will be offered to client for their participation in this study.
If the client would not participate if the compensation was not offered, then the client should decline to participate in my research project.

Possible Benefits:
- By participating in my study, findings may lead home health nurses and nurse leaders to reflect upon and better their practice with the older SA population who receive home care nursing services.
- By older SA clients participating in my study, findings may have implications for future nursing practice, research, education, and policy in the particular context of home health nurses who provide care to older SAs who live at home.
- For society, the information gained from this study may contribute to future quality improvement in the field of HHNsg.

Withdrawal of data
The client may withdraw at any time, without explanation and consequences or penalty.
Upon withdrawal, the client's data will not be used in my research project and the client will still receive the compensation that I promised at the time of consent. If the client withdraws, he or she will continue to receive their current home care nursing services.

Anonymity and Confidentiality:
- The study's data for e.g. my fieldnotes will not contain any personal information like the client's name, personal characteristics, or age nor will it contain any information about family members in the home.
- Considering my observations will take place in your home, I will request the client and/family member and the home health nurse not to disclose to anyone who took part in my study or what happened during the home visit.
- Since the sample size is small in this study, this may be a limitation to the client's confidentiality.
- I have asked the third-party who promoted the study to you not to disclose the client's and/family member's identity or contact details to anyone nor will I share any information with the third-party.
- I will maintain a master list of participant's actual names, their contact details, and their pseudonym or false name. Access will only be in the event that I need to communicate with you or to withdraw the client's data. This master list will be locked in filing cabinet stored within my residence.

- If a medical emergency or life threatening circumstance occurs during an observation, I will call emergency services for e.g. the police, ambulance or fire department. If the client discloses that they are at risk for harm due to an existing illness, and then I will ensure that appropriate medical, crisis or emergency services are offered to the client.
- Paper copies of my fieldnotes will be stored in a locked filing cabinet, located within my home.
- Electronic copies of my notes will be stored in password protected files on my personal laptop, stored at my residence and protected by anti-virus software.
- Throughout the course of the study, fieldnotes will be linked to fictitious names and will be analyzed by my supervisor/co-supervisor and I.
- Paper and electronic copies of fieldnotes will be stored for a period of five years after my study is completed.

Disposal of Data:

- Paper copies of the data will be shredded and computer files of observation fieldnotes will be deleted/erased after five years from the completion of my study.

Dissemination of Results:

- The information that participants provide is part of the researcher's graduate studies.
- The findings from this study may be shared at my thesis presentation with other fellow graduate students and faculty
- The complete report of my study will be posted on the UVIC website.
- The findings from this study may be published in an academic journal.
- Upon completion of the study, upon request, I can provide an executive summary of my study's results to participants or the recruitment site.
- The findings from this study may be shared at a professional conference or professional development workshop
- The client's name or any other identifying information will not be in any reporting of the results from this study.

Questions or Concerns:

- I have provided my contact information at the top of page 1;
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545 ethics@uvic.ca

If you have any questions or concerns, I can discuss these questions or concerns with you.

A copy of this information letter will be left with you. The client still has to sign their consent form.

Appendix L: Electronic and paper consent form for Nurse Leader participant

University of Victoria **School of Nursing**	***Nurse Leader Participant Consent Form***

Project Title: How does the organizational culture in Home Care nursing (HHNsg) influence the day to day practice of home health nurses (HHNs) as they provide care to older South Asian (SA) clients who live at home?—An ethnography

Researcher(s): My name is Jonquil Francis and I am a graduate student in the School of Nursing at the University of Victoria (UVIC) who can be contacted by email or phone (removed for privacy purposes). **Supervisor:** Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria can be contacted for more information or concerns.

Purpose(s) and Objective(s) of the Research:

The purpose of this study is to i) describe the organizational culture in HHNsg practice; and ii) develop an understanding of how organizational culture in HHNsg practice influences the day to day practice of HHNs seeking to improve the health and well being of older SA clients living at home.

