EXPERIENCES OF NURSES PROVIDING CARE TO SURVIVORS OF STROKE

EXPLORING THE EXPERIENCES OF NURSES WHO PROVIDE CARE TO SURVIVORS OF STROKE WITHIN A SPECIALIZED STROKE REHABILITATION UNIT

By

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Abstract

The purpose of this hermeneutic phenomenological study was to systematically explore and gain understanding into the perceptions, beliefs, and feelings of nurses who provide care to survivors of stroke within a specialized stroke rehabilitation unit of a tertiary care hospital. From the literature and my experience on the stroke team, there seemed to be poor relationships among the nurses and survivors of stroke, their families, and other stroke team members. A first step in improving team effectiveness and quality of care to survivors of stroke is to improve interpersonal and interdisciplinary communication. As I began to interact more with the nurses and think about their concerns, I realized that I knew very little about their experiences in providing care to individuals following a stroke.

Six themes revealed that these nurses: (1) enjoyed their work; (2) considered their role pivotal to the rehabilitation process; (3) found it difficult to let patients struggle to complete their every day tasks; (4) believed these patients get short-changed in their rehabilitation nursing care; (5) felt others did not appreciate their role in stroke rehabilitation; and yet (6) maintained a positive outlook.

A new literature search produced four sensitizing concepts that reflected (i) the historical roots of nursing within a institutional patriarchal setting; (ii) the stereotyping of nursing as a female-orientated job akin to the role of wife and mother, thus leading to its invisibility; (iii) societal devaluation of those nursing tasks dealing with bodily waste by-products; and (iv) lastly, the combination of all the above factors that stifle the nurses' attempts to gain empowerment and to have more control over their work life. By exploring the nurses' concerns, I hope to create an atmosphere of thoughtfulness that will improve clinical practice within the stroke rehabilitation unit and facilitate the empowerment of the nurses to become equal partners in providing care to individuals following a stroke.

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I would especially like to thank all the nurses who shared their stories with me. I deeply appreciate their willingness to trust me. This journey of discovery has changed me, enhancing my understanding of the experiences of nurses caring for individuals after a stroke. I hope this story will resonate with others, encouraging reflective thought about the expertise of nurses and the important role they play within a stroke rehabilitation team.

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Introduction

The incidence of stroke in Ontario is predicted to increase from a rate of 50,000 individuals per year as our population ages (Heart and Stroke Foundation of Ontario, 2003). In 1989, the World Health Organization (WHO) defined a stroke "as an acute neurological dysfunction of vascular origin with a sudden or at least rapid occurrence of symptoms and signs corresponding to involvement of focal areas of the brain" (p. 1407). The Heart and Stroke Foundation of Ontario (2003) refers to individuals who have had a stroke as "survivors of stroke," a person-sensitive term that many patients prefer. Despite these individuals experiencing the greatest amount of neurological recovery within the first three months following a stroke, they often have difficulties performing their activities of daily living and resuming their previous social roles (Bonita & Beaglehole, 1998; Duncan, Goldstein, Matchar, Divine, & Feussner, 1992).

Characteristics of Individuals Following a Stroke: Part of the Rehabilitation Problem

"No two strokes are alike" is a common response given to individuals and their families as they struggle to understand the consequences of a stroke. This statement reflects the findings of numerous prediction and intervention studies that have documented the diversity within the stroke population (Dombovy, 1993; Teasell, Doherty, Speechley, Foley, & Bhogal, 2002). Depending on the lesion's size and

location, individuals may experience a variety of difficulties following a stroke (Dobkin, 1997).

There are many variables that contribute to the heterogeneous nature of stroke. Lesions that occur in different parts of the brain may cause distinct neurological deficits (Kandel, 1991; Leonard, 1998). To illustrate this point, an infarct within the internal capsule affects the initiation of movement whereas a lesion in the brainstem area often disrupts the balance centre (Kandel, 1991; Leonard, 1998). Even if the site of the stroke is in the same territory (e.g., the middle cerebral artery), the resulting neurological symptoms may vary in the degree of severity (Baxter, 1987). As well, each cerebral hemisphere gives rise to different sensory, motor, cognitive, and emotional behaviours (Teasell et al., 2002). For example, when the right hemisphere is involved, individuals may demonstrate left-sided paresis, visual-spatial perceptual deficits, poor insight and initiation, impulsiveness, and subtle communication and behavioural problems following a stroke (Teasell et al., 2002). On the other hand, left hemisphere involvement may cause patients to experience severe communication deficits, various types of apraxias, depression, and right-sided neuromuscular deficits (Teasell et al., 2002).

Furthermore, various co-morbidities such as diabetes, heart disease, and arthritis may impede motor recovery following a stroke (Agency for Health Care Policy and Research [AHCP&R], 1995). Not only is it difficult to plan an effective treatment for the individual following a stroke but it is also difficult to accurately predict that person's functional recovery and place of discharge (Dombovy, 1993; Oczkowski & Barreca, 1993). Finally, to deal with their various losses after a stroke, individuals may employ

different coping mechanisms such as using physical activity to decrease their frustration, displacing their anger, or taking more risks than usual (Bishop, 1987). Consequently, these individuals often have differing needs and treatment goals following a stroke (AHCP&R, 1995; Zwygart-Stauffacher, Lindquist, & Savik, 2000).

In summary, individuals who have had a stroke present with a myriad of physical, cognitive, sensory, and emotional limitations that may affect the amount of functional recovery they can achieve during the rehabilitation process.

Stroke Rehabilitation

Stroke rehabilitation is an interactive, dynamic, goal-oriented process that helps individuals gain their optimal functional level following a stroke. The focus of rehabilitation is to improve a person's quality of life by promoting maximal independence and reintegration back into the community. Even though hospitals discharge many individuals directly to their homes following a stroke (23 per cent), a large percentage of survivors of stroke admitted to acute care (32 per cent) still required inpatient rehabilitation (Tran, Nadareishvili, Smurawska, Oh, & Norris, 1999).

Stroke rehabilitation teams are comprised of various health professions (e.g., physical medicine, nursing, physical and occupational therapy, psychology, recreational therapy, speech and language pathology, and nutrition). These healthcare providers frequently work as a multidisciplinary team, collaborating on the achievement of common patient goals while at the same time recognizing each other's clinical expertise. There is strong evidence that these types of teams attain better outcomes, such as shorter

stays in hospital and greater change scores on functional measures, for individuals following a stroke as compared to the usual care provided on general medical wards or in the community (Teasell et al., 2002).

However, these multidisciplinary teams have often experienced communication and interpersonal problems (Gibbon, 1995, 1999). For example, nurses were frequently observed to be absent at team conferences (Kneafsey & Long, 2002; Pound & Ebrahim, 2000). Within many rehabilitation units, an "upstairs-downstairs" phenomenon occurred where survivors of stroke practised walking, transferring, and self-care activities with their occupational and physical therapists but did not continue to perform these skills with the nurses (Thorn, 2000). As well, nurses differed from other stroke team members in their expectations about the amount of functional recovery an individual might achieve following a stroke (O'Connor, 2000). Lastly, confusion about the nursing rehabilitation role seemed to contribute to poor team interaction and interprofessional hostilities (Kneafsey & Long, 2002).

My interest in stroke rehabilitation made me wonder whether some of these issues might be germane to our own team dynamics. I initially considered conducting a survey to assess the nurses' knowledge of stroke recovery and explore their attitudes towards individuals who had had a stroke. When I thought more deeply about the issues, however, I changed my initial plans from wanting "to fix the nurses" to wanting to listen to their voices. In the next section, I will share the beginning of this journey into exploring the experiences of nurses including excerpts from the journal I kept throughout this study. These excerpts are followed by the notation (SB, date of the entry).

Journal excerpts: A journey from "fixing the nurses" to listening.

"Despite all our team building exercises over the last fifteen years, we still struggle to bridge the gap between the nurses and the rest of the team. We need to get nurses on board so they are on the same page as the rest of the team—sharing information and giving our patients lots of opportunities to practise their activities of daily living. However, our nurses rarely attend conferences or gait rounds, no matter when we have them. This has led to team frustration" (SB, July 14, 2002).

"First thing I did was a literature search, a natural first step for me from doing quantitative research. From my class readings, I now understand that doing this [a literature review] is somewhat controversial. Some qualitative researchers state that one should not undertake a literature search—that learning about the topic may bias your outlook and ability to "be an open slate" to the developing process. Others suggest that a literature review is acceptable, allowing the researcher to have a broad overview of the existing themes that may be helpful during data analyses. I undertook this process even before I knew I was going to do qualitative research. I did what was familiar to me. I can now understand why the process of reflexivity or being conscious of my values and biases is important. It is possible that I selectively read the material to support my assumptions about nurses and their interactions with survivors of stroke and other stroke team members.

So what did I think hindered a better working relationship between the nurses and the other team members? It seemed to me that the nurses, as compared to the physiotherapists, lacked a foundation of neurological rehabilitation theory that could help them deal better with the heterogeneity found within the stroke population. As I began actually to talk with the nurses on the unit [not just saying "hello"], I sensed that I was heading in the wrong direction. My scanty knowledge about some major nursing theories seemed to help me have a more meaningful dialogue with the nurses. Soon my motivation for conducting this study shifted from wanting 'to fix the nurses' to wanting to understand this complex issue from different standpoints. I realized that the front-line nurses were silent about how they viewed team functioning. It was then I decided to go back to school, enrol in a MSc program, and seek the guidance of experienced qualitative researchers to help me explore this issue" (SB, September 14, 2002).

One of the purposes of reflexivity (Finlay, 2002) was to track my cognitive processes as I began to develop my research question. At the beginning of this project, some individuals questioned my motives in wanting to explore the experiences of nurses and not those of physiotherapists, especially as I worked as a part-time physiotherapist

and research clinician on the stroke rehabilitation unit. My initial response to their concerns came from my assumption that physiotherapists did not seem to experience the same degree of difficulty when interacting with survivors and other team members. However, my thinking changed.

Journal excerpts.

"In a CBC interview, Stephen Lewis commented that resolving issues, whether between two nations, two states, two companies, two teams, or two people begins with the willingness to compromise. This statement resonated deeply with me. I would now respond differently to the initial reactions about my study. I now realize that not only are physios part of the problem, the whole team has a role in it, and I think resolving our issues begins with hearing the nurses' perspectives" (SB, September 21, 2002).

The SARS crisis [2003] made me realize that nurses are front-line professionals who must work under stressful conditions and perform life-saving procedures. And in this situation [the SARS crisis], no one appeared to listen to their assessment of the situation. Although the literature reported that some nurses labelled survivors of stroke as difficult, it also seemed that many patients expected the nurses to do everything for them (i.e., to care for them, an antithesis of the rehabilitation nursing role (SB, February 3, 2003).

By explicating my assumptions, I hope to make transparent my journey of change from initially wanting nurses to complete some type of attitude survey and knowledge quiz to realizing that a qualitative approach, not a quantitative one, was needed. The nursing staff that is comprised of registered nurses (RN) and registered practical nurses (RPN) plays a critical role in the recovery of survivors of stroke, assisting them with their most basic and personal needs. Although the nurses make up, by far, the largest group of health care professionals who work in our own specialized stroke rehabilitation units, we

know very little about their experiences of providing care to individuals who have had a stroke.

