UNDERSTANDING HOW NURSES EXPERIENCE LIVING THEIR VALUES AMIDST ORGANIZATIONAL CHANGE: A NARRATIVE INQUIRY

By

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Abstract

Values are foundational guidelines that underpin nurses' actions. They serve as fundamental points of reference for nurses; and, as such, determine their moral nursing practice. Understanding how nurses' experience of living their values amidst organizational change sheds light on how this social condition influences the narrative composition of nurses' lives and their practice. This Narrative Inquiry (Clandinin & Connelly, 2000) illuminates the temporal connections of life events; how social conditions mutually shape personal conditions; and how actions that occur within a place give meaning to the experience. Six nurses from a large academic health centre in Southern Ontario were recruited and interviewed over eight months. During initial analysis, letters were constructed for each co-participant to reveal the experience of living values amidst organizational change. Subsequently, a composite narrative in the form of a letter was composed, revealing four plotlines: responsive relationship, moral distress, reflection and reconstruction, and knowledge and identity. These plotlines intersect to describe the extent to which nurses meet their moral obligations within relational practice. This inquiry brings to the foreground four narrative terms, including *stories to commit by,* that contribute to a new way of thinking about familiar issues. It illuminates the personal and the active movement of reflection that reside in a person and the choice(s) she/he makes to re-craft a life. Considerations for practice, education, policy, and research highlight the importance of a deeper level of reflective practice, the connection between personal and ethical knowledge, and the need for becoming aware of one's moral horizon.

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Dedication

This thesis is dedicated to my parents Ricardo and Lourdes Manankil who showed me how to care and find the courage to live out my values in difficult times. Their love shaped the person that I am.

I would also like to share this accomplishment with Professor Barbara Brown, my teacher, who captivated me with her love for reflection. She taught me the meaning of reflective practice and its importance in the nursing knowledge landscape.

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Chapter One

Situating Myself in My Narrative Inquiry

When starting a narrative inquiry, I must begin at 'experiencing the experience' (Clandinin & Connelly, 1994, p. 418). 'Experiencing the experience' means engaging with stories, co-participants and my own, in a deep and embodied way to surface reflective thoughts as I move through an analytic frame (Clandinin & Connelly, 2000). The research brings to the foreground the phenomenon as it is lived. What is this experience that I am to explore? It is a question that led me to reach within myself to understand who I am and the root from where my inquiry begins. I was lost for a while, not knowing how to proceed in the murky waters. After going backwards in time to the writings of Clandinin and Connelly (1994) on the personal experience methods, I am able to gain some clarity on the process that is narrative inquiry. Narrative Inquiry builds on Dewey's (1938) notions of interaction and continuity that suggest human beings understand the world through their interactions and that these perceived experiences are connected and continuous; meaning that past experiences, inform present ones, and create future situations. Clandinin and Connelly (2000) adds the dimension of place in the understanding of experience and as such three dimensions make up the analytic process in narrative inquiry: sociality (interactions), temporality, and place. This theoretical concept is reflected in the use of the present tense in my writing throughout this thesis. Reflecting on my past sheds light onto aspects of my life that help me see the social world and myself more clearly. It provides me with the understanding of my connectedness to my research interest that ultimately leads to my research question.

This thesis explores the research question: How do nurses experience living their values amidst organizational change? Illuminated through my stories of experience, my inquiry process begins.

Growing up in the Philippines

It is a bright sunny morning in Manila. The sun's rays pierce through the windows like sharp wedges. Itay, my grandfather is on his knees rolling the quilted mat we slept on the night before. Inay, my grandmother, is busy getting my younger sister Anne and me ready for the day. Mom and Dad left early this morning for their daily commute to work. My uncle who also lives with us has gone to work as a refrigeration mechanic at the same company that employs my mother. Ortensia, our helper, is in the kitchen preparing breakfast. The radio is loud while playing music from the 1960's. There is always a buzz in the house. We are an extended family under one roof. I spend my days in close proximity with important people in my life within the confines of small living quarters.

It is later this morning that Anne and I are sitting on the windowsill of our apartment from the second floor of a duplex, watching the street. There is much to see. Many people are walking the streets. There are cars that drive by but not often. A tricycle carrying passengers passes through. Older children are walking to school in their uniforms with their schoolbags. A few of the ladies stop at houses to chat with their friends. There are stray cats and dogs. As I look harder, I see a rodent shuffling its way through the maze of garbage left on the street. If there is a buzz in our house, there is

even more buzz outside. Inay cautions us to stay inside. We are not allowed to go outside without her supervision. I did not ask why. I am six years old and Anne is four. Raised to be obedient, we comply with Inay's expectation.

Not knowing anything better, we continue to sit on that windowsill watching life unfold. Observing life becomes a way of being in my life. Later, I learned that Inay was worried about abduction and how little girls were more prone to be victims of this horrific act in our country. This fear was explained in a conversation with my mother as an adult. "Louela, Inay was always so protective, but you cannot blame her. We lived in a dangerous place, and we needed to be vigilant. Many people are good but there are also people that cannot be trusted." The fear that both Inay and my mother carried left Anne and I spending a great deal of time in the house, playing and pretending in our early years.

My Relationship with Inay

Inay is a significant person in my life. My mother provided financially while my grandmother became my caregiver. She would dress me in the morning. "Ella", she calls, "Halika! Come" she said. She is not a woman of many words. I run to where she is standing in my parents' room. I am six years old. She helps me remove my pajamas to put on my day clothes. It is a pink dress with eyelets and frills. Inay slips this dress over my head as I wiggle myself through its neck. I pull it down to fit it onto my body. She takes a brush, parts my hair to the right and places a bobby pin to hold my bangs from my face. I sit on the bed while Inay helps me with my socks and shoes. After my dress is on

and my shoes are on my feet, Inay takes a soft puff and dips it into a container full of white fresh smelling powder then plunks it onto my face in a round rhythmic motion until she is satisfied. She is a make-up artist. I cringe from the amount of powder she applies. I give Inay a hug and a kiss. She smiles back and gives me a hug. This is our ritual. I felt her presence in my life in a direct way. It is our time together. She calls for my sister. It is her turn.

I watch Inay perform her actions as she cares for me that morning. She moves her arms with intention, focused on her task. She bends her knees to kneel to help me with my shoes but she flinches from the difficulty of sitting up from a kneeling position. It must have been difficult for Inay because of her unhealed wound on the left leg that she treats with home remedies. She hobbles in the house because of it and often feels a great deal of pain. When in pain, Inay lies down on the mat my grandfather rolls out for her on the floor to rub her wounded leg with a capped bottle filled with hot water. “Oh ang sakit (Oh it hurts)” as she continues to apply heat as a form of self-care until she falls asleep. It is surprising that each morning, Inay seems perky again ready to do what she intends for the family.

I realize that my observations of my grandmother’s actions and behaviours became a way for me to understand who she was and the meaning that gave rise to our relationship. My grandmother was a quiet lady. She never read me stories like I did for my children when they were growing up. All I knew was that she dedicated her time to look after my sister and me while my mother worked. Inay taught me how to care and to give of myself. She lived this life through her role in the family day in and day out. We

all had a role to play to keep the family moving forward. This was how we survived. We are a collective.

Living in a close spatial geography with my family members provided me with the living theater to observe lives as they happened. I saw how my mother loved and protected my uncle. I felt the close relationship of my grandparents. It was not hard to know and sense that I am part of the lives of those around me. It was not hard to love when I felt care in the midst of many people. This experience shaped my ability towards empathy. Carper (1978) stated "empathy (is) the capacity for participating in or vicariously experiencing another's feelings" (p. 17). As a nurse, I find myself integrating this value into my patient care. Empathy allowed me to be comfortable with my patients at vulnerable moments in their lives. The seed of a nurse was planted amidst my family. I wonder how stories of our lives from the past shape our professional selves as nurses. I wonder how the values we learned from living amidst our family translate into nursing practices. I wonder how nurses live out these values in their workplaces.

Connelly and Clandinin (1990) claim we live our lives through stories that have formed us and that we can use to build new narratives. In other words, reconstructing our experiences paves the way for living anew in our storied lives. Dewey (1938) stated that as humans, the social dimension of life could not be separated from the personal realm. The person is shaped by social conditions and the personal and social elements of human life are intimately connected through continuous interactions over time.

My stories of childhood have influenced me as an adult person. As an adult, I carry my autobiography as I interact with my environment. As I live within my setting, I

shape it with the person that I am. I also know that the same setting influences me. This thought takes me to my stories of practice. I chose a story that encapsulated my experience of enacting my values in the nurse-patient relationship. It was this story that provided me with immense satisfaction and revealed to me what I value as a nurse. It took place in the year of 1991. The names used in the following stories are pseudonyms.

Nursing at the Bedside

It is 7:20 in the morning, I am sitting at the nursing station in front of the whiteboard with all the patients' names listed and their labour and delivery status. I am in my scrubs with my pens in my pocket and hands washed ready to start the day. Sheila, the charge nurse from the night shift is getting ready to give report. There are only three patients on the board, one with a scheduled caesarian section this morning. I am assigned to Sarah and Joe who are having their first baby. Sarah's water broke at 6:30 AM and she is moving quickly to the active phase of labour.

Sarah tells me about her pain and requests to go back to bed after walking the halls this morning. She does not want any pain medication. She had already used the shower to help manage her pain and does not want to try the Jacuzzi. Her cervix is 5 centimetres dilated and fully effaced. I prepare the room for comfort. The lights are low and soft music is playing. I turn my body towards Sarah as I sit at the foot of the bed rubbing her leg covered with a top sheet. Joe is by her side. "Sarah, look at me and follow me…Breathe in…Breathe out… Let's do it again…Breathe in…Breathe out…It is almost over…Again, breathe in….Breathe out…It's over. Take a rest…Joe, you can give her the

ice chips and wipe her face with this cool cloth." They had not done this before but neither have I. My son had not been born at this time. I am their nurse.

Learning to care for women in labour comes from my education as a nurse and from being with women in labour. I know how to anticipate the needs of labouring and birthing women. At that moment, I know that Sarah needs support and care during this difficult time. I know to be there to comfort and keep her and Joe safe as they move through the process of labour and birth. At times, I leave the fetal heart doppler on longer during the rest periods so that Sarah and Joe can hear their baby's heart beat. Deep within me, I want Sarah to have the strength that she needs to get through her labour and birthing process. I know that she needs support, care, and positive reinforcement to be able to give birth with the least amount of medical interventions. Knowledge and experience teaches me this. I know both mom and baby are safe. I know that I am enacting my role as a nurse. I am providing nursing care to Sarah and Joe. In that moment with my patient, who I am as a nurse at the bedside has meaning. My values around support, care, safety and knowing the patient are present in my interactions with my patient. I am true to myself.

The year 1991 was a time when hospital restructuring in Ontario was beginning to take hold in the health care system (Chan & Lynn, 1998). Although these tensions occurred, I did not feel the impact of budget cuts on how I gave care to my patient. I did notice that a form of management restructuring was taking place within our organization. There were also initiatives on our unit that affected part-time staff. I was still able to sustain my way of caring for my patient. This brought satisfaction both to my patients

and me. I continued to feel that I am able to enact my values amidst current changes on the unit.

Story of my Experience Within a Hospital Organization in 1991

It is 0930 and time for morning break. I prefer going at this time. At 0930 every morning in the Cafeteria during the weekdays, a Leader from my organization tells and reflects on a story to share with staff. It is our organizational ritual. It was a time for me to pause.

Mr. Job is standing at the podium. He holds a red book at his hand and is getting ready to speak. There are other managers and directors around in different parts of the cafeteria. I am sitting with my colleagues having my routine oatmeal in the morning. Mr Job taps the microphone to ensure everyone can hear him. “Good morning everyone, hope your day has started out well. Today I have a story about life from a point of view of a director”. He reads his story, reflects on this, and then wishes us, the staff, a good day. This ritual took 15 minutes.

As I sit there with my peers, I remember feeling important. This action tells me that I matter and that inspirational motivating messages are important to how I produce my work as an employee. I feel like I belong to something bigger than my direct responsibility at work. I am part of an organization that cared to communicate who they are as people to members of their staff.

The question for me is whether this story translates into actions in the workplace. I remember a story of a director whose visits to the units are part of her day. Dr. Shannon

RN PhD, Vice President of the hospital, is doing her rounds. She enters our unit and says hello. I am at the desk looking through my charts. “How are you Louela? *She knew my name.* “I am fine. How are you?” I said. “I am good. It is a nice day outside. How is everything here? I see that you are all busy. *She has a smile on her face.* I just came to say hello. Have a good day.” She leaves. Directors of the organization occasionally come to visit their staff. It is a social visit and not an audit. She is not delivering a nursing message except that she cares. She is willing to take the time out of her busy schedule to take 5 minutes to say that as employees we matter. This feels like the organization’s value of supporting the dedication of their employees is real.

I wonder how nurses experience their organization at this time of ongoing hospital changes. I wonder if they feel like they matter to leaders in the workplace. Are nurses and organizational values congruent? Do their stories, as lived, influence their work-lives on the units? These questions bring me to the inquiry into the meaning of place and the social realm of experience in narrative inquiry.

Clandinin and Connelly (1994) claim that attention to place is important because it is where action occurs, stories are lived out, and where social and cultural influences shape the experiences of living. The story of the organization and the actions of leaders had an influence on my perception as an employee in my organization. My wonder about how nurses experience their values amidst organizational change sheds light on nurses’ experiences of living within the context of their workplaces and the impact of organizational directives on their lives as nurses. Health care reform has not slowed since 1991 and organizations continue to implement changes in the workplace. The directive of

establishing evidence-based quality care is an example of a recent health care system redesign (MOHLTC, 2015). How do nurses' accountabilities as self-regulated autonomous professionals interact with their roles as employees of an organization? Do they find these roles conflict in certain situations when providing care? How do they make sense of the experience? How does the workplace setting impact their ability to live out their values from their experience?

Returning to Today – My Story as a Nurse Educator

As I taught the last class of the final theoretical course in our BScN program, the students and I go through three layers of narrative-based care scenarios to help them think through the realities of the workplace. Jason shares stories of his time in Africa. Jason responds to our discussion about managing care at the bedside from a different context.

> I remember feeling helpless looking after Tony, my patient in Africa. I did not have enough equipment to look after him. Everyday, I would squeeze the pus from his infected wound. Tony sat on his stretcher, waiting for me to come. He was happy with what I was able to do. I remember being frustrated because I wanted to help him more, only if I had the tools to do it. All I could do was to clean his wound and sit beside him…I remember taking him outside in his wheelchair to feel the rays of the sun on his face. I recall that face. It was an expression of gratefulness. Tony was happy to be outside amidst his pain.

As Jason narrates his story, I think about what he may be feeling in that moment as he reflects back to a time from his international placement. He wants to do more for his patient but cannot. I feel his frustration and the pain. As a large group, we continue to discuss how we can cope in these similar situations in the future. What will they do if

they encounter the inability to enact what they intend to do for their patients in the workplace?

I recall another story from Jessica, a Level 4 nursing student, who shares how her belief about ensuring breastfeeding success is challenged by nursing practices in the workplace. Jessica narrated,

> I had a patient Joanna who had a premature baby named Jenna. Jenna had a difficulty latching on the breast. Her small mouth and mom's large breast made it hard for her to latch. Being premature, contributes to her decreased energy level for latching. I wanted her to succeed because from what I had read from the literature and the directives of the baby friendly initiative, I knew that Joanna would just need some support and teaching regarding latching strategies. At the next feeding, I sat by Joanna, I gave her Jenna to hold. She cradled her, took her left hand towards her right breast, and gently manoeuvered her nipples into Jenna's mouth. Jenna was slow to latch but with a bit of coaxing, she opened her mouth and latched. I rearranged the pillows that were under her arms to bring her more comfort and to enable her to bring Jenna closer to her chest. I had mom and baby covered with a blanket. I watched for a while to make sure mom and baby were getting it right. I told Joanna, she was doing wonderfully. I left them alone once I was satisfied that Jenna remained latched on and was breastfeeding successfully. It felt rewarding to know that I was able to influence Joanna's breastfeeding success and that I persevered to make this happen. Jenna, still needed some supplementation to keep her blood glucose at a certain level. I made sure that she received formula via cup feeding rather than through a nipple to avoid nipple confusion. I did not want to cut corners. I would often see nurses cutting corners by bottle-feeding for supplementation rather than cup feeding because they had many patients. I am pleased that I remained beside Joanna's side to help her.

Despite the difference in perspectives between hers and that of other nurses Jessica perseveres in working with the new mother towards successful latching. In the end, she feels triumphant that she is able to help the baby latch.

Both stories from different settings in my worklife as a nurse teacher suggest that there are students who understand what it means to live out what they value at the bedside. Even with the constraints of the environment, they feel a sense of knowing what is the right thing for them to do. Supported by her knowledge of evidence, Jessica perseveres with breastfeeding to help her patient. Knowing that he performed all the interventions that he could do for Tony, Jason chooses to sit with him to provide comfort. These two exemplar stories convey that students develop a sense of knowing that is beyond technical and is oriented towards the person. At that moment with their patients, they lived out their belief that the person mattered. Tanner, Benner, Chesla, and Gordon (1993) stated that knowing the patient included "an in-depth knowledge of the patient's patterns of responses and knowing the patient as a person" (p. 275). The personal aspect of knowing was further reinforced by Zolnierek (2014) who added that 'knowing the patient' is anchored within the nurse patient relationship and is highly influenced by the external environment.

I wonder how my students will be able to live out their values when they get to the workplace. How will they cope when others within their workplace environment respond in ways that are incongruent with their sense of what matters? This is the reason why I want to explore how nurses' experience living their values amidst organizational change. It is my hope to glean from nurses' stories how they re-story or reconstruct

challenging experiences in the workplace so that I may better support and teach my nursing students. Nurses are role models and preceptors for students and understanding how they live their values inform the teaching-learning relationship.

Surfacing my multiple selves (Clandinin & Connelly, 1994) through this inquiry clarifies the connection and interaction between the personal and the social. Reflecting on my life as a person reveals how my values come from past experiences with my caregivers. This understanding leads me to discover how values become relevant to my role as a nurse and how I feel when individuals from the organization enact congruent values. In my current position as a nurse teacher, my stories and the stories from my students enable me to ask questions about practice. As a researcher I want to understand nurses' experiences of living their values at this time of organizational change. This question is significant to me as a person and is based on my experiences. The next step is to scan the literature to further understand the significance and role of values in shaping life and living.

Locating the Significance of Nurses Living Their Values Amidst Organizational Change

Values reflect an individual's inherent beliefs and portray his or her personal commitments (Johnson, 2004). They establish the foundational guidelines that underpin one's actions (Pauly, 2004). The conversion of values into actions and decisions demonstrates what one proclaims to be morally right or wrong. Values serve as a fundamental point of reference for nurses; such have determined her/his moral nursing

practice. Gadow (1996) describes this phenomenon as an ethical narrative where the value within a situation is exposed. These values depict the morally good actions that arise from the relationship between nurse and patient (Gadow, 1996).

Contextual factors also have an influence in shaping nursing work lives. Health care changes in nursing practice, such as bed closures, unit and program restructuring, nursing layoffs, increased nursing workloads, inadequate patient care supplies and pharmaceuticals, have all impacted the delivery of nursing care (Baumann, O'Brien-Pallas, Deber, Donner, Semogas, & Silverman, 1996). The establishment of the Local Health Integrated Network (LHIN) adds another layer of administration to manage the system. These networks are part of a concerted effort to bring together communities and health providers to design their local health systems (Ministry of Health and Long Term Care [MOHLTC], 2008). The LHINs mandate is to work with communities in their jurisdiction "to increase access and equity, system integration and coordination, quality, sustainability and the overall health status of the population" (MOHLTC, 2008, p. 10). To this end, the LHINs continue to work with communities and hospital corporations to realign and shift programs in order to build a more effective and efficient system (MOHLTC, 2008).

Currently, hospitals are enacting the Excellent Care for all Act (MOHLTC, 2010). The introduction of this Act is intended to help ensure evidenced-based quality care for patients. This means establishing quality improvement plans and redesigning work processes. "The government is taking important steps to support evidence-based care, to foster joint accountability and to drive integration among providers to achieve a patient-

centred system that improves health outcomes and sustainability" (MOHLTC, 2015, para. 1). As nurses work within a fluid world with constant change (Porter-O'Grady & Malloch, 2011), it has been necessary to appreciate the way they live out their values within the framework of such organizational changes.

The experience of nurses living their values amidst organizational change from the lens of narrative inquiry has been understudied. This way of studying experience provides another window for understanding how nurses enact their values in their workplace. In particular, it highlights the interaction between personal and social conditions that may tell us something about how nurses live out their storied-experiences. These stories constructed from the nurses' own history may contribute significantly to understanding how stories of life are created within a context/place and manifested in the landscape of professional practice.

A study using Clandinin and Connelly's (2000) Narrative Inquiry as a methodology for understanding the storied experiences of nurses living their values amidst organizational change has not previously been conducted. An approach comprising the methodology of a three-dimensional Narrative Inquiry space provides the analytic frame to interpret the interconnections of personal and social conditions; past, present, future experiences; and place in this thesis (Clandinin & Connelly, 2000). The use of this methodology will contribute to illuminating a different perspective about a familiar phenomenon through the focus on the autobiographical nature of life made evident in the interconnection of personal and professional lives into a narrative of how nurses experience living their values within the context of organizational change. This

study has the potential to reconceptualize nursing experiences in the workplace that opens the space for reconstructing organizational approaches that foreground the role of values in nursing practice. As nurses in education and practice construct a pathway for nurturing nursing students in becoming nurses, this study may also inform further reconstruction of curricular learning activities that address the role of values in the nurse as a person and professional.

The purpose of this narrative inquiry is to explore and understand the experiences of frontline nurses working at a large academic health science centre with regard to how they live out their values within an environment of organizational change. Understanding human experiences in this way sheds light on how perceptions and responses are shaped by nurses through their interactions with their contexts (Clandinin & Connelly, 2000).

Organization of the Thesis

Chapter one introduces the autobiographical source of my research interest. It outlines the personal, practical, and social justifications for engaging in this research journey. The levels of justification will be further elaborated in subsequent chapters. Chapter two presents a literature review related to the key terms that emerged from my research question. These are: nurses, experiences, living values, and organizational change. Other terms emerged as these four key terms were explored. Chapter three presents narrative inquiry (Clandinin & Connelly, 2000) as the methodology employed, including the three-dimensional narrative space. It starts with a discussion of Qualitative Inquiry and where narrative inquiry fits within the interpretive paradigm. It outlines how

to conduct this methodology through narrative thinking and writing, as well as implementing the design elements specific to narrative inquiry (Clandinin & Connelly, 1994; 1995; Clandinin, Pushor, & Orr, 2007). I move from field text with six co-participant interviews into construction of a composite letter. Chapter four introduces a composite letter that gathers up my co-participants' responses to my research question. This chapter also highlights the personal and practical/professional justifications used to interpret the composite story. Chapter five discusses the social justification of this study and how what is revealed matters in the professional knowledge landscape. Significance and considerations for practice, education, research, and policy are also discussed.

Chapter Two

Literature Review and Background

This literature review provides a starting point for the exploration of my research question. Clandinin and Connelly (2000) claim that "terms emerge not from the literature but from our concern for experience and from our purpose" (p. 49). The key terms for this thesis comes from the research question; namely *nurses, experiences*, *values,* and *organizational change*. The term *nurses* comes from the College of Nurses of Ontario (2015) definition. Experience as a term is from Clandinin and Connelly's (2000) and Dewey (1938)'s perspectives on experience. As I reviewed the literature for the term *value,* two new relevant concepts, *personal and professional values* became evident. The term *organizational change* is reviewed through the literature defining its impact on nurses and historically, including healthcare organizational restructuring from 1990 to the present. These terms anchor my inquiry and keep me focused on the purpose of my research. The gap in the literature justifies the professional significance of this research study to nursing knowledge.

Definition of Key Terms

The term *nurse* in this study refers to the Registered Nurse (RN). The College of Nurses of Ontario [CNO] (2014) defines the entry level RN as "one who has graduated from an approved baccalaureate nursing education program and is registered with the CNO for the first time". This definition is time specific and defines the RN as having a baccalaureate degree, a stipulation for entry to practice for nursing practice in Ontario

since 2005. The Canadian Nurses Association [CNA] (2007) provides a more robust definition of the RN as follows:

> Registered nurses are self-regulated health-care professionals who work autonomously and in collaboration with others. RNs enable individuals, families, groups, communities and populations to achieve their optimal level of health. RNs coordinate health care, deliver direct services and support clients in their self- care decisions and actions in situations of health, illness, injury and disability in all stages of life. RNs contribute to the health- care system through their work in direct practice, education, administration, research and policy in a wide array of settings (p. 6).

This definition highlights the diverse skill sets nurses possess, identifies the self-regulated element of the role, and does not limit the use of the term RN to those only with baccalaureate degrees. This definition assimilates individuals who are licensed to practice as RNs prior to 2005. Although the term nurse also includes the Registered Practical Nurse and Nurse Practitioners (CNO, 2015), for the purpose of this study and the literature review the term nurse will refer to the Registered Nurse. This is the group of interest because an RN is the role my nursing students take upon graduation.

The second term *experience* arises from Dewey's (1938) theory of experience. Dewey (1938) claims that there is continuity to life experiences where past experiences come forward into the present and inform the future. Experience, however does not necessarily imply growth. There are experiences that proceed forward in time perpetuating similar experiences rather than broadening or taking the experience into different directions. Dewey (1938) refers to these types of experiences as "mis-educative"

(p. 25). Experiences where deliberate thought and reflection are applied offer the possibility for expansion and imagination of different futures. The criterion of growth becomes a differentiating element of experience.

The term *experience* also suggests an interaction between a person's internal conditions and his/her environment where both entities influence each other in situations (Dewey, 1938). In other words, the personal influences the social domain and vice versa. My inquiry explores how nurses are shaping, and are shaped by, the healthcare environment.

Stories or interpretations of experiences are subject to selective emphasis which means that when one tells about their experience, it does not necessarily become a record of events rather a re-presentation that draws attention to a significant aspect that is worth telling (Clandinin & Rosiek, 2007). Clandinin and Rosiek (2007) suggest that experience provides the groundwork for perceiving new experiences through deliberate thought. As such, an 'educative' experience is one that promotes personal growth through reflection (Dewey, 1938). Having defined the terms *nurse* and *experience*, I turn to a review of the literature defining *values* based on the personal, practical, and social level of experiences. *Personal and professional values* as key terms emerged as a result of this review.

Values in Nursing Practice

Pauly (2004) asserts that values guide actions. The College of Nurses of Ontario (2014) and the Canadian Nurses Association (2007) have both established Codes of Ethics that have provided nurses with principles and statements to guide their practice.

Yarbrough, Alfred and Martin (2008) claim that common professional values exist amongst nurses across the globe. These authors and nursing organizations have reinforced the role of values in anchoring the actions of nurses in practice.

Stacey, Johnston, Stickley, and Diamond (2011) state that the development of nurses' values begins with their basic education, and are reinforced through role modeling and observation. The value of a person-centered approach to care, for example, is a governing belief that guides action (Stacey et al, 2011). Leduc and Kotzer (2009) also claim that there are more similarities than differences in the values of nursing students, new graduates, and seasoned nurses. However, this American study found that new graduates have higher awareness of the Code of Ethics than do students and seasoned professionals.

The literature suggests that following the Code of Ethics and application of ethical principles do not fully explain how nurses respond to complex ethical issues in practice (Johnson, 2004). Tschudin and Forget (2007) claim that nursing action and patient care are influenced by moral values that guide nurses' thoughts and actions. The interaction of nurses with patients through their care leads them to acknowledge the moral good as a source of their value orientation. Nursing practice may be perceived as a way to observe nurses' values-in-action when they provide patient care. Gadow (1996) refers to nursing practice as moral practice in which the good of the relationship between the nurse and the patient becomes evident through nursing care. In moral practice, the values of both nurse and patient are considered in order to make decisions about care (Gadow, 1996). Sellman (2011) suggests that nursing values need to be firmly entrenched so as to repel the

noxious pressures of the workplace. Stacey and colleagues (2011) state that organizational constraints impede nurses' abilities to enact their values in the workplace that lead to consequences such as low motivation, role uncertainty, and inability to create and improve practice.

The current literature reviewed on the concept of values suggests that nurses enact their values when providing nursing care and that these values come from and are affected by the environment. It describes nurses' practical and social experiences where values are largely externally mandated (i.e. public perceptions, professional associations, and regulatory body). There is also evidence in the literature that acknowledges that values learned in nursing school transfers to the work setting. The literature also conveys that some of these values are reshaped once new graduates enter the workforce. What is paid little attention to in the literature is the influence of personal values in nursing practice.