This Research is Important because:

In Vancouver, the older South Asian population may increasingly require home care nursing services, a service that enables seniors to live independently in their homes and with the support of family members. Therefore, research studies about the organizational culture in HHNsg practice is needed to understand the day to day practice, the strengths and challenges faced by HHNs in their everyday work as they provide care to older SA clients who live at home.

Participation:

You are invited to participate, if you are a nurse manager, team leader, clinical nurse specialist, or clinical educator with at least three years of leadership experience.

Participation in this project is voluntary.

What is involved?

You are invited to participate in a face-to-face individual interview which will take approximately forty five to sixty minutes. Interviews will be transcribed verbatim and transcripts anonymized. I will invite you to discuss the organizational context (collective values, beliefs, practices and structure of the organization that influence the everyday work of HHNs) of HHNsg practice and its effects for HHNs who provide care to older SAs who live at home.

Inconvenience: The main inconvenience is that participation in this project involves your time. You may choose to participate after work hours. To minimize these inconveniences:

- I will ensure that the follow-up interview is conducted in an organized and systematic way, as well as I will carry out the interview at a pace that is suitable for you. You have the option to review interview questions prior to the interview and to abstain from answering questions during the interview. During or after your interview, you can also request me to delete specific comments in the audio-recording. I will test audio-equipment ahead of time to avoid delays during the interview process.

- If you have child or personal time commitments, I can schedule your interview at a time and place that is convenient for you. I am open to rescheduling the interview as per your individual needs and preferences.

Compensation:

In appreciation for your participation in this study, a stationary gift worth twenty dollars will be offered to you for your contributions to this study.

If you would not participate if the compensation was not offered, then you should decline to participate in this research project.

Possible Benefits:

- By participating in this study, nurse leaders can personally reflect upon and share with colleagues the implications of current gaps and strengths of the organizational culture in HHNsg for HHNs who practice with older SA clients in their homes.

- By participating in this study, findings may have implications for future nursing research, education, practice, and organizational policy as relevant to improving HHNsg practice in the context of the older SA population

- For society, findings from this study may contribute to future quality improvement projects in the field of HHNsg practice.

Withdrawal of Participation:

- You may withdraw at any time, without explanation.
- When you withdraw from the study, there will be no consequence or penalty.
- If you withdraw from the study, your data will not be used in the research project.
- If you decide to withdraw your data, you will receive the compensation promised at the time of consent.

Anonymity and Confidentiality:

- Throughout the course of the study, the study's data that is audio recordings and interview transcripts will not contain any personal information like for e.g. your name, age, or place of work.
- Since the sample size of my study is small, this may be a limitation to your confidentiality. Therefore, I have used pseudonyms to depersonalize your data.
- The third-party will not disclose your identity to anyone nor will I share any of your data with the third-party.
- I will maintain a master list of participant's actual names, their contact details, and their pseudonym or false name. Access will only be in the event that I need to communicate with you or to withdraw your data. This master list will be locked in filing cabinet stored within my residence.
- If a medical emergency or life threatening circumstance occurs during an interview, I will call emergency services (e.g. the police, ambulance or fire department).
- Paper copies of interview transcripts will be stored in a locked filing cabinet in my home.
- Electronic files of interview transcripts will be stored in password protected files on my laptop which will be stored at within my residence and be protected by anti-virus software.
- Throughout the course of the study, data will be linked to fictitious names and will be analyzed by my supervisor/co-supervisor and I.
- A transcriptionist will sign a confidentiality agreement to transcribe audio-taped interview data verbatim. Audio tapes will be held by the transcriptionist until transcription is completed.

- Paper and electronic copies of interview transcripts will be stored for a period of five years after my study is completed.

Disposal of Data:

- Paper copies and computer files of interview transcripts will be shredded and deleted respectively, after five years from the successful completion of my thesis. Audio recordings will be deleted / erased by me after my study is successfully completed. Interview notes will be shredded after I confirm that the notes correspond to the content in transcripts.