Research Question

Qualitative research helps us understand different realities based on the suppositions that (i) it is important to study individuals in their own environment; (ii) beliefs, not facts, form perceptions; and (iii) interpretation, not measurement, is the goal of discovery (Laverty, 2003). As there has been no Canadian research on this topic, I wondered if there were common threads in the lived experiences of nurses and, therefore, proposed to systematically explore and gain understanding into their perceptions, beliefs, and feelings about providing care to survivors of stroke. My question asks "What are the experiences of nurses who provide care to survivors of stroke within a specialized stroke rehabilitation unit located in a tertiary care hospital in southwestern Ontario?"

Rationale

There is enormous pressure on the stroke units to provide efficient and effective rehabilitation that can be measured by meaningful clinical changes, decreased hospital days, and increased financial savings (Heart and Stroke Foundation of Ontario, 2003). To achieve these outcomes, primary care team members must work closely together. Without a doubt, nurses are important members of that team, as survivors of stroke spend most of their time with them. However, past efforts have not produced consistent, successful, and meaningful interpersonal interactions among the nursing staff, the various

allied stroke health professionals, and the survivors of stroke (Gibbon, 1999; Heart and Stroke Foundation of Ontario, 2003; Jones, O'Neill, Waterman, & Woods, 1997; Kirkevold, 1990, 1997; Kneafesy & Long, 2002; O'Connor, 2000, 2002; Pound & Ebrahim, 1997; Secrest, 2002; Thorn, 2000).

As the voices of nurses working with survivors of stroke have not been heard, there is validity in exploring their thoughts, opinions, and concerns. The potential benefits of this study are both social and financial. A first step in improving team effectiveness and quality of care to survivors of stroke is to improve interpersonal and interdisciplinary communication through "hermeneutic phenomenological reflection [that] deepens thought and therefore radicalizes thinking and the acting that flows from it" (van Manen, 2001, p.154) When we better understand the experiences of nurses, we are better able to increase awareness around the role they play in caring for individuals following a stroke. More important, by listening to the voices of nurses, we may capitalize on this deeper understanding to create an increased willingness to change and improve clinical practice within the stroke rehabilitation unit. Rather than teaching specific skills and instituting managerial policies through this study, I hope to foster "thoughtful learning which is at the heart of our pedagogic life" (van Manen, 2001, p. 154). With this rationale, I will present my thesis. Before going into further depth about my methodology, however, I will discuss various nursing theories that may act as a bridge between practice and theory in stroke rehabilitation nursing; between the professional and lay perspective of caring; and I will continue to reveal any suppositions that may consciously or unconsciously influence my research about the topic. After

discussing my choice of methodology—the qualitative tradition of hermeneutic phenomenology—I will present my findings, explore the clinical implications of my research, and finally suggest future directions.

2

Literature Review

The purpose of this review of the literature is threefold: (i) to provide a brief overview of the extant literature from other countries regarding the relationship of nurses with individuals following a stroke; (ii) discuss the concept of caring from a nursing and lay perspective; and (iii) to examine a nursing theoretical framework that may influence how nurses provide care to survivors of stroke.

Potential Theories That May Guide Nurses in Their Treatment Approaches Towards Survivors of Stroke

Although the nursing profession has a rich diversity of historical assessment frameworks that provide a basis for its clinical skills and research, there appears to be a lack of neurological nursing theory (Myco, 1994; Nolan & Nolan, 1998; O'Connor, 2000; Waters & Luker, 1996). In reviewing four potential nursing frameworks for the practice of neurological rehabilitation, Hoeman (1996) concluded that, for a variety of reasons, the King open system model (King, 1971), Neuman system model (Neuman, 1995), Orem self care model (Oren, 1985), and the Roy adaptation model (Roy, 1988) were of limited value.

Does a Lack of Practice Models to Guide Nurses in Their Treatment Approaches Towards Individuals Following a Stroke Affect How the Nursing Role Is Understood?

If a theory or a toolbox has not yet been developed that could assist the nursing staff in how they provide care to an individual following a stroke, perhaps it is not needed. However, a review of the literature would suggest otherwise (Lewinter & Mikkelson, 1995; Lui & Mackenzie, 1999; Nolan & Nolan, 1998; Pound & Ebrahim (2000); Secrest, 2002; Secrest & Thomas, 1999).

For three months, Pound and Ebrahim (2000) observed and compared British nurses working with survivors of stroke in three different clinical settings. They were surprised to find that (i) rehabilitation nursing was not occurring within the stroke units; (ii) nurses did not participate with the stroke team; and lastly, (iii) there was a "lack of warmth towards patients on the stroke unit" (p. 1437). In fact, Pound and Ebrahim questioned whether "better outcomes achieved on stroke units are *despite* rather than *because of* the nursing they receive there" (p. 1437).

Furthermore, survivors of stroke were asked about their rehabilitation experiences and to name staff members who helped them most during the rehabilitation process. Nursing researchers were disconcerted to discover that these patients often failed to mention nurses despite spending most of their time with the nursing staff; instead they often mentioned the positive role that therapists, social workers, and even the cleaning staff played in their recovery (Lewinter & Mikkelson, 1995; Lui & Mackenzie, 1999; Nolan & Nolan, 1998; Secrest, 2002; Secrest & Thomas, 1999). When specifically asked about their interactions with nurses, they characterized nurses as sometimes "kind or nice

but not standing out in their rehabilitative care" (Secrest, 2002, p. 178), while family members painted nurses in a negative light, stating that "nurses didn't know what they were supposed to do and most nurses did not know the stroke survivor" (Secrest, 2002, p. 180).

When O'Connor (2002) asked ninety nurses working in twenty-one stroke units in Great Britain about the type of care they provided to individuals following a stroke, they reported that it was difficult to facilitate the recovery process, especially when they had to choose between letting the client struggle to accomplish a task and doing it themselves. While some nurses denied the importance of their role in retraining the bowel and bladder, monitoring vital signs, and providing basic care in individuals following a stroke (Kirkevold, 1997), other nurses complained about being overworked and unable to offer more than just basic care (Pound & Ebrahim, 1997).

Thorn's (2000) critical review of neurological rehabilitation nursing studies (n=43) found that many articles were of poor quality and did not clarify the role of a rehabilitation nurse. Much of this literature described the role of the nurse as a team manager with very few articles commenting on nursing interventions (Singleton, 2000). Nurses themselves identified the need for more knowledge in order to provide better care to their clients with neurological deficits. As one nurse stated, "we have the skills but don't have the principles" (Dowswell, Forster, Young, Sheard, Wright, & Bagley, 1999, p. 5).

Lastly, nurses expressed concern about the quality of their interprofessional relationships, as they experienced a sense of being disenfranchised from the rest of the

stroke team (Dowswell et al., 1999). In particular, some nurses resented their role as understudies to physical and occupational therapists in which they were expected to follow scripts (Dowswell et al., 1999). The nurses did not see any reciprocity occurring within the stroke team where, for example, the therapists would practise transfers, such as getting clients on and off the toilet in the clients' own rooms, thus freeing up the nurses' time to allow them to do other necessary tasks (Dowswell et al., 1999).

What Other Practice Models Might Guide Nurses in Their Treatment Approaches Towards Individuals Following a Stroke?

A core nursing concept that appears to guide nurses in their treatment approaches is care and caring through the act of nursing.

Concept of Caring From a Nursing Perspective

Although the concept of caring often occurs in the nursing literature, there appears to be considerable diversity about its meaning (Morse, Solberg, Neander, Bottorff, & Johnson, 1990). These researchers identified the following five conceptualizations of caring: (i) caring as a human trait; (ii) caring as a moral imperative; (iii) caring as an affect; (iv) caring as an interpersonal interaction; and (v) caring as an intervention. I will briefly summarize these five major tenets.

Caring as a human trait.

Those theorists who support caring as a human trait were not explicit about what induces nurses, either as a cultural group or as a response to assigned roles within a bureaucratic hospital institution, to care more or in better ways than other healthcare providers (Morse et al., 1990). Other theorists were of the opinion that caring was an integral part of being human (Morse et al., 1990). In particular, nurses demonstrated their bond with others by the genuine way they perform their job.

Caring as a moral imperative.

Brody (1988) espoused another viewpoint, that caring should be considered to be the main virtue of nursing and in this way, morally correct and good. Warelow (1996) argued that this caring ideal is difficult for nurses to maintain in light of health care costs, higher nursing workloads, and increased technology. In fact, he questioned the wisdom of linking caring to moral behaviour as it may result in some nurses feeling that they are not good practitioners if they do not always act in a caring manner.

Caring as an affect.

In this conceptualization, caring has been described as an "emotion, as a feeling of compassion or empathy for the patient that motivates the nurse to provide care for the patient" (Morse et al., 1990, p. 9). The thrust of this notion of caring is that nurses become skilled in showing different forms of caring by viewing the situation from the patient's perspective.

Caring as an interpersonal interaction.

Within this context, caring is viewed as a relationship between the nurses and the patients where mutual elements of trust and reciprocity are demonstrated. Thoughtful and caring actions help the clients cope successfully with a stressful situation, and this success enriches the experiences of the nurses.

Caring as an intervention.

In this light, caring is seen as a restorative intervention, focused on the needs of the patient regardless of how the nurse feels (Morse et al., 1990). Theorists who espouse this concept define caring as a series of tasks where nurses provide information, assist with pain, observe and reassure patients, and advocate for them.

In summary, the nursing concept of caring is complex, with each definition having its own purpose and focus. In an effort to better understand how caring contributes to nursing practice, the four main authors extended their original research; they critically analysed this concept and challenged what appeared to be an unequivocal acceptance of caring as a mainstay feature of nursing (Morse, Bottorff, Neander, & Solberg, 1991).

The selected characteristics of caring were formulated into a matrix to answer the following four questions: Is caring unique to nursing? Does the caring intent of nursing vary between patients? Can caring be reduced to behavioural tasks? Does the outcome of the caring affect the patient, the nurse or both the patient and the nurse? Morse and her colleagues (1991) concluded that the concept of caring remained poorly developed, as

caring seemed to mean something different to nurses who practised in different clinical settings. None of the four questions could be answered conclusively from the analyses of the twenty-three studies included in the review. This debate continues today, with Tarlier (2004) proposing that "the focus on care has been at the expense of understanding the true nature of the relationships between caring and the broader base of ethical knowledge that underpins nursing" (p. 230). For this reason, I decided to refrain from defining care and caring, but instead let the nurses who provide care to survivors of stroke tell me what this concept means to them.

A Framework for Rehabilitation Nursing: Kirkevold's "Unified Theoretical Perspective"

Before exploring the experiences of nurses who provide care to individuals who are admitted to a stroke rehabilitation unit of a tertiary care hospital in southwestern Ontario, I would like to outline a theory of rehabilitation nursing proposed by Marit Kirkevold, a Norwegian researcher. Although this framework has not been used in North America, Kirkevold (1997) recognized that traditional nursing care, which places the emphasis on the nurses doing things for their patients, conflicted with commonly accepted rehabilitation goals that focused on the clients taking an active role in learning how to accomplish their tasks of everyday living.

From the literature, her fieldwork, and ensuing qualitative analyses, Kirkevold (1997) distilled four key nursing functions that combine caring behaviour and

neurological principles. These functions make up Kirkevold's Unified Theoretical Perspective.