Schwind, Lindsay, Coffey, Morrison, and Mildon (2014) suggest that the personhood of the nurse enters into the interactions with patients and colleagues within the healthcare team. In a study of nurse teacher's legacy, Lindsay and Schwind (2015) claim that values are the operating compass in moving through the terrain of the teaching learning experiences with nursing students. A segment of a composite letter to self as a mid-to-late career teacher from this study writes "if it is true that 'everything I am, I carry with me', then that is true for students too" (Lindsay & Schwind, 2015, p. 7). In the same vein, Savett (2014) writes a letter to an aspiring physician or nurse to describe how values inform a practitioner's judgment; although, he did not speak specifically of whether he

views personal and professional values as integrated. What is consistent in the literature is that nurses seek the moral good in their relationships with patients, that their values inform actions, and these values may be both personal and professional in nature.

The next section describes the literature on the impact of organizational change on nurses. This is followed by a historical perspective of organizational change through healthcare restructuring in Ontario. The term *change* emerged as a concept that has personal, practical, and social manifestations. The term *moral/ethical climate* surfaced as a possible influencing factor to the experience of organizational change.

Organizational Change and its Impact on Nurses

Organizational decisions that lead to changes at the unit level influence the lives of nurses providing direct care (Baumann, Giovanetti, O'Brien-Pallas, Mallette, Deber, Blythe, Hibberd, & DiCenso, 2001). A study of Canadian health care organizations reports permanent reductions in their workforce as a result of hospital restructuring (Wagar & Rondeau, 2000). These organizations experience lower satisfaction rates for employees, increased organizational conflict, but no significant lasting impact on the overall efficiency of the organization. Copnell and Bruni (2006) explore nurses' experiences with change and state that nurses do not openly challenge changes in their clinical practice and as such, an eventual normalization of changes as part of practice occurs. Nurses cope with the issues by reflecting on the change in dichotomies i.e. 'big/small, dramatic/subtle, formal/informal, and at times rational/irrational in reference to their colleagues' reactions to change (Copnell & Bruni, 2006). In this study, nurses did

not see change as a range of reactions that span a spectrum where two opposite experiences make up the start and end. What nurses experienced were contradictory poles of an issue ie. big/small.

McMillan and Peron (2013) suggest that when dealing with change, two types of experience occur; either nurses resist change or they are fatigued because of it. Change resistance refers to demonstrating negative disruptive behaviours that compromise change initiatives (McMillan & Peron, 2013). Change fatigue, a different type of reaction, demonstrates nurses' experiences of stress and exhaustion relating to extensive exposure to change (McMillan & Peron, 2013). Stensaker and Meyer (2012) describe a slightly different outcome that reflects compliance and the development of capabilities in nurses as a result of exposure to change over a long period of time. Segesten, Agelii, Elmcrona, Linström, and Lundgren (1994) claim that change involves chaos and conflicts but as time progresses these experiences transform into support for ideas and hope for the future. In this study, nurses are moving from a mixed staffing model to a completely RN model. The findings also include that nurses require support from nursing leaders outside their units to continue with their process of change (Segesten et al., 1994). The findings of Kieffer (2005) reinforce the notion that change either promotes growth and development, or is costly, as individuals attempt to manage issues in the workplace.

These studies suggest that change causes varied reactions that are either positive or negative. The positive reactions and outcomes describe healthy imagined possibilities for the workplace and for relationships, including evidence of the potential for growth. The negative reactions and outcomes, however, have an adverse impact on nurses' sense

of self, workplace dynamics and experiences. These negative experiences can be perceived as highly problematic and may lead to costly consequences for the nurse, profession, and organization. Brown, Zijlstra, and Lyons (2005) state that nurses experience lower coping effectiveness in contexts that have high levels of changes. Hansson, Vingard, Arnetz, and Anderzen (2008) claim that a high rate of sick time results from ongoing change. While ways to mitigate the impact of change on nurses has been discussed in the literature (i.e., participatory decision-making with managerial support) (Brown et al., 2005), what is missing is an exploration of how nurses reconstruct their experience as a way to manage changes in the workplace and how these reconstructed experiences do or do not maintain their ability to enact their value-driven patient care.

Ethical climate. Olson (1998) asserts that the term *ethical climate* sets the context for behavior and decisions. In her study of 360 Registered Nurses working in two acute settings in Midwestern United States, Olson (1998) illuminates the relationship between the internal context and its external manifestations. In particular, the instrument items she developed (Hospital Ethical Climate Survey) reflect values that are important to nurses when relating to peers, patients, managers, hospital, and physicians such as "peers listen, patients know what to expect, managers help, hospital policies help, and nurses and physicians trust one another" (Olson, 1998, p. 347).

This study echoes Humphries and Woods' (2015) qualitative descriptive study that highlights the impact of a negative ethical climate on nurses' experience in their work setting. Main themes such as 'being burdened', 'push the bed', and 'us and them' depict nurses' experiences in their work setting (Humphries & woods, 2015, p. 5-7).

These themes reflect the personal experience of being burdened by the low nurse to patient ratios in the practice setting, while 'push the bed' described the practical experience of having to respond to bed management objectives in contrast to keeping the patients' concerns at the heart of their work (Humphries & Woods, 2015). The 'us and them' theme reflects a social experience for nurses of hierarchy and separation from management and describes the influencing nature of the workplace relationships on nurses' perceptions of their practice (Humpries & Woods, 2015). This study contributes to the understanding of moral climate by highlighting how the context shapes and informs nurses' experience of their work-life.

Historical Perspective of Healthcare Restructuring in Ontario

Healthcare restructuring took place in Ontario during the mid to late 1990s and occurred in response to political directions of the Ontario government and to recommendations from the, then newly established, Health Services Restructuring Commission (HSRC) (Sinclair, Rochon, & Kilbertus, 1998). The Commission, formed in March 1996 by the Ontario Legislature, was composed of policy leaders, physicians, health care educators, former hospital administrators, and board members, and became the force that pushed the restructuring agenda (Sinclair et al., 1998). Its overall mandate was the development of an integrated health care system to effectively and efficiently meet the health care needs of Ontarians, particularly of the growing aging population. While recommendations from this group entailed re-investment of health care dollars into different sectors of the health care system, its primary objective was to decrease

budgetary allocations to hospitals (Anderson, Tang, & Blue, 2007; Shamian and Lightsone, 1997).

According to Burke (2003) the proposal of a forecasted $2.5 billion reduction in health care spending in 1996-1997 meant closures and mergers of hospitals in Ontario, mergers of hospital programs, and ultimately, reductions in human resources. This resulted in nursing layoffs and an increase in part-time or casual employment for nurses (Fisher, Baumann, & Blythe, 2006). Practice environment decisions and restructuring affect nurses including "burn out, needle stick injuries, workplace violence, and job (dis)satisfaction" (Cummings, 2006, p. 322). As Ontario hospitals attempted to work with the new directives, the initial organizational strategy was to redesign the leadership structure, resulting in the layoff of many managers, educators and clinical specialists, and eventually front line workers (Chan & Lynn, 1998). Hospitals moved to a program management approach, altering their service delivery from departmental to program delivery (Chan & Lynn, 1998). Spence Laschinger, Sabiston, Finegan, and Shamian (2001) stated that "between 1996 and 1999, 33 public hospitals were closed and 14 amalgamations involving 44 hospital organizations were called for by the HSRC. As a result of these efforts, the HSRC reported an estimated annual savings of 800 million dollars" (p. 6).

The Romanow Report (2002) submitted to the Governor in Council at the federal level of government outlined what Canadians felt were important in a universal medicare system. This evidenced-based and values-driven report marked essential considerations for sustaining a publicly funded health care system. Of particular importance was

Romanow's emphasis on nurses as health care providers. He claimed that morale in hospitals had declined within organizations and identified this as one of the reasons for nurses' decision to leave the profession (Romanow, 2002). Furthermore he stated

> Changes in health care services are organized and delivered in hospitals and other settings have had a direct impact on the workload of nurses and the competencies they are expected to have…many non-nursing functions have been transferred to nurses…As a result, nurses are spending less time nursing and are not able to use their full range of skills…The problem is only partly about supply. It is about distribution, scope of practice, patterns of practice, and the right mix of skills among various health care providers…For nurses, their patterns of practice has changed, they have had little control over those changes (pp. 94-126).

The report identified existing issues in the health care system at the time. Specifically, it sheds light on the issues nurses' face in the practice setting. While the report did not specifically identify the issue of *moral climate* as an element in the workplace environment that influences nurses' patterns of practice, the environmental factors he identifies is presumed to emerge from organizational value decisions that make up, in part, the aspects of a moral climate. Rodney et al. (2013) defines moral climate as those values that are considered tacit and those that are definite and known that drive practice and influence the workplace. The authors argue that nurses are capable of crafting a safer moral climate but would need support from administration and other health care colleagues in creating the space to develop this.

Governmental and healthcare system initiatives continue to impose changes in the workplaces of nurses, an ongoing phenomenon. The recent Ontario Hospital Association document on Funding and Capacity Planning for Ontario's Health System and Hospitals'

Report (2011) suggests that hospital organizations are now at their maximum in their ability to reduce cost. The next phase of change that will have an impact on the system and the workers is one that intentionally makes investments in the community sector by strategically reducing funding in some other areas of the system (OHA, 2011). These types of decisions will once again expose hospitals to more organizational changes and perhaps threaten nurses' abilities to enact what they embody as good nursing care.

Current reforms in Ontario's health care system include the initiation of the Excellent Care for All Act ([ECFAA], 2010) and the patient-based funding model (OHA, 2012). These two reforms reinforce a focus on evidence-based quality of services and a funding model that serves the needs of a hospitals' patient population (MOHLTC, 2015). The ECFAA is legislation that requires the establishment of Quality Improvement Committees in hospitals with the mandate of focusing on evidence-based quality care services (MOHLTC, 2015). An Ontario Nurses' Association letter to the Ministry of Health in 2010 recommends that front-line nurses be part of the membership composition of the Committee (Ontario Nurses' Association, 2010).

The Chief Nursing Executive is a legislated member of a Quality committee of a hospital but there was no legislation that front-line nurses be part of such a committee. The Ministry leaves the membership open to the hospital's discretion with the exclusion of mandated membership from: (1) one member of the hospital's medical advisory committee (MAC), (2) one member of other stakeholders who works in the hospital but is not a physician or a nurse, and (3) the hospital's administrator (MOHLTC, 2015). The ECFAA will influence the decisions regarding organizational initiatives in a hospital that

may ultimately affect nursing work life. This is the same for the implementation of the patient-based funding model that compensates hospitals based on the evidence-based quality of their services (MOHLTC, 2015). These current reforms in Ontario's landscape are drivers to workplace changes. Organizational change is a phenomenon that impacts nurses' daily life and serves as a context to practice. Exploring this further will provide a deeper understanding of the elements that contribute to nurses' living their values in the workplace.

This literature review provides definitions of the key terms of my narrative inquiry and a temporal lens on the changes nurses experience in direct practice (1990 to the present). The constancy of change will continue into the foreseeable future. Moral climate is a significant factor in the experience of nurses in the workplace and is said to shape decisions and actions. Values play an important part in enacting nursing care. While the practical and social levels of experiences are highly represented in the literature on values, there is very little written about values from the personal level of experience. Additional key terms that emerge from the review of the literature are *moral climate* and *personal and professional values.* Narrative Inquiry provides a suitable methodology to answer the research question as it facilitates the deliberate exploration of these terms through co-participant stories of experience with living values in the context of organizational change.

Chapter Three

Methodology

I begin this methodology chapter by discussing the qualitative paradigm and its overarching premises as a way to frame where Clandinin and Connelly's (2000) Narrative Inquiry is situated. Denzin and Lincoln (2005) refer to the term *qualitative* to describe the entities, processes, and meaning that are apparent in human existence and cannot be measured or quantified. Qualitative inquiry provides an approach to illuminating human phenomena based on meaning and its construction where the focus of the researcher becomes one of understanding the experience (Streubert & Carpenter, 1999). Qualitative research assumes closeness between the researcher and co-participants as their lives intertwine in the process of collaborating towards understanding (Denzin and Lincoln, 2005). Maykut and Morehouse (1994) add to the understanding of qualitative research through the concept of multidimensionality which means that a person's perception of his/her own reality is not solely of his own creation but that of an interaction between his/ her own world and that of the "other". Denzin and Lincoln (2005) deepen this perspective by suggesting that qualitative research opens the space for interpreting phenomena from the multiple perspectives of self or multiple "I's". As such, a co-construction of relationships and experience occur between the researcher and the participant where the researcher's multiple selves interact with the participant's multiple selves in the process of telling and re-telling of a story/experience (Clandinin & Connelly, 1994; Denzin & Lincoln, 2005). For me, the multiple selves include person, nurse, nurse-teacher and researcher.

As a field of inquiry that focuses on discovery and understanding of experience, qualitative research is comprised of the interpretive paradigms namely: post-positivist, constructivist-interpretive, critical, and feminist-poststructuralist (Denzin & Lincoln, 2005). These four interpretive paradigms under the umbrella of the qualitative research impose certain demands on the researcher that differentiates them from each other. For example, the inquiry aim of the constructivist theory is to gain understanding and/or reconstruct an experience while the post-positivist is about explanation that entails prediction and control (Denzin and Lincoln, 2005). These differences delineate the specific framework and researcher actions when conducting research. Narrative Inquiry is situated in the constructivist paradigm where the goal of the researcher is to reflect on and reconstruct experience (Connelly & Clandinin, 1990; Clandinin & Connelly, 1994). Based on Dewey's (1938) philosophy, Narrative Inquiry assumes that people live storied lives and that studying the experiences of life offers the possibility for reconstruction that opens a new avenue for living (Connelly & Clandinin, 2000).

Narrative Inquiry is about understanding the situated lives of people through reflection and reconstruction of experience, using stories as the foundational basis for such an understanding (Clandinin & Connelly, 1994; Pinnegar & Daynes, 2007). It aligns with philosophical assumptions of the subjective and multiple natures of reality within qualitative research (Creswell, 2007). Narrative Inquiry is distinguished from other qualitative research methods in that it acknowledges: the historical, contextual, and temporal nature of the relationship between the researcher and the participant; that language is data and as such it may foster an interpretive understanding of experience;

and, the acceptance of multiple lenses through which to glean meanings and acquire knowledge (Bleakley, 2005; Pinnegar & Daynes, 2007). These developments led to the formation of a new and unique methodology based on an analysis of experience, and as generated through an integrated lens of time, social interaction, and context (Clandinin, Pushor, & Murray Orr, 2007; Connelly & Clandinin, 1990).

Ontologically, Narrative Inquiry is interpreted as transactional, meaning that the researcher, through inquiry, constructs a new relation between the person and the social environment that enables a renewed and awakened perspective from the original narrative (Clandinin & Rosiek, 2007). Epistemologically, knowledge claims become discernable through the reconstruction of experience into a different representation (Clandinin & Rosiek, 2007). Connelly and Clandinin (1990) point out the interrelationship between phenomenon and method in Narrative Inquiry. According to the authors, narrative is both phenomenon and method, where the former represents the life being studied and the latter refers to the process with which a researcher studies the phenomenon and engages in the act of re-telling (Connelly & Clandinin, 1990). The act of studying experience narratively requires that the researcher engage in self-inquiry. Autobiographical writing becomes the means with which a researcher makes visible their interpretation of the experience under study anchored within the context of the researcher's larger life story (Connelly & Clandinin, 2006). A researcher engages in constant reformulation of the inquiry through consistent introspection into one's life and social context that reveals the perspective of multiple selves. This resonates with Denzin and Lincoln's (2005) use of multiple "I's" in qualitative research. This methodological consideration addresses the multiple levels of

experience embedded in the analysis and frames the personal, practical/professional, and social justifications of the study (Clandinin & Connelly, 1994).

I chose Narrative Inquiry by Clandinin and Connelly (2000) to answer the research question; how do nurses live their values amidst organizational change? Based on Dewey's (2005) notion that a transactional relationship exists between the self and the environment, Narrative Inquiry offers a way to understand this relationship through reflective inquiry that has the potential to inform new ways of relating within a context (Clandinin & Rosiek, 2007). In this methodology, the researcher returns back to experience to validate insights and new perspectives; as such, the relationship is transactional because the self returns to the experience with a new sense of growth.

Narrative Inquiry terms bring to the foreground the commonplaces embedded in this inquiry. "To undertake Narrative Inquiry, there needs to be a simultaneous exploration of all three commonplaces" (Clandinin & Connelly, 2007, p.23). These commonplaces are embedded in the metaphor of the three-dimensional space and provide the analytic frame for understanding participant stories (Clandinin et al., 2007). Based on Dewey's (1938) notion that the past, present, and future are connected in a continuous fluid flow, temporality is a commonplace that reflects the connections across time within a storyline (Clandinin & Connelly (2000). Sociality, the second commonplace refers to the intersection between personal and social conditions (Clandinin & Connelly, 2000). This commonplace draws on Dewey's view that experience has both "internal and existential conditions" and that the person is in essence also a social being influenced by his/her environment (Clandinin & Connelly, 1994, p. 416). Morgan (2014) claims that

belief and action are inseparable, suggesting that choices on how to act are linked inextricably with one's knowing and internal understandings. In other words, the social environment influences the person and actions of the individual emerge from the person's thoughts, feelings, or beliefs. The third commonplace is place and describes the context of the experience(s) where the inquiry takes place and can be perceived as the landscape of the inquiry (Clandinin et al, 2007). The place is the context of the experience. Reflecting on place may differ when a researcher moves across the temporal continuum. These commonplaces create the three-dimensional frame for analysis. The researcher engages in the analytical frame to reflect upon the story created from the field texts in order to glean understanding to be used for the reconstruction process embedded in the process of re-telling. Reflection as a key term is the process used that surfaces thoughts and feelings from the given text for closer critical inspection and examination (Atkins & Murphy, 1993). This reflection takes the researcher to the reconstruction of stories that has the potential for changes in both the lives of the co-participants and the researcher, and of the social situation (Clandinin & Connelly, 1994; 2000).

To clearly understand Narrative Inquiry, it is essential that the meaning of thinking narratively is understood, the key role of the researcher be appreciated, and the design elements be explicitly described. These components of Narrative Inquiry are crucial to understanding the methodology.

Thinking Narratively

To better understand Narrative Inquiry, Clandinin and Connelly (2000) discuss the significance of thinking narratively. Thinking narratively means understanding the notions of "temporality, people, action, certainty, and context" (Clandinin & Connelly, 2000, p. 29-33). Thinking narratively brings to the forefront the autobiographical influence of the researcher's story as she reflects upon the experience shared by the co-participants. The researcher transforms what co-participants share with her through an embodied process of reflecting that takes into account her history and current experiences. It is through working with the story over time that a new version is revealed Clandinin & Connelly, 2000). This type of writing style and narrative thinking reveals to the researcher the intersections amongst personal and social conditions as well as temporality when a series of experiences are disclosed through a story. Clandinin and Connelly (1994) expand on this notion by their claim that stories exist between the general and the particular, interceding between what is known and the personal, practical/professional, actual demands of living. Narrative Inquiry calls for the embodiment of this understanding and experience throughout the process of writing narratively.

Thinking narratively means opening space for tentativeness rather than certainty. Ongoing reflection allows for deeper understanding of the phenomenon. Action is taken up as a "narrative sign," that must be interpreted in light of the participant's histories or life circumstances (Clandinin & Connelly, 2000, p. 30). The relevance of context is

considered for both the participant and the researcher when reflecting upon the experiences (Clandinin & Connelly, 2000). These assumptions structure the approach to narrative thinking and guide the researcher through all aspects of the research process.

Narrative Design Elements

Clandinin et al. (2007) describe three types of justification related to undertaking a Narrative Inquiry: personal, practical/professional, and social. Personal justification refers to the researcher's personal motive for engaging in a Narrative Inquiry. Practical/professional justification concerns itself with questions that relate to what this particular study may contribute to one's own thinking about his/her practice and that of others (Clandinin et al., 2007). Social justification relate to questions about potential contributions to knowledge in the field. These justifications, considered by the researcher at the beginning of the study, make her/his critical role visible in the process of Narrative Inquiry.

The first design element I consider is the **narrative space of the researcher**; described as my personal, practical/professional, and social justifications for engaging in this particular journey. In this study, I engage in autobiographical writing of my life both from a personal and professional perspective. I reflect on meaningful stories from my personal life, practice and organizational experiences. These stories help me become aware of the origins of my research question and my emergent values. They provide my personal, practical/professional, and social justifications for engaging in this research.

I reflect on stories from my childhood, nurse-patient relationships, organizational influences, and nurse-teacher experiences. My story began with my relationship to my grandmother and my experiences with my collective family circle to help me become aware of where my values emerged as a young child. I carry these values across different experiences in my lifetime. As I reflect upon my practical/professional experience, I realize how important it is to attend to the needs of my laboring and birthing patient. I wonder how attention to patients may be compromised in this current climate of organizational changes and corporate cut-backs. These questions underpin my practical/professional justifications. As I think further about the issue of nurses' experiences of living their values within the context of the current climate of economically driven changes, I realized that it is important to understand nurses experiences of these changes from their personal lenses. Understanding nurses' lives through their stories illuminates the personal and contributes to knowledge for practice and education. This forms my social justification for engaging in this research. Using the literature to explore my initial personal question provides the significance and relevance of the question within the context of the professional knowledge landscape (Clandinin & Connelly, 1995). This transforms a personal query into a research question grounded in the use of a specific methodology.

The second element is the **identification of the problem of interest**. In this Narrative Inquiry, my life shapes and frames the problem of interest. This is consistent with Clandinin and Connelly (1994) who claim that autobiographical writing is the source of problem identification. The inquiry facilitates 'experiencing the experience',

meaning that I determine the interconnections amongst the emerging question and my life, discovering how my story is situated within the problem of interest (Clandinin & Connelly, 1994, p. 414). As I engage with the co-participants through their stories, I also live the phenomenon in my life, reflecting on what the co-participants share and tell while discovering resonances of their stories in my experiences. This is consistent with Clandinin and Connelly (1994) who state "as researchers we are observing ourselves in participation with co-participants" (p. 414). Clandinin et al. (2007) further reinforced this aspect of the methodology by accentuating the process imbedded in enacting a narrative view of the phenomenon. As a researcher, I need to understand how the stories of my co-participants influence me as a person and as an academic nurse educator. Experience is the main focus of study in this methodology and how it is storied and re-told is also conceived narratively (Clandinin & Connelly, 1994). Narrative is both phenomenon and method so experience is what co-participants tell and the researcher re-tells this as a story, as a narrative of experience (Clandinin & Connelly, 1994). As such, Narrative Inquiry is a specific way to understand the phenomenon.

The third design element is the **methods used to study the phenomenon.** Clandinin et al. (2007) suggest that Narrative Inquiry researchers primarily imagine the multi-dimensional life space to be the place for analyzing experience. As Dewey (1938) states, past experiences influence the present in a continuous flow that informs the future. As such, the researcher need to be aware of what is happening in the life space that includes reflecting about the past experiences of co-participants and how it influences their current experiences. The other component of this design element is to think through

the types of field texts most suitable for this study. This involves understanding the different texts that may be used in Narrative Inquiry. In this study, field text used are research interviews, conversations, and personal reflections in my personal journal.

The fourth design elements concern itself with **the process for analysis and interpretations.** This element is discussed in detail below in the data analysis and interpretation section of this methodology chapter. This element refers to the ongoing reflection that needs to occur in the process of transforming field texts (interviews, conversational transcripts, and personal journal writing) into stories that depict the co-participants' experiences (Clandinin & Connelly, 2000). It involves thinking through questions of meaning, significance, purpose, character, audience, while engaging in the personal, practical/professional, theoretical contexts using the three dimensional space inquiry frame to give meaning to the narratives produced in the process (Clandinin & Connelly, 2000). A unique reflective and reflexive thinking takes place as I, as the researcher, engage with participant stories. I move back and forth into my life in relation to the lives of my co- co-participants to understand their experience. This is a critical process that propels me towards the discovery of the narrative of experience (Clandinin et al., 2007).

Narrative Inquiry requires me to pay attention to voice as it was experienced in the study (Clandinin & Connelly, 2000). The aspect of co-creation between participant and researcher places the influence of relationship and voice in the foreground of writing interim texts. I assume that an equal relationship exists between the co-participants and that requires me to honour their voices in the process of re-telling (Clandinin & Connelly,

1994). I undertook a series of member checks, meeting one of the criteria of rigour in qualitative research that allowed for authentic interpretation throughout the study (Miller & Crabtree, 2005). This occurred throughout the interview process and after the construction of interim texts that depicted what I discerned from each of my co-participants' experiences. The six interim texts were then transformed into a composite narrative in letter form. It is written by a fictional character that represents the experiences of all my co-participants while preserving their anonymity. The purpose and construction of a composite letter will be described in more depth in the data analysis and interpretation section of this chapter. The creation of multiple interim texts is a re-storying process where the researcher initially provides the space for the participant to tell her/his story and then proceeds towards mutual storytelling and re-storying as the research unfolds (Clandinin & Connelly, 1994).

Another process for analysis and interpretation is the idea of signature. Signature refers to the researcher's interpretation as it is written in the text (Clandinin & Connelly, 2000). While voice and signature are closely associated, signature refers to my interpretation of the experience that was negotiated with my co-participant and is instrumental in the crafting of the final research text (Clandinin & Connelly, 2000).

The fifth design process is concerned with **how the study is positioned in scholarly conversations.** Clandinin et al. (2007) indicate that there are three ways in which narrative studies should be positioned against existing bodies of knowledge. First, these studies should be positioned against other research that related to the same phenomenon, so as to further enhance understanding (as was done in the literature

review). The second involves positioning the narrative study against selected research so as to shed light on how this type of study could or could not illuminate specific study areas. The third positioning relates to how the narrative study could be positioned against other forms of inquiry. This type of positioning provides a means to discern the circles of conversations that a researcher wishes to join (Clandinin et al., 2007). The positioning against theoretical contexts allows for deeper investigation about how the story that emerged from the analysis mattered.

The sixth design element is **contributions to knowledge from engaging in Narrative Inquiry.** This aspect focuses primarily on the unique contributions of this methodology. The impact of using stories as a conceptual lens for understanding a phenomenon was one way to illuminate the contribution of this methodology to the knowledge landscape. The intense focus on the personal level of experience through Narrative Inquiry was also another way to illuminate the phenomenon in ways that may not have been studied before in the past.

The seventh design element comprises those issues related to **ethical concerns that must be addressed in all research studies involving human subjects** (See Appendix A for REB approval). In particular, ethical concerns in a three-dimensional Narrative Inquiry space, as created by the relational nature of the research process (from the beginning of the study to the representation of the research text), highlight the researcher's responsibilities to honour the co-participants during the interpretive process (Clandinin, et al., 2007). An example of this would be how I, as a researcher, reflected on a particular field text in light of the participant's imagined presence during the

interpretive process. The reiterative process that exists in Narrative Inquiry allows for consistent pauses wherein I ask ethical questions about relationship and method. This deepens my commitment to the ethical values that underpin this method. Clandinin & Connelly (2000) state "We wonder if reframing concerns of ownership (of stories/experiences) in Narrative Inquiry into concerns of relational responsibility is a more useful way of thinking about this matter… Questions of ownership are not as important as are questions of responsibilities to those with whom we are in relation" (p. 177). This act of ethical relationship was consistent with Guba and Lincoln's (2005) depiction of the reflective process embedded in establishing trustworthiness.

The eight' design element relates to issues **of representation and the types of research texts employed** (Clandinin et al., 2007). Thinking narratively throughout the research process was essential for maintaining the integrity of the research methodology. In this study, the final representation of the research text was not decided upon until the final narrative was generated. This allows for reflection on how to best to represent the learning that resonated with the experiences of the co-participants and the researcher. Clandinin et al. (2007) raise awareness about the impact of the audience on crafting of the final research text. It is necessary to consider multiple audiences for whom the texts are relevant when composing the final representation of the research text (Clandinin & Connelly, 2000; Clandinin et al., 2007). In this inquiry, the co-participants' stories are represented as a composite narrative in the form of a letter that reveals the resonant narrative threads across all the six participant stories. As a final re-presentation of my

experience of the narrative, I offer a poem that captures what I learned from the process of engaging in Narrative Inquiry.