Dissemination of Results:

- The information that participants provide is part of my graduate studies.
- The findings from this study may be shared at my thesis presentation with other fellow graduate students and faculty
- The complete report of my study will be posted on the UVIC website.
- The findings from this study may be published in an academic journal.
- Upon completion of the study, upon request, I can provide an executive summary of my study's results to participants or the recruitment site.
- The findings from this study may be shared at a professional conference or professional development workshop
- Your name or any other identifying information will not be in any reporting of the results from this study.

Questions or Concerns:

- I have provided my contact information at the top of page 1;
- Contact the Human Research Ethics Office, University of Victoria, (250) 472-4545 ethics@uvic.ca

Your signature below indicates that you understand the above conditions of participation in my study, that you have had the opportunity to have your questions answered by me and that you agree to participate in my research project.

Name of Participant		*Signature*		*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Can I contact you in the future if I wish to use your data for secondary analysis _____

Appendix M: Fieldnote template

(HHN's activities in the older SA client's home)

Date: Pseudonym:

Time:

Nurse's actions which indicate personal or organizational values during the visit. How do these actions of the nurse correspond to your research question and topic of inquiry?

Nurse's words which reflect the organization's values in relation to older SA clients. How do these words of the nurse correspond to your research question and topic of inquiry?

What activities did the nurse engage in while in the client's home? How does the nurse engage in the various activities?

What organizational artefacts (documentary evidence) did the nurse use during the visit? What meaning does the nurse attribute to the organizational artefact? Does the nurse talk about how the organizational artefact represents the organization's values and beliefs?

What was my reaction to the nurse's actions and words?

Summarize the nurse's explicit and implicit values and beliefs. Discuss these values with the nurse in the interview that takes place later:

Did I notice anything surprising in relation to the nurse's actions and words? Do I have any questions about anything that the nurse did during the visit that did not make sense to me, the researcher? How have I interpreted what happened during the visit? How have I interpreted the nurse's actions, values and beliefs in relation to the organization?

How did the nurse talk/interpret the organization's values and beliefs explicitly or implicitly?

Write a descriptive summary of what you saw, heard, and felt?

Analysis/Memo entry of my fieldnotes:

How does this observation relate to your research question?

Are there any literature references that may be applicable to this observation?

How does this observation compare or contrast with other observations?

How does this observation compare or contrast with data from interviews with HHNs and or Nurse Leaders?

Appendix N: Interview guide for HHNs

I am a Masters in nursing student at the University of Victoria.

[I will review the consent form prior to using the interview guide]

How long have you worked as a HHN?

Today I would like to discuss with you how the organizational culture in HHNsg influences your day to day practice as a HHN and especially as you seek to improve the health and well being of older South Asian (SA) clients who live at home.

1. Tell me about the client we visited today...

2. Did you prepare in any particular way prior to visiting this client?

3. Walk me through the visit we did today. Tell me how you decided what to do from the time you entered the client's home.

Probes:

• What would you say are the needs of this client?

• How do you make decisions about what is important for the client?

• How do you go about assessing the client's needs in their home?

• Who are the other players in this client's care?

• How do you communicate/interact with these other care providers to provide care to this client?

• What did you do after the visit in relation to the client's care?

4. How do you create a care plan for the client?

5. What are the strengths of the current care plan for this client?

6. What are the day to day challenges of meeting the care plan?

7. What would you say the challenges are of meeting this client's day to day needs? How do you deal with these challenges?

8. Do you know how the client feels about their care plan?

9. Do you feel there are limits to your ability to respond to these challenges? Tell me about that. How would your co-workers meet this client's needs? Would they follow the same process as you? (probe)

10. What are some of the values and beliefs of the organization you work for?

11. How do these explicit values and beliefs provide you with support in meeting your clients' needs?

12. Do you have any additional thoughts or questions?

13. Do you know how to contact me/ethics department?

Appendix O: Interview guide for Nurse Leaders

I am a Masters in nursing student at the University of Victoria.
[I will review the consent form prior to using the interview guide]

How long have you worked as a nurse leader in the organization?