Interpretive function.

In this capacity, the nurse conveys information to survivors and their families. Kirkevold (1997) stressed the importance of nurses providing a realistic picture of the deficits caused by the stroke and the potential areas of functional improvement. Because of the suddenness of a stroke, clients and families need to adjust to this devastating event as soon as possible. The interpretive function makes nurses responsible for obtaining accurate information about their clients, being knowledgeable about prognostic indicators, and working closely with other team members so as to better inform survivors and their families.

Consoling function.

In this role, nurses demonstrate their caring. There is no doubt that survivors of stroke grieve the sudden loss of physical mobility and their roles within their families and society. As approximately 50 per cent of survivors of stroke are diagnosed with clinical depression following a stroke (Teasell et al., 2002), nurses have an important role in helping them deal emotionally with the consequences of the stroke.

Conserving function.

Performance of this function involves more than nurses giving basic care. The prevention of complications that may arise from poor hygiene, bowel and bladder problems, mobility limitations, and swallowing difficulties are essential aspects of rehabilitation nursing. Kirkevold (1997) previously found that nurses tended to devalue this type of care. In fact, without bowel and bladder control, many survivors of stroke are unable to return home (Oczkowski & Barreca, 1993).

Integrative function.

The integrative function of the nurse is the one most closely aligned with rehabilitation. It involves the nurse providing opportunities for motor learning in a variety of circumstances. Rather than feeling they are understudies for physical and occupational therapists, nurses rehearse the client's new skills in real life situations. As well, the nurse assists patients in regaining their basic social functions and roles.

Empirical Support for Kirkevold's Unified Theoretical Perspective

From the Culminative Index of Nursing and Allied Health Literature (CINAHL) database (1989–95), Kirkevold found 605 nursing intervention studies. From this search 53 articles were found to be relevant, of which 22 were of poor quality. Of the remaining 31 articles, 11 studies supported conserving nursing functions while the other 20 substantiated the consoling and interpretive activities of nurses. Given nurses' past complaints about being understudies to physical and occupational therapists, Kirkevold

(1997) found it ironic that no research was published on the ways in which nurses help survivors of stroke incorporate new and relearned skills into their daily lives.

O'Connor (2000) furthered the research in this area by interviewing 90 nurses from 21 stroke units to find out what they felt their role should be within the rehabilitation model. O'Connor (2000) added to Kirkevold's theory by categorizing the delivery of nursing care into two additional modes: facilitative interventions and the process of non-intervention.

Facilitative interventions.

O'Connor stated that it was not enough for nurses to be positive about potential recovery for an individual following a stroke but that they must demonstrate their attitude in what they do. In other words, O'Connor (2000) saw the role of nurses as facilitators where they decide how much assistance they will offer, based on their observations and knowledge about a client. Rather than doing everything for the individual who has had a stroke, the nurses use their clinical judgment to encourage the person to participate in multiple opportunities to practise various tasks.

Nonintervention process.

This process is closely allied to the facilitative interventions. In this function, nurses use their clinical judgment in knowing when to assist, when to supervise, and when to let the client do the task independently. Because these individuals are a heterogeneous group, O'Connor (2000) concluded that finding this balance between

facilitation and non-intervention represents a problem for nurses. Nurses needed to know when to assist patients and by how much—so that the facilitation action becomes therapeutic—and when to withhold assistance altogether.

In summary, Kirkevold's theory clearly describes different aspects of the nursing role within a rehabilitation setting. By articulating neurological treatment principles for nurses, it offers guidelines as to how nurses might improve the functional recovery of individuals following a stroke. Although the addition of O'Connor's (2000) work expanded the original model, there has been a lack of research to test this conceptual framework's predictive ability.

Lay Perspective of Caring

In writing about care and caring, van Manen (2002a) changed his traditional approach and abstained from including various literary passages to explicate their conceptual meanings. He maintained that these concepts, care and caring, are so embedded in our everyday lives that there is a danger of distorting their real meaning by analysing the language or drawing inferences from available novels. For example, in tracing the etymological history of the word "care," van Manen (2002a) found it described as "mental suffering, sorrow, grief, trouble," and "burdened state of mind arising from fear, doubt, or concern about anything" (pp. 6–7). He found it curious that the idea of care as worry did not appear in any of the definitions generated by Morse and her colleagues (1990, 1991), although solicitude and concern seem to be related notions. If the term "caring" is heavily dependent upon context for its meaning (e.g., caring for a

child differs from the nursing usage of the word as it does from advertisements for lawn care), it made little sense to van Manen (2002a) to determine if there was a core meaning to caring.

In a similar vein, Frank (1991) reflected on what it is like as a person to become critically ill and receive care. In a chapter of his book entitled "Care has no recipe," Frank wrote that care had to be individualized, as the fears of one person differed from those of another. According to Frank (1991) "*care* begins when differences are recognized" (p. 45), an action that requires time to learn what each individual wants, needs, or fears as compared to *treatment* where everyone is managed in the same way.

Using a grounded theory approach, Attree (2001) explored the perceptions of patients and their relatives about what constituted quality care. Her work supports Frank's personal observations that quality care, when focused on the individual person's real and anticipated needs and delivered through a close and supportive relationship, led patients to express feelings of being cared for by the nurses. On the other hand, Attree (2001) found that standardized, routine protocols performed in an unthinking manner made patients feel that they were not being treated as people. Again, it would appear that the lay perception of caring rests on what the patients identify as important to them.

Williams (1998) concluded that patient and healthcare professionals view quality nursing care differently. While hospitals stress efficiency through care maps, standardized care plans, and critical paths, their patient satisfaction surveys often failed to measure the things the patients valued most (i.e., that their viewpoints were validated so they felt safer, comforted, and mentally better able to cope with their illnesses).

From the study by Sherwood (1993) of patients' responses to nursing care, eight major themes emerged. Patients expressed feelings of being cared for when nurses (i) helped them maintain a positive mental attitude, (ii) assisted them towards recovery, and provided (iii) a sense of protection, (iv) physical comfort, and (v) reassurance. As well, the daily interactions between the nurses and the patients needed to echo elements of (vi) mutual trust, (vii) the acceptance of patients as people, and a (viii) caring nursing attitude. Rieman's (1998) phenomenological study supported Sherwood's findings, determining that not only was the physical assistance nurses provided to their clients important but also nurses' willingness to sit down and listen to that person's concerns.

A review by Hafsteindottir and Grypdonck (1997) described the physiological and psychosocial experiences of individuals following a stroke. These survivors struggled to overcome tiredness, conserve their energy, recapture their functional abilities, and emotionally deal with the numerous losses in their social roles. More important, the results of four qualitative studies showed that survivors of stroke often had clear goals by which they measured their progress in rehabilitation, and that these goals differed greatly from those of the healthcare providers (Hafsteindottir & Grypdonck, 1997). Jones and her colleagues (1997) surmised that survivors might expect nurses to do everything for them so that they could get to their therapy in a timely fashion. In this way, they could conserve their energy. In fact, some nurses expressed difficulty in performing a therapeutic role because survivors perceived nurses to be uncaring if they let them struggle to become independent (Hill & Johnson, 1999; O'Connor, 2000).

In summary, caring from both a professional and lay perspective appears difficult to conceptualize. Caring seems to take on different meanings depending upon the context in which care is given and received. As noted previously, I did not define the concept of care, but let the nurses describe in their own words what it meant to them to provide care to individuals following a stroke.

Before articulating my methodology for this study, I completed an exercise whereby I wrote about my experience as a physiotherapist in providing care to a survivor of stroke. This action is recommended as part of phenomenological writing. The researcher pursues the pre-reflective meaning of the phenomenon through a continual interplay of collecting and analysing data, writing, and thinking about the material and one's assumptions (van Manen, 2002b).

What Does It Mean to Me, as a Physiotherapist on the Stroke Team, to Provide Care to a Survivor of Stroke?

Journal excerpt.

"At 3 o'clock each day, I see Nora for physiotherapy. Nora is a seventy-two-year-old former emergency room head nurse who experienced a massive infarct in the pontine area of her brain. This type of stroke left her in a locked in state for several months. Although Nora was aware of her surroundings, she was unable to move any of her limbs. She was placed in a chronic care facility but when she began to show some signs of improvement, her family advocated for her to have a chance at rehabilitation.

Because of her severe dysarthria and drooling, Nora is difficult to understand. She has marked spasticity in all her limbs and from a therapist perspective, represents heavy care (i.e., she is difficult to transfer, heavy to lift, and limited in her potential to perform functional activities such as standing, walking, or dressing independently). At the end of the day, I am sometimes very tired and dread the hard work she requires. Worse still, she unintentionally sprays me with spit numerous times each day. She laughs and cries

without reason, so you have to be patient. But when she is focused, she works hard at whatever you try with her—you can see what it means to her mirrored in her big, brown eyes that watch your every move. I then don't see her as work but as a person who retired as a nurse and who is still a wife with a supportive husband, a mother of three interested daughters, and a grandmother. She is now extremely vulnerable. I treat her as I would like to be treated—giving her choices about her therapy, challenging her abilities to stand and move, teaching her family how to transfer her with a sliding board, and most important, attempting to lessen her pain.

As I approached her the other day, she started to wail. It took me a long time to settle her down, trying to find out what was wrong, if she was in pain. Finally, she stopped crying and told me I was kind. I was touched by her comment and teased her that she still had to do her exercises. I hope I don't ever lose my compassion for others" (SB, November, 2004).

What Would Nurses Say About Their Experiences in Providing Care to This Individual?

To me, the role of the nurse in assisting Nora is even more challenging than mine. Intensive nursing care must be provided to her on a twenty-four hour, seven day a week basis, encompassing bowel and bladder retraining, keeping her clean, feeding her and ensuring proper swallowing, watching for choking episodes, dealing with her lability, giving emotional support, supervising her medication, teaching her how to dress, bathing her, transferring her to and from the bed and the toilet, and interacting with an articulate and demanding family. I do not know how they would describe their experiences. I feel like a photographer who has been handed someone else's negative to develop. Waiting to hear the voices of the nurses is similar to waiting for the picture to be developed. Just as I have no idea what the picture is, I also do not know what nurses will say.

My ideas about history, documents, trials, and personal stories have changed as realize that "truth is in the telling of the story" (SB, November 6, 2003). I have come to

appreciate that our experiences, beliefs, and expectations filter our perceptions. When I reflect on who I am as a qualitative researcher, I would say that I am more aware of my presuppositions. In doing reflexive practice, I use a dictionary to help me decide if a word I want to use reflects what I am trying to say. In thinking about the word "bias," I found it defined as "a presupposition or prejudice or the edge cut obliquely across the weave of the fabric" (*Oxford American Desk Dictionary*, 1998). When I read the last connotation of the word, I thought that it made a good metaphor for my role as a qualitative researcher. I would like to become an investigator who "does not let her biases cut across the narratives of the participants" (SB, October 15, 2003). In other words, I want to be an instrument for reflecting the words of nurses, without tearing the fabric of their stories.

3

Methodology

This chapter will provide an understanding of how the study was conducted. As hermeneutic phenomenology guided this research, I will present an overview of its philosophical underpinnings. In addition, the setting and the participants will be described fully, including the way in which I gained access to the nurses, how they were selected, the interview process, any ethical considerations that arose during the data collection process, and the various processes that were used to provide some structure to the vast amount of data.