Setting

The co-participants are nurses who currently provide care at the bedside in an acute care hospital. Recruited from different nursing units within a large academic health centre located in Southern Ontario, they have experienced the organizational changes outlined in the literature review. The setting provides the context for understanding how nurses live out their values within the environment of organizational change. The co-participants are not limited to a particular nursing unit within the organization. Social conditions are created in a setting and the notion of place changes within the analytic frame depending on the time frame of the story my co-participants are sharing (Clandinin & Connelly, 2000). For example, my co-participants reflect about a nursing unit at one time and, on another occasion, the place that they talk about is the dinner table in their homes. The setting where the interview took place was dependent on where my co-participants found it convenient to tell their stories. My office was offered as a place to hold the interviews and conversations. There were occasions that a participant's house with her/his permission became a more suitable place to hold the interview/conversation.

Sampling Strategy

A purposeful sampling strategy was employed. This sampling strategy is consistent with a qualitative research methodology where co-participants were chosen because they purposefully informed the researcher of their experiences with the topic of

inquiry (Creswell, 2007). In this study, inclusion criterion and snowball sampling strategies were used (Creswell, 2007).

Criterion sampling outlined specific criteria by which to select the nurses for this study (Creswell, 1998). Specifically, this study was interested in nurses who were currently experiencing organizational changes and have experienced such over an extended period; approximately 10 years. This was purposeful in terms of the participant having a decade of time to experience organizational changes in their professional world. Only nurses who were willing to share their narratives were included in this study.

Nurses were initially recruited using a study flyer (See Appendix B) that was posted by the elevators of the hospital. Two nurses were recruited through nurse educators who knew about the study. No other participants came forward so snowball sampling was initiated. This type of sampling allows for co-participants to be recruited by way of other co-participants who recognize the importance of this study and were willing to become involved and to recommend colleagues (Creswell, 2007). The need for four remaining participants was filled through the second nurse recruited in this study.

Once the co-participants were identified through the suggestions of fellow nurses, I approached them through email. An information/consent letter was attached to the email and an invitation to meet was included (See Appendix C). The information letter indicated how their privacy, anonymity, and confidentiality would be maintained. It was stipulated that their nurse educators, managers, or peers would not know they participated in the research and would not be privy to the raw data.

Participants

The proposed study sample size was six co-participants. A sample size of six co-participants allowed for in-depth, intensive study of the narrative lives of the co-participants (Creswell, 2007). This sample size was congruent with studies on identity formation in the work setting as described by Clandinin and Connelly (2000). This sample size accounted for attrition; however, all co-participants remained in the study until the end of the interview process. Co-participants engaged in a prolonged relationship with the researcher and agreed to multiple interactions over an eight-month period. The interactions equated to four to five hours per co-participant within this period.

Data Collection

Role of the narrative researcher in data collection. The three-dimensional Narrative Inquiry space approach requires that the researcher reflects on all components of the research journey and is not merely an observer or a distant participant in the process. I am not removed from the narration of the experience, but truly am a part of the construction of the unfolding story (Clandinin & Connelly, 2000). The manner in which questions are asked through words and researcher (interviewer) intonation shapes the responses of the interviewee (Clandinin & Connelly, 2000). It was essential to ensure that co-participants are invited to share their experience and that the researcher be aware of their responses to what is being narrated. This study highlights the relational role of the researcher as listener and co-participant. Every story requires a listener (Kirkpatrick, 2008). The listener attends to the story as it is shared, knowing that what emerges is

based on the co-participants' selective memories (Clandinin & Connelly, 2000). I am affected by co-participant stories and see how my narrative is at play in the research process. As Lindsay and Schwind (2014) articulate "in contrast to the common qualitative strategy of bracketing inquirers out, narrative inquirers bracket themselves in to an inquiry" (p. 3). The role of the researcher becomes one of "making sense of the life as lived" (Clandinin & Connelly, 2000, p.78). It is essential that I am aware of this process so as to ensure that the meaning of the experience remains at the centre of my interpretation (Clandinin & Connelly, 2000). As such, a reflective researcher role is critical to this research.

Data sources/field texts. This research has three data sources, otherwise known in Narrative Inquiry as field texts (Clandinin & Connelly, 2000). These include research interviews, conversational texts, and my personal journal. The field text became the source for the cognitive/reflective movements within the three-dimensional space (Clandinin & Connelly, 2000). The way they are composed is in itself an interpretive process meaning that as each subsequent interaction with the co-participants took place, I, as the researcher, asked co-participants to expand and clarify aspects of the previous interview or conversation text (Clandinin & Connelly, 2000). This allowed me to build on my previous understanding of their story while co-constructing the new story with my co-participants. This was done concurrently with re-searching the literature.

Research interview. In Narrative Inquiry, the research interviews are sources of field texts (Clandinin and Connelly, 2000). Research interviews are different from conversations in that they are semi-structured in nature meaning that set questions were used to engage the co-participants in the storytelling. The co-participants were asked open ended questions about their experiences: about enacting nursing care, on the impact of organizational changes on their way of caring for patients, and on how their environment caused them to act and feel. The first interview initiated the participant-researcher relationship and co-participants described current experiences on their unit. The second interview was an opportunity to explore the participant's past history and gain an understanding of how certain stories emerged in their lives. This line of inquiry allowed me, the researcher, to understand how my co-participants' social histories influenced their experiences and unfolding stories over time. Interviews were conducted through face-to-face encounters only.

Conversation. I referred to conversations as the fluid interactions between the co-participants and me, conducted after the first two interviews. Within this type of field text, my co-participants established the issues or topics that they wanted to discuss at a time of day convenient to them and me (Clandinin & Connelly, 2000). It differed from a research interview in that conversations were not propelled by a set of researcher questions, rather were more open where the co-participants established the tone and topic of the interaction within the scope of the research question (Clandinin & Connelly, 1994). As such, this enabled an equal relationship between the participant and the researcher (Clandinin and Connelly, 2000). Conversations occurred outside of work hours and

spanned approximately sixty minutes. It allowed the co-participants to shape this field text.

My personal journal. As a researcher, I reflect intently on what I experience while listening to/analyzing the experience of my co-participants. The journal is my place to identify and reflect through the puzzles I encounter in my research process. This is consistent with how journals are used in Narrative Inquiry (Clandinin & Connelly, 2000). It helps me to become aware of perplexing thoughts and emotions. It gives me a source for discussion with my Narrative Inquiry mentor. My journal is the place to foreground my different selves as I try to make sense of stories and how to reconstruct them. Revealing my multiple selves or "I's" allows for my story to be re-storied (Connelly & Clandinin, 1990). For example, my researcher "I" takes into consideration through narrative thinking, the different "I's" revealed through the process of reflection. My different selves (I's) emerge as I move back and forth through my stories of practice both as a bedside nurse and academic nurse educator. It is apparent as I reflect upon my co-participants' stories that my researcher "I" becomes a predominant self in this inquiry process. This reflective process provides the opportunity for new awareness and transformed perspectives (Clandinin & Connelly, 2000).

My journal is a means for me to document my feelings, thoughts, reflections, moods, hunches, and experiences in the research setting. It is a place to understand the interaction between my voice and the co-participants' voices. In writing in the journal about voice, I become aware of the multiple plotlines both my co-participants and I live and the multidimensionality of our experiences, thus allowing me to honour and to be

honest about our experiences (Charon, 2006; Clandinin & Connelly, 2000; Frank, 1995). In essence, my personal journal is a place for me to discover my narrative in relation to my co-participants' experiences and how these enter into the co-creation of the emerging central narrative (Clandinin & Connelly, 2000). My reflections thus become part of what my study reveals.

Determination of Data Completion

I continue to bring my interpretation to my co-participants' experience at every interview and conversation in order to gain clarity about what they are telling me. Clandinin and Connelly (2000) refer to the text that I brought to the participant as interim text. I consider the story complete within our given timeframe. Narrative Inquiry requires that the researcher remain open to reinterpretation and reconstruction of narratives (Clandinin & Connelly, 2000). The starting point and the ending point of Narrative Inquiry depends on the researcher's exploration and questions (Connelly & Clandinin, 1990). New data may have emerged as a story was reconstructed again but that would be another study.

A Way that I Managed the Data

A professional transcriptionist transcribed the digital recordings from the conversations and interviews. Interpretive procedures then guided my data analysis. Immersion within the text was achieved both by reading the text and by listening to the digital recording for intonations and emphasis on phrases. This process facilitated the initial steps for the analysis of the data (Janesick, 2000).

The transcripts were formatted with 2 ½ inch margins on one side so I could record spontaneous thoughts and questions. This provides room for the initial and immediate researcher response to the text that addresses the personal level of justification. To discourage voice recognition, the recordings will be destroyed after the completion of this thesis. The transcripts will be kept in locked storage for seven years after the end of this study. No qualitative analytic software was used in this study. The computer is password protected and the transcripts are encrypted using a password.

Data Analysis and Interpretation Procedures

The three-dimensional Narrative Inquiry space provides the interpretive frame for this study (Clandinin & Connelly, 2000). This involves certain mental/reflective movements; inward, outward, backward, and forward within the space in order to make sense of the stories that were lived (Clandinin & Connelly, 2000). The inward movement focuses my analysis of the data on the internal conditions of "feelings, hopes, and moral dispositions" also known as personal conditions (Clandinin & Connelly, 2000, p. 86). The outward movement focuses primarily on the environment and its influence on my co-participants (Clandinin & Connelly, 2000). This facilitates the identification of social conditions. The inward/outward movement is fluid and focuses my attention on how personal conditions are shaped by social conditions and vice versa.

The backward and forward movement allows the recognition of the temporal plotline and assists in developing the historical links of the past to present behavioural manifestations. These movements were employed in the writing of each participant's

singular story. This facilitates an understanding of the intersection between time and place. Particular attention was paid to how co-participants described their practice. The backward and forward movement also applied when I reflect upon my life. My co-participants' stories trigger aspects of my experience that propel me to move backward in time to appreciate and understand what the situation may have been like for them.

The impact of place was analysed against the emerging narrative. Place is an aspect of the three dimensional inquiry space (Connelly & Clandinin, 2006) that shifts. For instance, in this study, my co-participants describe their experiences in their workplace and at times their stories led them to their experience as a patient in an emergency unit of a different hospital. There were also occasions when my co-participants describe stories about their family members in the context of a nursing home. Understanding the impact of place helped me become aware of how this aspect of the three-dimensional space narratively shapes the experiences of my co-participants. It also deepens my understanding of how different places are interconnected and influence the patterns of practice that my co-participants experience.

This analysis is a part of an interim research text, or participant's narrative account, that was used for member checking. Member checking is an ongoing process used to validate my interpretation of the interactions with my co-participants (Creswell, 2007). It occurred throughout the conversation and interview encounters. The narrative accounts of my six co-participants were used to develop a composite letter, an interim research text from which the findings were drawn to illuminate my personal and practical/professional justifications.

It was crucial that a distinction be made between the analytical frame and the interpretation procedures. While the frame refers to the three- dimensional space, the interpretive procedures refer to the re-storying process. In other words, interpretation emerges from the analysis using the three-dimensional inquiry space approach and the steps I took to answer the research question. The re-storying process is a crucial aspect of the interpretive process.

Re-storying process. Re-storying involves complex cognitive/reflective movements and a deliberate analysis of how the co-participants' stories are connected to the broader conversations of the experience (Clandinin et al., 2007). In other words, my focus is on answering the research question that expands understanding of the experience. The auto/biographical aspect of Narrative Inquiry became the platform for which to understand self (Clandinin & Connelly, 1994). The re-storying process is a combination of both the researcher's reflective self and the analytic frame. Given this inquiry stance, I acknowledge my assumptions about the re-storying process, and integrate this with the central analytical frame to arrive at my process for generating the new story, an essential feature of the Narrative Inquiry process. The re-storying process involves several reflective movements towards the discovery of the new story. The first involves moving from field text to the construction of each of my co-participants' stories. These stories were written in the form of a letter and composed the narrative accounts. A letter as a narrative device allowed me to foreground the personal and practical knowledge of my co-participants (Ciuffetelli Parker, 2011). This was followed by an across-story interpretation of the resonant narrative threads (Clandinin, 2013). Once this was

established, I composed the composite narrative that involved a literary re-organization of narrative account text materials to reflect the resonant narrative threads/plotlines in a letter. This letter is the final interim research text from which my justifications emerge. The re-storying process that engages a reflexive journey continues forward until the chosen end for this thesis, a poem that re-presents what I learned. The re-storying process is continuous process of reflecting and reconstructing. Through an exemplar, I demonstrated how a segment from my co-participant Alice's field text continued forward in my writing of her narrative account that then became a part of the composite narrative (Appendix D). I followed this same process in relation to my five other co-participants (Laurie, Karen, Isabelle, Jane, and Cherie) when composing the composite narrative.

From field texts to narrative account. The field texts offered the raw data from which a participant story emerges. The story is constructed from my analysis and was re-presented in the form of a letter from the participant to me. A letter is a way for me as the researcher to experience the experience of my co-participants. A letter, a narrative inquiry method, is a form of literary narrative that demonstrates reflection and brings to the foreground the personal practical/professional knowledge of the writer (Ciuffetelli Parker, 2011). The letter is a way for me to tap into this aspect of my co-participants' stories as shared with me. As such, it is through a letter that I am able to bridge both voice and signature of my co-participants in answering the research question (Clandinin & Connelly, 2000). It was a literary act of organizing segments of the transcripts into a coherent form to relay my co-participants' answers to the research question.

From narrative accounts to resonant narrative threads. A second layer of analysis involves looking across narrative accounts in search of patterns and plotlines (Clandinin, 2013). The term resonance means "echoes" or "reverberations" across the accounts (Clandinin, 2013, p. 132). This is different from searching for essences or themes that may be applicable in different methodologies. The aim of reflecting upon the threads is to identify the resonant elements that will be relevant in the construction of the composite story. Resonant narrative threads identify interconnections amongst the accounts, evidences of gaps, silences, and dissonances (Clandinin, Steeves, Li, Michelson, Buck, Pearce et al., 2010). Once these resonances across all stories/accounts are captured, they are used to compose the composite (He, 2003).

The composite narrative. The construction of the composite narrative follows a similar process used by He (2003) in her composite of three Chinese immigrants born during the Anti-Rightist Movement in China and who grew up during the Grand Cultural revolution (p. xviii). In protecting the anonymity of her co-participants He (2003) crafted a composite that allowed her to tell a story of their experience. The composite from this study weaves the narrative resonant threads into a reconstructed narrative.

The resonant threads of the stories were integrated into a narrative plotline where a singular fictionalized voice was readable through the text. This voice maintains the narrative truth (He, 2003) as revealed through the resonant threads. The reader (audience) reads a story that represents the co-participants from this study, as well as an anonymized organization where the story is situated. The intent of this composite story in the form of a letter is to retell the nurses' experiences that reveal their personal and practical

knowledge (Ciufettelli Parker, 2011) while protecting their anonymity. The composite narrative (Clandinin & Connelly, 2000) is justified from the personal, practical/professional and social levels of experience.

At all levels of justification, the three dimensional space is engaged and I, as the researcher moved backward and forward, inside and out in this metaphorical space to make meaning of the composite and generate new understandings.

Personal justification. This stage of justification focuses on the immediate and spontaneous personal response as a researcher to the composite. I use a letter as way to respond to the composite narrative from my co-participants. It is a way for me to include my voice and introduce my signature in the co-construction process. Specifically, the composite letter brings to the foreground questions, thoughts, feelings, and senses in an embodied way in response to the composite from a personal level of experience (Clandinin & Connelly, 2000). The composite letter presents aspects of myself that are relevant to my multiple selves as an academic nurse educator, nurse, and researcher. These responses depict the autobiographical nature in Narrative Inquiry and its role in the process of making meaning of my co-participants' narrative accounts (Clandinin & Connelly, 1994).

Practical/professional justification. At the level of the practical/professional justification, I use the literature to engage with the composite letter in more depth in order to understand its significance to the practical/professional experiences of nurses. This requires a dialogue between the composite and the literature relevant to the experience. At this level of analysis, I ask questions brought from the personal level of experience of

the composite text to deepen the understanding of the practical/professional experiences of nurses (Clandinin & Connelly, 1994). This fluid transition from the personal level of justification to the practical/professional allows for 'continual reformulation of the inquiry' (Clandinin & Connelly, 2000, p. 124). At this level of justification, I analyze the contents of the composite letter for how it enlarges (or not) the conversations in the literature around the phenomenon studied in this research (Clandinin & Connelly, 2000).

Social justification. The social justification positions the composite letter within the professional knowledge landscape. At this level of justification, I look for the significance and relevance of the composite letter within the literature and the field of discipline (Clandinin & Connelly, 1994). This sets the stage for the theoretical justifications or contributions to knowledge by this study that provides for new ways of perceiving familiar stories in practice and of living anew (Clandinin, 2013). This leads to the discussion of how my research analysis matters and contributes to practice, education, research, and policy.

Trustworthiness

In Narrative Inquiry, we present evaluative criteria to address the rigour of the research. Congruent with its philosophical underpinnings, we identify the end of this inquiry, presenting what was uncovered and what new questions arise (Dewey, 1938). There is no limitations section as found with other methodologies. Current discussions addressing rigour or validation in qualitative research emphasize two different approaches (Lincoln & Guba, 2005). The first approach involves the implementation of

epistemic criteria to establish methodological rigour within the whole research study; the second alludes to the rigour of interpretation that would be deemed essential to the nature of narrative analysis (Creswell, 2007; Lincoln & Guba, 2005). Both of these ways of thinking about rigour are applied in this research study.

The epistemic criteria concern itself with the evaluation of the trustworthiness of the study that includes credibility, auditability, confirmability, and applicability (Creswell, 2007; Hallett, 1995). Credibility refers to following the philosophical underpinnings of the methodological frame of the study (Creswell, 2007). In this study, this was achieved by ensuring that the study design was constructed through the lens of the three-dimensional narrative inquiry space of Clandinin and Connelly (2000), based in Dewey's philosophy (1938). Evidence of the interaction between personal and social conditions as they relate to the research questions is evident. The element of time (past, present, and future) is considered in the narrative accounts. The impact of 'place' on the analysis of the resonant narrative threads is provided. These choices are evident in the writing of the chapters. Key elements of design include the autobiographical influence, the justifications/analysis from the three levels of experience, and reflection that highlights the researcher's multiple selves are also evident in this study.

Auditability describes the way the design follows the research method systematically and clearly (Hallett, 1995). Transparency and a systematic approach are core principles that address quality in qualitative research (Meyrick, 2006). Transparency of the narrative text means that the processes are clear and visible not only for auditability purposes but also for clarity of thought (Koch, 1998; Meyrick, 2006; Sandelowski, 1986).

Auditability of the research process is maintained through detailed accounts of meetings, decisions, and reflections throughout the study. By tracking my analysis/interpretation from field texts to research text, my Narrative Inquiry mentor acts as an auditor to my analytic trail throughout the process of analyzing my data and writing this thesis.

Confirmability ensures that my co-participants affirm the interpreted data as accurate and credible (Creswell, 2007). In this study, confirmability is established through validations pursued during the conversation and interview encounters with the co-participants. Once the interim texts were crafted, they were taken to the co-participants for feedback on the accuracy and credibility of the account. Verification of this resonance to the co-created story by the co-participants ensures confirmability of the interpretation through story.

Applicability, also known as transferability, refers to how the data is applicable to a number of contexts (Hallett, 1995). Rich, profuse stories allow readers to discern the transferability of the stories across differing contexts (Creswell, 2007). In this study, the composite narrative letter and my response to it provide rich, profuse descriptions of the participant's experiences as stories to enhance applicability.

Ethics

Throughout this research study, I assessed ethical issues embedded in every component. It is my firm intent to respect and honour my co-participants as co-constructors of this Narrative Inquiry.

A Corporation Research Ethics Board approved the research proposal (REB # 12-348). Nurses selected per the previously described criteria volunteered to participate in this study. Once the co-participants were identified through recruitment, an informed consent was obtained. The co-participants were given copies of the information letter and the signed consent. The co-participants' actual names were not used in the transcripts or on any documents by which information was disseminated. After every interview/conversation with the participant, the tape was coded with a pseudonym to represent the participant, the type of interaction and its sequential number, and the date, time, and place of the interaction.

This study posed minimal risks to my co-participants. Privacy and confidentiality were rigorously protected. Each interview was audiotaped. Immediately following each interview, the recording was transferred to a password-protected computer and encrypted. The recording was labeled and dated. The recordings were transcribed with all identifying information removed from the transcripts. To ensure that there could be no voice recognition, the recordings were erased from the digital recorder after transfer of the data to the computer. Raw data were not shared with anyone outside the previously described circle.

I maintained strict adherence to the required processes of informed consent. The participant's right to withdraw at any time during the study with no repercussion to him or herself was emphasized. My co-participants were given the right to stop an interview whenever he/she felt it necessary due to health concerns or discomfort with the topic being discussed. None of my co-participants voiced any concerns or discomfort. I

provided both verbal and written information during the initial informational meeting with potential co-participants. I emphasized my co-participants' right to have the time to consider participation in the study as well as the opportunity to ask questions (Richards & Schwartz, 2002). I protected the anonymity of the co-participants and place of the interview.

Narrative Inquiry emphasizes the relational responsibility of the researcher to discuss how the final report shall be written (Clandinin & Connelly, 2000). This concern relates predominantly to the issue of voice and signature in the final report. The researcher aims to consistently listen attentively to the co-participants during the interview process while bearing in mind that the storyteller has an important story to relate. The researcher is mindful of the participant's imagined presence throughout the interpretive process. This was a way of honouring the stories of co-participants. It is essential that the voices and stories resonate faithfully with the co-participants (Clandinin et al., 2007). The choice of the composite letter that integrates the narrative truths from the participant stories is another layer of protection to the co-participants and the organization (Lindsay, Cross, & Ives-Baine, 2012). This way of representing experience captures the common narrative threads of the co-participants' stories without divulging the core of each participant's identity revealed through their individual story (He, 2003).

This chapter presented my movements as a researcher within this research study. It situated Narrative Inquiry within the interpretive paradigm of constructivism within qualitative research. Underpinned by Dewey's (1938) philosophy of experience, I discussed how the notions of continuity and interaction made its way in the Clandinin and

Connelly's (2000) three dimensional Narrative Inquiry approach. The remainder of the chapter discussed how I applied the essential design elements of this method and how I implemented the criteria for trustworthiness in my work as a researcher. The following chapter will present the composite letter and the justifications from the two levels of experience: personal and the practical/professional. Chapter 4 reveals the narrative of experience of how nurses live their values amidst organizational change.

Chapter Four

Interpretation of Text

In this chapter, I present a letter from Tanya, respond to her with personal justifications for my inquiry, and then provide practical/professional justifications that illuminate the first two levels of significance of my inquiry (Clandinin & Connelly, 2000). Tanya's letter is a composite derived from the stories of my six co-participants. The process of crafting the composite narrative was discussed in the last chapter and this interim research text addresses my research question. A composite narrative in the form of a letter provides a way to bring together the experiences of my co-participants in a coherent form as if they were one person and is a powerful way to clearly understand the story they want to convey. The literary device of a letter is purposeful in two ways. It provides an opportunity to reveal practical knowledge that affirms the transactional relationship between experience and the process of telling a story (Ciuffetelli Parker, 2011) while re-presenting the interweaving of participants' voices and signatures in an organic way (Clandinin & Connelly, 2000) and preserving co-participant anonymity. In writing a letter to Tanya as a form of response, I engage in spontaneous dialogue with her to reveal my personal justifications. This process evokes emotions and connections to my experience that influence my thinking and writing. Clandinin (2013) suggests that the personal justifications awaken you to how you may be changed as a researcher from living alongside your co-participants. This process prepared me for the next layer of analysis that composed the practical/professional justifications. This place in the journey

of moving deeper into meaning rests on the dialogue between Tanya's letter and the literature. As our stories unfold, I am pulled in the spirit of co-construction.

A Letter From Tanya

Dear Louela,

Thank you for giving me the opportunity to share my ideas about how I experience living my values amidst organizational change. This is really an important question to ask as my organization continues to move through ongoing change. I hope that what I contribute helps you understand your question with more clarity.

I graduated from a BScN program and worked in medical surgical units, cardiology, ICU, and the resource team. I also teach part time. Initially, you asked me to share stories of my life with you. What stood out was a story about my relationship with my grandfather. When I was a little girl growing up I had a great father figure in my grandfather. My grandparents took care of me when I was a little girl while my parents worked. My grandfather came from an era where there was a lot of scarcity and people had to prove themselves to others in order to get the better jobs and succeed. He was a tailor and in those days it was hard to find work. He had high-end customers who were well off. In order to get the business of this group of people, my grandfather had to prove himself to a lot of people and grow. He read a lot of books and learned a lot.

He never stopped growing. He influenced me a lot. He always said "you always have to prove yourself, it doesn't matter that you live in a different world where everything is at your fingertips. Your self-worth is dependent on growth and that's

dependent on you. What is it that you want to do and how do you want to evolve as an individual?" He influenced me to grow and develop and to never stop trying, never stop doing different things, and to always keep engaged. Engaged in your work and engaged in what you are doing. I mean he's been doing the work of a tailor for 50/60 years. He can create a suit with his eyes closed or make a dress. He enjoyed his work so much. He enjoyed contact with people and enjoyed making things for them. From birth to age 5 or 6 to have that kind of strong figure who was always showing me different things definitely influenced me. He did a lot of needlework and sewing. He would come and put me on his lap and show me how to sew and he would show me all these things. And he would always talk about his life and teach me. In my culture, the elderly are the wise ones. People do listen to them because they have more experience. I respect them.

My grandparents definitely took my sister and me under their wings. They did a lot of teaching that stays with me to fuel my desires. Also the fact that the majority of my family are in medicine with the exception of my dad also contributes to how I feel. My grandfather told my Dad that there's enough physicians in the family so pick something else. So my Dad became an architect. My dad always pushed medicine for me because that was his passion and what he wanted to do. He would comment that I would be great in medicine. At the dinner table, my aunt, a paediatrician, her daughter, a paediatric nurse, and my whole family would talk about different medical things. It's not uncommon as I said to have these conversations. My whole family influenced who I am. They became my role models.

As I think about my life and that of my patients, I cannot help but realize that patients are somebody's child or somebody's brother or sister. I have brothers, sisters, and children and I just feel that the kind of care that I should give is the kind of care that I would give to my own. Everybody deserves that, and knowing their story and who they are and why they are here are all part of that. To make sure that the care I give is family centered care, I need to know what's going on in the family. Knowing their story and trying to help them through makes a difference. If I don't really know them then it doesn't help me care for them. I need to know who they are, what they expect, and what they expect from me as well.

I was a patient recently and was very disappointed with the way I was taken care of at a hospital as a patient. In fact, I went to a couple of hospitals that were not in the immediate city. I was really sick and I was completely ignored. Nobody validated that I was actually sick and needed to be looked after. I was simply put in a waiting room. Nobody checked up on me for four hours. Nobody did the re-triage to see if anything was changing. My condition was actually changing. I did not even know if I had periods of black-out. I had no idea what was happening with me. The nurses at the triage desk could not see me because of the way the emergency department was set up. The waiting room was around the corner from the triage office and I did not see a nurse leave the triage office to look around the waiting room to see how people were doing and their status. When I was finally seen at the third hospital after leaving two other hospitals because of inattention to my concern, I was actually in need of intense care. My condition was very serious. I was septic, febrile and admitted with the medical diagnosis of bacteremia.

My symptoms started in the morning. I was finally seen at 7:00 in the evening at the third hospital. I had passed out for six hours not knowing what was happening with me. The prior two hospitals ignored my calls for help. They ignored my symptoms and did not really bother to check to see if there were any changes to my symptoms. I could have passed out in the waiting room and nobody would have seen me. I needed medical attention. When I was better, thinking about it really made me angry. For the first time in my life I was let down by the healthcare system and by nursing. In my mind, we stand for empathy, compassion and a helping hand. I saw none of that except for ignorance and neglect. I did not see the care that I wanted to see from nurses.

I was moving from one hospital to another in the city because I felt I was not getting the care I needed. When I left the second hospital, the nurse said and I quote "bye-bye". I was not a rowdy patient. A couple of times I did ask how long it was going to be for the physician to see me because I was feeling very sick and felt like passing out. I asked them to check my sugar to which a nurse replied, "your sugar is fine" without even checking it. So I said again, "can you please check my sugar". I was caring for myself. As a nurse I was caring for myself in the waiting room. There should be nurses to take care of me. My cognitive status was impaired because I was septic. Everything was just overwhelming at that point and I was really glad that my husband came to get me. He was my representative and got me to a hospital that would look after me.

I am so sad that we live in this day and age with all this technology but we have lost compassion and care. I saw none of it. I saw no compassion. I saw no care. It makes me wonder, what does our healthcare system stand for? People could be dying in waiting

rooms because they're neglected. What is it that we've lost? Where did we go wrong? Compassionate care is what we are based on. We've lost it and why did we lose it? I am very disappointed about that. I am not saying that all the people, nurses in every emergency department, in every hospital are the same. From my experience, the ones that are in bigger cities seem to have lost it. They lost that foundation that we are built on. Are we replaced by technology? What makes us human is not there anymore and makes me really angry as a nurse and as a patient. I was really sick and I felt that nobody cared. I was septic and nobody noticed.