Tell me what is known about the older SA population here at this HHNsg Unit?

What are some of the key challenges faced by nurse leaders in the context of home care nursing at the present time?

How do nurses go about their day to day work here (at the recruitment site)? How are the organization's culture, values, beliefs and mission meant to shape the day to day work of the HHNs?

Do nurses talk about specific challenges they face in meeting the health care needs of SA clients they are assigned to care for?

Tell me about the organization's values and beliefs and, if you can, give me an example of how these are integrated into the day to day work of the HHN?

Are there any organizational policies or nursing practice guidelines that are applicable to nurses who deliver care to the older SA clientele?

Do you have any additional thoughts or questions?

Do you know how to contact me/ethics department?

Appendix P: Transcriptionist Contract

University of Victoria **School of Nursing**	

Please read the following contract for transcription of interview tapes for the following project**:**

Project Title: How does the organizational culture in Home Care Nursing (HHNsg) influence the day to day practice of Home health nurses (HHNs) as they provide care to older SA clients who live at home?—An ethnography

Researcher(s): My name is Jonquil Francis and I am a graduate student in the School of Nursing at the University of Victoria (UVIC) who can be contacted by email or phone (removed for privacy purposes). **Supervisor:** Dr. Mary Ellen Purkis or Debra Sheets at the School of Nursing, University of Victoria can be contacted for more information or concerns.

Purpose(s) and Objective(s) of the Research:

The purpose of this study is to i) describe the organizational culture in HHNsg practice; and ii) develop an understanding of how organizational culture in HHNsg practice influences the day to day practice of HHNs seeking to improve the health and well being of older SA clients living at home.

You have agreed to be the transcriptionist for the study called: ***"How does the organizational culture in Home Care Nursing (HHNsg) influence the day to day practice of Home health nurses (HHNs) as they provide care to older SA clients who live at home?—An ethnography"***

As the transcriptionist for this study you will be expected to do the following:

1. Transcribe audio tapes verbatim
2. The taped interviews that are transcribed for this study is confidential information and should not be disclosed to anyone
3. Transcribed data and interview tapes cannot be accessed by anyone else, only the researcher for this study.
4. The audio taped interview tapes, disks or paper copies have to be stored in a locked filing cabinet.
5. After you have completed transcription, please return the audio-taped interviews to me and erase all computer files or shred paper copies of transcript data for my study.

If you have any questions or concerns:

- My contact information is noted above
- Contact the Human Research Ethics Office, University of Victoria, 1 (250) 472-4545 ethics@uvic.ca

Your signature below indicates that you understand the conditions of this agreement, that you will adhere to the terms of this agreement and that you have had the opportunity to have your questions by me. This contract for transcription of interview tapes is an agreement between the researcher of this study, and _____transcriptionist on _____(date)_____

Appendix Q: Fieldnotes and memos

Fieldnotes: Home visit and Story 1

July 10, 2013 09:30 am

We went up the stairs to the living room. Client receives us at the top of the stairs. Client asked nurse about shoe covers and nurse looked surprised. Nurse said that she would bring it next time. Nurse asked about the drainage amount. Client goes over to get her notebook. Client says husband very "picky" about keeping track of drainage.

Nurse asked about doctor's appointment. Nurse asked about any new meds? Client could not remember. Client went and got recent pill bottle so nurse could note doctor's name. Client said that she has to call for next appointment with doctor. Nurse tracks supplies in the home. Client complained that the nurses' visits only lasted for 7-8 minutes. "Then their gone!" (She does not look very happy)

As nurse changing dressing, she kneels on the floor. Client is standing. Client asks the nurse if the wound looks better as the wound is on her back of her right hip.

I noticed that the nurse was taking her time to clean the wound. As nurse cleaning wound, client is talking out loud (to me?) about how she has become inactive. Nurse makes no response. Then nurse said that she would use no sting wipe to allow the dressing to stick better. Client asking why dressing comes off and nurse said maybe we (the nurses) should go back to the original dressing that was being used before. Client holds the dressing to her own body while nurse reinforces the edges of the cover dressing.