Journal excerpt.

"In wanting to understand what it means for a nurse to provide care to a person who has had a stroke, I can see how language can get in the way. From my initial readings, even the word "care" is fraught with multiple meanings. This appears to be a process like developing a picture where I take a snap shot (my interest, my perspective) that may differ from how another person might arrange the shot. The end result (picture in hand) is developed through a continual interactive process over time. How does this happen? The paper is placed in the developing solution where you see the wisp of something. This is where I am right now in this qualitative process! Then as you add the chemicals (further questions and analyses and more questions), the picture ceases to be a fuzzy, barely visible outline. Just as the photo is enriched by vibrant colours to become clear and distinct, in a similar way I hope that my continual striving to analyse, interpret, reflect, and write will result in a study that gets a 'phenomenological nod' from others." (SB, September 20, 2002)

Research Tradition

Although different qualitative approaches could be used to explore the nature of nurses' experiences providing care to survivors of stroke within a rehabilitation setting, I

believe that a hermeneutic phenomenological approach is most appropriate (Streubert & Carpenter, 1999). Hermeneutic phenomenology, with its holistic perspective that is grounded in the nature of human experiences, has been valuable in investigating similar phenomena that have shown to be important to nursing practice; for example, researchers have explored the experiences of pregnant women and of persons with diabetes or dementia (Giarranto, 2003; Hansebo & Kihlgren, 2001; Matwa, Chabeli, & Levitt, 2003).

While traditional phenomenology focuses on describing the lived experiences of human phenomena, hermeneutic phenomenology focuses on the interpretation of the experience (van Manen, 2001). This paradigm or set of basic beliefs has its roots in the works of Martin Heidegger and Hans-Georg Gadamer and more recently, Patricia Benner and Max van Manen (Conroy, 2003). The hermeneutic process refers to the way people make sense of all their experiences that come from being interconnected to other individuals, objects, events, and places. According to van Manen (2001), the aim of hermeneutic phenomenology is to gain "a fuller grasp of what it means to be in the world as a man, a woman, a child, taking into account the socio-cultural and the historical traditions that have given meaning to our ways of being in the world" (p. 22).

Some researchers utilize this methodology (hermeneutic phenomenological approach) to answer ontological and epistemological inquiries about our being. While ontological questions probe the nature of reality, the epistemological question explores the relationship between the person who wants to become acquainted with the experience and what can be known about it (Guba & Lincoln, 1994). Three basic beliefs underlie this methodology. The first belief maintains that there are multiple realities that are construed

from people's life experiences. In other words, reality is viewed as "complex, contextual, constructed and ultimately subjective" (Thorne, Kirkham, & 0'Flynn-Magee, 2004, p. 2). Second, as there is no *real* reality but instead an interactive dynamic link between the researcher and the participants that helps reveal the meaning of the phenomenon over the course of the exploration (Guba & Lincoln, 1994). Third, meaning emerges through an interpretation of the data (Conroy, 2003). Researchers who employ this philosophical framework believe that no single established theory could encompass the multiple realities, but instead, understanding of the experience comes with reflective thinking of both the researcher and the participants (Wilson & Hutchinson, 1991).

Hermeneutic phenomenology attempts to interpret the experience through a text. Language, culture, and history all play a role in the naming of these experiences; in other words, our pre-existing values and ways of seeing the world help us interpret it, often when we are unaware of them (Willis, 2001). I agree with those qualitative researchers who believe that narratives are never purely descriptive but are hidden by language (Benner, 1994; Conroy, 2003; van Manen, 2001). In this way, the stories are continually reinterpreted, initially when the participants try to describe their experience in words, next when the researcher listens to the story and then tries to capture its meaning in writing, and finally when it is read for its meaning. As our prior understandings may shape the interpretive process (Conroy, 2003), I decided to use this framework in my approach to analysing the narratives.

In order to reveal the common shared practices of the experience, it is important for researchers to (i) think intensely about the phenomenon, questioning its fundamental

structure; (ii) investigate experiences as they are lived rather than as we conceptualize them; (iii) reflect on the essential themes that distinguish the phenomenon; (iv) provide deep and rich descriptions of the phenomenon through writing and rewriting; (v) remain committed to the quest for meaning; and (vi) interpret the text by balancing the personal narratives that are positioned in the foreground against an elusive, socially constructed background (van Manen, 2001).

As interpretive processes become shaped by our previous experiences (Laverty, 2003; Moule, 2002), it becomes important to attend to the undertones of language when conducting a hermeneutic analysis. From the various readings, I realized that sayings, expressions, idiomatic phases, and metaphors might be helpful sources of phenomenological meaning; these analytic devices might assist in piercing my filter mechanism in order to perceive things in a new way (van Manen, 2002a). The idea of incorporating metaphors as part of my data analyses came to me while reading van Manen, *Researching Lived Experiences* (2001). The following sentence acted as the catalyst: "By way of metaphor, language can take us beyond the content of the metaphor towards the original region where language speaks through silence" (p. 49). The metaphor embraces the expressive, evocative, and poetic elements of language (Van der Zalm, 2000). The word "metaphor," comes from the Greek word, *metaphora*, which is derived from *meta*, meaning "over" and *pherein*, "to carry" (Hawkes, 1972). It is one of the most basic forms of figurative language where aspects of one object or idea are carried over or applied to another, suggesting a likeness between them (Hawkes, 1972). A modern perspective on the utility of the metaphor extends the idea that metaphors create

reality for us; however, "it is not a new reality so much as the reinforcement and restatement of an older one which our total way of life presupposes" (Hawkes, 1972, p. 91).

Different types of data allow the analyst not only to triangulate the material but also to analyse it from different sources of expression, mirroring the multi-dimensional aspects of the human experience (Deacon, 2000). For example, when participants are asked to generate a metaphor, they immediately use their imagination to assist in this reflective process. Cade (1982) referred to this type of creative task as leaving established mindsets to think about the topic in a different way. Although I had not previously conceptualized how nurse-generated metaphors might inform my analysis, my coursework provided three directions, namely, to (i) reach some level of pre-reflective thinking; (ii) act as a link to emerging themes or concepts; and (iii) generate new ideas.

In summary, hermeneutical principles seek to understand the world of participants through an immersion in their world; to draw out what is hidden within the narrative accounts; and constantly to search for misunderstandings and deeper understandings through reflective practice and writing (Conroy, 2003). Not only are the shared lived experiences of nurses the best source of knowledge about how they provide care to individuals following a stroke, but also hermeneutic phenomenology appears to be an appropriate methodology to understand their experiences (Van der Zalm, 2000; van Manen, 2001).

Setting

Although there are two local stroke rehabilitation units in this tertiary hospital located in southwestern Ontario, the study took place at the site that employed the researcher. This unit, consisting of fourteen beds allotted to survivors of stroke and fourteen beds designated for individuals with spinal cord injuries, has a staffing model of one registered nurse (RN) to every two registered practical nurses (RPN).

Sampling and Recruitment

A purposive homogenous sample was sought so there would be common threads of the experience that could be described in detail and vividness (Morse, 1994). Nurses were approached to volunteer for the study who worked on the specific unit that admitted survivors of stroke. Sampling continued until no new themes or categories emerged and emerging interpretations appeared visible and clear (Morse, 1991).

Participants

An information letter (Appendix 1) was sent to the full-time and part-time nursing staff (n = 67) who worked with persons with a primary diagnosis of stroke. This mailing included RNs who were either degree or diploma prepared and RPNs. The nurses were invited to participate in the study and were given a consent form (Appendix 2) to sign before any interview took place. In particular, the number of RNs and RPNs was

selected to purposefully reflect the approximate ratio of four RNs to eight RPNs that is currently in place on the stroke unit.

The initial mailing for volunteers, however, only garnered one participant, who informed me that the other nurses were apprehensive to be interviewed, as their conversations would be tape-recorded. After consulting with my thesis supervisor, I organized an informal session with eight nurses on the unit where I had an opportunity to reassure them that the transcripts would be kept confidential and more important, their anonymity assured.

Journal excerpt.

"Casey (pseudonym applied) met me in the parking lot this morning and informed me that the nurses were throwing my information letter in the garbage. She said 'they didn't want to participate because they didn't want to be recorded.' I felt ill—after all this work, going back to school, doing a thesis, and then to find out that the nurses did not want to participate.

Finally, for the first time in the last two weeks, I am feeling better about this project. Today I met one of the nurses on the stairwell who started telling me about the cutbacks to the nurses on the ward, the transfer of ABI (acquired brain injury) patients to another ward, and how the nurses were feeling. It was an opportune time to mention my desire to help the nurses have their voices heard. She agreed that something had to happen, as they had been working very hard to get good nursing on the floor, and when finally everything was going well, management up and changes it, without any consultation with the staff. We decided to have an information session about the study on Wednesday afternoon.

At first there was only one nurse, with the other nurses walking by and glancing in. I was getting a little apprehensive but decided to chill and see what would happen. Within ten minutes, there were eight nurses sitting around the table. Their biggest concerns were the questions and how to prepare for them. When I reassured them that I was only interested in hearing about their experiences and was not going to quiz them on motor recovery in stroke, they visibly relaxed. I also stressed the importance of confidentiality and how as a researcher, I must uphold the requirements placed on me by

the Research Ethics Board (REB). They wanted to know how I would share the results. I told them that I would hold a series of lunchtime meetings, give a copy of my thesis to management, and publish a paper in a peer-reviewed journal. They talked about how things get misinterpreted by other health care professionals when they hear the nurses talking among themselves. They felt they needed to let off steam and that sometimes their words were misconstrued. They asked 'what was the purpose of the study?' I told them that I wanted to create a greater awareness amongst the team about how nurses provided care. The group thought this was good and would help other nurses as well." (SB, May 7–19, 2004).

Ethical Considerations

I was aware that my dual position as employee and researcher might either affect the comfort level or the expectations of the participants or change the type of information that would be reported. For these reasons, I interviewed only those participants with whom I did not have a direct working relationship; during the months we were conducting the interviews, I refrained from interviewing those nurses who were providing care to patients assigned to my caseload. Some researchers feel that an insider who is familiar with an institution, its culture, and the people may be more successful in gathering meaningful data as long as that person is not in a position of power over the participants (Acker, 2000; Banks, 1998; Coghlan & Casey, 2002). However, for this study, the interviewing was shared between the researcher and another experienced qualitative interviewer who was employed to interview those nurses who worked directly with me. The additional interviewer was an occupational therapist completing her PhD.

Prior to the interviews, the study was submitted to the institution's Research Ethics Board for approval. As the length of time to complete the study was longer than

the original time frame, an extension of ethics approval was requested and received. In addition, the transcriber and the hired interviewer were asked to sign confidentiality agreements (Appendix 5).

Data Collection Procedures

Prior to the commencement of the study, the researcher and the hired interviewer extensively discussed the study objectives and interviewing techniques. To lessen the possibilities of directing the interviews, the number of pre-determined questions was limited. Instead, the interviewers used active empathetic listening skills that include silence, patience, reflexive thinking, and follow-up conversational probes to help the participants activate new thoughts about the phenomenon (van Manen, 2001). Moreover, to help build rapport with the participants, an interview guide was used, consisting of open-ended, broad statements and questions that were intended to encourage the participants to express their experiences in their own words (Appendix 3).