It is ignorance. I was completely let down. I needed fluids. I did not ask for medications, I asked for fluids. There is a huge difference when you come in and say I need fluids. I am not here to ask for morphine. I am not here for pain medication. I am not a drug addict. I am not searching for a quick fix. I am asking for fluids because I am extremely dehydrated and febrile and I need to be connected to an IV and given antibiotics. I mean I am a nurse so I know what I need.

I did not see professionalism. I did not see compassion, empathy, nor communication. The nurses told me to take a seat and wait. For how long, 6 hours, 10 hour, until I die? My symptoms did not come to light for them. Dehydration, fever, decreased oxygen levels, "not feeling well", in pain, clenching my chest. Nobody came by to see if I was alive around the corner in the waiting room. I felt like I was dying.

I am a huge advocate for nursing but for the first time in my entire life I was let down by a nursing profession. It hurts as a professional to see that happen. Although this experience had been horrible, it taught me a great deal. It taught me about what I will do

for my patients as a nurse. Coming from that side, I have come to know and see what the patient is going through. I think it makes me a better listener.

I had something similar happen with my father. My dad was sick for a year and a half with cancer. He got really depressed. For the first six months or a year I spent my days off trying to figure out what I could do in terms of treatment for him. I took him to his appointments where we would sit in a waiting room for hours. It was the most frustrating year. When you got there, the doctor asked three questions and the appointment ended. We went home. I hated it. I hated the healthcare system that year because it did my dad no good. When he came back from Florida, I tried to get him some treatment, even a diagnosis. I was so mad at the healthcare system. I was angry at his family doctor and everybody because no one did anything and the process would take months. He needed a CT scan and this was scheduled a month from next February. It was horrible. The system failed me and I was upset about it. I was almost embarrassed to be working in the system because Dad got no help. It was a long year and a half of waiting. He was exceptionally healthy for a man of his age until he got cancer.

I remember one of the nurses sharing her story about her dad who recently died. She said, “He was in the hospital three months. He went in for a bump on the head and they quickly bounced him from an acute care to rehabilitation. He had nothing to be rehabilitated for because he did not have a head injury. Something else was going on and causing the falls. Nobody looked into it and he started having the falls again. The PSWs and health care aides were looking after him. I finally said, could somebody do a set of vital signs when he falls”. In my mind, this would be the first thing I would do when a

patient falls. I would do a set of vital signs but it was not the norm at the place. When they did do a set of vital signs they discovered his heart rate was 30. Nobody reviewed his medications or thought that he is on a beta-blocker. So taking the nurses away from the bedside has consequences. It is the patients that suffer. So you see Louela, from my personal experiences, I can see how patients should be looked after in the system. Patients want us to do our jobs as nurses. Sometimes I wonder if we can. I do not think that we can delegate the care.

Getting to know my patient instead of just knowing their name and their vital signs is important to me. Being at the bedside helps me do this. From my perspective, there is an actual human being behind the name. This is why nursing is the way it is for me. I see it as taking the time to do my full head-to-toe assessment and to look at patients and their situations while spending some quality time to get to know them. There's more than just the medical aspect of taking their vital signs and doing whatever assessment I need to do. There's the other aspect of understanding their situation and providing the appropriate care. When I was taught my basic nursing skills, I was taught not only the science of nursing but also its emotional component. Whole nursing care is not just the care of the body but that emotional care also exists. Having been a patient in a hospital, I remember that it made me feel good when I received it. That's important! It's important to know that everything is being covered. Good nursing is providing the best possible care which span from the physical to the emotional. I feel that good care is holistic. Getting to know patients on that personal level is important so that I can adjust how I do my care.

The same goes for relating with the family. I like the feeling you get, when I establish rapport with a family and that they are comfortable with me. I am doing everything that needs to be done for the patient and I sensed that the family feels relaxed and are asking questions. I am teaching and there's a feeling of comfort. They will remember how I was pleasant and how they felt when they were taught or helped. This is important.

We often have students on the unit and teaching them is also important to me. When I get decent students that want to learn, not the ones that sit and doodle in their book, but the ones that say to me, my assignment is a little light, can you show me something? I love that. I would say, "Let's go and learn about cardiac monitors or about IV pumps. Let's go do this". I love that. I like teaching nursing students the right from the wrong. I like getting ones that aren't, sorry "lazy" but the ones that want to know, I love it. I just really like that.

Things have changed. There was a time when I had a little more time to go in the morning, do a bed bath and perform my whole assessment. I realize that there are other ways of doing an assessment then to give a patient a bed bath, but it was all part and parcel of the full care. Do you ever go a day without a shower? I know I don't. We are suddenly expecting patients to not be washed. But then, I understand that in the hierarchy of things that needs to be done in some days, getting your meds administered tops that. When you have no time, bathing your patient is the kind of nursing action that slides. True that it is not going to kill them to not have this done, but to me it feels like stuff is sliding away a bit. It feels more piecemeal as opposed to caring for the whole patient.

Some days I would love to be able to go in and say to a patient, “okay here’s what we are doing, our plan is you are going to have a good bath. I can look at you and I can get a feel for how you are feeling. How is your pain? How you are moving? What kind of marks do you have? What is the whole picture?” To me, this is holistic care. You’re doing it and the patients are not even aware that you are doing it. This makes it a lot nicer. You can teach while you are giving care and I love it.

If every morning everybody received that, it would make me feel like I knew exactly what was going on with every patient. Today, there are some shifts during the transfer of care when I will ask my colleague whether he/she caught the mark on the patient’s back near their coccyx, and my colleague would say I think honestly I did not. I wasn’t able to give them a full bath today and all I know is that I think I got all my meds signed off. This little red mark could be something! This is just one of the incidents.

I hate this kind of nursing. I want to know that I’ve had the time to give to everybody the care they deserved and do that whole thing. I also want to make them feel good. It is not even just about what I am going to chart on the computer. It is also what’s going to make them feel good. Like I said earlier, do you go a day without a shower? I sure don’t! A patient in bed is going to feel like crap and I am not even able to throw a wet facecloth at them? I feel that these practices have been affected. I find that I spend the time on the things that are important in my care and so hopefully everything gets done that needs to, as far as if I have to go to court I can say “thank you your Honour, I gave the ampicillin, but I did not wash their toes”. Sometimes there are things that can get missed when I am running around putting out the fires for different patients.

When I first started, a patient with morphine drip was either in step-down or on a smaller patient assignment, maybe 3 to 1 or 2 to 1. A nurse with a traech patient would be a 2-1 assignment. And right now it is not uncommon to have multiple patients on a 4 to 1 or 5 to 1 assignment. Now management does not see a problem with giving me a 4 or 5 patients and one patient with a traech in my assignment. I think the reason for this comes down to funding and money. They can only hire so many or only have so many nurses working per shift. It is not safe. It's scary and it's getting worse. People complain about unsafe workload but nothing seems to get done.

Management tries to hire people at the same rate as people leaving. We have a lot of people on our floor who are off on long-term sick time. We just recently had a lady retire and they are trying to fill the position. Management fills it with a brand new grad. This makes it harder for everybody. I find it challenging. I sometime wish we had more staff and that we would be able to have smaller assignments. The reality is that the unit is under staffed with a high patient to nurse ratio. It means that I just have to be more organized or be content with not getting as much done, as I would like. I just have to tell myself that I can't do everything because I have to spread myself around. I still have to do all the meds, the dressings, as well as feeding. In terms of the little extras, like bathing, I have to be prepared to let some things go by the ways side. I am just too busy. It is unfortunate and you feel bad that you can't. On the other hand, it is the way it is. You get used to it because that's just how we work. We have expectations but we can't always meet them every day.

One of the biggest changes that we are currently dealing with on the unit is the challenge of electronic charting. It takes me away from the bedside. And what I see happening more is the pressure to perform at the bedside and do the job that is required when resources are limited. The current practice is taking me away from the bedside and sticking me in front of a computer. Entering E-care does take a long time. I don't mind the computer or the documentation, but it is the way it is set up on the ward. I have four or five patients and I am struggling for a computer. I hover around the desk area to claim a computer. When I am focused on doing my documentation at a computer at their current place, I don't hear all the bells and whistles. I don't even see the cardiac alarm ringing off because my attention has shifted to documenting at a computer far from the patient's rooms. I think it is dangerous.

My relationship with management is another issue. I think that there are many people who are not really happy on my unit. It is so busy and we often work short. There have been many changes in management. For example, I think about a year ago they moved our manager somewhere else and they put a new one in place. She is very good and very nice. But then we also had two clinical leaders for two areas. They got rid of one of them and so now the other one has to do double the work and I think she is really busy and stressed out from it. Because she is overwhelmed, things are not getting done the way they should be and that is causing bad morale.

When I am at work, conversations come up with colleagues and we end up talking about stress. We discuss what we think might happen and our feelings towards this. Recently the organization asked us to fill out a survey and so I know a lot of people were

very open and honest because it was anonymous. So I felt comfortable stating my displeasures with the organization. I questioned if anything will be done with the information once it is analyzed. How is the organization going to use the information is the question that I asked. I did not find out.

To know that the organization is open and honest about things will probably create more satisfaction with the place and the organization. I know that's important for keeping me happy and satisfied. It increases my job satisfaction and makes me want to stay, work, and be proud of my organization. It would be better if management actually listened to us as nurses and took our thoughts into consideration. This is why I questioned the survey that was recently given out. It is a step in the right direction, but I am still unclear about what the organization is going to do with the information.

The actions of our manager also help in developing a better morale. It is always nice to be brought into the office and be told when I do something good. Not every week but just to know that she heard something that happened the other day that she just wanted to let me know and thank me for doing a good job. To be thanked for my time and effort, the difference I made, and to keep it up only took 30 seconds. It did not take a long time but it helps with morale. It is better than hearing "can you come to my office because I have to talk to you about something that happened last week" and when I get there, I am reamed out for something.

So it helps to know that I can work with my boss. There is also another leader on the unit that I do not think I could have worked with for the next 10 years. Everybody can see it but she is still there. She drove me crazy. She drives everybody crazy. There is

nothing I can do about it. I voiced my concerns but she is still there. So I had to leave, I couldn't handle it. She was just not a good role model.

Finally, since we are working with new graduates, I find that another problem is that students who are graduating are not prepared. We've got new nurses coming on the floor that have no skills and they're being taught by young nurses that haven't developed their skills so as a result we're just seeing craziness. Too many new bodies all of a sudden being trained by bodies that have only been there for 3 or 4 years and really bad things are being taught. Mistakes are being taught because these girls don't know from experience.

On their defense, I also think the clinical nurse educator has a role to play with this. She needs to come upstairs and teach the new nurses how to manage patient issues. The younger nurses with less experience need more and more help from the older nurses because it's overwhelming for them. Unfortunately, this takes me away from my own work. I don't mind helping people and I think I am good with helping younger staff but it's just exhausting. This leads me to consider skill mix in terms of senior/junior nurses on the unit when it comes to creating the assignment, assigning the appropriate nurse to acute patients.

The students also pose another issue. They say they take critical thinking but then I watch them try to calculate meds or they come to me and ask me questions and I say why do you think you need to give this and they can't answer me and I say you need to go back and think about that and figure it out but come to me later and tell me why you think you need to be giving this med or why you think this patient should get this med or

why does this patient needs to get up. I think that there needs to be a better balance between thinking and tasks.

Maybe I am a dinosaur and maybe I am going to have to change my way of thinking; but one thing I cannot change is to stop what I am doing and answer my patient's call when he/she asks. When someone comes to me and says little Johnny has to go pee while I am on the computer, I have to respond immediately. I cannot count the times when a patient's family member requests for nurses help while they are on the computer and they'll say, "I'll be there in a minute" and do not move for 15 minutes. All I can think when I see this is that you have never been in the hospital and had to go pee all of a sudden. I could never do this to a patient. I say give me a second to come off the computer, I will be right in because I can't go in 15 minutes later. I am a good nurse and if a family comes to me, they know I am going to get up. For patients that have been there for a while, their family members know the nurses that will get up. My son has been in the hospital frequently in his life, I would hate it if he had to wait to hold his urine. He has always been lucky because I have been there. We have patients that have nobody. How do you not get up and help patients when they need to go to the bathroom? So it is easy to get your charting done when you can tell a family member I will be there in a minute and arrive in the patient's room 20 minutes later to put him/her on the bedpan. You finished your charting but the patient held their urine to wait for you. I can't do that. What happens is that there are many of us that leave late. Yet there are others that do not leave late but I can tell the difference.

Sometimes I get a bit resentful. I've had to cope with the situation at work and I have accepted some of the changes. I am always going to nurse a certain way, there will be days that I do more and some when I do less. I am not perfect, but what I've come to accept is how I nurse. I would rather work on the computer at lunch then to stay late. I can live with that decision because it relieves some of my stress. My desire is always to do the best job possible and be a good nurse, not the best nurse but a good nurse. It is to know that I am doing a good job. This would make me very satisfied in my role. And I find that not doing the full holistic type of care with patients makes me unsatisfied. I feel that I could be doing so much more nursing in my role as a nurse as opposed to doing administrative and other aspects that are now incorporated with nursing. Being more at the bedside, more patient focused, and hands-on are important to me as a nurse. I wouldn't want to take shortcuts. I would want the best possible care provided.

The reality is that the unit is crazy and busy. Every day you think it is going to be better but it turns out to be ridiculously crazy. I am going crazy. I think it is causing many people to want and find a better place to work. It was getting out of control. I guess it is okay when you are young and that's all you know. I've done this for a long time and I can see myself getting burnt out and tired and grumpier. My husband would ask me when I came home from work why I was not talking to him. I remember responding, "I have been talking for 12 hours I don't want to talk anymore, nothing against you honey". He could tell I was burning out. I didn't want to talk to anybody. I was shutting down. So I finally decided to leave.

For a couple of years I thought if I ever moved I would like to go to the Urgent Care unit because a lot of nurses I know have gone there and they said it is a better place to work than on the ward. The three main reasons for me is that 8 hour shifts are better than 12 even though you don't have as many days off. Right now I would rather work 8 hours and be done. My husband works 8 hours a day Monday to Friday. Really to have 5 days off from doing the 12-hour shifts was nice when my kids were little but now that they are grown and out of the house for the time being, it is better to have a normal life and be home on weekends. The new unit has less night and weekend shifts and it is only an 8-hour shift. So three reasons! I've decided to make a move. Now, I go home and still have energy in my days. The 8 hours does not take a toll and the new unit is not as crazy.

The situation on our unit is forcing us to make choices that I don't necessarily want to make. It may be the way of the future because there just isn't the money. I get the budgetary constraints but when there are compromises, there comes a point that you reach a 'line' when there is too much compromise. Is it okay if a family member helps wash their child every Monday and several days after that? That would be fine. And there are a lot of family members that would say I would rather do it myself anyway. At what point does the 'line' move when we say it is too much. Where is it that we can all be comfortable? We have not found that yet. So, I am going to do what I can do to the point where it frustrates me. And then either chat with a friend or be practical and realistic and ask myself what I can sacrifice today and maybe tomorrow will be a better day.

In reflecting back on my experience as a patient and family member, I do not know where we have gone wrong in teaching nurses. Did we forget to recognize the

people that truly need our help? Do we even know what to look for with people that are sick? Do the managers know what is happening in their waiting rooms? Does the hospital know what is happening? Do they know the people who work for them? It makes me wonder about their skill and education levels.

What are the criteria for working in an emergency department? Do they need to have a certain amount of skill level and experience to be able to work in this setting? Are we recruiting people right out of school without any experience to work as 'frontline' nurses in a busy unit? As a nurse, I need to recognize who is sick or not. This comes with skill and experience. If you come right out of school, you do not have the experience to notice those who are sick or not in a busy environment.

When I got back to work after my time as a patient at the hospital, I was more sensitive to the symptoms of my patient. I was more responsive. I was really listening to what they're telling me because I know what it is like to be on the other side. If I see something I am not going to just dismiss it, I am going to follow-up on it. If I, or the family, have some concerns, I am going to follow-up. This is what I should do as a nurse. My patients are there because they need to be and it is my job as a nurse to figure out what they are asking of me. I think as healthcare professionals we definitely forget where the patients are coming from at times. We should not forget to the point of ignorance and neglect. Certainly, this is not what I stand for. I think my experience was a real eye opener.

Change is hard. Change is part of living in my organization. Change is like a train coming at you; you either get out of the way or get nailed by it. As nurses we need to

intentionally care for ourselves as well in order to adapt to the current situations that we face. In situations of change, I have to change too. You need to really focus on not losing your cool. You need to choose your battles. I think that with support we can get through the changes on the unit. It is an opportunity for growth and learning new things. Other people, however, no longer want to learn. You can't change that in them. For those people maybe they need to move to a place where there are fewer changes; one that is more routine.

You know, the things I worry about most are not going to change whether we are here, there, or anywhere else. I worry about what nurses are made of. Who are they when they become nurses? We can work on organizational stuff if we are starting from a good place. If you are a good nurse who has good ideas, and really care about your patient care, you can look at problems and maybe come up with good things. What good is it for anybody, if you get out there with people that are just complaining because they do not like to move or change. I have to say that some things have not been as bad as we thought they were going to be and a great deal of it comes from within us. If you are in a good place, then you are in a better place to make suggestions and work together. It comes from the type of foundation you are built upon. How you were raised. What you have been through makes you the kind of person that you are. Can you face changes and can you work with things? We have to give things up. It is not a free pot of money. It is prioritizing choices to make these things happen. Is this something we can do and work together on, or is this something we have to fight for? Is it something we can just let go or make do? This is better than saying "I don't like this".

So I am allowed to have an opinion, everybody is but it is not good enough to merely complain. It is about helping solve problems and making realistic and doable suggestions. I find that this has made me more at peace with my job. I see sometimes a bit of a sense of entitlement with some of the younger ones because they have not been in the profession long enough to know things. It is a matter of taking the risk to lead the change. I wasn't always very good at leading change. I was one of the ones that wanted to complain. Whereas now, I see that it has not moved anybody anywhere. It never does. So I don't feel it is horrible anymore. I am more inclined to sit back and think as opposed to react in a knee jerk fashion. You're not going to change everybody but you may influence some by responding differently. If I can be changed, maybe a handful more can.

Yet, as I said earlier, I think we need to think about at what point does the 'line' move to where we say it is too much. I feel like I have changed a little bit inside but I keep in mind this foundation in my head about what I think nursing should be. Change is part of life. As long as I know that when I leave the unit, my patients and their families are good then I can mostly live with it.

I think there's room for great improvement. My first suggestion is to enhance communication between management and frontline nurses. I don't necessarily think frontline nurses fully understand the organization and its challenges when it comes to budgeting or economic constraints. Knowing more about this may help me understand their side. When I ask why I don't have new equipment or the unit can't afford this, it may be helpful to know the reason so I can understand better. For example, regarding the

price of supplies, why not let nurses like me know how much a roll of tape is or how much a pair of scissors cost. This might cut down on the wastage of supplies. This goes the same with medications. Can't someone make a little chart to show how much an antibiotic costs? This may make people including me stop and think. Sometimes I feel that maybe the organization should be a little more forthcoming and just a little more open about certain things.

Speaking of computers and where they are located, why not attach a computer right outside a room that would do for two patients. The same number of computers would probably suffice but if they were placed closer to the rooms, I wouldn't have to fight for them. I could observe my patient while I document rather than being miles away. This is more reasonable. Perhaps, if I was part of decisions I would be more accepting of changes. I think that I would feel more valued rather than feeling that management is imposing or doing stuff to me. When I feel empowered and part of a process I am going to be more positive about it.

I also think the problem with a lot of people is that they stay in their crazy place because that's all they know. They are afraid of change. You get into a way of doing things, even if it is not good. It is familiar. It is stressful. To help nurses like me deal with change, I would recommend having a positive outlook. Don't resist change. Just try to think of the positive things about the change. I think I have to understand that there have been studies and there have been people that have decided this is the best thing and I have to trust that it will work out and that it is the best thing for everybody involved. So I have to trust and stay positive.

I also think healthcare professionals need to work on themselves. I need to change and adapt to different things. In my career, I am never going to be the same from when I was 20 to when I am 50. I am always going through changes. I am always learning new things. I also recommend to never become stagnant in a career. Always strive to do something to better yourself. Bring more life and joy in what I am doing. I am making a difference, whether or not I get the thanks for it every day. It should not matter because at the end of the day I know I have done my job. If, at any point in time, I feel static in my career I think I should find something else that I enjoy doing. If I do not like what I am doing then it is time to make a change so that I can find something else that I like to do.

As a nurse, I have the option to switch and work in different areas. I think it is wise to choose a different area that I would like to work in to reduce my stress. I might come upon situations that are disturbing. I need an outlet to release some of these feelings be this jogging, talking to a friend, painting, or sculpting. I think that thinking about my well-being as a nurse is important. Over time I can see that the changes are for a good reason.

Louela, I picked a career that I am passionate about. It is a hard career and not everybody can do it. I have no aspirations to do anything different. I know everyone finds his or her niche. Some people like research and some people want to be Nurse Practitioners and that's great. We need each of us. I am perfectly content with nursing. I like the teaching and the hands-on. That's me and I do love what I do. I am eager to learn. I enjoy the ability to use my skills to the fullest. I like to contribute to patient care and see the immediate effects of my nursing actions. I enjoy seeing my patient respond to

medication and to treatment and get better. I like knowing that somebody is sick and I am intervening right there to make an immediate difference in a life and death situation. I love my job. There are so many things I enjoy about being a nurse.

Change is not going to stop. We need to change with it. We need to know where to draw the 'line'. I have to feel that when I come to work I can judge that my care is good. I know that I am a good nurse.

Thank you again for the opportunity to share my thoughts with you. I hope I addressed your questions. It's nice to talk about the issues I face in practice and good to know that someone cares about what I am thinking and doing.

Sincerely,

Tanya

Reflecting on Writing the Composite Narrative

The composite narrative helped me re-enter the lives of my co-participants. While their words blended together into this narrative letter, I felt their imagined presence through the composite (Clandinin et al., 2007). As such, the experience helped me to understand and appreciate the meaning of relational responsibility in Narrative Inquiry that invites the researcher to be attentive to how stories are framed and re-constructed (Clandinin & Connelly, 2000). This phase of the research process opens the door to personal justifications.

Personal Justification

The personal justifications reveal how this inquiry is intertwined with my life as a researcher, educator, nurse, and person. It is at this level of justification that my multiple selves are revealed in a form of a response letter to Tanya. Clandinin (2013) identified that when attending to my personal justifications, I must consider how I have become aware of the root of my inquiry, my internal changes, and my reflective process in the inquiry. I will discuss each consideration as they arise in response to the experience of my co-participants as represented in the composite narrative letter. Clandinin (2013) states narrative inquirers must heed to the question of "who we see ourselves being, becoming within the inquiry?" (p. 36). The words Tanya uses as she responds to my questions impact different aspects of myself. Within the three-dimensional inquiry space, I understand how her experiences of the nursing landscape are similar and different from mine. It reinforces my responsibilities as an educator to future nurses and awakens me to the 'line' that makes me who I am as a nurse.

Clandinin (2013) describes how it is important to consider "what brings each of us to our research puzzle" (p. 36). This question brings me backward to my narrative beginnings. Writing this personal justification helps me see the common plotlines of Tanya's and my childhood stories. It reminds me of the significance of relationships in both our worlds and how they contribute to the way we embody our past experiences and express them in practice. A third consideration related to personal justification of my research is the need for self-awareness in this reflexive and reflective methodology. "Without an understanding of who we are in the inquiry, we are not awake to the ways

we attend to the experiences of research participants" (Clandinin, 2013, p. 36). My personal journal is key to helping me through my process of self-awareness. As I immerse myself in the research experience, spontaneous thoughts emerge. I park them in my journal and return to them to ask why they stand out. These notes and reflections influence my justifications and help me stay awake in the process of interpreting my research participants' experiences.

A Letter to Tanya

Dear Tanya,

Thank you for sharing your experiences with me. I am learning a great deal from your perspectives. You are giving me so much to ponder upon and your story influences my understanding of what it means to be a nurse, educator, researcher, and person. Your wisdom infiltrates my world of education and creates new ways for paying more attention to the personhood of patients and nursing students. I hear your comments about the need of nursing students for further rehearsal with critical thinking. Your reflections move me. Your comments about the presence of a 'line' that depict too much compromise reminds me, as a nurse about the need to be aware of my values and the impact of my choices. I want to share my responses to the issues you raised in your letter to me.

The story of your relationship with your grandfather resonates within me. I can imagine how your grandfather cradled you on his lap to teach you about his craft. This must have been a warm experience. I too had a special bond with my grandmother who helped shape the person that I am. She helped dress me in the morning as a young girl.

Her actions prompt me to appreciate and understand what it means to care for someone. I wonder whether this is the same for you. Your love for learning seems to emerge from your early relationships. Our experiences show how our values in life grow and are nurtured amidst persons with whom we relate. For both of us, our family are partly responsible for the patterns in our lives. We both grew up being cared for by loving grandparents. Have we transferred our belief about the benevolence of elders to the administration of our hospitals? As you said, "the elderly (from your culture) are the wise ones. People listen to them because they have more experience". You respect them. I wonder do we see management or hospital leaders as "the wise ones". Does this make us question less? You yourself said, "There have been people that have decided the change is the best thing and that it is the best thing for everybody involved". Does our trust of leaders move beyond their proven accomplishments to our own association of their role to those individuals in our lives who took leadership in taking care of us as young people? I am realizing that it is through these family stories that we gain an understanding of the world. I wonder if you seek these stories in your relationships and future experiences.

Like you, I am disturbed by your patient story. I am perplexed that someone did not notice your call for help. You mentioned the need for nurses to notice individuals who come for assistance and need to be assessed thoroughly. I wonder whether this acute sense of knowing comes from your vast experience as a nurse. You possess knowledge and skill that you implement when you assess and evaluate a patient's status. I can appreciate your frustration when you did not receive this care from the two hospital

emergency units that you visited. Your stories stirred my emotions. If you were not cared for properly while you knew your condition was worsening, how could nurses in the particular nursing units say that they fulfilled their commitments to you as a patient? Is this not one of our values as nurses? I too am hurt when I see the lack of compassion and responsiveness from nurses at the bedside. Like you I also see that values make up the stories we live by as nurses. It is unfortunate that these values are compromised in your patient experience.

I appreciate the values that are implicit in your letter. They are consistent with our College of Nurses Code of Ethics (2009). I appreciate the difficulty you felt as you provided the best care that you could to ensure your client's well-being. It must be challenging to enact your intentions when you have so many patients to look after and be unable to spend adequate time to get to know them and adjust your care. I can understand why you are frustrated. Even within an intensive workplace you are able to find creative ways of adapting to the situation to maintain commitments to your clients, self, future colleagues in nursing students, nursing profession, and quality practice setting. These are values that you and I share. Like you, I learned them from nursing school. They operate as my compass of being in the world. You clearly stated this in your letter. This resonated with my life as a nurse and academic nurse educator. I suppose as nurses, this is what we do; we cope with situations we face and we continue to create new ways to engage. I wonder whether this is part of our sense of surviving within our environment and our need to continue living within its constraints?

I agree with how you perceive emotional care as part of your practice. In my past experience as a nurse at the bedside, emotional care enabled me to support my labouring patient through her birthing experience. I remember my patients needing that care. The sound of a newborn's cry is like a beautiful chime alerting us that new life has arrived. Hearing the sound of life rewards my efforts and provides me with purposefulness in practice. I knew I kept my patient safe and supported. I feel that knowing the patient is essential to care. I can appreciate that your judgment of good care stems from your ability to know the patient. This was also my experience as a labour and birth nurse. This is what I teach in my nursing classes. Knowing the patient is critical to providing person centred care. As you eloquently noted, it is this aspect of your knowledge that is threatened by workplace constraints. This disturbs me because who we are as nurses is shown through what we know and how we enact our practice. Knowing the patient has become a core of my practice and to compromise this against competing demands feels suffocating. I can understand where you stand on this point.

I noticed that there is a tone of anger in your letter specifically when you describe events where assessments are missed because of the intensity of work demands. There seems to be many things in your workplace that causes you stress. I recognize your frustration of not being able to do what you want or perceive you ought to do in your nursing practice because of constraints. It seems to be ongoing on your unit. As you said, "it is crazy busy". I think that you really have to know what is critical in the care of patients. I think that this is our commitment to them. Certainly, knowing what is critical to teach to meet the course outcomes of a course is essential in my practice as an

educator. Only if I am able to meet this, will I feel that I am attending to my commitment to students. So I hear your voice in saying that what is critical is not merely the tasks in providing care but the humanistic side of nursing as well. The workplace constraint of increased workload minimizes the time for engaging with the patient that allows you to provide person centred care. The lack of time forces you to make other choices. The difference in the choice that you enact because of constraints and the choice that you would have made causes your frustration. It is sad.