Nurse leaves an extra dressing for the client to use in an emergency. They agree that the next visit is on Friday.

Memo

I realized that the client was not satisfied with the care she was receiving and was in need of emotional support. The nurse and her colleagues failed to respond to the emotional aspects of the client's care and requests regarding shoe covers. Following the client's expression of daily frustrations with the nursing care, she sadly expressed that her activity levels are not the same as before. I wondered if this had any significance for how her life had changed and the meaning of this for her day to day coping. I can only imagine that she was experiencing grief and worry related to her functional losses and sick time off work. From my fieldnotes, daily nurse activities are focused on tasks: recording medication, observing and monitoring wound and drain care. Although these activities are objective indicators of the client's progress, these tasks do not aid the client's ability to cope with her health condition. Instead, the client is viewed through a physiological lens and is broken down into problems which need to be solved.

Appendix Q: Fieldnotes and memos continued...

Fieldnotes: Home visit and Story 2

June 10, 2013 at about 0930

We enter the house. The door is already open. We walk up a flight of stairs to the living room. Client is waiting while being seated on living room couch. Bandages are open on the floor. LPN says, hello Mr. S. She says, "I'm going to wash my hands." "I haven't seen you for some time! Your wound looks a bit better!" LPN leans over side table to write out meds. Puts chart on the couch to refer to care plan. Client shows scar to her by turning his leg and showing the back of his leg. LPN queries: "What are your blood sugars? Any high numbers?" Client responds saying "not over six." Mean while she squirts NS on a tray, soaks up gauze and cleanses two puncture wounds on the inner and outer side of his ankle and medial foot. The LPN conveys that she is going to take some pictures of both wounds. She takes a picture of dressings and makes a note of wound measurements. She quotes: "A bit bigger than last time." She measures again and crosschecks against old measurements. On the table lies a blue bottle of soap, brown paper bags, and brown towels. She asks: "Do you have any other appointments?" "What about the neurologist?" Then she uses a stool to lift clients' heavy leg which she wraps with cotton kling. Client helps nurse by putting things away in the garbage. He confirms that he had his shower and took bandages off. Nurse says that she will ask GP for recent neurologist report. LPN asks about shaky hands. At this time client is talking about vascular surgery (This was a bit disjointed as nurse is talking about neurology and client is talking about vascular related to wound)
LPN explains to me that son in law organizes client's appointments. While she does this, client gets up to get his pills. He hands a white cardboard pill (blister pack) organizer to the LPN Jane. The LPN checks the blister pack against the med sheet in the paper chart. She says, "I think the neurologist increased the dose of your pills." "Your leg does not shake as much when you lift it up." Client is now putting stocking net over the leg. Writer notices that LPN Jane checking supplies and counting supplies. The LPN bids him farewell and leaves via front door.

Memo

Why does the LPN ask the client about blood sugars? Also this client appears like he's independent and able to direct his own care. What was his plan of care and how did they go about creating a care plan for this gentleman. What about the showers? How does the client know when he has to shower as it relates to his nursing visits? Who decides this? Routine LPN assessments include asking about blood sugars, doctors visits, checking medications, documenting and commenting on wound progress. Are these core tasks the most important when it comes to daily care planning? What about other aspects of this gentleman's care? I will ask LPN more about this man's history.

Appendix Q: Fieldnotes and memos continued...

Fieldnotes: Home visit and Story 3

August 10, 2013 at about 11:00 am

Nurse enters the home and asks: Anything new? Client's son says, "No coughing and looking good since January." (Upon entering nurse comes in with black bag on rollers and a brown paper bag). Nurse stands while her things are on the couch.

Nurse asks "when do they take her weight." Son says, "Every morning!" (They refer to home support workers). Does she have any more appointments with the Heart Function clinic? Son responds by saying there is no change in meds. Son says, "She is still taking everything." (The nurse and son knew the context of the conversation and respond to each other's cues very well) Nurse asks: How's sleeping? Son responds "no problems." Nurse sits while taking notes on yellow pad. Nurse asks if sleep gets bad, we can get the doctor to order a sleeping pill.