The interviewers conducted a series of in-depth, individual, tape-recorded interviews (lasting one to two hours) in settings selected by the participants. During these conversations, the interviewers were keen observers and kept field notes of gestures, physical expressions, and voice emphasis that were incorporated alongside the transcribed texts (van Manen, 2001). Guidelines given to the secretary outlined how to transcribe the interviews (Appendix 6). In order to guard against the loss of data, all files were electronically duplicated. To ensure the accuracy of the transcripts, I listened to each tape while reading the typed interviews. The data were managed using Microsoft

Word 2000 with the transcripts and notes organized in such a way that the data were easily retrieved, linked, and separated.

According to van Manen (2001), data may come from a variety of sources. In addition to the raw data and field notes, the researcher and the interviewer also recorded their reflexive thinking. Whereas some researchers in descriptive phenomenology adhere to the concept of bracketing or suspending one's beliefs (Finlay, 2002), van Manen (2001) maintained that researchers cannot transform themselves into blank slates, for their suppositions are what got them interested in exploring the phenomenon in the first place. Instead, I tried to explicate my assumptions in my journal and to remain mindful of them throughout the different phases of the study (Streubert & Carpenter, 1999). In my journal, I recorded decisions, questions, and ideas during the study as part of an audit trail. As colloquial phrases used by the participants are often "born out of lived experience" (van Manen, 2001, p. 60) and may provide clues to the original experience, I paid special attention to their root origins. In an additional effort to capture a sense of pre-reflective thinking, the participants were asked to try to generate a metaphor by completing the following sentence: "Providing care to survivors of stroke is like ..." (van Manen, 2001; Appendix 3).

Although data collection and analyses have been separated into two sections, a hermeneutic phenomenological approach sees them as part of an iterative process (Miller & Crabtree, 1999). In other words, collecting information becomes an occasion for reflection where the researcher continues to search for the meaning of the phenomenon.

Approach to Data Analysis

Savage (2000) maintained that different approaches to analysing the data may not, in fact, lead to fundamentally different interpretations but rather to different emphases on the meaning of the narratives. Qualitative analyses frequently involve defining the concepts, mapping the dynamics of the phenomena, creating typologies, finding associations between the themes, and seeking understanding (Ritchie & Spencer, 1994). Furthermore, "piecing together the overall picture is not simply a question of aggregating patterns, but of weighing up the salience and dynamics of the issues" (Ritchie & Spencer, 1994, p. 186).

Interpretation is a complex and dynamic craft where the researcher enters an iterative process that involves describing, organizing, connecting, corroborating, and representing the account (Miller & Crabtree, 1999). I will briefly refer to the different phases and articulate my choice of analytic procedures.

Describing.

In this process, the researcher practices reflexivity by being mindful of the selected paradigm and whether the collection methods and the proposed analytic approach remain cohesive. The analyst needs to think about (i) how the data collection process may change earlier assumptions and (ii) how language and culture shape ongoing interpretations. From the beginning of this project, I wrote down my thoughts and questions in an electronic journal. I kept track of the changes in my suppositions and in a graduate seminar presented my transformation from a quantitative to a qualitative stance.

Organizing.

Three basic organizing formats appear to be commonly used in qualitative research. In the template style, the analyst uses a code manual or template as an organizational structure to enter into the text and then identifies passages for further analysis. The editing organizing style, which is commonly incorporated in hermeneutic phenomenology, uses a slightly different approach. In this format, the researcher first enters into the text and then begins to divide out those sections that seem to be most pertinent to the research question. The codebook is developed after the entry into the text and results from the researcher's continual interaction with the narratives. I decided to use this format. The third style, referred to as immersion/crystallization, relies heavily on intuition. It is similar to the holistic method where the reader makes a Gestalt judgment about the overall meaning of the text. Although one reader's interpretation is as valid as another's, there is a "greater possibility to err and to see meaning that is idiosyncratic" (van Manen, 2001, p. 94); therefore, I did not use this particular method.

Connecting.

In this phase, making sense of the data goes to a new level. Through constant immersion in the material, the researcher discovers significant statements that are then grouped into various categories and linked to themes and patterns (Lord, Schnarr, & Hutchison, 1987). Various techniques such as matrices, diagrams, and maps may help display the information and suggest new connections. In brief, themes are described as

being, at best, a simplification of the purpose of the story (van Manen, 2001). I used a variety of techniques that included counting, matrices, and searching for examples of metaphorical language to help discover salient themes.

Collaborating.

This process is closely linked to efforts to see if an interpretation has "a ring of truth" about it, rather than representing "the truth" (Thorne, Kirkham, & O'Flynn-Magee, 2004). Here, the analyst revisits the text in order to search for alternative explanations, disconfirming evidence, and negative cases. Although member checking is one way to check the trustworthiness of the data, some analysts maintain that returning to the participants creates another set of problems, especially if they disagree with their original statements (Eakin & Mykhalovskiy, 2003; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998). Instead, I hope the methodological rigour of my study will be demonstrated by (i) an audit trail of the raw data, the analyses, and my ongoing reflexivity; (ii) a search for indices of saturation; (iii) filling a gap in knowledge by the clinical relevance of the study; (iv) vivid, thick descriptions of the phenomenon; and (v) having my thesis committee members act as external reviewers.

Representing the account.

Sharing my findings is the final phase of the interpretative process. Writing involves an audience, and as this project is part of my MSc thesis, I am writing with my

committee members in mind. I will continue to write and rewrite the findings of this study until my thesis committee feels that the essence of the phenomenon has been captured. I hope my writing will be sensitive to (i) the subtleness and undertones of the language used by the participants; (ii) the etymological origins of significant colloquial phrases; (iii) the interrelatedness of the themes; and (iv) the issues that appear to hide themselves by not appearing in the participants' narratives (van Manen, 2001). This phase of the study (i.e., writing my thesis) is still a continuation of the process of reflection, data gathering, and analyses. Relevant phenomenological philosophies, social psychology and neurological rehabilitation nursing theories, and root derivatives of words will be used to assist in the interpretative process.

Procedures

Thematic analysis began with the data from the first two participants where the two interviewers began to sense the overall richness, depth, and diversity of the data. During this initial stage, the process of abstraction and conceptualization was started. We compared our initial codes and reflections about the narratives, continuing this procedure for the next four interviews. I read all the transcripts many times in an effort to detect any patterning of particular views or experiences.

A coding procedure was employed to identify sections of the material that fell under broad topics. According to Miles and Huberman (1994), codes in the text are "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study" (p. 56). The codes were continually modified and refined until

I felt that they captured the major concepts that would help explain the phenomenon (Appendix 7). The final codes were as follows: (i) positive feelings; (ii) negative feelings; (iii) feelings of frustration; (iv) problems arising from providing care to individuals following a stroke; (v) problems interacting with the family members of survivors of stroke; (vi) problems arising from relationships with other team members; (vii) problems related to the administration of the stroke unit (viii) other problems; (ix) strategies to deal with problems; (v) how nurses feel survivors of stroke perceive them; (xi) how nurses perceive their role on the stroke unit; (xii) nursing perceptions of survivors of stroke; (xiii) values and beliefs; (xiv) determinants of patient outcomes; and (xv) research ideas.

In doing a thematic analysis, I continually searched for significant statements, phrases, or words that could be found in the texts. These findings were summarized using *in vivo* coding that identified the actual persistent words or phrases used by the participants (Addison, 1999) and placed into categories. In analysing the data, I repeatedly asked myself "what's the story here?" Themes were selected when all or almost all the nurses commented on the topic, when the majority of the nurses commented on the topic numerous times, and when removing the theme diminished the overall sense of the interviews. Text excerpts that were generally typical of the interviews were carefully selected to support the themes; I consciously tried to avoid choosing "hot bits" of narrative that could possibly lead to distortion and misinterpretation. The identified themes were first discussed with my supervisor and then amongst the thesis committee members until there was agreement that enough material had been collected.

In summary, I tried to be flexible in my thinking and sought critical feedback

from my various professors and thesis committee members. As I am not a nurse and have not lived the experiences that are being studied, I used a line-by-line approach to examine the data. Using an editing style of coding found in other healthcare studies (Addison, 1999), I continually searched for patterns and connections. Piecing together the overall picture was not simply a question of combining the patterns or themes, but thinking about the salient aspects of the various issues (Ritchie & Spencer, 1994). In determining the invariant quality of a theme, I followed van Manen's (2001) protocol, asking if the phenomenon would be the same if I imaginatively deleted or changed a theme.

4

Results

In this chapter, I will (i) outline the demographic characteristics of the nurses who participated in the interviews; and (ii) provide thick, rich descriptions from the participants' narratives to illuminate the ensuing themes.

Journal Excerpt.

"Reviewing the literature made me aware that some nurses found it difficult to let survivors of stroke struggle to accomplish a task, for example, putting on their socks, while others gained satisfaction in teaching these individuals how to adjust to the many changes that occur after a stroke. Nurses often attributed the challenges of rehabilitation nursing to a lack of time.

I wonder if similar themes will emerge from my data. How do the nurses feel about shedding their traditional role as care providers, a role where they did everything for their clients? How do they handle conflicts arising from two competing paradigms of providing nursing care ('rehab nurse versus care provider')? Will the issue of time be raised? If similar themes do emerge, I hope I can extend my analyses further in order to better understand the experiences of nurses providing care to survivors of stroke.

Conscious of my assumptions as a physiotherapist working on the stroke team and mindful of not having lived the experience, I am going to use a detailed line-by-line approach to code the material. Hopefully this technique will keep me immersed in the text and help me develop the themes in a systematic and vigilant manner. My worries are similar to those expressed by Caelli (2001); what if I, as a neophyte researcher, get it wrong when I begin to generate codes and themes from the narratives" (SB, October 21, 2004)?

Participants' Characteristics

Table 1. Demographic information of the nurses interviewed

Participant	Education	Work status
Loren	RN	Full-time
Kendal	RN	Full-time
Leslie	RN	Part-time
Carey	RPN	Full-time
Regan	RPN	Part-time
Casey	RPN	Full-time
Britt	RPN	Full-time
Andrea	RPN	Part-time

The three RNs, with an average age of 52, had worked an average of 28.3 years with an average of 19.6 years specifically on the stroke unit. The five RPNs, with an average age of 48, had less work experience overall. They worked an average of 19.4 years with an average of 12.3 years specifically on the stroke unit. I have used pseudonyms to protect the identities of the nurses while still naming them to allow their presence to be felt.

Six Themes

Theme 1: Nurses enjoy providing care to survivors of stroke.

In contrast to the literature (Hill & Johnson, 1999; Kirkevold, 1990) that often portrayed the nursing staff as having mixed attitudes towards individuals who have had a stroke (i.e., rewarding but requiring heavy nursing care), all the nurses talked about how much they enjoyed working with this patient population. The nurses felt they formed deep, supportive, and therapeutic relationships with their patients and their families. Helping individuals deal with the consequences of a stroke allowed the nurses opportunities to comfort and reassure their patients, two important aspects of being a nurse. As well, their knowledge about stroke recovery enabled them to communicate timely and meaningful information to their patients.