Your story triggers my imagination on how I will cope with larger class sizes currently being implemented in my School of Nursing. Will I be able to know the students the same way as in smaller groups? My guess is not. What is critical for me is to think through how I will get to know and foster growth in each of my students. This is important to me. This is what I need to reflect deeply about. Your story challenges me to imagine my future.

I also hear that you are seeking support from your manager. You want support from leadership to solve issues that impact your work life. You want to be heard. I remember the story of my Director who came around the unit to talk to her staff at a personal level as opposed to delivering updates and messages from the organization. At that time, I felt like I mattered as an employee. I wonder whether you feel that you matter. I wonder whether this influences your relationship within the organization and your feelings of commitment. The actions of my Director certainly influenced my dedication to the organization. I took pride in my work and I knew that I was viewed as

an essential member of a larger team of nurses in the organization. I feel your yearning for this type of relationship.

Your feedback about new graduates and their need for support in practice after graduation makes me feel anxious for them but curious about how to better prepare them for their journey beyond the walls of my classroom. You did mention that new nurses need much support in managing the care of highly acute patients. Perhaps, it is this area of knowledge development that students need more rehearsal/practice. I also wonder how we can conceptualize the relationships between faculty and nurses in practice so that we are on a continuum together as students gain experience, deepen their knowledge and skills expertise.

Another aspect of your letter that stood out to me was the way in which you reflected on your practice and attempted to reconstruct your experience in order to cope with your situation. I admire your reflection and sense of self-awareness about your thoughts and feelings in living your values amidst organizational change. You are clear that there are things that you are comfortable in giving up but that there are aspects of your practice that need to stand and for which there are no compromises. This relates to your comment about your response to call bells. I acknowledge your ability to decipher what you are willing to give up and what you will not. Your engagement with the reflective process helps me see how using this process is useful to nurses when dealing with issues of change. You did not stop there as you offered helpful solutions for improving your workplace to support your work. This reminds me about how as people we are wired to reconstruct our experience so that we can live better. This is exactly

what you did when you decided to leave in order to find a work-life balance with your personal life. What your story highlights for me is the need for reflection in order to become aware of what is important in life. This helps in gaining some balance and energy to continue with our work as nurses. I wonder whether this reflective experience helps you further delineate how to live your values in the workplace amidst change. Did it help you hone in on the critical aspects of care that you can live with or not? Does it help you to see the 'line' past which you won't compromise?

Your idea of crossing the 'line' brings me to the core of my practice. It helps me reflect upon where my 'line' lies as an educator and where I no longer see myself as an educator rather a technician prescribing how nursing students should think. My values lie in nurturing an identity that is fuelled with curiosity, critical and reflective thinking, and creativity.

Throughout this letter, I think we have been in dialogue about our own identities as nurses. I responded to your letter in ways that allowed me to tell my story alongside yours. This reminds me of how our identities are revealed to us by the stories we live by (Clandinin & Connelly, 1998). Our stories about what is important amidst changes illuminate our moral perspectives and our mutual aspirations towards relationship and effectiveness. I see this as part of our identity. This triggers reflection on how I foster the development of this identity in my nursing students. Your experiences bring to the foreground how our knowledge shapes our identities and that minimizing such knowledge reshapes our sense of selves. I suppose we are also talking about what we can do about it. You provide some solutions but what I think may be missing is how as

nurses, we see ourselves as drivers of change as oppose to merely adapting and responding or perhaps resisting it. Perhaps, this is still new to our way of reconstructing our identity. How can we protect the 'line' on which there is too much compromise if we are not awakened by our experience to stand guard and lead? I wonder whether it is time that we see a new horizon.

You have given me much food for thought. Thank you very much for sharing your experiences. Your stories have awakened me to the way I teach as an educator. You reinforced and broadened what is important to a bedside nurse. As a researcher, you provided me with the narrative plotlines and patterns to think more deeply about. As a person, you helped me connect to my heart. Thank you for your generous gift of practical wisdom.

Sincerely,

Louela

Reflecting on Writing My Personal Justification

By reflecting on Tanya's letter through my personal justifications, I experience what it is like for her as a nurse to live her values amidst organizational change. I encounter her experience through her sharing of her professional practical knowledge (Clandinin & Connelly, 1995). As I reflect on my experience, in writing the personal justifications, I feel her story reverberate in my life. I am being re-formed. This narrative experience is re-composing my life and I am becoming more sensitive to the issues that nurses face in bedside nursing practice today. Working in academia seems to protect me

somehow from the realities of the practice setting. Although we stand in different places on the same landscape, I hear the stories of practice from my students who are preceptored by nurses. As such, it is even more crucial that I learn from Tanya's knowledge to inform the way I teach and influence the lives of my students who will one day be Tanya's colleagues. I am gaining a sense of embodied knowing where Tanya's story vibrates into my life and creates within me a thirst for deeper understanding of what it means for nurses to experience living their values amidst organizational change. I now turn to the practical/professional justification as the next layer of analysis.

Practical/Professional Justification

As I continue to reflect on Tanya's story of living her values amidst organizational change, I see the plotlines that compose her narrative. The layer of analysis through the practical/professional justifications allows me to bring these plotlines and the literature into dialogue, laying out a deeper understanding of the nature of nurses' experience of living their values in the milieu of change. As Clandinin (2013) suggests, the practical/professional justification "makes visible how lives are shaped" by contextual influences (p. 37). The four narrative plotlines that stand out as significant storylines within Tanya's letter are: responsive nurse patient relationships, moral distress, reflection and reconstruction, and nursing knowledge and identity. Plotlines, considered alongside the literature, make visible how Tanya currently experiences her workplace and how its social conditions influence her both personally and professionally. These

plotlines also reflect the temporal nature of experience and show how the future is shaped by the present that is connected to the past.

The use of an overarching conceptual lens to explicitly understand the dynamics of the experience further deepens my discernment of Tanya's issues. Doane and Varcoe's (2013) perspective on the connection amongst relationships, ethics, and nursing effectiveness is helpful in pulling together the plotlines of Tanya's story to create the pattern that is the narrative of experience.

Responsive nurse-patient relationship. As I reflect on Tanya's letter, her desire for responsive nurse patient relationships stands out as her goal of living her values at the bedside. She yearns for more time with her patient in conversation in order to adjust her care. She uses the task of the bed bath as a way to make the time she requires with the patient to thoroughly assess, engage, and discern patient issues while providing comfort. The high patient to nurse ratio and patient acuity reduces the time she can spend with each patient to attend to what she feels ought to take place. Bergum (2013) in her discussion of the concept of relational ethics states that it is within relationship that meaning and moral action is determined and negotiated between the nurse and the patient. In order to be purposeful or responsive to the needs of the patient, the nurse needs to spend the time for dialogue and skillful engagement to understand the situation from his/her voice (Bergum, 2013). Tanya's words evoke a sense of grief related to not being able to know her patient because of the multiple tasks that she needs to complete. It is as if the meaning of purposeful care is being redefined in Tanya's situation.

The patient needs her/his medications and wound dressings, as well as to be fed and toileted. These are tasks that Tanya describes in her letter and they serve the purpose of caring for the patient. Tanya, however, expects to provide nursing care that is beyond what she can currently give. She desires to give holistic care that integrates both the science and art of nursing. This difference in expectation between what Tanya wants to provide her patient and what she can realistically accomplish within her shift creates dissatisfaction. Tanya may be "working in between (her) own values and that of the organization" (Rodney, Varcoe, Storch, McPherson, Mahoney, Brown, et al., 2009, p. 298). Working in this reality means being adrift from one's values in order to comply with organizational demands. Tanya is in between two realities: one that she desires and one that is organizationally and economically driven. This reality is not peaceful, it is disorienting. Austin (2012) claims that the health care restructuring that focus on corporate cutbacks are demoralizing to professionals. Tanya claims that she desires to be a 'good' nurse and from her perception her current experience does not seem to align with her own perception of a 'good' nurse. As she said, "you get used to it because that's just how we work. We have expectations but we can't always meet them every day". What seems to be amiss is the time to engage in a meaningful way with the patient to reflect and respond to the shifting needs of care.

The time for care enables Tanya to know the patient. It is in this act of knowing the patient that Tanya judges herself to be a 'good' nurse. Tanner et al. (1993) state that knowing the patient refers to "understanding the relationship of particulars" (p. 275). In other words, this act refers to knowing the patient's responses to her/his illness trajectory

and personhood (Tanner et al., 1993). On reflecting back to Tanya's letter, the intention to enact this kind of nursing action is important and embedded in it is her perception of what it means to do 'good' for the patient. I wonder whether the absence or lack of a nurse's in-depth engagement with the patient distances her/him to issues that matter to the patient and not merely the illness progression. If so, does this place nurses like Tanya in positions that tunnel their vision and reshape their obligations of commitment to patient's healing? A "detached stance is a common moral position. It allows clinical decisions that are based upon external interpretations, not upon the meanings as constituted by the patient" (Tanner et al., 1993, p. 277). Tanya's letter suggests that she values knowing the patient as part of her nursing care yet, the context predisposes her to experience what it may be like to be detached from one's moral stance. While Tanya is able to resist this influence based on her moral position, other nurses like those whom she encountered in the emergency unit and nurses from her own setting who prioritize documentation over answering a patient's call bell seem to enact a detached moral position.

Tanya's story as a patient further reinforces her call for responsive care. Her experience highlights the vulnerabilities that a patient experiences when nurses fail to pay appropriate attention to a patient's changing condition. Tanya claims that she did not feel compassion, empathy, or engagement from nurses. She felt ignored while her condition was worsening as time elapsed in the waiting room. Schwind (2008), a nurse-teacher, describes her experience of being a patient as one of fearfulness, powerlessness, sadness, and distrust. To be ill evokes feelings beyond that which is associated to the illness itself. It

is in moments of vulnerability and illness that patients require responsive, engaging action from the nurse. Schwind (2008) claims that it is at times of illness that patients as "care-receivers" have "diminished voices", feel objectified, and fragile (p. 82). Dialogue opens the space to recognize a person's fears, explore issues, and find solutions (Bergum, 2013). Time for dialogue is essential in actualizing this critical nursing response. Inability to provide this time places nurses like Tanya in conflict with themselves and possibly creates what has been termed as moral residue defined as a lingering distress from an aftermath of experiencing moral distress (Epstein & Hamric, 2009). The issue of moral distress was a plotline discovered from Tanya's story.

Moral distress. As I reflect back on Tanya's letter, I am reminded of her descriptions of her yearning for care centred on the person and the opportunity to perform a thorough assessment. When she cannot do this, she "hates this kind of nursing". Tanya wanted the time to spend with her patients. Tanya's story echoes that of the elements of moral distress. Moral distress can be defined as:

> the pain affecting the mind, body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about correct action, yet as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong (Nathaniel, 2002, p. 42).

Tanya's story resonates with the pain experienced as she struggles to manage her intentions with those of competing demands in practice. She speaks of an alternative way of enacting care but because of workplace constraints is unable to perform it. The

resolution she takes in managing these demands is to omit those tasks that she perceives to be “part and parcel of care”. She admits “sometimes there are things that can get missed when I am running around putting out the fires for different patients.” It is this omission that causes her turmoil. She has seen how this can cause harm such as the potential development of bedsores. From Tanya’s perspective, caring involves knowing the patient through his/her illness responses and as a person because, from her perception, this has implications for healing.

This brings to the foreground the issue of choices in practice. Tanya reflects that the organization is forcing her to make choices and questions “the line where there is too much compromise”. In keeping with the notions of co-construction in Narrative Inquiry and the multiple “I”, this statement moves me into my own personal questions about the ‘line’ in practice where I stand. As nurses, how are we aware of this line? In a descriptive qualitative study of Registered Nurses’ convictions about end of life treatment decisions, Wurzbach (1996) claims that good nursing practice is a moral ideal for nurses. This moral ideal is consistent with Tanner et al.’s (1993) elements of knowing the patient. Gadow (1996) states that what is determined as ‘good’ in patient care are made visible through the engagement that takes place within the nurse-patient relationship. Tanya’s ‘line’ of ‘good’ practice may be similar to the organization’s perception of good practice but where both differ is the perception of the amount of time it takes to accomplish this kind of care and who provides it for every patient. Given the time constraints and intensity of workload from high patient to nurse ratio and patient acuity, Tanya finds herself comprising her care. Tanya also comments on how a patient’s health status is not

assessed properly because someone less qualified than a Registered Nurse was looking after the patients. The Registered Nurses' Association of Ontario [RNAO] (2015) urgently addresses this contemporary issue as healthcare organizations replace RNs with less educated workers for lower salaries. They raise awareness about the negative impact of shifting staffing models on patient care and reinforces the research evidence that demonstrate how a high proportion of RNs providing care reduces mortality and morbidity rates, and length of stay (RNAO, 2015). Yet, the staffing model that focuses on reducing RNs for direct care continues despite evidence in the research literature that mortality rates decrease when patients are cared for by an RN (Kutney-Lee, Sloane, & Aiken, 2013). I recognize Tanya's frustration in her experience of having to deal with these compromises during every shift. Tanya's story speaks about the dynamic movement of this 'line' from one point to another and highlights the notion of compromise.

The boundary of a 'line' in practice that Tanya draws is consistent with Rodney et al.'s (2009) metaphor of a moral horizon. According to the authors 'the moral horizon' is an arbitrary 'line' that depicts the good practice that nurses strive towards (p. 298). It is relationally derived and honours values that are consistent with nursing's person-centred lens of "relief of suffering, preservation of human dignity, the fostering of choice, physical and psychological safety, the prevention and minimization of harm, and patient and family well-being" (Rodney et al, 2009, p. 299). As Tanya points out, this 'line' continues to shift as competing values between the nurse and organization interact. The question that arises is: "at what point does the 'line' move when we say it is too much?" The fact that Tanya claims that "we have not found that ['line'] yet" suggests that she

lives in this constant tension between her own values that drive her perception of good practice and the competing values within her workplace.

Moral compromise has been identified as one of the morally distressing situations in practice and results from navigating through conflicting intentions (Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Taking action towards what a nurse may feel she/he ought to do does not relieve the distress, as the tensions remain inherent in the forces within the ethical dimensions of practice (Pauly, Varcoe, & Storch, 2012). For Tanya, this relates to the competing and conflicting obligations she experiences in the workplace. The ongoing exposure to moral compromise leads to moral residue, a lingering distressing feeling as a result of an unresolved initial distress (Epstein & Hamric, 2009). Attention to her experience with moral distress matters.

The experience of moral distress may be related to a person's belief framework and the individual differences about what each person may find morally distressing (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005). This calls attention to how a person's value orientation contributes to how situations are experienced. As I move backward to Tanya's story of her grandfather and his influence on what she views as important, I am reminded by how these values are narratively shaped. The notion that individuals have their own particular belief framework that bumps against compatible and competing frameworks is telling of how values are autobiographically composed (Austin et al., 2005; Clandinin, 2013). As I wondered in my personal justification: Do we look for these stories from the past in our present lives in order to establish our own sense of internal coherence? I am reminded that who we are in our personal lives is who we are as

nurses in practice (Lindsay, 2008). Part of navigating through the tensions of work and the conflicting demands that force us to make choices is influenced by past experiences of what it means to care and to know. The moral distress Tanya feels in her workplace is narratively composed and driven by her personal and professional moral horizon, whose beginnings emerged from the tutelage of her grandfather about tailoring and learning. Those experiences inform her belief framework and set the groundwork for what she feels she ought to do in practice. This experience brings me to the third plotline in Tanya's story about reflection and reconstruction. How does Tanya navigate through the moral issues raised in practice and continue to persist in a context that she finds morally distressing?

Reflection and reconstruction. As I look back to Tanya's letter, I recognize that she had many moments of reflection. These were triggered by emotional turmoil that she processed in her own terms. Her story as a patient described the pain she felt in not being attended. As Tanya spoke about her father's journey in getting attention from the health care system, I sensed her frustration and grief over the cancer diagnosis and his care. As a professional, Tanya's letter shared how she felt conflicted due to the compromises she made as she lived out her values amidst organizational change. In all accounts, these instances showed an internal process of recognizing emotions and thoughts that surfaced within her experience. In some instances it showed how her experience led to transformations as evidenced by her statements.

> I was one of the ones that wanted to complain. Whereas now, I see that it has not moved anybody anywhere. It never does. So I don't feel it is horrible anymore. I am more inclined to sit back and think as opposed to react in a knee jerk fashion. You're not going to change everybody but you may influence some by responding differently. If I can be changed maybe a handful more can.

Tanya's story as a patient was an example of how she became more sensitive to the needs of her patients after having gone through the experience in the emergency units of two hospitals she visited as an ill person. Tanya's story on living out her values amidst change was shown with examples of internal dialogue that may have begun a few years prior writing this letter. She stated that two years ago, she reflected that she may want to move to another unit in the future. For her, this resulted in a transfer to an Urgent Care unit. Perhaps, her process of 'letting go' of current experiences started when she reflected on this future workplace. This vision became experience when she decided to leave the place where she is currently working to move to her previously imagined nursing unit. These experiences remind me of two sets of literature: reflection as we understand it in nursing (Johns, 2009) and transitions (Bridges, 2001).

Nursing's conception of reflection suggests that it is a process (Atkins & Murphy, 1993; Buns & Bulman, 2000; Ruth-Sahd, 2003; Kuiper and Pesut, 2004) that promotes transformation (Mezirow, 2000) and is connected to learning (Boyd, 1981; Kolb, 1984). This reflective process is facilitated by the use of frameworks to guide the internal movement that needs to occur within one self (Driscoll & Te, 2001). Tanya's reflections are within the moment, spontaneous, and connected to her life and living. This process is built within herself to help resolve issues. As Tanya narrates her story to me, she is

engaging in dialogue with herself. This experience resonates with Johns (2008; 2009) concept of dialogical movements embedded in crafting a narrative. In this experience, Johns (2009) breaks down the six movements (the hermeneutic circle) as follows:

> dialogue with self to create a story text; dialogue with the story as an objective and discipline process of reflection to gain insights (produce a reflective text); dialogue with tentative insights and other forms of knowing to inform insights and position within the wider community of knowing; dialogue with guide(s) and peers to develop and deepen insights (co-creating meaning); weaving a coherent and reflexive narrative text that adequately plots the unfolding journey; dialogue with new experience and with others to move to social action (p. 45).

These movements describe what may have occurred in Tanya's reflection as a patient. In reliving her story in this letter, Tanya crafts a story that she is able to dialogue with through the process of telling. She gained insight through the process that made her more sensitive to the call of her patients. This moment of transformation leads to the new experiences for both her and her future patients.

Johns' (2009) concept of gaining understanding through the dialogical movement sheds light on Tanya's experience. In particular, it highlights the role that she and others play in arriving at insight from experience. Contextual factors are woven into the narrative construction as Tanya reflects on the situation. What seems to be amiss in this conceptualization of reflection is the envisioning of the emotional process that takes place during reflection. This brings me back to my Masters of Science research thesis on reflection (Manankil-Rankin, 2003).

In a phenomenological study of what it means to be a reflective practitioner to graduating nursing students I interviewed nine Level 4 students about their experience in

being reflective practitioners. What I understood from this study was that there was a process that lies within the students that involves focusing, unearthing, viewing, integrating, affirming, and letting go (Manankil-Rankin, 2003). I called this reflective experience as reflective acts. As I experience this thesis again in light of Tanya's story, I see these acts as part of the emotional process that accompanies the cognitive processing that occurs with reflection. This, in my mind, is crucial for moving forward into newer grounds. This may actually be part of the emotional process that facilitates adaptation to issues in practice and provides the opportunity for reconstruction.

The concept of letting go takes me to the work of Bridges (2001) on transitions. This work resonates with Tanya's story of moving on from her "busy and crazy" lifestyle to a more sustainable reality that balances her personal and professional worlds. Bridges (2001) makes a distinction between change and transition. "Change is a situational shift while transition is a process of letting go of the ways things used to be and taking hold of the way they subsequently become" (p. 2). It is psychological in nature and involves three phases that begin with an 'ending' then proceeds to a 'neutral zone' that finally arrives at 'beginning again' (Bridges, 2001, p. 2). The three phases have a distinct role to play in moving individuals forward into new chapters of their lives. The 'ending' is recognizable when a person experiences a loss that requires letting go of the past associated with this loss. This awareness is important for moving forward. Bridges (2001) describes the neutral zone as the phase that provides the groundwork for the internal work of reorientation, personal growth, authentication, creativity, spiritual understanding, and renewal; while beginning again, a phase that refers to taking hold of a new reality, opens

the door to a new self or identity. This concept of transition has been applied in managing organizational changes but Bridges (2001) applies the concepts he discusses as a consultant to his own life as a process for narrative reconstruction when he experienced the loss of Mondi, his wife of 37 years. I do not associate transitions with isolated incidents that force us to reflect spontaneously in order to make sense of a troubling experience. Rather, I view transition as a wider perspective that describes the growth in life.

Tanya's story is particularly telling of this concept of transition as she narrates a thought several years prior about a desirable place to move to in case she decides to make a possible shift in her workplace. As she discusses her journey of change, she provides a tone of dynamic movement that allows her to transition with the changes on her unit. "Change is hard. It is part of living in my organization". Although she moved to a different setting within her organization to gain a better personal and professional life balance, she opens herself up to adapting to the changes within her organization. Living one's values amidst organizational change is also engaging in a form of reflection and reconstruction that allows a nurse to adapt to existing or new situations. Reflecting on the experience provides the precursor for letting go of emotional turmoil. Ongoing reflection with self and others lead to a transformation that is a source for social action (Johns, 2009). Internal change that involves letting go of past assumptions or 'ways of doing' to appreciate new ones also need to occur. If change is part of life as Bridges (2001; 2009) suggests then it is prudent to transition with these changes in order to adapt and find new meaning in new experiences.

Herein lies the crux of the experience of living values amidst organizational change that Tanya reveals. She claims that a 'line' exists for which there is no compromise. A moral horizon is drawn in the lives of nurses like Tanya, where a boundary exists of what can be lived or not. There comes a point in our experiences as nurses where we make a choice whether to transition to the new change by letting go of past realities or to remain strong in holding on to the moral perspective that make up our moral horizon. As critical questions are asked of our experiences, we are drawn deeper into the meaning of this horizon to us as people and professionals. Transitioning to the changes is not only helpful to the nurse but also to the organization as it brings employees along to its vision. What I hear from Tanya is my need, as a nurse to be vigilant in protecting this 'line' while engaging in the process of transition. She calls me to stay awake and cognizant of its shifting movements. In a less explicit way, her words suggest that I remain present to the experience of changes in that they do not blur the clarity of my horizon such that it is no longer visible. Tanya further delineates the relationship between a nurse's obligation to the organization and to her patients, practice, and self as a moral agent. This requires reflection on assumptions that make up our practice and who we are as people. Mezirow (1990) uses the term premise reflection when reflecting upon assumptions. Critical reflection is a way of asking questions about our practice and how we are thinking about it (Freshwater, Taylor & Sherwood, 2008). Critical reflection is one path for clarifying the choice a person makes to either transition or strengthen one's commitment to their moral perspective and may be an essential skill for nurses in this current climate of organizational changes. This thinking leads me to the plotline of

knowledge and identity and how they are influenced in Tanya's experience of living her values amidst organizational change.

Knowledge and identity. As Tanya reflects back to her personal story of being a mother to a son who had been a patient in a hospital as a child, she reminds me of how knowledge is narratively composed and reveals itself through actions in practice. The way she responds to her patients is related to her own perception and judgment of what the patients may be experiencing. This is based partly on her own experience as a family member of an ill person. Personal knowledge is a kind of knowledge that is integrated into our ways of knowing (Chinn & Kramer, 2008). Tanya's response time for attending to patients differs from her perception of the way her colleagues respond to patients' calls for help. This troubles her. She is willing to give up her documentation time in order to respond to her patients call as soon as they request. This choice to respond immediately has been informed by her personal experience that makes up her personal knowledge.

Knowledge is created through reconstructing experiences in life (Dewey, 1938). How knowledge begins to inform practice is related to how nurses are awake to such knowledge. For Tanya, her memory of her son's experience during his illness reminds her of the need to respond to call bells immediately. Similarly, her desire to provide holistic care at the bedside is knowledge learned from repeated exposures to situations where early attention makes a difference. These are examples of how personal and professional experiences coalesce into an understanding of the moral approach to a situation but

constraints on the enactment of this knowledge changes the tone of this knowledge into something different. The person who holds that knowledge also changes as a result.

Tanya's story of how her knowledge is compromised is also shown through her relationships with the organization and manager. She yearns to be listened to, respected for her contribution, and engaged with through open and honest dialogue. Her request for openness and honesty was met by a lack of response from management. For Tanya, this creates a tone of mistrust and reveals the limits to her actions because of workplace constraints. As Chinn and Kramer (2008) suggest, the context provides the meaning of actions and determines what is acceptable or not. Her values of commitment to patients, self, and others are reshaped by the social relationships within her workplace. This reshaping determines the acceptable knowledge within the context and also informs how values are lived and experienced. If values inform ethical knowledge (Chinn & Kramer, 2008), then the constraints to the enactment of values stifle this knowledge and poses consequences to nurses' moral identities in the workplace.

As I reflect back on Tanya's story, I am reminded how her moral identity is supported by the knowledge on which it is based. This knowledge is not limited to theoretical knowledge but includes her practical knowledge informed by her everyday experiences in practice. Her ability to enact her moral standards is indicative of her moral agency that includes "rational and self-expressive choice, embodiment, identity, social and historical relational influences, and autonomous action within wider societal structures" (Rodney, Kadyschuk, Liaschenko, Brown, Musto, & Snyder, 2013, p. 163). This resonates with Clandinin and Connelly's (2000) assertion that narratives of

experiences reveal themselves through a careful look into the interaction between personal and social conditions, time, and place. Living out one's values in the workplace is representative of how a nurse enacts her moral agency.

Several problematic issues arise from Tanya's story that affect how her moral agency is constructed. Tanya's relationship with management that describes a situation of ineffective communication is one of these issues. Tanya complains of not being heard by management as she discusses issues that can be construed as moral challenges to her practice. The same story line of more than a decade ago that depicts how nurses are 'not listened to' (Lindsay, 2001) continues to live on. Although nurses were asked for their thoughts, reform continued and amalgamations that downsized care from nurses to nursing aides occurred (Lindsay, 2001). Tanya's experience reverberates through the same plotline. This time, change is no longer perceived as an era that presupposes an ending; rather it is viewed as an ongoing constant variable in the lives of health care providers. Porter-O'Grady and Malloch (2011) claim that change is constant. As Tanya states "change is like a train coming at you, you either get out of the way or be nailed by it". Although Tanya enables herself to shift with the implemented changes in the organizations, there seems to be a gap in the way she is able to persuade others with her voice. Tanya alludes to leading change as an option, but there seems to be timidity in her voice as she states "I wasn't always good at leading change". It is interesting that she does not see driving the train of change, or even being on the train, as an option for her. Tanya is willing to share her thoughts about the changes but is frustrated with the lack of response she perceives from management. Does this mean that a shift in her moral

identity needs to occur to shed light on her moral obligation and give voice to the moral issues with which she grapples in her practice? What is this shift? Does it mean being comfortable in leading changes in the workplace? Does it also call for appreciating what it means to lead change at the bedside? As her moral identity is constrained in practice, attending to her voice may also be constrained and positive and courageous shifts in her identity may be difficult to undertake. Perhaps, this was the reason why she chose to remove herself from her unit and chose to work in a different setting. In finding the balance between her personal and professional life, her choice to move to a different workplace gives her the control that she perhaps lacked in the previous practice setting. Her way of reconstructing her experience to give credence to her inner voice of increasing intolerance to her work experience is to move. At least she had control over this choice. As nurses, perhaps we need to think about the nature of our voice and how we can reshape the storyline of being in a position of 'not being heard' and reconstruct the pattern that has been existent in our lives for years.

Another issue that Tanya faces is how she may be internalizing the constraints in the workplace. Initially, as I reflected on Tanya's comments about new graduates, I felt a feeling of disappointment with my work as an educator. Questions about how I can better prepare my students to the realities of the workplace emerged. I wonder about the gaps in the curriculum that will facilitate a much smoother transition from academia to practice. Rodney, Kadyschuk, Liaschenko, Brown, Musto, and Snyder (2013) illuminate the issue as they explain that nursing behaviour that critiques the work of their junior colleagues as inefficient is a reflection of their own internal responses to their experience of constraints.