Before Nurse goes to take blood pressure (BP), client automatically rolls her sleeve up. The family had their own BP cuff but it was not working properly. Nurse uses her manual cuff to take BP. Nurse leans over client's lounge chair which is in front of the fire place (client's favorite spot to sit). The background of the fire place has pictures of Hindu Gods.

After Jackie takes BP, she inputs the information in her cell phone. Nurse takes the client's pulse. Client has a smile on her face as nurse is checking client's vital signs like BP, pulse, breathing, circulation, and her weight.

For instance, client leans forward for nurse to listen to her chest. Client leaned backwards for nurse to listen to her heart)

Now the nurse, client and son have decided to walk to the bathroom to do a weight check. This takes some time, but they eventually get to the bathroom. There is a lot of conversation back and forth between son, client and nurse. The client steps on weighing scale it doesn't seem to work and the weight does not seem accurate. The scale shows that the client has put on three pounds, but Nurse says this is probably due to clothes adding to the weight and that it is mid-day. And then the son, client and nurse make their way back to the living room. Nurse ends the visit by asking: "how often are we (the nurses) coming to see her?" Son requests to "reduce visits to once a month." Nurse encourages son to call if needed. Everyone is happy. The son says, "I hope it's you Jackie!"

Memo

I was not included in any of the conversations during Nurse's visit with her client and the son. They behaved as if I was not in the room. From observation, the patient-nurse interaction appeared to be based on tasks: monitoring daily weights, medication from the blister pack, and vital signs. Although the client and the son appeared to like Nurse very much, I would have liked to see more open-ended questioning and conversations among them. It seems as if they had known Nurse for a long time. I wonder what Nurse's history was with this client. I could not get the sense if Nurse had incorporated the client's values, beliefs, spirituality into her daily care. This was the most enjoyable visit mainly because the client and the son appeared very happy with the care. I would like to find out more about what has brought them to this point of satisfaction. Another interesting point was that the son and his mother or the client automatically knew what Nurse was going to do from moment to moment in the visit- this indicates some sort of order). Again like the other two visits, tasks focus on noting measurements, medications and vitals. Also conversations seem closed-ended.

Appendix Q: Fieldnotes and memos continued...

Fieldnotes: Home visit and Story 4

We go in through the back door. Client is sitting at the kitchen table expecting our arrival. He appears to know that Nurse's arrival time. Nurse greets him. She asks, "Have you been outside." He replies, "Went out for coffee." (Nurse bends over his chair to do his wound care. There are brown paper bags all over the floor- supplies from previous visits). Nurse asks "How have your blood sugars been?" He lists the values: 7.2, 7.4, 4.2, 4.6, and 8.4.

Wound care: Nurse washes his leg with warm water. She comments that she took pictures on Monday. She puts old dressings in white garbage bag on the floor. She puts a sterile drape over blue pad. She then asks, "Do you have any doctor appointments?" He responds, "Only with the GP!" Pause.

The Wound Care nurse said that you can shower. Client responds "I don't want to get foot wet!" (I noticed that there is a lady in the background cooking). Subsequently, the client says that the home support workers bathe him before he goes to the temple to pray. He mentions that he is going to a funeral today. Nurse does not respond to his comments.

Client tells Nurse how to wrap the cotton kling several times around his ankle so that the dressing does not fall off. Then he tells her how to apply the white tape on the cover dressing.

Memo

I noticed Nurse did not probe deeper when Client talked about the home support and bathing services that he was getting. It seems as if this was important to him especially since he seems religious by his mention of his visits to the temple. Wondering about this man's history with home support? Have there been any issues between the nurses and him? He seemed very pleasant. He appeared to be living alone in a big house. He appeared to have help in the home. He also appeared to be quite independent and to have a good knowledge base regarding his diabetes. His kitchen table seemed very organized with his medications and equipment.