"Yes, I can tell that you do get a lot of joy out of, cause, when you get the patient, they're so frightened, most of them are so frightened when they come, and ah, they don't think they are ever going to walk again, they are teary eyed, and you know, you encourage them and they are very leery, and I'll say, give yourself a month to see how far you go, take it one day at a time, and it's nice to see, um, them two weeks later and I'll say, see you couldn't do that two weeks ago, and that encourages them more. It is very rewarding I find." [Casey, RPN]

Not only did nurses enjoy seeing their clients improve, but they also gained a sense of fulfilment in seeing them discharged home. The rehabilitation setting facilitates holistic nursing care, a departure from the biomedical approach that focuses on treating a body part. While many nurses elsewhere in the hospital see their patients discharged or transferred quickly, these nurses may watch individuals progress from being totally

dependent on others for all aspects of their care to becoming independent enough to go home. The nurses were able to offer emotional, physical, and spiritual help and in this way, received a professional sense of satisfaction in seeing their efforts culminate in a survivor of stroke getting better.

"There's a fulfilment there to know that you've helped somebody get better, go home and to be the best they can be, to be as independent as they can be. And I think that, that in itself is very rewarding." [Loren, RN]

Theme 2: Nursing has a pivotal role within the rehabilitation setting.

All of the nurses described their role as pivotal to the rehabilitation process. Whereas other stroke team members only work weekdays, the nurses highlighted the continual teaching and cueing that occurs "24/7" as they help survivors of stroke relearn how to perform various functional tasks. Responding to the individual's needs to be moved or dressed or toileted allowed the nurses to use these opportunities to practise these tasks in a meaningful context. With survivors spending the majority of their time on the unit with the nurses and needing extensive teaching, these practice sessions became an important part of the recovery process.

"A huge thing is teaching, teaching, teaching. You teach them first, reinforce the teaching they've already got, sometimes they don't hear the initial teaching or they don't hear [it] the third, fourth, or fifth time, sometimes it never clicks in." [Leslie, RN]

The nurses described their role as essential and extensive, using vocations such as teacher, care provider, therapist, motivator, facilitator, advocate, and coach to emphasize the full range of their responsibilities. They saw themselves as independent healthcare professionals whose practice incorporated components from the other disciplines.

Because of their round-the-clock interactions with survivors of stroke, they possessed unique information about that individual—information that other team members need and should get from the nurses. The nurses recognized the large scope of their rehabilitation practice that requires them to be accountable for timely assessments and interventions.

"I think everything revolves around the nurse because really and truly, the nurse sees the patient 24/7, and that if they have any questions, they should come to the nurse and ask them, especially the nurse providing care over a long period of time because the nurse should know." [Kendal, RN]

"Well I think that it, it's, [long pause] a big role. ***I think it's everything, really,*** *[emphasized] it includes physio and occupational therapy and it's quite a big role, because you are basically doing all that just with morning care, even if you are shipping them off at 9:00 o'clock to speech."* [Casey, RPN]

Theme 3: Nurses find it difficult to step back from helping survivors of stroke.

The rehabilitation nursing role requires the nurses to step back and allow the individual to struggle with the tasks rather than jumping in to assist. Their training prepares them to provide care and comfort, two reasons why many people become interested in being nurses. The rehabilitation role requires nurses to behave differently. Some nurses (5 out of 8 nurses commented) found it difficult to watch survivors become upset and frustrated during a task, especially when neglect and inattention makes the activity even more challenging.

"It's hard not to, um, just jump in there and do the tugging and the pulling of the shirts if they're having problems. In trying to direct them they don't know what you mean and they, they don't feel that side and they don't see that side and um, so when you're trying to tell them to pull their shirt over their shoulder, they're not even realizing that there's a shoulder there, and so it's easier for me to just go and tug it over instead of having them work." [Carey, RPN]

Some nurses literally had to put their hands in their pockets, indicating how hard they found it to refrain from providing the type of traditional nursing instilled by their training and previous work experiences.

"I had to, when I first came here put my hands in my pockets because I was always helping the patient. And in rehab, you've got to make the patients learn to do that for themselves." [Kendal, RN]

The first use of the word "nurse" was recorded in England in 1590. Its root derivative is *nutrire,* to suckle. "Nurse" means "the person who takes care of the sick." (*Online Etymology Dictionary*, 2005). This time-honoured way of nursing has created both nursing and certain societal expectations. Individuals who are ill and admitted to a hospital believe nurses will look after them, fulfilling a tender mother-surrogate role. Instead, these patients may become very upset if they receive a hands-off type of nursing care. They may feel that the nurses are either lazy or uncaring which, in turn, makes it harder for nurses to do rehabilitation nursing.

"We have really, you know, good stroke nurses up there who will ***not*** *[emphasized] do anything for the patient at all and the patients hate these nurses,* ***they hate*** *[emphasized] them, they (the nurses) say 'No you can do it yourself' but then I'll say OK, I'll help you [laughing]."* [Casey, RPN]

Without clear explanations and support for rehabilitation nursing, it is difficult for nurses struggling with their own inclinations to jump in and help their patients to perform that role.

Theme 4: Nurses feel survivors of stroke are short-changed by competing demands.

While nurses see their rehabilitation role as important, there appear to be obstacles as to how this role is accomplished in real life. The repetitive training requires time for the individual who has had a stroke to practise the steps involved in learning how to dress, bath, toilet, and transfer safely and independently. Without extra staff, this functional approach results in other nurses having a heavier workload.

"There's a few [nurses] that are um, really um, dedicated to the rehab aspect of it, and they will do their rehab of the patient, but what happens is the other nurses have to pick up the rest of her work in order for her to do it." [Carey, RPN]

Not all nurses seemed to find the time to do rehabilitation nursing. An emic typology appeared to be emerging from the interviews.

"But, to have someone tell you that there's a Box 1 nurse, a Box 2 nurse and a Box 3 nurse and a Box 1 nurse no one really wants, a Box 2 does what is expected of her to do and goes home, a Box 3 nurse does what's expected of her, looks around and sees what else needs to be done, jumps out of the box and will give 110 and 120 per cent and always do that, and everybody wants a Box 3 nurse. But then I'm a Box 3 nurse, I've been told that, however, I've also been told, get back in your box and stay in Box 2 because they don't like it when you do that." [Britt, RPN]

A Box 3 nurse seemed to be a nurse who resists the various workload pressures in order to have his or her clients practise their personal care activities. When asked about the people who were telling her to get back into her box, Britt named some managers and colleagues. It seems that nurses experience tension in performing their role that stems from the perceptions of survivors and their families, their peers, and hospital administrators. Without a doubt, it takes time to provide rehabilitation to individuals who

present with severe sensory, physical, and cognitive impairments and have difficulty learning how to dress or bath or toilet. Without proper resources, some nurses may resent doing extra work while others feel badly when they cannot do their job properly.

Upon reflection, I wondered if RNs and RPNs held different perceptions of their role. To check out my intuitive feelings, I reread all the transcripts and applied a matrix to explore which nurses tended to categorize the nursing staff or talked about time constraints. From the following matrix, I concluded that the RPNs referred to different types of nurses.

Table 2. Matrix of references to a typology of nurses or time constraints

	RN1	RN2	RN3	RPN1	RPN2	RPN3	RPN 4	RPN5
Reference to classifying nurses (yes or no)	NO Hardest thing is to teach someone rehab nursing	N0 I just do rehab nursing	N0	YES Stroke nurse Other nurse	YES Box 1,2,3 nurse	YES Good nurse Bad nurse	YES Each nursing dept. has different types of nurses	YES RN role more acute than the RPN role
Mention of time	YES	-	-	YES	YES	-	YES	YES
Mention of patients with SCI taking more nursing time	-	YES	-	YES	YES	-	YES	-

The RPNs tended to attribute their difficulties in performing rehabilitation nursing to a lack of time caused by looking after the needs of the individuals with spinal cord injuries [SCI]. This made me wonder whether the RNs delegated parts of their caseload to the RPNs, in turn, creating more time for the RNs to work with survivors of stroke. Perhaps education, status, and experience empower individual nurses to carry out the rehabilitation nursing role.

By having two very diverse patient population groups on the same nursing floor, the nurses are constantly put in the position of trying to establish a rehabilitation nursing role while at the same time fulfilling their obligations to provide traditional nursing care. Often individuals with spinal cord injuries take two to three nurses to perform their care. The nurses want to be fair to everyone and seemed faced with an unwinnable situation where they are trying to meet the needs of a young person with quadriplegia who, for example, requires assistance with her personal care while at the same time wanting to help dress an anxious, elderly woman who has had a stroke.

"Oh I had Mrs. So-and-So, a spinal cord patient. It's going to take me two hours to do her ADL's with her bowel programs, and then I have to get her up and I have to put her back to bed to catheterize her and stuff, and here's poor old Mrs. J. [survivor of stroke] over here and Mrs. J. needs emotional support, she needs health teaching, she needs the ADLs just the same as this one does, but she is more mobile and therefore this one is going to get more attention. I can't tell you the number of times um, over the past year where you've had two or three stroke patients in a room and a spinal cord patient in the room and the stroke patients get washed, buffed, polished in fifteen minutes of fame, sort of thing, and then out for the rest of the day. It's not fair, it's not fair to that stroke survivor and there actually have been times where they have said 'I don't mind waiting but gee, every day, every day, he takes two or three staff and where's my care?' You know, I don't think that's fair." [Britt, RPN]

In the end, the nurses felt that those patients who have had a stroke get short-changed in their nursing care. Despite these individuals being more mobile than those with spinal cord injuries, the nurses were uncomfortable with the allocation of their time. Being invested in the rehabilitation role, they thought it was unfair that individuals who have had a stroke do not get more rehabilitation nursing care.

"I think the way the wards, ah, are divided with spinal cord and stroke, is another reason why I think it probably hasn't worked well because of the fact that you are rushing the strokes because you know the spinal cords going to take more time. But actually the stroke patients should have more time." [Casey, RPN]

Theme 5: Nurses feel others devalue their role.

The nurses perceived their role in providing care to survivors of stroke was devalued by the patients, their families, team members, and management. The nurses gave instances where survivors of stroke "treated them as a servant," perhaps in part the result of the type of work nurses do. Survivors and their families may view intimate bodily care as distasteful or embarrassing, even though toileting and cleanliness are basic human needs.

"I think when you touch people physically, physically touch people, um, they have a different interaction with you than if you sort of get them to walk, or get them to use their hand, or get them to talk again. I think they (survivors) see you on a lower level sometimes, because you are more of a care provider, and these people are more of a teacher, helping them to learn something—no they don't quite hold you in high esteem because you are touching them intimately, Like you are cleaning them or you are washing their privates, or whatever you are doing. I think it makes a big difference in how they perceive you, I do." [Leslie, RN]

Receiving any form of personal care from the nurses seemed to trigger in some survivors of stroke a disrespectful attitude towards the nursing staff that at times escalated into bouts of anger.

"It (intimate care) makes a difference. You know that they (patients) have peed the bed. You know all what they do and then they can go downstairs, and say look what a model patient I am, I'm walking up and down the halls, meanwhile upstairs they are having temper tantrums because they didn't get their, you know, their brown piece of bread with their breakfast or something." [Leslie, RN]

Sometimes episodes of verbal abuse and angry outbursts resulted in a patient becoming violent.