This other layer of perceived additional work in supporting new graduates further shifts the nurse's moral identity that is being constructed in the workplace. The College of Nurses of Ontario (2009) suggests that a nurse's responsibility is to support learners in the workplace by teaching students as part of their obligations as nurses. Does this lead to conflicting moral obligations as nurses have responsibilities to patients and to students that blur the moral horizon and lead to a confused identity?

The compromises that Tanya makes may contribute to what Rodney et al. (2013) refers to as moral disengagement; a state wherein a nurse cognitively alters her perception of moral standards in order to prevent a psychological experience of self-condemnation. This state leads to changes in nurses' moral identities. The fact that Tanya is able to know what she is willing to compromise or not in relation to her definition of good practice is a positive sign that her moral identity remains coherent with the values she wants to uphold. However, her story is encumbered by consistent challenges that place her in positions of moral disengagement. It is evident through Tanya's story that she reflects and reconstructs her experience. While this serves her in dealing with the pressing issues in practice and managing the impact of the organizational changes on herself, the level at which she reflects may not be serving her in protecting her desired moral identity. Her challenged voice is not persuasive enough in altering the trajectory of her current experiences in practice. Tanya presents her experience of being a nurse who negotiates each shift on her own and does not see herself as part of a group that might make a collective nursing voice heard. Tanya's future may be dependent on deeper reflections about her moral perspectives and horizon in order to awaken herself to the core of her

moral identity and engage in relationships at multiple levels of the organization that reflect who she is as a person and nurse.

Knowledge and identity are intertwined. Moral identity is shaped by the knowledge that is enacted in practice. The values the nurses live by are influenced by workplace constraints. These constraints may push nurses into moral disengagement. Moral agency is historically and relationally influenced and depicts nurses' embodied choices and actions within the context of societal structures (Rodney et al., 2013). Nurses' moral agency provides a lens for viewing how commitment to moral standards and practices shift due to dynamics in practice. Reflection and reconstruction are ways to strengthen moral agency. Tanya is capable of both. Deeper reflection may be required for reconstruction of experience that involves a retelling through nurses' voices that will resonate with organizational leaders to make meaning (Clandinin & Connelly, 2000). Narrative reconstruction involves reflection, reframing, and re-enacting. "Identity is constructed in relationship and through reflection on life experience" (Lindsay, 2008, p. 27).

Understanding relational practice and nursing moral obligations. The four plotlines of responsive relationship, moral distress, reflection and reconstruction, and knowledge and identity coherently converge in the conceptual lens of relational inquiry and nursing moral obligations (Doane & Varcoe, 2013). This lens offers a deeper understanding of how these plotlines intersect and how they can be reshaped. Doane and Varcoe (2013) suggest that relationship becomes the lens to understand and enact moral

obligations that includes three overlapping premises: “to be reflexive and intentional, to open the relational space for difficulty, and to act at all levels to effect the potential for health and healing” (p.151). Living out these obligations in this way facilitates a renewed sense of engaging in responsive relationships. These three are perceived to operate not in isolation but are meant to form a whole that complement each other and work together. To be reflexive and intentional requires a nurse to look beyond surface situational messages into assumptions and issues that influence one’s perception in order to act with purpose. To open the relational self to difficult experiences in practice is a state of tentativeness and openness where a nurse is able to engage within a zone for reflection that offers the best possible solution for action rather than judgment and reaction. To act at all levels to influence health and healing requires a broader view of influences that cut through the experiences in practice (Doane & Varcoe, 2013). The plotlines from Tanya’s story interconnect with relational inquiry and moral obligations through the meaning of reflective practice and narrative reconstruction.

The notion of being responsive in relationships with patients requires that as nurses we open ourselves in creating a moral space where our moral horizon blend with the patients’ needs in order to determine the best care possible. This requires that we first know who we are and where our moral horizon lie. In my life, being responsive to the commitments I have with my student requires me to know who I am as a person and my strengths and areas for growth as an educator. For Tanya, it is in knowing who she is as a nurse and how the narrative composition of her life informs her perspectives that draw

the ‘line’ of her moral horizon. It is this knowing that allows both of us to engage in an awakened way towards our students and patients in order to fulfill our commitments to them and facilitate the generation of our mutual knowledge within the context of our situations. The classroom for me creates the context for this experience while the nursing unit offers Tanya the place for engaging in responsive relationship. The kind of relationships predicated by reflection and personal knowing that we establish with those whom we serve offers one layer for the interaction that creates relationships based on reflexivity and intentionality. This kind of knowing facilitates the visibility of our intentions and helps us craft our actions.

Doane and Varcoe (2013) call for a much deeper reflection in practice that allows for critical introspection of one’s assumptions and their influence on a person’s intentional action. This state of awareness reshapes relational practice into a reconstructed experience fuelled by awareness where all ways of knowing and knowledge merge into the right thing to do for the patient. Given the workload and acuity issues of nursing practice, time to reflect at the bedside is constrained as Tanya points out. What Tanya’s story illuminates is that the capacity for nursing effectiveness through critical reflection may be absent or non-existent. The process for engaging in this type of reflection involves time, space and energy. Given that critical reflection has the potential to contribute to effective nursing care, it may be beneficial to view this internal process as an ethical standard of practice, a deeper process than expected by the current Quality Assurance Program from our regulatory body that relate to practice reflection on learning needs that require an improvement in knowledge, skills, and judgments in delivering safe

patient care (CNO, 2014). This is part of the process that engages knowing the patient and deciding upon the interventions that best serves them.

The notions of space for constructing relations, articulating moral justifications, and knowing actions require further exploration in relation to this first moral obligation. Lindsay (2002) claims that there is a liminal space in which new stories to live by have not been created. This may be a place for which reflection can thrive. Tanya's story suggests that the liminal space is a place for moral tensions to be considered. Considering the person as a potential space opens the door for conceiving a geography that sets the context for envisioning the coming together of all ways of knowing to establish the relational space between nurse and patient where responsive care can take place.

The conceptual perspective of person as space does not eliminate the distinction of the liminal or moral spaces but rather accentuates the space available for deep reflection necessary for creating responsive relationships. It also crafts a perception of closer connection between the body and the mind and makes possible the link between intentions and actions. Bergum (2013) states that relational ethics is an action ethic for which embodiment lies as one of its central themes. Embodiment calls for coming together of the perception of mind and body as one with the notion that life is attached to both and not merely one. The body has a life that is lived that Bergum (2013) refers to as "body as lived" (p. 132). Moral obligation that seeks reflexivity and intentionality also calls for an understanding of a person as space, deeply open for reflection, closely connected to body, and has potential for creating a wide territory for relations. To understand what it means to be morally obligated in this way is to embody the knowledge

that is gained from life as lived through reflexivity. Clandinin and Connelly (1990) claim that this knowledge reveals itself through stories of experience.

The second notion of opening relational space that focuses on embracing suffering as part of life further reinforces the need for an internal process of reflection to deal with the emotional triggers brought about by difficult situations (Doane and Varcoe, 2013). This moral obligation, that accepts difficulty as part of life, prompts two processes of internal movements that echo transition and reflection. Part of the process of reconstruction in difficult situations in practice involves adaptation to the new situation that allows letting go of old ways, engaging with creativity to find new ways of coping or managing in situations, and taking hold of reframed realities (Bridges, 2009). The other parallel process is reflection that helps a nurse focus more clearly on the kind of effective care to be given using her practical knowledge (practical reflection) or through reflection on her assumptions (critical reflection) (Taylor, 2004). From Doane and Varcoe's (2013) perspective, these two internal processes blend together to better understand competing/conflicting situations in practice and to act courageously to bring about moral awareness. Tanya's story points towards the depletion of critical reflection and makes it difficult to assess the extent to which a nurse like Tanya can open her/himself up to difficulty. Although, Tanya reflects and reconstructs her experience in order to adapt, the constraints in practice shape her experience of these internal movements. She may get out of the way or go along with change and adapt to it that shows her ability to transition with the organization. However, the question that continues to arise is: at what point does a nurse open herself up to difficulty and say enough is enough? Her situation in practice

suggests that she is experiencing moral distress because her ability to implement her commitment to her patients is constrained by time, difficult communication patterns with management, non-conducive locations of computers for ease in documentation. When does openness to difficulty lead to a blurring of one' moral agency? It seems that to be grounded in this openness will require deep knowing of oneself. This requires both skill in reflection and organizational support that acknowledges reflection as a key component of practice. Perhaps implicit in Doane and Varcoe's (2013) interpretation is the notion that deliberate engagement in relationships triggers the process of reflection that facilitates knowing the right choice to make and the action to take that leads to courage in pursuit of an ethical end. A relational lens that integrates suffering as part of life enables a nurse to work against constraints to do what is right (Doane & Varcoe, 2013). As her nursing unit lays out the expectations of change, Tanya moves into situations of compromise. Time for reflection that enables courage is impeded. Since life is narratively composed, arriving at this state of reality will involve shifts not only in relating to organizational structures but also in Tanya as a person and professional. This shift will involve changes in organizational climate and Tanya's openness for reflection and reconstruction.

Using the concept of person as space, the nurse will also need to learn to release negative energy from the relational space in order to not interfere with relationships. I wonder whether "hardy" individuals have a way to release such energy. Hardiness, a characteristic trait, enables a person to find meaning in problematic situations and perceive negative experiences as opportunities for growth (East, Jackson, O'Brien, &

Peter, 2010; Lützén & Kvist, 2012). It has also been associated with optimism (Abdollahi, Talib, Yaacob, and Ismail, 2014). Perhaps it is in nurturing these characteristics that a nurse can clear out the negative stimuli that can cloud seeing a moral horizon. It may be that the consistent exposure to difficult situations without judgment, but in search for meaning, facilitates the internal growth of moral resilience, the capacity to overcome difficult situations by finding meaning in both positive and negative conditions (East et al., 2010; Lützén & Kvist, 2012). Tanya reiterates that nurses need to constantly learn and seek outlets that will release feelings from difficult situations in practice. Part of this release is engaging in reflection and reconstruction. The development of hardiness may be a consequence of being open to difficult situations.

The third moral obligation speaks to the interconnection of the social contexts and the personal realities of nurses. This is consistent with Clandinin and Connelly's (2000) interaction of personal and social conditions. To act is to engage reflectively about the wider circles of influence. To nurse is "to act at all levels to affect health and healing" (Doane & Varcoe, 2013, p. 154). A focus on relationships and the moral obligation to act at all levels necessitates a deeper clarity of a nurse's moral horizon. Awakening to how a nurse lives out her values by thinking and reflecting on the multiple influences that affect her/him provides space for reshaping one's identity within the organization. Tanya reminds us how her knowledge is constrained by the contextual influence of workload. Acting at all levels suggests that nurses use their voice in persuasive ways. This was not the case for Tanya, nor has it been for a decade as shown by experiences of other nurses (Lindsay, 2001). There continues to be a gap between what is known by nurses and

evidence in the literature and what can be achieved. Constrained nursing knowledge persists and, as such, identity is affected. Making moral obligation a reality involves infrastructure changes that conceptualizes nurses as knowledge-makers and provides nurses the resources to enact their intended role as nurses.

Doane and Varcoe's (2013) reframing of nursing obligations poses the need for "reflexivity and intentionality, openness to difficulty, and action at all levels" to provide an opportunity for positive reconstruction of nursing identity (p. 151-156). Tanya's current story suggests that infrastructure changes that lay ground for multiple spaces that promote reflection, dialogue, and support are crucial to positively shift nurses' moral identities to be congruent with their moral horizon. Reflection and reconstruction are key processes for shifting from their current reality to one that is relationally focused. Currently, Tanya's story poses challenges to a relationally focused moral obligation.

This way of viewing practice provides a different frame for engaging with moral issues that influence nurses' ability to perform their role in practice. The development of reflective practice and narrative reconstruction pose hopeful solutions to the path towards a relational perspective of patient care. Engaging in relationships in the way Doane & Varcoe (2013) purport involves a reframing of not only the concept of moral obligation but also of our perception of personhood to include person as a potential space for deep reflection, dialogue, and whose moral horizon lie in the intersections of all knowledge that reveal itself in actions through the body.

Reflecting on Writing My Practical/Professional Justification

The practical/professional justifications provide me with a deeper understanding of how Tanya and my story intersect with the literature. It is a process of stepping back to gain a broader perspective of the narrative elements that compose Tanya and my life and living. In doing so, I am able to see the broader pattern that interweaves the four plotlines of responsive nurse patient relationship, moral distress, reflection and reconstruction, and knowledge and identity. The lens of relational practice and moral obligation (Doane & Varcoe, 2013) further illuminates the narrative pattern being shaped. While this conceptual lens offers a way to think anew about current situations in practice, Tanya's story is still misaligned from this way of engaging. Her narrative tells me that the context needs reshaping in order for her practice to shift towards the kind of responsive relationships Doane and Varcoe (2013) suggest. The layers of analyses requires further examination to ask why Tanya's story matters to nurses, to organizations, education, research, and policy. The social justifications described in the next chapter ground the next phase for understanding nurses' experiences of living their values amidst organizational change that looks across the wider influences on nurses' knowledge landscape.

Chapter Five

Social Justification and Ends-in-View at This Point in Time

Social justification is the third layer of reconstruction in Narrative Inquiry (Clandinin & Connelly, 2000). Clandinin (2013) asserts that this layer grounds the theoretical justifications that make up the knowledge contribution of this study to the wider discipline. It also responds to the 'who cares' and 'so what' questions that demonstrate significance of my inquiry and reveal considerations (social action) for practice, education, research, and policy (Clandinin, 2013; Clandinin et al., 2007).

In this chapter, I continue with the perspective of stories of experience as a way to anchor my knowledge contributions. The stories that emerge create the conceptual lens that describe how nurses experience living their values amidst organizational change.

> What matters is that lives do not serve as models; only stories do that. And it is a hard thing to make up stories to live by. We can only retell and live the stories we have read or heard….They are what we must use to make new fictions, new narratives (Connelly & Clandinin, 1990, p. 2).

My co-participants continue to live their stories amidst the landscape. While my participation in their lives provides an opportunity to reflect and share their stories, I proceed forward into writing this thesis in the hopes that their stories offer the discipline of nursing another perspective that illuminates the meaning of their experience and our research phenomenon. I am cognizant that the story I discuss in this layer of social justification describes my standpoint. Another story can also be told based on the experience of a different inquirer. This is Narrative Inquiry. The relationship built

through co-construction between participant and researcher shapes the stories that are told.

The Conceptual Lens of Stories

The conceptual lens of stories offer a way of understanding the issues raised in this inquiry. Keeping my eyes firmly on the research question, I discover that the narrative of experience is made up of stories that interact and weave together. The complexity in practice is shaped by these intersections of stories and plotlines. Viewing this complexity through the lens of stories and re-storying offers new ways of thinking about the issues of practice. This leads to my discovery of the narrative of experience. The unique contribution of Narrative Inquiry to the nursing knowledge landscape is that it provides a way to view nurse's knowledge development as narratively composed and where intersections of the ways of knowing articulated by Chinn and Kramer (2008) can be explored through stories. Narrative Inquiry, through the lens of stories, also highlights the importance of multiple relationships and its impact on the practical knowledge of the nurse. As such, the lens of stories provides an avenue for exploring relationships and how they unfold and contribute to narrative construction of knowledge and identity. Insights that arise from a focus on personal and social conditions, time, and place would not have otherwise been known through alternative methodologies. The 'stories in the parade', 'disruptive stories/stories to change', 'process of re-storying', 'stories to commit by', and 'stories to live by' provide a way for understanding the narrative of nurses' experiences living their values amidst organizational change.

Stories in a parade. A practitioner (teacher or nurse) embodies her/his personal practical knowledge, that shapes practitioner understanding, exists in the past and present and informs the future, when acting within the context of their landscape (Clandinin & Connelly, 1998). This is similar to Benner, Tanner, and Chesla's (2009) conceptual understanding of the socially embedded practical knowledge that they describe to be one that is gained by the practitioner through her/his interactions within the context of practice. While the two concepts share similar tones, they differ in that Benner et al. (2009) do not highlight the influence of a practitioner's personal experience and the narrative composition of practical knowledge. While this may be implied in their concept, their writing has bounded the experience of practical knowledge to its social embeddedness within the professional context. Narrative Inquiry makes explicit the intersection of both personal and professional knowledge into a coherent understanding of choices and provides a way to perceive knowledge as narratively composed and embodied by a practitioner (Clandinin & Connelly, 2000). This knowledge, both practical and personal, is used in the interconnecting and interweaving of relationships within the workplace. Through this perspective, we can envision that nurses bring their stories both personal and professional through their personal practical knowledge into their work. These stories contribute to an unfolding parade, a metaphor from Geertz's anthropology (Clandinin & Connelly, 2000), for intersecting relationships that move toward a common purpose and are experienced by everyone participating (Clandinin & Connelly, 1998). This metaphor also accentuates the temporal nature of experiences (Clandinin et al.,

2007) as there is a sense of action both within a parade as well as the movement as it passes through time.

> Each participant in the landscape, in the parade, has a particular place and particular set of stories being lived out at any particular time. Our influence in the landscape, in the parade, is uncertain. We cannot easily anticipate how our presence, our innovations, our stories, will influence other stories. The parade proceeds whether we wish it to or not (Clandinin et al, 2007, p. 27).

In contrast to Tanya's metaphor of a train coming at her to depict the power of changes, a parade creates a sense of invitation or participation rather than one that is one-dimensional with a distinct purpose of getting at a destination. As such, it provides an opportunity for exploring how nurses may join a parade or why nurses choose to be bystanders and remain as observers to it. The metaphor of a parade offers a way to understand how multiple stories and plotlines intersect to discover deeper meaning about the issues in practice. It foregrounds choice and how it is affected in the wider perspective of the professional knowledge landscape.

I introduce the concept of 'stories in a parade' to propose a perspective of how practitioner stories are socially embedded and narratively composed. My inquiry expands our current understanding of social embeddedness of knowledge as described in Benner et al.'s (2009) viewpoint. The story of Tanya as a composite of my six co-participants' experiences highlight how stories are both personally and professionally shaped. Tanya's stories of conversations with her grandfather while sitting on his knee learning about tailoring and at the dinner table discussions about medicine with her extended family make up in part the person that she is. Her personal experience as a patient in an

emergency unit drives her understanding of the importance of "listening to patients" as part of a thorough nursing assessment and in knowing them. These personal stories are elements of her personhood that become part of the professional landscape parade.

As Tanya engages in practice as part of this parade, she reveals the intersection between her personal and ethical knowledge (Chinn & Kramer, 2008). This interconnection shows the bridge between her commitment to her patients and her life story. The overlap between these two types of knowledge enables her to see her moral horizon. As Tanya comments,

> One thing I cannot change is to stop what I am doing and answer my patient's call when he/she asks. When someone comes to me and says little Johnny has to go pee while I am on the computer, I have to respond immediately… My son has been in the hospital frequently in his life, I would hate it if he had to wait to hold his urine.

Tanya's response to her patient's call bell is an example of how the immediacy of her response corresponds to her life story and her commitment to her patient. This action describes what she feels she ought to do in the situation. She engages in the practice setting as a whole person and her choice to act in a particular way is influenced not only by her professional experience but also by her personal story. This merging provides a glimpse of her values that make up her moral horizon. While all knowledge overlap in a person's story, Tanya's story explicitly reveals the intersection between ethical and personal knowledge. Acting upon awareness of this overlap has the potential to reshape practice.

Tanya's life story, based on past experiences along with her present stories of life, co-exist in a sense of wholeness and become part of a parade that is constantly shaping and reforming relationships within the workplace. What this research brings to the foreground is the notion that nurses' experiences create stories that become part of the context. They engage in relationships in practice through their multiple kinds of knowledge [personal, empirical, ethical, aesthetic, & emancipatory] (Chinn & Kramer, 2008); but the extent of living out their knowledge or stories can be constrained in the workplace. As such, Tanya experiences a different way of caring for her patients than what she originally intends. As Tanya reiterates "I hate this kind of nursing".

Parades include music. The parade continues and Tanya experiences two different tunes that shape her experiences. As one tune fades away and another band comes up the street, I can imagine Tanya choosing whether to stay where she is in the parade or to move herself to a different place in the parade, a new work setting. This echoes the vibration of her values and horizon and re-orients her to her purpose. Consistent with Chinn and Kramer's (2008) notion of moral knowing as grounded in the everyday engagement with what a person believes to be good, Tanya maintains the value of commitment to responsive relationships. The second much stronger decibel is the organizational sound that also shapes her practice. Tanya marches to this organizational tune where she consistently responds and re-stories her life in order to manage and cope in the situation. She makes a transition within herself in order to move along with the changes in the hospital. Tanya claims that she used to be "the one that wanted to complain" but that she saw that it did not get anyone further. Through reconstruction, she

is “more inclined to sit back and think as opposed to react in a knee jerk fashion”. This helps her continue living in the workplace. When she realizes that the impact of her experience in her unit is affecting her personal life, she makes the change to move to another setting. Tanya engages in re-storying her life in light of the parade. As she leaves one location, she joins a different part of the parade that creates a more coordinated rhythm for her than the one she left.

When I think of a parade, I think of individuals moving in a coordinated fashion to pay tribute or for a celebration. It brings about feelings associated with joy and cotton candy. Tanya’s story did not share this sentiment. Tanya feels that engaging with responsive relationship based on knowing the patient is critical to her care. Yet, the current workplace practices influenced by high patient to nurse ratio and patient acuity affected the way she enacted this value. The situations in practice subjects her in making choices that are incongruent with what she feels is the right action. She minimizes her interaction with her patients and curtails her ability to know her patients. As such, she experiences moral distress. These experiences are shaping Tanya’s use of her knowledge and her identity as a nurse. The discord is an emotional trigger to pay attention to such issues. As such, a ‘parade’ that historically evokes positive feelings but currently arouses undesirable ones provokes questions for further exploration. Understanding the narrative of experiences described in this study through the lenses of ‘stories in a parade’ accentuates the way nurses apply their knowledge about issues in practice through the choices they have had to make and how this knowledge is at times compromised. It highlights the aesthetic quality of their experience and sheds light on their humanity as

actors within a context whose performance is personal as well as ethical and empirical (Chinn & Kramer, 2008). This perspective highlights a different aspect of the experience that spawns questions for further understanding. Questions such as: who is managing the parade? What is the parade route and destination? How do participants understand what they need to do in order to act in a coordinated fashion? Do they have the correct music to play? Have the participants in the parade tuned their chosen instruments? The term 'stories in a parade' provides a different perspective about how interactions and relationships interweave to form a reality. This provides a new way of envisioning the workplace and as such a new way of understanding those relationships. 'Stories in a parade' also leads to discoveries of stories that hurt, cause pain, and have the potential to shape the understanding of who we are as nurses and persons. This insight contributes to a deeper understanding of the experience and new choices for action.

Disruptive stories/stories to change. A disruptive story is both personal and professional in nature. It is a term borrowed from the health care and business literature that describes disruptive behaviours as those that refer to "incivility, bullying, horizontal/lateral violence" (Lachman, 2014, p. 56). This notion is similar to the concept of initial stress that Fry, Harvey, Hurley, Foley (2002) describe in reference to moral distress. These authors claim that a person experiences initial stress when unable to enact her/his moral responsibilities in a given situation. This stress turns into reactive stress if the situation continues with a person unable to change the course of action towards meeting a moral end (Fry et al., 2002). As such, I perceive moral distress as a disruptive

story. This term is a way to represent the experience that causes pain and anguish in the work lives of nurses. The term disruptive in relation to the workplace has been associated with behaviours that are perceived to be in contradiction to the Code of Ethics for Nurses (Small, Porterfield, & Gordon, 2015; Lachman, 2014). Experiences that promote negativity perceived as hostile because of the pain and anguish they cause and negative physical manifestations that they induce may be referred to as disruptive.

Tanya's story suggests that the inability to enact responsive relationships brings feelings of moral distress. Her perceptions and reactions to patient care are not uncommon in the literature. Peter and Liaschenko (2013) discuss the notion of the nurse-patient relationship as fundamental to the practice of nursing and that the threat to this relationship causes moral distress. Hufferman and Rittenmeyer (2012) also identify this aspect. Understanding Tanya's experience from the perspective of a disruptive story brings to the foreground the impact of such story on the lives of nurses who experience them. Moral distress has been known to manifest bodily responses such as headaches, stomach issues, and/or sleep disturbances (Austin et al., 2008). Viewing stories as embodied experiences make it more evident why moral distress can produce these responses in nurses. Moral distress as a disruptive story with the power to reshape lives both personally and professionally makes this workplace problem even more significant to change. As Tanya shows, leaving the workplace is one way to remove oneself from such distress. Withdrawal from the situation has become one of the strategies for coping with the issues in practice. According to the Canadian Federation of Nurses Union (2012) "twenty percent of nurses in the hospital sector leave their jobs annually with the cost to

the hospital by some at $25,000, and by others at $60,000 per nurse as a result of the transition. Workload is often cited as a key factor in turnover" (p. 7-8). O'Brien-Pallas et al. (2008), CNA (2009) and CFNU (2012) further reinforced the statistic of cost to hospitals of $25,000 per nurse as a result of turnover. Leaving in order to cope with situations in practice not only influences the nurse but also creates an economic impact on organizations.

Perhaps, Doane and Varcoe's (2013) second moral obligation of 'openness to difficulty' provides an opportunity for reconceptualizing a 'disruptive story' to one that can be altered through the concept of 'story to change'. This takes a different mental frame for responding to difficult situations. It requires a certain level of openness to reflection to become aware of disruptive stories and think about how to change them. It needs the awakened perspectives of the leadership team to attend to issues of moral climate. As Tanya has shown, this sense of openness to difficulty is only partially experienced. Tanya continues to face situations of not being heard in her interactions with her managers and may also be internalizing the issues of the workplace particularly through her expectations of new graduates. Although she notices the harm in the form of potential bedsores that an inadequate responsive relationship creates, she is unable to shift the current practices in the workplace. The findings of harm as a result of increased patient to nurse ratio is not new to nursing literature (Aiken, Clarke, & Sloane, 2000). What this study contributes to the discussion is the notion that by reflecting on a disruptive story, a nurse may transform such story to one of 'story to change'. A view of moral distress from a disruptive story to one of 'story to change' offers an awakened view

of experience. Although moral agency maybe constrained, the awareness that a disruptive story can be changed initiates the starting point for conceiving a new reality in the work place. It may trigger a point in the narrative construction where Tanya could feel courage and take action towards new beginnings. Reflecting upon the issues to transform a 'disruptive story' to 'story to change' is key to this process. In Narrative Inquiry, this process of transforming stories is through the process of re-storying that engages reconstruction of experience (Clandinin & Connelly, 2000). Tanya's story offers the potential for transformation, as she is able to engage in internal changes in order to adapt to the influences in the workplace. She understands that organizational change is hard and realizes that it is part of living as a nurse within her context. Perhaps, what she needs is organizational support in her process of re-storying.

Process for re-storying. Reflection and reconstruction are critical to narrative construction (Clandinin & Connelly, 2000; Lindsay, 2001). In particular, reflection that leads to personal growth as an educative experience provides the opportunity for renewal (Dewey, 1938). The key is that reflexivity occurs through the bridging of both reflection and action. This is also where intentions come to a nurse's awareness and contribute to the transformation of nurses' perspectives in the workplace. The elements of reflexivity and intentions have been viewed as components of moral obligations when engaging in relationships (Doane & Varcoe, 2013). Narrative reflection is one way to engage in Doane and Varcoe's notion of moral obligations.

What this research shows is that this type of reflection is not readily observed in practice. Critical reflection and reflexivity are limited because of the lack of time and

space to engage in these activities. Tanya's story highlights that engaging in critical reflection may be a way to open oneself further to the state of accepting difficulty as part of life so as not to react to it with judgment, but to reflect deeply and move forward through praxis. This situation brings to the foreground the meaning of one's intentions and how to make desired change happen. As this research demonstrates, this way of storying life involves cultural acceptance of reflection as part of practice that goes beyond the expectations of the College of Nurses of Ontario (2009) through its targeted quality assurance program. It calls for viewing reflection as a way of being a person and a path towards personal growth (Dewey, 1938). What is also significant is that the term reflection in the literature has been referred to as the internal work that a nurse employs to gain understanding of what to transform and then acts upon this (Ruth-Sahd, 2003). While the emotional impact of reflection had been discussed in the reflection literature, this aspect of the process continues to reveal different experiences that allow individuals to move towards transformation. Bridges' (2003; 2009) notion of 'letting go, neutral zone, and taking hold' shed light on the emotional aspect of reflection from the perspective of dealing with change. In difficult situations, these may be the critical processes that facilitate nurses in managing change. This was evident in this study through Tanya's adaptation to change. By letting go of assumptions that placed her in conflict with the organization, she was able to transition into a state of taking hold of the changes within the unit.

In regards to reflection and reconstruction, two processes within reflection became visible in this study. I learned how an emotional aspect occurred in the

experience of living out values amidst change as described through the process of transitions. I also learned that the process of reflection that takes nurses to critical reflection is absent in practice. This deep reflection during a time of difficulty may be a necessary nursing action in order to open oneself and accept the presence of difficulty in life (Doane and Varcoe, 2013).

A process of re-storying, a term that emerged from understanding the narrative of experience in this study, is an essential practice that allows nurses as moral agents to retell their lives. The perspective of re-storying in relation to nurses' experience contributes to a new way of acknowledging nurses' capability to transform their lives and live anew. Rushton and Boss (2013) explored narratives of clinicians to understand the impact of moral distress in their lives and provided a unique lens that merged resilience and moral agency as a way to manage moral distress. It also identified emotional labour as a key aspect of this experience (Rushton & Boss, 2013). What the authors illuminate is a unique way to bring to the foreground concepts that have been alluded to but not fully explored within the area of moral distress. The use of narratives in this research enabled the identification of issues relevant to practitioners as they live their practice within landscapes of moral distress. My study offers another lens to understand moral distress as a resonant thread of nurses' experiences living their values amidst organizational change. By illuminating the narrative of experience, this study contributes to deepening our understanding of the meaning of moral distress as a disruptive story with potential to be a story to change.

Stories to commit by. 'Stories to live by' are stories that exist in practice that have been reflected upon and contribute to the shaping of one's knowledge and identity (Clandinin & Connelly, 1998). The 'stories to live by' in this study is a way to speak about how nurses create their knowledge in practice and also shape their identity. It is borrowed from the concept introduced by Clandinin and Connelly (1998) from the teacher education literature. These stories of experience depict the voice of nurses that are otherwise unheard. Tanya shares that she feels unheard by management in terms of influencing practice. The term 'stories to live by' make explicit the stories of the landscape by nurses as they craft their personal practical knowledge at the bedside with their patients. By thinking about these stories this study opens a door for another way of exploring how nurses live in practice. By viewing life as narratively composed where the personal and social are connected, we can begin to illuminate another way for understanding how life as a nurse is shaped at the bedside. There is an active tone in the stories to live by as they cannot emerge unless reflected upon. As such, the process of re-storying need to exist in order to access these stories that are within a person. In this study, part of Tanya's 'stories to live by' are the personal life history that contribute to who she is as a nurse and how these stories contribute to her perception of practice and continue to live through her actions. Her story of leaving one practice setting for another as Tanya negotiates her personal and professional tensions is another example of one of the 'stories to live by'. Tanya's story of letting go of past perspectives to live with changes and her story of releasing negative energy to continue to move forward are

stories of managing tensions in a parade. The process of re-storying becomes a way to live anew and to continue creating such stories.

Following the term ‘stories to live by’ (Clandinin & Connelly, 1998), I develop the term ‘stories to commit by’. The knowledge that emerges from the process of re-storying offers a way to understand how ‘stories to live by’ are composed, how ‘stories to commit by’ emerge as a thread in these stories, and how the unfolding process sheds light on the emerging identity of nurses in the workplace. These are stories that make visible to the nurse the moral horizon that is the line in the nurse’s moral perspective. This will be described more fully later in this section. Rodney et al. (2009; 2013) described the moral horizon as one that outlines what is determined as ‘good’ for nurses to move toward. The authors claim that this horizon is not fixed but rather shifts to accommodate the issues that arise in the nurse-patient relationship (Rodney et al., 2009).

In relation to this study, the moral horizon can be perceived as the moral line that creates a space for stories of values that stem from responsive relationships and emerge from the context of care. Through Tanya’s story, this research showed how the contextual factors on the unit interfered with her abilities to provide care within the responsive relationships that she feels she ought to live. Through reflection, Tanya is able to transition to manage some issues. A sense of adaptation occurred in her experience but she continues to question the shifting of line that makes up her moral horizon.

My study sheds light on the ‘stage of reflection’ inherent in Nathaniel’s (2006) grounded theory study on moral reckoning. A Narrative Inquiry study differs from that of a grounded theory study in that reflection is not particularized to a stage within a process

but happens simultaneously in all aspects of the experience. The three-dimensional inquiry space provides the forum for continuous movement of inside and out, backwards and forwards as an inquirer makes sense of the experience (Clandinin & Connelly, 2003). Nathaniel (2006) reveals that at this stage, nurses' "remember issues from practice, tell their stories, examine their conflicts, and live with consequences" (p. 432-433). It is the phase of examining conflicts that resonate the most with my study. Nathaniel (2006) claims that at this phase, nurses discover their limits or "a point beyond which they will not again be willing to go" (p. 433). This is similar to the 'line' that Tanya delineates. Similar to Nathaniel (2006) Tanya describes this line as her limit or boundary for compromise. She can no longer go beyond this limit and still call herself a Registered Nurse. Tanya claims that there comes a point where the 'line' is too far. The 'line' shifts in practice. Nurses and the organization have not arrived at this common 'line' that is comfortable for both parties. My study contributes to the notion that within this line are stories that can be perceived as 'stories to commit by'. These stories are based on experiences in practice and make visible the boundaries for nurses. Nathaniel (2006) did not acknowledge the possible existence of such stories but my study highlights this aspect and illuminates what may be happening within the context of the line nurses speak about and the limits beyond which nurses are not willing to go.

In another study, Fackler, Chambers, and Bourbonniere (2015) uses a hermeneutic phenomenological method based on Merleau-Ponty to reveal three themes in hospital nurses' lived experience of power namely, "*knowing my patients and speaking up for*

them; working to build relationships that benefit patients; and identifying my powerful self" (p. 269). The themes echo similar plotlines to my study and in particular the theme that makes the connection between power and self that highlight the relationship between knowledge and identity. Feckler et al. (2015) describes that a sense of power emerges from acknowledging how nurses' knowledge influences decisions and patient outcomes. The authors describe how nurses' identity, their sense of self, is influenced by the way they are able to use their knowledge in situations. Identifying nurses' powerful selves arises from validation of their actions by others (Feckler et al., 2015). This study brings to the foreground the relationship between identity and knowledge. In my Narrative Inquiry study I also recognize this relationship but my interpretation differs in that, knowledge by nurses is not limited to what nurses express within the context of the lived-experience. It stems also temporally beyond the everyday practice to shed light on how their experiences as parents and children inform their present lives within the context of their professional environment. My Narrative Inquiry study illuminates how past knowledge informs the present and has an impact on the future. Tanya's experience as a mother caring for her sick child in the hospital informs her ethical knowledge of how to respond to patients. This value reverberates in her current responses in practice as she acts quickly when her patient calls for help to go to the bathroom. In Narrative Inquiry, knowledge is experienced holistically within the context of a life and discerned through multiple interactions over time between the inquirer and co-participants (Lindsay, 2006). Understanding this perspective allows an inquirer to experience the stories of the co-

participants as a whole within the temporal frame past, present, and future (Clandinin & Connelly, 2000).

While different qualitative methodologies reveal different and complementary perspectives to a common phenomenon, it is clear that in this Narrative Inquiry study my co-participants histories, through Tanya's story shapes the values that they live by in practice. They contribute to Tanya's perspective of her moral horizon. Tanya's story acknowledges that the moral horizon in the organization is in constant shift. Reflection on the moral line using the process of re-storying may enable nurses to see clearly the stories that lie on their horizon. These stories may also reveal what Austin (2007) discusses as the 'geographies of responsibility' (p. 83). The author refers to this geography as a map that shapes the moral lives of nurses in practice. The concept of 'stories to commit by' contributes to the conceptual lens of mapping these geographies. As Tanya indicates, a responsive relationship in the form that it takes in the current context, such as answering call bells of patients in a reasonable time, is one of these stories. The 'stories to commit by' extend the notion of 'stories to live by'.

Understanding life through stories. The 'stories in the parade', 'disruptive stories/stories to change', 'process of restorying', 'stories to commit by', are concepts grounded in the narrative composition of life as it unfolds. It foregrounds the personal and the active movement of reflection that lie within a person and the choice(s) she/he makes to re-craft life. The conceptual lens of stories provides a useful way for

understanding the narrative of experience. This way of thinking about the world has significance for practice, education, research, and policy.

Practice

As I look back on Tanya's story, a composite of my six co-participants' experiences, three issues come to mind: the impact of moral climate on nurses narrative construction of their lives; nurses need to embody reflection and reconstruction as part of their lives; and the potential of foregrounding nurses' collective voice through participation at multiple levels in the organization. Attending to these issues addresses the "so what" questions of Narrative Inquiry (Clandinin et al., 2007).

Rodney, Buckley, Street, Serrano, and Martin (2013) define moral climate as "the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered" (p. 188). The authors claim that the corporate perspective on the delivery of care places constraints on nurses' moral agency and as such makes it difficult for nurses to enact good quality care (2013). This is consistent with Tanya's story, which is also the story of many nurses delivering care in Canada, and Western countries where corporate ideas of saving money are a justifiable means for providing health care service (Rodney et al., 2013). Stein (2001) asserts, "efficiency is not an end, but a means to achieve valued ends" (p. 24). As such, organizational changes under the banner of efficiency may not necessarily promote quality patient centred care. Tanya's story is an example of how being extremely organized with her care does not necessarily advance patient centeredness. Her own effectiveness as a nurse is compromised because of her

inability to engage in relationships with her patients to fully and holistically address their needs.

Effectiveness from the perspective of Tanya's story relates to knowing what to do for the patient based on knowing the patient and not through financial or organizationally defined efficiency. Increasing the patient to nurse ratio and minimizing the time available to spend with each patient is one aspect of her context's moral climate that Tanya finds problematic. Inattention to this situation may create what Rodney et al. (2013) refer to as the moral winter where ethical issues relating to care are no longer questioned but normalized and nurses lose their voice to enact their moral perspective. In this situation, the moral horizon is no longer visible. As Tanya described, this situation points towards a state where the 'line' has shifted too far.

Rodney et al. (2013) suggest that influencing the moral climate involves "turning negative characteristic around and strengthening positive characteristics" (p. 198). One simple way is for managers to improve communication patterns between nurses and themselves. Lindsay & Schwind (2015) in a study of mental health nurses engaging in person centred care claim that nurses see all persons including themselves as "individuals, with aspects of uniqueness, readiness and knowledge, that must be accounted for in building relationships" (p. 8). Nurses want to be heard. The historical pattern of not being heard has been part of nurses' story over time (Lindsay, 2001) and continues to be relevant in the experiences of nurses today as exemplified by Tanya's story in this study. Perhaps it is not so much a problem of being heard but more fundamentally how nurses are conceptualized. Are they seen as knowledge-makers or as

interchangeable units? As Nelson and Gordon (2006) claims, the critical discussion in health care should be on the way nurses use their knowledge and skills in practice. The shift in the conceptualization of a nurse in practice may be one way to turn a negative characteristic in the workplace around.

Another issue that may influence the moral climate is the nature of leadership in organizations. In certain organizational contexts, nurses may not have a manager who is also a nurse, but rather a manager from another discipline or one with a more corporate background. This situation may create either a disconnection or an opportunity. One positive development in the current Ontario health care system is the appointment of the Chief Nurse as a full member of the Board of Governors; a provincially legislated role and mandate arising from the Excellent Care for All Act (MOHLTC, 2015). Although this role has a non-voting capacity, it does suggest that nursing's voice is present at the highest level of decision-making within the organization. The Administrator, Chief of Staff, and the President of the Medical Staff are also required to sit on the Board as non-voting members. This provides an opportunity for interprofessional collaboration and communication that may possibly lead to ripple effects in the relationships at the unit level. This governmental mandate has introduced another story in the parade that may influence the experience of voice at different layers in the organization.

One way of enhancing positive characteristics in the organization is to provide nurses with opportunities to gather and collectively use their reflective capacity to address moral issues in practice. When nurses are able to dialogue about their thoughts and feelings, similar to my co-participants in this study, they may be able to identify

'disruptive stories' and potentially transform them to 'stories to change'. Austin (2012) states that the development of a moral community could be a mitigating factor to moral distress. A moral community is a space for making visible shared moral values across multiple relationships and where ethics and action find congruence (Austin, 2012; Rodney et al., 2013). Fostering such a community is an organizational action that may have an impact on positively influencing moral climate.

Attending to the moral climate by enabling a deeper level of reflective practice of nurses has the potential to align nurses' values and actions with organizational values. Tanya's story alerts us that critical reflection is absent in her experience. This type of reflecting is perhaps essential in developing a moral community where nurses become clear about their assumptions about care and the vision of their moral horizon. Innovative approaches that respect the personal practical knowledge of nurses is also useful in broadening the perspective of how personal knowledge influences values and stories in the parade. Lindsay and Schwind (2015) used an innovative approach of arts-informed narrative inquiry focused on practice development to engage nurses in thinking about their practice through a person centred care lens within an organizationally mandated relationship-based care approach. Using artistic activities, meditation, mandelas, and music, the authors guided nurses to discover their knowledge as persons and professional through the process of reflection and reconstruction of experience (Lindsay & Schwind, 2015). The findings of the study revealed language that emerged from nurses' internal world that defined relationship-based care as "*heartbeat of the person, respect for self, co-staff and patients, cohesive team relationships, and facilitates patient recovery"*

(Lindsay & Schwind, 2015, p. 4). This study adds to alternative ways to influence practice by recognizing the autobiographical nature of reflection and the use of art to retrieve insights deeply rooted in the personal practical knowledge of an individual. Chinn and Kramer (2008) claim, "art is present in all human activity that involves forming elements into a whole" (p. 153). After engaging in the artistic activities, nurses from Lindsay and Schwind's (2015) study understood how their own stories merge with those for whom they care and that caring involves also taking care of oneself. This message resonated with Tanya's story as she discusses the need to have an outlet to release negative energy. Using aesthetics as a way to develop practice is an innovative approach in assisting nurses to understand who they are as persons. This may set the stage for enabling them to engage in the moral community from an awakened perspective.

Doane and Varcoe (2013) suggest that a nurse's moral obligation is to engage at different levels of the organization. Implied in this moral obligation is the need for the nurse to share her voice with others. It calls for sharing one's story so that it may influence the unfolding parade. As the need for quality improvement plans are legislated by the Excellent Care for All Act (MOHLTC, 2015), the active use of knowledge in the practice setting becomes essential. Nurses need to find a way to use their voice and assert the required time to spend with patients in order to prevent harm such as bedsores. Engaging in quality improvement plans within the unit and organizationally may be one way to formally acknowledge nurses' contribution to quality care. Nurses' personal practical knowledge matters and attending to quality improvement initiatives at the

bedside, in the nursing workplace, and within the organization are opportunities for shifting old stories in the parade. As Tanya states

> Change is hard… It is a matter of taking the risk to lead the change. I wasn't always very good at leading change. I was one of the ones that wanted to complain. Whereas now, I see that it has not moved anybody anywhere. It never does. So I don't feel it is horrible anymore. I am more inclined to sit back and think as opposed to react in a knee jerk fashion. You're not going to change everybody but you may influence some by responding differently. If I can be changed, maybe a handful more can.

Considerations for practice. Considerations for nurses' practice that emerged from this study involve participation in multiple venues such as committees, debriefing sessions, and interprofessional groups that make visible nursing's collective voice within the organization. The possibility of making M & M Rounds (mortality and morbidity) inter-disciplinary and demonstrating the knowledge nurses bring to practice is a strategy organizations could employ.

Specifically, nurses need to make space to dialogue with other nurses about the issues in practice that affect their patients and themselves. Conducted in a reflective way that facilitates awareness, engaging in dialogue will provide nurses with the opportunity to delineate their moral horizon and its impact on their experience of care. Nurses need to engage in reflection and reconstructing of their experiences through a variety of different avenues that could include arts-informed activities to understand the autobiographical nature of their knowledge construction in practice. Reflection may also help nurses uncover 'disruptive stories' and transform them to 'stories to change'.

Considerations for organizational leaders involve creating space for nurses to gather and dialogue openly about issues in practice. This space includes time and physical geography so that nurses can reflect and think about issues in practice and deliberate with one another. Rodney et al. (2013) suggest that the organization initiate

> a nursing ethics journal club; sponsor a nursing ethics committee and/or a nursing research committee; support a nursing ethics grand rounds and plan for interdisciplinary participation; provide an annual ethics educational program for all staff; circulate a nursing ethics article of the month and foster related discussion" (p. 199).

Management needs to establish meaningful communication with the nurses and ensure that changes on the units are clear and well understood. Nurses want to feel heard when they speak of issues in practice that impact their work lives. Management needs to create an environment that empowers nurses to solve and own problems at the bedside. Rodney et al. (2013) claim that knowledge is the weapon that prevents our profession from returning to an earlier era where nurses felt disenfranchised.

Education

How did Tanya influence me as an academic nurse educator? Reflecting upon Tanya's narrative, I realize how important it is to help nursing students become aware of their moral horizon. Students arrive in nursing schools equipped with their autobiography authored with their significant others. They will one day assume the role of the nurse who may ask the question: 'what is my moral horizon'? It is this question that resonates with me deeply. Nursing curricula has a responsibility to help nursing students understand that their lives are autobiographically and narratively composed. Their knowledge does not

come from one way of knowing but is composed by multiple ways. As such, nursing curricula may consider the explicit integration of the ways of knowing with particular emphasis on personal and ethical knowledge as key features of attending to moral issues in practice. Ethical knowledge base could extend beyond that of understanding the Code of Ethics and traditional ethical frameworks into understanding the meaning of moral practice and the development of an identity based on an understanding of moral values (Benner, Sutphen, Leonard, & Day, 2010). What does it mean to maintain one's commitment to patients, colleagues, and the profession as stipulated by the standards of practice (CNO, 2009)? What does it look like? These are questions to ponder and explore through learning activities? This could pave the way for some clarity about the meaning of moral practice (Gadow, 1996) and the minimization of moral disengagement that can sometimes occur in a context of increasing tensions as noted from Tanya's story.

Teaching students how to recognize the impact of their assumptions on their practice through critical reflection can help them deal with power dynamics in practice. The act of critical reflection helps students become aware of how to challenge taken-for-granted premises and power relations within contexts (Brookfield, 2000; Hannay & Ross, 1986). This skill may assist nursing students to recognize the impact of oppressive forces on their practice, know how to navigate the complexities, and advocate for themselves which may help in maintaining their own moral integrity. This is consistent with the views of Edgar and Pattison (2011), who claimed that nurses need to gain the capability of reflecting and deliberating in light of the complexities of the context and its impact on current and potential actions by using their knowledge, evidence, and personhood. As

shown in this study, Tanya's story demonstrates absence of opportunity for critical reflection.

Finally, acknowledging the personhood of the nursing student within my classroom is a way to embed the value of honouring the person in them. Co-constructing my students' lives through the classes we share, I am reminded that my impact on their experience of personhood may become an orienting example that may one day contribute to the way they craft their moral horizon. Becoming a nurse is not merely an understanding of the knowledge about context, health and healing or learning and knowing but also about personhood and caring (McMaster University School of Nursing, 2014). It is in understanding the interaction of the person in different contexts and with multiple relationships that allows the individual to make visible what it means to care. The person is critical to understanding what it means to live, reflect, dialogue, and act within the context of one's moral horizon. This became evident in Tanya's story.

Considerations for nursing curricula. Nursing curricula need to ensure that ethical knowledge development extends beyond the understanding of the Code of Ethics to the meaning of nursing values, personal values, and morals. In particular, it is facilitating the understanding of how personal values influence professional values and that choices are influenced by values that are meaningful to the person. Arts-informed activities through creative reflections may contribute to understanding self in a different way. Nursing curricula need to further enhance their emphasis on what it means to be in relationships with patients, colleagues, and self. Using relational inquiry (Doane &

Varcoe, 2013) as a lens to develop the curriculum may offer a unique perspective in helping students understand their moral obligations. As a teacher, I need to ensure that living with the phenomenon of change is discussed in the curriculum and provide opportunities for students to learn about these issues and their significance in practice. Finally, nursing students need to be given an opportunity to deliberate what it means to engage in the multiple levels in the organization, to have a voice, and how to use it. Nursing students need time and space to reflect upon issues relevant to transitioning from academic life into professional life with a particular emphasis on how to keep visible one's moral horizon amidst organizational change.

Dewey (1938) claims that education needs to build experiences that are educative or in other words promote growth that positively influence the future. This research study has moved me to continually engage students in reflecting and reconstructing their experiences. Understanding Tanya's story has made me embody the importance of pausing, taking stock, in order to live anew in positive ways. It reinforces the need for my own reflective practice to become aware of the impact of my teaching learning strategies on students' wakefulness to the challenging issues they will face in practice. I have to be cognizant in facilitating their potential in envisioning solutions for change. Nursing students need a solid understanding of reflective practice and its usefulness for enriching, making sense, and creating life that is 'educative'.

Future Research

Future research arising from this study points to the exploration of more stories in practice. How do nurses develop their practice amidst the tensions in the workplace? The practice development movement addressed by McCormack and McCance (2006), and Lindsay and Schwind (2015) may be a useful lens for understanding future research in this area. My questions arise from my understanding of stories. What are the disruptive stories and stories to change that exist in the workplace? How do nurses re-story their lives amidst disruptive stories? Looking more closely to my life as an educator, I am intrigued by my own story of practice. I ask, how do academic nurse educators experience adapting their teaching and learning practice in response to organizational change? How do academic nurse educators' experience identifying and responding to disruptive stories in their practice? What are academic nurse educators' stories to commit by? These questions vibrate in my mind as I think about Tanya's story and mine. The questions she raised through her experience has informed my life to explore what it may be like for academic nurse educators teaching their students. Have we shared similar lives? How are they the same or different? As nurse and academic nurse educator, Tanya and I are part of a continuum that nurtures nursing students in becoming nurses. We are both nurses from different positions in the nursing knowledge landscape. We enact our knowing and knowledge in different ways with nursing students. My interest in Tanya's life is fuelled by my desire to understand what it may be like for my students when they graduate. Now I am filled with more questions that reflect my life. I have learned from

Tanya's narrative and my six co-participants. They triggered my curiosity to ask more questions about life and living as a nurse and an academic nurse educator.

The role of emotions in reflection also intrigues me as a source for further research. Its evidence in this study contributes to further questions about the relationship between intuition (Benner et al., 2009) and knowledge and skill (Nelson, 2004) in relation to moral actions in practice. Benner et al. (2009) claim that intuition is part of being an expert nurse and a distinguishing element in the novice to expert stage of nursing practice. Nelson (2004) challenges this notion as she brings to the foreground the paramount aspect of knowledge and skill as contributors to the nurse's ability to judge what is good. Benner et al. (2009) accentuates moral intuition, distinctive to expert practice, and visible through emotions while Nelson (2004) challenges the category of expert practice as the only source for making moral intuition visible in nursing practice. Nelson (2004) offers the term ethical capacity to describe how nurses' respond to the varying ethical situations in practice. Tanya experienced challenges to her moral agency and perhaps her ethical capacity. She exercised some control over the influences in her life when she decided to let go of assumptions and adapt to the current change in practice. How did her moral intuition help her do what is right? How does her moral reasoning reinforce her moral intuition and possibly explain her experience of moral distress? Do all nurses regardless of stage in nursing practice embody a moral intuition that guides them towards what is right and good in nursing practice? How does reflection assist in understanding nurses' moral intuition?

Haidt (2012) claims that moral intuition (emotion and embodied knowing) emerges before moral reasoning when making moral judgments. The author calls this the social intuitionist model (Haidt, 2012). Haidt (2012) states that responses to situations begin with “rapid and compelling intuitions and continues on with post hoc reasoning done for socially strategic purposes” (p. 78-79). This model may possibly shed light on the current debate in the literature about the role of intuition primarily in expert practice (Benner et al., 2009) and the development of ethical capacity inclusive of knowledge and skill in practice (Nelson, 2004). Haidt (2012) opens the door for further re-conceptualization of ethical comportment in nursing practice. He points my thinking towards how moral intuition exists in all people and follows that nurses across all nursing stages of practice possess moral intuition. Engaging in Narrative Inquiry through different avenues may illuminate 'stories to commit by' that has the potential to contribute to another way of understanding moral/ethical comportment that is not limited to expert practice. This poses considerations for taking into account multiple patterns of knowing in our reflection and reconstruction of experience in order to understand the role of moral intuition in making moral judgments in practice. This is a source for further research.

Finally, Storch (2013) introduces the notion of ethical fitness as a concept that relates to “how one prepares to make good choices and take action that benefit others” (p. 2). It involves reflecting and knowing ethics as a way to navigate through ethical issues in practice (Storch, 2013). This begs the question whether understanding one’s own ‘stories to commit by’ make an individual ethically fit? This is another question for future research.

Considerations for nursing research. My lens for understanding the world is shaped by Clandinin and Connelly's (2000) Narrative Inquiry. I appreciate the unique contribution of stories to the intimate understanding of the issues that nurses' face. As such, I recommend that future research focus on understanding how lives are autobiographically written and narratively composed. Exploring experience, foregrounding emotions and moral, intuition through approaches that acknowledge multiple ways of knowing may be helpful in understanding nurses' moral horizon. Studying the multiple terms that make up the conceptual understanding of the narrative of experience based on Narrative Inquiry are the primary considerations from this research. Future research surrounding the exploration of disruptive stories/stories to change; the process of re-storying; stories to commit by are the main considerations for future research. These stories can be research within the context of academic nurse educators' lives, nurses' lives, or administrators' lives. Narrative Inquiry research will provide a much a deeper understanding of the person who enacts a role within the system and how their storied lives influence the professional landscape. Understanding how the personal intertwines with the professional in shaping relationships within a workplace, organization, system may provide a broader understanding of how lives within these contexts are shaped and constructed.

Policy

Pauly and Storch (2013) claim, "policy decisions are moral decisions" (p. 236). Policy drives decisions and actions that influence all people concerned and as such

requires the integration of values that are important to all stakeholders including nurses (Pauly & Storch, 2013). The Canadian Nurses Association (2008) asserts that nurses' ethical responsibilities include the development of a quality work environment as well as self-reflection and dialogue. These two elements contribute to the ability to enact ethical practice and to bring to the foreground the nurses' moral agency (CNA, 2008). As Rodney et al. (2013) claim, the corporate perspective and efficiency view of health care system based on economics that drive processes within the organization create a discord with nursing values at times. It impedes nurses' ability to enact their ethical practice with their patients, families, and communities. The authors further affirm that negative consequences that emerge from "the processes by which changes are planned, the processes by which changes are implemented, and the lack of systematic evaluation of the effects of the changes are problematic" (Rodney et al., 2013, p. 189). As such, it is critical that ensuring a quality practice environment involve thoughtful deliberation and policy development and review on the processes of change as well as its evaluation.

Policies that are based in conceptualizing nurses as knowledge-workers and that support nurses to self-reflect and dialogue about issues in practice are consistent with the stipulations of the Canadian Nurses Association (2008). Austin (2007) and Marck (2013) suggest that the development and maintenance of a moral community in practice will enable nurses to become explicitly aware of the values and responsibilities that inhabit their practice and how to enact them. Austin (2007) recognizes that moral communities are challenged by the competing tensions in the workplace that continue to perpetuate assumptions around efficiency and power inequities. Policies that support the

development of moral communities to be built on respect and dialogue that fosters an environment of "at-homeness" is crucial in enabling nurses to live out their ethical praxis (Austin, 2007, p. 84). To be at home in your practice environment is to perceive that one's practice actions are congruent with one's values (Austin, 2007).

The creation of moral communities may also accentuate and make visible practitioners' responsibilities towards the public. As Romanow (2002) indicated, the core values of "equity, fairness, and solidarity" that the health care system is based upon have been connected to the public's understanding as citizens of Canada and as a consequence they view these values as part of their experience within the system (p. xvi). This aspect of the Romanow report is supportive of the need for the establishment of a moral community.

Considerations for policy. Policies that include ethical considerations for planned change may be a useful intentional action that brings to the foreground the essential nature of thinking about the impact of change. Initiatives need to be evaluated for its impact on key outcomes. An evaluation plan for any initiative should be included in the policy statements for any planned change. Policies that support the development and maintenance of moral communities as essential to the creation of quality care environments needs to be included in the organizational vision of everyday ethical practice. This would require participation of nurses in ethical committees and grand rounds (Rodney et al., 2013).

These policy considerations have the potential to reshape the 'stories in the parade' and also force the transformation of a different kind of parade that has the

potential for more coordinated actions. They also facilitate nurses' awareness of their 'stories to commit by' thereby reinforcing and reaffirming the values on which nurses' stand. Finally, these policies may promote and foster the process for re-storying amongst nurses that will contribute to their continuous awakened state towards their moral horizon.