"The other morning and I was very pregnant at the time, and on day shift it took six of us to hold him down and jab him with the halidol (mumbling) ... he was very angry and we were trying to keep him calm because really and truly, he would definitely get hurt. Course they don't give a hoot usually if nurses get hurt half the time, right" [Leslie, RN].

Most patients are transferred from acute care where they observe the nurses doing everything for them. Consequently they may stereotype nurses, seeing them as Florence Nightingale prototypes—female, virtuous, and caring—(Jones, 1997). This categorization sets up expectations that nurses are there to help them whenever they ask for assistance, an antithesis of rehabilitation nursing. If such expectations are not met, these patients may conclude that the nurses are not doing their job well. This mismatch of perceptions about the role of nurses on the stroke unit may contribute to bouts of verbal and emotional abuse nurses receive from survivors of stroke and their families.

"Well, they expect us to do these things that they are quite capable of and they assume that because we're there we should be there at, basically at their beck and call.

And when we'll leave them to do things that they are capable of, unsupervised, sometimes they think OK, she hasn't done anything for me. Well some families don't understand our role." [Andrea, RPN]

As well, patients may view nurses as a means to an end (i.e., meeting their personal goals of getting to therapy on time) and therefore, do not appreciate the care they receive from nurses.

"I've had some patients who just stand there and bellow, I have to get down to my program! Physio is the only thing I need." [Kendal, RN]

Often nurses do not know how the patients are improving in physiotherapy. Instead they experience awkward moments during the patient conferences when the therapists express surprise that the patients are not already walking to the washroom.

"Patients will tend to say, 'I'm not walking or anything like that.' Because I had found out, just through our conferences, that the physio will say, "Oh he can walk. What's he doing in a wheelchair going to the bathroom? He can walk." Then you start getting them up and start walking them to the bathroom." [Kendal, RN].

Although nurses are hired to perform a rehabilitation role, they do not understand why management does not support them more.

"I don't think we have enough staff to really give their best shot at rehab, and if you can't teach someone, not teach, that's the wrong word, if you can't help someone to rehabilitate into as normal a lifestyle so they can manage after having a stroke, why are you here? You know, we need to do more for them, we need to do more with more staff, not with less." [Britt, RPN]

Not only do the nurses believe that there is not enough staff to allow them to perform comprehensive rehabilitation nursing, but they are also frustrated with the lack of assistance from the other stroke team members. Survivors of stroke tend to receive

their therapy on the first floor—apart from where the nurses could observe, confer with the therapists, and where patients could practise functional activities such as transferring, toileting, rolling, dressing, and walking in a meaningful context.

"Either you (meaning therapists) need to be up there or we need to be down here, I don't know how you'd fix that. That's a big issue with me." [Casey, RPN]

When a patient becomes acutely ill, the situation becomes even more tense and stressful. The location of the stroke unit in a freestanding rehabilitation center means limited access to laboratory services and physician support, especially at night and on the weekends. The nurses are responsible to their regulatory body for their clinical decisions. A lack of additional nursing staff, physician support, and technological services contributes to a stressful situation for all the nurses working on the unit. The nurses experience a great deal of anxiety in having to make correct assessments and decisions, knowing that they must justify their reasons should things go wrong.

"Like they're not here, like we have radiology, but we don't have a lab [technologist] all the time, we don't [have] the doctors and that sort of thing, we don't have crash cart, so therefore if somebody is sick and really needs support like that, it all has to come in to us, and sometimes it gets pretty hectic when you're trying to get all the stuff done for somebody that's, you know, that is ill, and needs to be looked after and needs more and it reflects on everything else that's going on around the ward." [Andrea. RPN]

Finally, the nurses expressed frustration at their ongoing relationship with management. Themes 1, 2, and 4 show how concerned nurses are that individuals who have had a stroke receive the care they need. Because many of the nurses have been working on the stroke unit for a number of years, they have opinions about what works

best in this clinical setting. They find it disheartening to have their ideas disregarded. The process for decision-making and the communication of those decisions leaves the nurses feeling disenfranchised.

"Most nurses cannot really stand putting in a day's work and feeling they have achieved nothing for it, and it's ironic that those little moments if you will, getting back to what we were saying, those little moments of, of, of, putting the energy in, only at the end of the day to have the wind knocked out of your sails by having everything you worked towards being overturned by someone who hasn't even had, let's say the foresight to say, well we're going to change this, we're going to do that, or why have you been doing that, what do you find works about it. Maybe there's not enough time for these people who are making decisions to ask that, or there's not really the right avenues, if you will, for people to exchange that type of information between different shifts." [Regan, RPN]

The nurses perceived that the continual changes on the unit such as reassigning staff, admitting different types of patients, and general down-sizing of auxiliary workers stemmed from political reasons rather than from efforts to improve clinical utility and effectiveness. The frequent disruptions in their daily working relationships and routines have culminated in the nurses feeling they have little autonomy over their work life.

"I think what gets in the way is politics, not the nursing that gets in the way. It's the usual political stuff that comes down, you know, this is the way you have to do it now so it's like, why do we have to do it that way?" [Loren, RN]

In summary, the nurses' perceptions of being devalued seemed to stem from several factors: (i) the beliefs of survivors of stroke who expect nurses to care for them rather than help them learn how to perform their activities of daily living; (ii) reinforcement of these expectations by other health professionals and family members who envision nursing as a means to get patients quickly to their various therapies that are delivered off the unit; (iii) the set-up of the unit where individuals with a diagnosis of

stroke are integrated with individuals with spinal cord injuries, creating an environment of valid but competing needs; and (iv) the lack of acknowledgement of the nurses' concerns by the hospital management. I wondered what it is about the nurses providing care to individuals following a stroke that fails to gain recognition from others.

Theme 6: Despite facing many obstacles in providing care to survivors of stroke, the nurses maintain a positive attitude.

I was surprised at the tone of these interviews. Despite feeling devalued and unsupported at times, the nurses refrained from making any disparaging remarks about other members of the stroke team and the hospital administrators. Even when the nurses were critical of some action or policy, they offered alternative interpretations to their perceptions of the situation. I wondered whether these qualifying statements might reflect the voices of an oppressed group who find it difficult to express their sentiments. However, their collective attitude appeared positive but assertive throughout the interviews.

"I've wanted the OT and PT to put up little sheets at the bedside of each patient but they don't have time to. I see that. But even if they verbally communicated it, what the patient is doing, and what the patient can do. So we don't find out two or three weeks later that the patient can walk to the bathroom with some assistance." [Kendal, RN]

To help them cope with the problems arising on the unit and to deal with tense situations, the nurses developed a number of different strategies such as humour, self-control, and walking away. Nurses seemed to have a special camaraderie similar to that of police officers or firefighters. They were supportive of each other, knowing they could

talk about their day and receive the understanding they needed to deal with personal and work stresses. Instead of complaining, the nurses generated research ideas and suggestions as to how to make things better for nurses and survivors of stroke.

"It would be nice to find out, aye, to do research, say let staff for three months do one-on-one in the morning, you know you don't need it for the afternoon, but in the morning wouldn't it be nice to do it for three months and then evaluate the difference in FIM [Functional Independence Measure] scores and how long they [survivors of stroke] stay in hospital." [Casey, RPN]

In summary, the following themes were identified from the material:

(1) Nurses enjoyed providing care to survivors of stroke that resulted in their clients improving and being discharged home.

(2) Nurses described their role that involves round-the-clock nursing assessment, nursing care, and teaching daily living routines as being pivotal to the rehabilitation process.

(3) Most nurses found it difficult to stand back and let patients struggle to complete their activities of daily living.

(4) Nurses felt that survivors of stroke get short-changed because of competing, valid demands (i.e., the needs of other patient groups, the lack of time and/or staffing) that prevent survivors of stroke from practising their daily life skills.

(5) Nurses felt that their role in providing care to survivors of stroke was devalued by others (i.e., patients, their families, or hospital staff/management).

(6) The nurses maintained a positive attitude suggesting ideas about how to improve care to survivors of stroke.

Interrelatedness of the Themes

For me one central theme emerged from the interviews—how devalued these nurses felt (theme 5). When I thought about the various threads that make up the fabric of the nurses' narratives, this theme seemed fundamental to their concerns. It was not so long ago that I began this project thinking the nurses had little awareness of the prognostic indicators of motor recovery post-stroke. In this sense, I was devaluing the extent of their training by making assumptions based on the literature. Being aware of my assumptions, the nurses may have been hesitant to participate in the study for fear of having to pass some sort of test of knowledge. Since then, I have discovered that the nurses are very familiar with the predictive variables of motor return and consequently stopped probing in this area. What I did not know were the multiple instances when clients and their families yelled at the nurses and the many times nurses experienced a lack of support from team members and management.

I wondered if perhaps I was "going native" by identifying so strongly with the nurses (Murphy et al., 1998). I discussed this danger with my thesis supervisor when we reviewed the material together. Not only did the nurses comment extensively about feeling devalued but they also used more metaphorical language to describe their thoughts. In talking about other issues, the nurses used language in a straightforward way; however, when they talked about their feelings of being devalued, they used terms such as "treat you more as a servant"; "Jack of all trades, master of none"; "beck and call"; "lip service"; "knocks the wind out of your sails"; "Box 1, 2, 3 nurse."

While theme 5 appeared to stand alone, there seemed to be a connection between themes 1, 2, and 6 (i.e., enjoying their work, nursing pivotal to rehabilitation, and maintaining a positive outlook). Although the nurses found it difficult at times to carry out the nursing rehabilitation role, both the RNs and RPNs liked their autonomy, enjoyed working with the stroke population, and wanted more services for them.

In a similar fashion, themes 3 and 4 (i.e., watching survivors of stroke struggle with everyday tasks and feeling they are short-changed) appeared interrelated. While some nurses found the transition from providing traditional nursing care to a rehabilitation nursing role challenging, institutional factors such as the set-up of the unit and the valid demands of other diagnostic groups seemed to make this switch even more difficult for them.

Contradictions

A hermeneutic phenomenological approach does not set out to find *the* truth. Instead this methodology assumes that there are multiple versions of the truth that may give rise to conflicting explanations. These different accounts of events are sometimes called the Rashomon Effect, referring to the famous Japanese film, *Rashomon* (1950), that explores a murder and rape from the viewpoints of four witnesses who tell the truth as they know it (Roth & Mehta, 2002). In attempting to grasp the essential meaning of the experiences of nurses who provide care to survivors of stroke, many contradictory beliefs emerged. These contradictions help illuminate the broader social and cultural forces that

shape the subjective meanings the nurses have about their experiences in providing care to individuals who have had a stroke.

(i) *Critical but devalued.*

The nurses see their role of assisting survivors to relearn how to perform the basic tasks of toileting, dressing, feeding, and gaining bowel and bladder control as critical to their getting home; however, patients and their families often failed to recognize nursing contributions, seeing other disciplines such as physiotherapy as more important. What is it about this type of nursing care that makes it seem unimportant?

(ii) *Multifaceted but restricted.*

The nurses describe their role as extensive, using vocations such as teacher, care provider, therapist, motivator, advocate, and coach to emphasize the depth and range of their responsibilities. However, due to valid, competing needs of other patients, they feel restricted by a lack of time to fulfil this rehabilitation role. Why are nurses expected to provide stroke rehabilitation nursing when the unit really is a general neurological unit comprised of different patient populations?