The analytic layer of social justification offers a way to view experience from the wider lens of nursing's knowledge landscape. Tanya's story of living her values amidst organizational change facilitates the emergence of new terms that provide a different way of viewing the issues in practice. The conceptual lens of the story opens the door for a new way of meaning making. Conceptualizing 'stories in a parade', 'disruptive stories/stories to change', 'process for re-storying', 'stories to commit by' sheds light on the theoretical justifications from this study. Implications for practice, education, research, and policy helped me discover different ways to reconstruct the stories in a parade that Tanya experienced. Considerations for each nursing domain facilitate the social action and policy that are in keeping with social justifications (Clandinin, 2013). I have come to the end of my journey (for now) and with a reflective lens I will re-present my learning. Tanya has become a part of me.

Conclusion to My Journey at this Time

As I look back on this journey of understanding the experience of nurses' of living their values amidst organizational change, I am pulled to reflect on my life and how this experience has taken me through a process of personal and professional growth.

In keeping with Dewey's (1938) notion of an educative experience, my consistent and ongoing reflection on what matters from Tanya's story has made me more reflexive. At every turn of my life through the spiral of learning, I find myself continually reflecting and reconstructing. I am living, telling, re-telling, and reliving (Clandinin & Connelly, 2000). I looked at my life in chapter one. I wrote about what is important to me as a person and why. Where did my values come from? I experienced my past as I was taken to the days in the Philippines where I lived with my extended family. Everyone had a role to play and as a collective we moved to the same tune of survival. In the process of surviving, I felt the meaning of caring, loving, and living. My close relationships at the time, especially with my grandmother, gave me the footings that I later used to make meaning and define my notion of caring. Reflection became a way for me to unearth and become aware of why my question mattered to me as a person. Why am I concerned with nurses' experience of living their values amidst change? As I reflect on this question now, I realize that values make me who I am as a person. It outlines my 'stories to live by' and make visible to me 'my stories to commit by'. I did not realize it fully at the time even when I continued to reflect on my stories of practice and organization. I knew that there was something I need to teach in a deeper way as I think about my stories as an educator. What is it? There was something about the question that I needed to learn.

Chapter two helped ground my question within the literature. I defined terms that were in keeping with my question. Terms such as nurse, experience, values, and organizational change were explored. I provided a historical perspective of health care restructuring in Ontario. This chapter helped me establish the significance of my

research. The gap pointed toward a study of the issue using Narrative Inquiry. This chapter helped me see the social significance of my question.

Chapter three oriented my research self to the methodology that assisted me in finding the response to my research question. Framed within the overarching umbrella of Qualitative Research, I chose to work with Clandinin and Connelly's (2000) Narrative Inquiry. This methodology based on Dewey's (1938) notion of experience uses the three-dimensional inquiry space that focuses on the interactions of personal and social conditions, time, and place for understanding stories. This reflective and reflexive methodology highlights the autobiographical nature of experience and narrative composition of lives (Clandinin & Connelly, 1994). In delving into the methodology, I begin to see how the process of co-construction occurs as Narrative Inquiry leads me towards 'experiencing the experience' of my co-participants (Clandinin & Connelly, 1994, p. 414). We write our lives whether we are asleep to its ongoing cycles or awake to see how life is crafted. Through understanding the methodology, I gained a deeper appreciation of the power of reflection and reconstruction to help me become aware of the person that I am. The methodology leads me to seeing that I write my life just as my co-participants write theirs. Experience is shaped by the interaction between the person and the social context. Understanding this experience, how it is crafted, and why it matters is at the heart of Narrative Inquiry.

Moving from field text to research text is perhaps the biggest challenge for me in this chapter. It is one that I struggled to understand. How does one move from transcripts to research text? How does one use the three-dimensional inquiry space as an analytic

frame for generating the knowledge that this methodology enables? Experience teaches you the way. Working with a Narrative inquirer helped align my thinking with the methodology. I learned that it is crucial in this process that an inquirer moves through the process with reflective intention employing reflexivity as a process for moving through the phases of the methodology and the analytic layers. One needs to be open to the movement. As I engage with intention, I feel my whole self, connecting in an embodied way with the data. This became a way for me to interact with the stories of my co-participants. For me, Narrative Inquiry is not just a methodology that necessitates my cognitive processing and analysis. It requires that I embody the methods, stay present to the stories, and be reflexive in the process of looking backward and forward, inward and outward to the lives of my co-participants and that of mine. Without the latter, an inquirer is void of the spirit that fuels Narrative Inquiry. The process of awareness is both emotional and cognitive in nature. I needed both processes to exist in order to hear and experience the stories of my participants and to understand the narrative of their experience.

Chapter four provided me with the opportunity to relate to the experience of my co-participants. Through a composite story, Tanya writes me a letter of her response to how she experiences living her values amidst organizational change. I respond back in the form of a letter as my personal justification. In writing this response that engaged my personal knowing of the experience Tanya speaks of, I find myself pulled by the emotions embedded in her story. It triggers my memory as I move backward in time to my stories of childhood. It was then that I realized that values emerge from significant

relationships of my past. These values continue to shape the person that I am. Tanya's story helped me re-experience my own story of practice and in the process I gain an understanding of her current story of practice. I am reshaped by my experience.

I look upon the literature to gain an understanding of Tanya's story through the lens of the current writers about the issues she raised. Four plotlines emerged to form my practical/professional justifications. Responsive relationship; moral distress; reflection and reconstruction; and knowledge and identity create the issues that I further explored. I understood how Tanya expected to construct responsive relationships in her care of patients and how she felt moral distress as a result of managing the competing tensions in practice. Tanya's story revealed that critical reflection was absent in her practice. Her reflective experience also showed another process that appears emotional in nature that could be explained through the concept of transitions. Letting go of old ways in order to take hold of new ones represents how Tanya adapts to changes in practice. This experience does not however eradicate the feelings of moral distress that continue to inhabit her ability to provide care.

Finally, Tanya's story helped me discover that knowledge and identity are mutually informing. Her knowledge is narratively composed. Past knowledge become part of present ones that includes experiences from our personal world. Tanya's responses in practice were influenced by past experience of caring for her son as a care receiver when he was in hospital. When attending to her patients, she responds with immediacy to the call for assistance rather than prioritizing her documentation. This response was triggered by the memory of a time with her son when he was hospitalized. Moral identity

is composed in part by the experiences of constraints in practice, control over change, the ability to influence the course of actions within the practice environment, and life.

Reflecting upon Tanya's story through the literature helped reinforce its significance. Attending to the issues that Tanya faces is important and requires attention. The literature helped me realize how Tanya's experience resonates with the literature and how gaps in her way of attending to the issues open the door for possibilities.

My deeper theorizing by exploring how Doane and Varcoe's (2013) conceptual lens of relationships and moral obligations sheds light on Tanya's story helped me become aware of how nurses' experiences can be reconstructed. I realized that Tanya's story is misaligned to the concept of moral obligations as inclusive of reflexivity and intention, openness to difficulty, participation in multiple levels within the organization. Narrative Inquiry forces me to think anew and relive and as such it opens my understanding to a different way of perceiving Tanya's story that offers the possibility for change and alignment.

Chapter five, this current chapter, presents my social justifications. I begin with discussing the conceptual lens of stories as a way to rethink about the familiar issues in practice. The lens of stories highlights the use of reflection and reconstruction as essential elements for change. It is through this medium that I can envision possibilities for change. I discovered the terms 'stories in a parade', 'disruptive stories/stories to change', 'process for restorying', and 'stories to commit by'. Some of the terms that emerged in this study such as 'stories in a parade' and 'stories to live by' were previously coined by

Clandinin and Connelly (1998) in their theorizing of educational reform. However, this study provided a different meaning to this term in relation to the context of health care. Specifically, it represented the meaning inherent in Tanya's story as a nurse living her values amidst organizational change. The lens of stories offered a new way for perceiving the issues of practice and provides another perspective for reconceptualizing solutions that may lead to a better future.

In this current chapter, I shared my thoughts on the significance of my inquiry and considerations for practice, education, research, and policy. In doing this I stand afar to look over the knowledge landscape to discern how my discoveries can lead to further reconstruction. I learned that the enhancement of reflective practice is a key recommendation of this research. Innovative ways such as the use of art to engage deeper reflection that make visible the connection of personal and ethical knowledge creates an avenue for becoming aware of one's moral horizon. Next, I will use the literary form of a poem to re-present my story findings in order to provide the reader with a different way to become engaged with Tanya's story. I enable myself to act coherently within my practice setting by being clear and present to my moral horizons. I realized that my moral horizon lies within the core of the person that **I AM**.

Here I stand, at this momentary pause in my journey. I have come to understand that learning does not stop. Tanya's story pulls me to think about the new possibilities in my life as an academic nurse educator. In thinking about this, I am reminded by the need to engage my students more deeply through the process of re-storying. Reflection and reconstruction is now a key element to my teaching practice. Tanya's story in a parade

triggers my thoughts about our stories as academic nurse educators in my workplace working within a parade that we co-construct with each other through relationships. I too need to look closely about how my stories contribute to the parade and how the parade influences me. Do I recognize the disruptive stories that I can transform to stories to change? Have I reflected deep enough about the issues that confront me? Do I even recognize them? How do I contribute to the building of a moral community in order that I along with others continue to shed light on our 'stories to commit by'? My moral horizon can only appear as clear as the effort I place on shedding light at the 'line' that makes up my moral identity. In doing this, I will become awakened to the 'stories I live by'. As the end of this inquiry is in view, what arises are new questions. I have begun the process of re-storying by opening myself to inquiry. Narrative Inquiry has shown me that it is through reflecting that I will continue to live anew. Clandinin and Connelly (1994) claim, "all we have are stories". The time is ripe to construct new ones.

This research gave me the opportunity to discover Tanya's story and the narrative of nurses' experience in living their values amidst organizational change. I did not set out to discover a grand narrative but to engage in discovering the narrative of experience. In the process of writing this inquiry, I learned that Narrative Inquiry as a methodology takes me on a journey of illuminating the "personal and social significance of my work" (Clandinin & Connelly, 2000, p. 161). Narrative Inquiry is about inquiry into life as lived. I would have never understood this life from its autobiographical perspective if it was not through the use of this methodology. Narrative inquiry provides a way to understand experience through co-construction. The conceptual lens of stories that emerged from this

study would not have been generated had it not been through this methodology. Narrative inquiry poses a new way for understanding experience that forces the inquirer to envision possibilities.

Life continues to push me forward towards new insights and understanding. As long as I am open to the way reflection awakens me to new versions of myself, I will continue to live anew. I will live, tell, retell, and relive. My life as stories has been refreshed with new understanding. Narrative Inquiry has given a way to discover life for what it is. It has given me the courage to move forward with the hope that by reconstructing my life I may live anew.

Re-presentation

As a final form of re-presentation, I offer this co-constructed poem from the words of my co-participants and my reflections on their lives. The words in Times New Roman (12 font) are words from my six co-participants. These were the phrases that stood out to me as I read their transcripts multiple times. I felt their pain and I carried them as I wrote this thesis. Now I want to give this feeling life by acknowledging them in this arts-informed literary form of poetry. My poem does not follow any particular poetic structure rather it is written purely from an emotional standpoint as I think about what I learned from Tanya's story. The word "Moral Distress" written in American Typewriter font depicts my understanding of their experience. I understood other things from Tanya's story but the plotline of moral distress brings to the foreground the incongruence between their values and that of their context. This experience highlights the emotional

impact of this incongruence. As such, I chose this to highlight the emotional situation of nurses' living their values amidst organizational change. What follows are words in italics that represent my reflections and what I learned from Tanya's story. The phrases in bold letters bring the story back to my life as an educator. I claim that I'll trust. This trust emerges from my openness to see something different once nurses reflect and reconstruct. I too am compelled to respond similarly to use the process for re-storying (reflection and reconstruction) as a way to commit and stay awake to what makes up my core, my moral horizon as person and nurse. It is in doing this that I can envision a better future for our story as nurses.

I Am a Nurse

Busy: You run around for 12hours with very little breaks

Busy: 1000 people asking you questions

Busy: Doing nursing things

Busy: Cleaning things

Busy: Portering things

Please do not shut me down

All I want to do is care for my patient

Use all that I know and have learned

Being with my patient is all that I desire

Listen, someone's dying

Does anybody else care?

They are my responsibility

Aren't they yours?

I feel pain

Why?

Do you?

Why should I?

Moral distress

Aha!

Wait there is hope

Reflect

Reconstruct

Live anew

Feel your voice

Touch your Heart

Your patient needs you

Commit

Change

You can turn this around!

Build a moral community

Dialogue

Share experience

Speak your story in different places

with a variety of people

This is your story

*This is **our** story*

I'll trust

I'll do my part in education

I'll teach in ways that will help future nurses

Think, Reflect, Reconstruct

Together we'll build a better future

One that makes visible

Our moral Horizon

As Awakened Nurse

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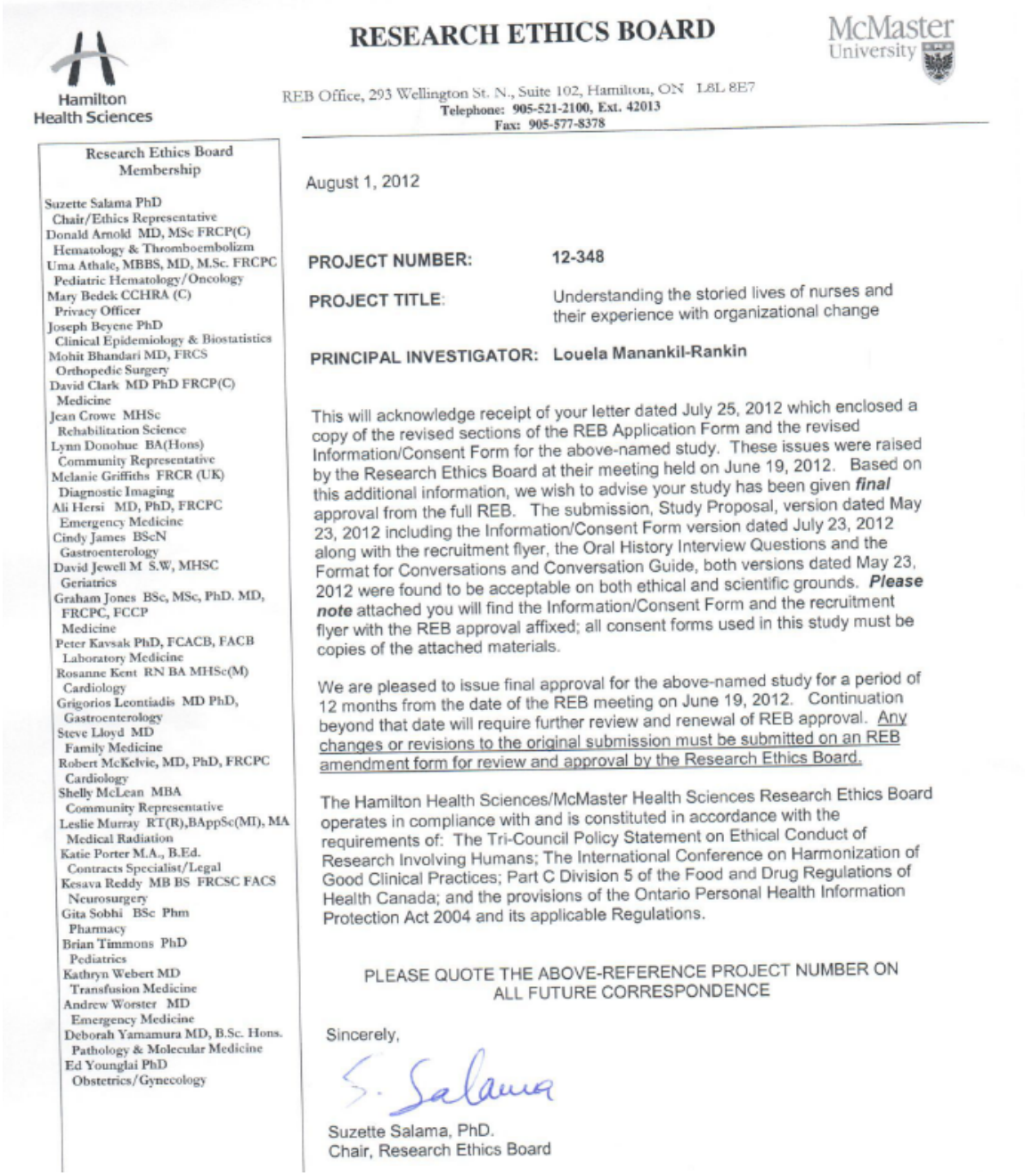
Appendix A



Hamilton Health Sciences

RESEARCH ETHICS BOARD

McMaster University

REB Office, 293 Wellington St. N., Suite 102, Hamilton, ON L8L 8E7
Telephone: 905-521-2100, Ext. 42013
Fax: 905-577-8378

August 1, 2012

PROJECT NUMBER: **12-348**

PROJECT TITLE: Understanding the storied lives of nurses and their experience with organizational change

PRINCIPAL INVESTIGATOR: **Louela Manankil-Rankin**

This will acknowledge receipt of your letter dated July 25, 2012 which enclosed a copy of the revised sections of the REB Application Form and the revised Information/Consent Form for the above-named study. These issues were raised by the Research Ethics Board at their meeting held on June 19, 2012. Based on this additional information, we wish to advise your study has been given ***final*** approval from the full REB. The submission, Study Proposal, version dated May 23, 2012 including the Information/Consent Form version dated July 23, 2012 along with the recruitment flyer, the Oral History Interview Questions and the Format for Conversations and Conversation Guide, both versions dated May 23, 2012 were found to be acceptable on both ethical and scientific grounds. ***Please note*** attached you will find the Information/Consent Form and the recruitment flyer with the REB approval affixed; all consent forms used in this study must be copies of the attached materials.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the REB meeting on June 19, 2012. Continuation beyond that date will require further review and renewal of REB approval. Any changes or revisions to the original submission must be submitted on an REB amendment form for review and approval by the Research Ethics Board.

The Hamilton Health Sciences/McMaster Health Sciences Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations.

PLEASE QUOTE THE ABOVE-REFERENCE PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

S. Salama

Suzette Salama, PhD.
Chair, Research Ethics Board

Appendix B

Recruitment Flyer

ATTENTION Nurses of Hamilton Health Sciences

Share your Stories of Practice
Join a narrative research study

My name is Louela Manankil-Rankin and I am an RN and a McMaster University PhD student in Nursing.

I am seeking participants for my research study to explore the experiences of nurses who practice at the bedside, are currently experiencing change in their work setting, and have lived with organizational change for 10 or more years. If you are a **nurse** who have: 1) **at least 10 years' experience in your area of clinical practice (ie. Med/Surg.), 2) claims to be experiencing change in your setting and 3) have experienced organizational change for more than 10 years, I am interested in your stories.** Understanding your stories will give insight to the reasons why nurses continue in their role at the bedside despite living with ongoing change.

If you are interested in participating, I will provide further information about the study. Please contact me by July 1, 2012 through email at manankl@mcmaster.ca or 905-525-9140 ext. 22511.

Appendix C

Information/Consent Letter to the Participant

February 21, 2012

Study: To understand the storied lives of nurses and their experience with organizational change

Researchers: LouelaManankil-Rankin, RN, BScN, MA, MSc and Dr. Janet Landeen, PhD (study supervisor)

Participant's Name (Please Print):

_____

To: Nurses of the McMaster University Children's Hospital, Maternal Child Program

My name is Louela Manankil-Rankin and I am Doctor of Philosophy nursing student at McMaster University under the supervision of Dr. Janet Landeen. I am conducting a qualitative study that uses narrative methodology to understand the storied lives of nurses currently experiencing organizational change. You are invited to participate in this study if you **1) have at least 10 years' experience in your area of clinical practice; 2) claim to be experiencing change in your setting; and 3) have experienced organizational change for more than 10 years.**

The aim of this study is to explore your experiences as nurses within the context of organizational change and to understand how you respond to the possible challenges this situation imposes. Using your stories as a way to understand your experiences will shed light on the nature of how nurses respond to organizational change. Narrative methodology offers a way to understand your stories from the perspectives of your past, present and future while also highlighting the dynamics between your personal and social contexts (ie. work place) (Clandinin & Connelly, 2003).

WHAT IS MY ROLE IN THE STUDY?

If you agree to participate, I am asking you to take part in the following:

(1) Provide background information about yourself such as your age, gender, role, length of practice, length of time in the role, length of time in the institution, and scope of responsibilities.

(2) Participate in two oral history interviews of approximately 60 minutes each over a period of 6 months. The interview will take place in my office, HSC-2J24E, in the McMaster University Health Sciences or in a place that is mutually convenient to you. The interview will be negotiated at a time convenient to you. To begin the interview, you will be asked to reflect on your practice and on morally distressing situations that you perceive to be due to organizational changes.

(3) Additionally, meet with me for 30 minutes for three to five conversation encounters through a face to face or telephone meeting to discuss your day and issues in practice that arise as you deliver patient care. All conversations will be within the 6 month time frame from the start of the study.

(4) Keep journals or chronicles to help you remember important stories or experiences that may be difficult or morally distressing to you and possibly how you may have used reflection as a way to deal with these issues. This is not a mandatory activity but may help you remember issues that you may wish to narrate during the oral history interview.

WHY SHOULD I PARTICIPATE?

Your opinions and stories are very important. It is only the nurses who have undergone organizational change over an extended period of time who can share what it is like to give care in this context. Only you as a nurse who has experienced change over an extended period of time, you can describe your experiences and responses influenced you as a person and as a nurse. Your participation may also inform the development of professional development forums or workshops in your organization that may help future nurses manage change.

ARE THERE ANY BENEFITS TO MY PARTICIPATION?

Many people enjoy the opportunity to tell their story and you may as well. Participation in this research provides an opportunity to tell your story, to reflect and think about your experiences, and to think about future plans. You can choose if you so wish to acknowledge that you participated in this research project as evidence of your reflective practice obligation with the College of Nurses of Ontario. You will be given a $100.00

gift certificate from a local store for participating in this study. You will also be given a free parking pass every time you come for an interview.

ARE THERE RISKS TO MY PARTICIPATION?

There are minimal risks for participating. Privacy and confidentiality will be protected. You will be deciding on the issues we discuss. Your recordings will be transcribed by a professional transcriptionist who is aware of ethical issues in research as well as ethical practices within her/his role. To ensure that there can be no voice recognition, the recording will be erased after I verify the accuracy and precision of the transcripts. All transcripts will be stored in a locked cabinet in my office for ten years. The transcripts will only be seen by my supervisor, thesis committee members, and a possible content expert on narrative analysis. I may choose to consult with a narrative analysis expert who is not part of my committee for the purpose of external checking in the process of completing this study. Your nurse educator who may have suggested your name as a possible candidate for this study or your manager will not be privy to any data or information you offer.

A summary of the findings will be given to you upon your request. Only my research supervisor, my thesis committee and I will be privy to the raw data.

Your anonymity will be respected. In handling your stories delicately, your stories will remain anonymous in the final report with the promise of no identifying data included in the findings. Your stories will not be discussed with anyone else other than amongst my thesis committee members and a possible narrative methodology expert.

In the event, you find that narrating your experience has caused you emotional distress; you will be referred to contact your organization's employee assistance program for counseling.

DO I HAVE TO PARTICIPATE?

No. Your participation in this study is voluntary. You may refuse to answer any questions. You may stop the interview at any time. Neither your organization, nor your employment will be affected, now or in the future.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

If you have questions about your rights as a participant in this study, please feel free to contact my thesis supervisor, Dr. Janet Landeen.

Janet Landeen, PhD, R.N.
McMaster University
School of Nursing
(905) 525-9140 ext. 22709

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THIS STUDY

If you have questions any questions about this study, please feel free to contact me at the address below

Louela Manankil-Rankin, RN
McMaster University
School of Nursing
(905) 525-9140 ext. 22511

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

HHS/FHS Research Ethics Board
293 Wellington Street North, Suite 102
Hamilton ON L8L 8E7
T: 905.521.2100 F: 905.577.8378

CONSENT

I have read the information presented in the information letter about a study being conducted by ……(insert researcher's name(s), of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

_____ _____

Name of Participant Signature of participant

In my opinion, the person who has signed above is agreeing to participate in this study voluntarily, and understands the nature of the study and the consequences of participation in it.

_____

Signature of Researcher or Witness

Appendix D

Exemplar of Moving from Field Texts Through to a Composite Narrative

In this analysis, I describe how I moved from the transcripts/field texts to my co-participant letter that made up the narrative accounts; and into the composite narrative in the form of a composite letter. These movements demonstrate the emerging understanding that became the co-constructed composite narrative. At subsequent interactions with my co-participants over the eight-month period, I clarified and reflected upon issues that were raised in the former interview and conversations. This was a form of member checking that occurred throughout data collection while simultaneously conducting the initial analysis. Working with the field text became the first step in the re-storying process. My process with the story of Alice (one of my co-participant) reveals my movements as a Narrative Inquirer. Alice states,

> To me it's like oh I hate this kind of nursing, I hate it, I want to know I've had the time to give to everybody and do that whole thing. And make them feel good too, [mmm hmm] it's not even just about what I am going to chart on the computer, it's what's going to make them feel good. Like I said do you go a day without a shower, I sure don't, so you've got to, a patient in a bed it's going to feel like crap because you weren't even able to throw a wet facecloth at them, that kind of thing I find has been affected. Though I find I spend the time on the things I, some days spend the time on, I think I need to spend on the important things and hopefully everything gets done that needs to be done as far as if I had to go to court, thank you your honour, I gave the ampicillin, but I didn't wash their toes, you know what I mean…. But I mean I feel like sometimes there's stuff that can get missed when I am running around like that, putting out the fires for different patients.

My Reflections and Thinking

Alice reacts to her personal desire of spending more time with the patient but finds herself unable to at this time because of increased workload. What seems to be affected is her ability to assess comprehensively and to address what matters to her patients as persons. Alice responds to the situation by saying that she hates it. Giving a bed bath is part of her historical past but was a way to assess the patient. She states that there are days that she feels like a fire fighters putting out fires. This suggests to me that she is managing the technicalities of her role and attending to the pressing issues of doctor's orders and basic nursing. She responds with dissatisfaction to her inability to provide humanistic care.

Alice's Co-Participant Letter

As a way to get at the personal practical knowledge of the participant, I used the narrative device of a letter (Ciufettali-Parker, 2011). This part of my analytic process allowed me to 'experience the experience' of my participant, a methodological element in Narrative Inquiry, that is essential in establishing the rigour (Clandinin & Connelly, 2000). This letter was composed from Alice's words and ideas.

> To me it's like oh I hate this kind of nursing. I hate it, I want to know I've had the time to give to everybody and do that whole thing. And make them feel good too. It's not even just about what I am going to chart on the computer, it's what's going to make them feel good. Like I said do you go a day without a shower? I sure don't. A patient in a bed is going to feel like crap because you weren't even able to throw a wet facecloth at them, that kind of thing I find has been affected. I think I need to spend time on the important things and hopefully everything gets done that needs to be done as far as if I had to go to court, thank you your

> honor, I gave the ampicillin, but I didn't wash their toes, you know what I mean… At times, I feel like I am a fire fighter putting out fires all day. This is so contrary to how I feel I should be caring for my patients.

The Composite Letter

The composite letter was constructed from the narrative resonant threads/plotlines that emerged from looking across all my co-participant letters. Using a fictionalized character named Tanya to represent the voice of all my co-participants I constructed a letter to express their perceptions of how they experience living their values amidst organizational change. Once again, the narrative device of a letter allowed me to 'experience the experience' of my co-participants and bring to the foreground their personal/practical knowledge (Clanidinin & Connelly, 2000; Ciufetelli-Parker, 2011). This excerpt of the composite letter is a thread from Alice's experience. My other co-participants also described their experience at the bedside with their patients in a similar way. The last line in italics represents a common experience amongst my co-participants.

> I hate this kind of nursing. I hate it. I want to know that I've had the time to give to everybody the care they deserved and do that whole thing. I also want to make them feel good. It is not even just about what I am going to chart on the computer. It is also what's going to make them feel good. Like I said earlier, do you go a day without a shower? I sure don't! A patient in bed is going to feel like 'crap' and I am not even able to throw a wet facecloth at them? I feel that these practices have been affected. I find that I spend the time on the things that are important in my care and so hopefully everything gets done that needs to, as far as if I have to go to court I can say "thank you your Honour, I gave the ampicillin, but I did not wash their toes". *Sometimes there are things that can get missed when I am running around putting out the fires for different patients.*