(iii) *Autonomous but isolated.*

The nurses enjoy being key players on the team who advise the physicians but at the same time feel vulnerable and left on their own, isolated, due to the lack of medical

back-up for patients who are ill or aggressive. What is it about the relationships between nurses and physicians that determine when the voices of nurses are heard?

(iv) *The good, the bad, and the ugly.*

As nurses are with the patients "24/7," they have a unique perspective and often see a side of patients and their families that remains hidden from other members of the team. Why is there silence about the multiple instances of abuse and violence towards nurses?

(v) *Rehabilitation nurse versus care provider.*

The nurses struggle with the issue of whether they should do things for the patients or whether they should force the survivors of stroke to do things for themselves. What influences this quandary?

I now had more questions. What is going on here? Before attempting to answer these questions in the discussion portion of this thesis, I decided to reread the nurses' metaphors to see if another approach offered any insights into what it is like to provide care to individuals who have had a stroke.

Exploring Participant-generated Metaphors

The very nature of the interview process cannot help but get the participants thinking about what they are going to say to the interviewer. Although open-ended questions and a relaxed atmosphere promote story-telling, there may have been some

issues that the nurses felt hesitant to discuss or thought the researcher would not need or want. Hermeneutic phenomenology continually searches for hidden meaning. This approach encompasses an iterative process of analysing and interpreting the narratives, with the researcher then comparing the findings of other studies to the emerging interpretations.

For example, European and American nurses often characterized the act of caring for individuals following a stroke as "heavy work," a term suggesting that these survivors required the nurses to give considerable amounts of physical and emotional care (Hill & Johnson, 1999; Kirkevold, 1990; Pound & Ebrahim, 1997). In my study, I noticed that the nurses rarely referred to their work as "heavy." This disparity puzzled me. Even when nurses were probed about this topic, they downplayed the overall physical and mental aspects of their work in caring for survivors of stroke. However, a pre-reflexive sense of that heaviness, similar to descriptions in the nursing literature, surfaced in the metaphors some nurses used to describe their experiences in providing care to survivors of stroke. For example, Kendal's comparison to trudging up and down hills until she reached the summit seemed to echo a sense of heavy work, but work she felt was well worthwhile.

"Hmm. [long pause] it is like being on a trip through a forest, [pause] ... you have the hills and the valleys [laughter]. It's a challenge around every corner, but then you have the nice view and the nice patients, and by the end of the walk you're tired but you're feeling good about it." [Kendal, RN]

Another participant also gave a metaphor that echoed a similar element of physical and mental effort.

"Providing care to survivors of stroke is like...[long pause] swimming up stream. Well, if you're not a good swimmer you won't get very far ... and sometimes it's a huge struggle with life, fighting up water, going up stream for somebody's patient and for nursing because to get them to do the small tasks, to become independent, sometimes is the biggest struggle." [Loren, RN]

This image of swimming against the tide—battling the swirls and eddies of the river is a picture of emotional determination and physical exertion. Even though the nurses did not directly express feelings about the physical and emotional demands of their job in providing care to individuals following a stroke, some of their metaphors painted an image of that burden. In this way, metaphors take us beyond factual descriptions of what the nurses do in their daily lives to that silent area of meaning which holds the implicit feelings and sensations of what it is like to provide care to survivors of stroke (Moule, 2002).

A metaphor may also allow the researcher or the respondent to express one idea in terms of another or to deal with things that are inexpressible in words. Wendler (1999) wrote that the "metaphor enhances the synthesis process and provides a context through which the defining attributes of the concept can be viewed" (p. 31). There seemed to be two ways in which metaphors could assist my analyses and interpretations.

Initially, I contemplated whether there might be a relationship between the metaphors and the emerging themes. Britt's metaphor appeared to link to theme 1 where the nurses talked about how much they enjoy working with survivors of stroke.

"[It's] like having um, the opportunity to have a clean slate every morning and make notations to make beautiful days." [Britt, RPN]

When Britt talked further about her metaphor, it was clear that she received a great deal of pleasure in helping survivors of stroke get better.

"I love the stroke population, I love working with stroke patients, I love having the, the chance to work and grow with them, so you know what, I might be a stroke survivor one day and I would hope that one, if I am, because my grandmother had a stroke, two of them, so if I were to have a stroke, I would hope to find a rehab facility like this where I could get my life back so, it's, so the end of that sentence would be I love to, to face a new day start again." [Britt, RPN]

Another nurse characterized the provision of care as "being an extension of that person," linking this metaphor to theme 2 that focused on all the things nurses do to help survivors become independent in their activities of daily living. It appeared that Regan thought of himself as an extra limb that allowed his client to do more things. Regan went on to discuss his thought:

"It's to fill in the empty places and, and, the shortfalls of that individual and provide those particular functions, if you will. When I said earlier about being the shadow, it's like you, you become the extension of the person. You're giving something of yourself in a way of a smile, in the way of some progress in their functioning, in a way of their individuality. So you feel great because you say 'Yah, we did it.' And always he did it, or she did it, you know." [Regan, RPN]

However, care needs to be taken in selecting a metaphor to illuminate the experiences of nurses. For example, two nurses [Carey and Casey, RPNs] generated a parent-child metaphor that seemed to juxtapose an emphasis on the nurturing aspect of nursing with the teaching component involved in rehabilitation nursing practice. It seemed to capture the pride and joy parents feel when a parent teaches a child a new skill and then delights in watching that child grasp a new concept or participate in a novel activity.

"[Providing care to survivors of stroke] is like, um, providing care for a child when they do something new that they've learnt. [It's] um, exciting and rewarding." [Carey and Casey, RPNs]

However, some of my classmates (nurses in the PhD program) expressed concern that their peers would compare an individual who has had a stroke to a child. Although I did not feel that this was their intent of their metaphors, it showed me how easily a metaphor may be misconstrued. A researcher's enthusiasm for a technique may provoke an unexpected reaction, causing more misunderstandings rather than creating more thoughtfulness amongst nurses and other health professionals. As well, there is a danger that, given the symbolic imagery of language and its ability to be interpreted multiple ways, the researcher may continually be searching for one metaphor after another in an effort to explain.

This process of linking metaphors, thinking about them in a broader context, and pondering their significance helped me stay immersed in the material. The metaphor "provides an efficient means of capturing a lot of possibly disconnected information and crystallizing it into a meaning set of ideas and relationships" (Aita, McIlvain, Susman, & Crabtree, 2003, p. 1424). I then realized that I had not reread the narratives specifically looking for other examples of metaphors besides the ones I had asked the nurses to generate.

I found myself paying closer attention to the way in which nurses, as members of a particular social and cultural group, used language. For the most part, nurses seemed to use adjectives and verbs in a straightforward manner; when they talked about their

contributions being devalued by others, however, they used more metaphorical language. For example, Kendal [RN] used the phrase, "Jack of all trades, master of none." *Brewer's Dictionary of Phase and Fable* (1989) describes this phrase as having a belittling tone, as it denotes "one who turns his hand to everything but is not usually expert in any one field" (p. 497). In contrast to other settings within the hospital complex where nurses are recognized for their traditional expertise, the stroke rehabilitation unit employs nurses in a new role. This made me wonder if the nurses were experiencing conflict and discomfort in a new professional role that asks them to dramatically change their scope of practice. Perhaps there is a professional sense in nursing that teaching by rehabilitation nurses is elementary and lacks the glamour of other more technologically complicated interventions.

Another nurse, Regan felt devalued when others paid only "lip service" to the nurses' ideas. Although their input was sought as to how best to run the stroke unit, the nurses felt their opinions were never seriously considered. Regan compared this result to "having the wind knocked out of your sails." His metaphor conjures up two images—of a sailboat stranded, floundering, dependent upon something that cannot be controlled and on the experience of not being able to breathe owing to the pain and shock of losing your wind. Various nurses commented on how their voices are not heard, how little control they have in their workplace, and how upsetting it is to get things on the unit going smoothly only to have them disrupted without warning. Regan went on to talk about "seeing everything you worked for overturned." Alterative meanings for "overturn" suggest "turn or throw from a basis, foundation, to subvert, to destroy, to

overthrow; to overpower; to conquer" (*Online Etymology Dictionary*, 2005). The synonyms such as destroy or subvert paint a more intense picture than "overturn," leading me to reread the text with a deeper understanding of Regan's feelings of being devalued. The process of looking up the etymology of the participants' words and phrases encouraged me to linger on their meanings.

However, the idea of using participant-generated metaphors was based on my pre-reflective assumptions that people think in an imaginative and creative fashion. During the interview process, I discovered that some individuals were concrete thinkers and found it onerous to construct a spontaneous linguistic comparison. For this reason, one interview unfortunately ended on a somewhat negative note as the participant struggled to come up with a metaphor. For example, Leslie told the interviewer to "shut the machine off for a moment while I figure it": there was a long period of silence followed by a reiteration of the factual details of her work. The task of generating a metaphor might have been made easier if, for example, I had asked nurses to describe their experiences as a kind of object using a popular song, a TV show, or a book (Deacon, 2000). However, I am uncertain whether this technique would have facilitated the process and if the exemplars would have been meaningful in exploring the experiences of nurses within this context.

In summary, participant-generated metaphors helped me get a sense of their pre-reflective thinking, showed links to emerging themes and concepts, and acted as a catalyst for generating new ideas. I agree with other qualitative writers (van Manen, 1997; Wendler, 1999; Willis, 2001) that the evocative and symbolic tension of the

metaphor has the ability to capture the meaning of an experience with the right combination of words. Exploring the meaning of the metaphors was a positive contribution to my analyses and interpretation where I gained a glimpse into the silence beyond the words.

My analyses left me with many questions, however. What is it about the provision of nursing care to survivors of stroke that makes it devalued by others? Does a strong teaching component to the nursing role in contrast to the caring component appear less like nursing to others? Why are nurses' concerns about their rehabilitation role not addressed? How do these nurses maintain such an optimistic attitude given the number of problems they face? Why are the nurses not angrier? More assertive? Why the silence? What is it about their training, experiences, or profession that result in their concerns not being considered or appreciated?

5

Discussion

As already outlined in the results section, my analyses identified six themes that reflected what it is like for nurses to provide care to survivors of stroke. In brief, the nurses enjoyed working with survivors where their rehabilitation nursing role embraced many interventions; however, staff shortages and the set-up of the unit made it difficult for some nurses to find enough time to promote the teaching component of the role. Although the nurses felt others did not appreciate their contributions to the rehabilitation process, they still continued to advocate for additional resources for their patients.

In this phase of the study, data analyses continue as I search for meaning by (i) examining my findings in light of the previous literature searches and (ii) conducting new searches to explore concepts emerging from the study that have not been addressed in the original review of the literature.

Examining My Findings in Light of Prior Literature Search

In many areas, my findings were similar to those reported in previous studies. The nurses' descriptions of their role in providing care to survivors of stroke corresponded to the stroke rehabilitation model originally proposed by Kirkevold (1997) and expanded by O'Connor (2000). Like their Australian colleagues (Pryor & Smith, 2002), the nurses considered their rehabilitative approach that emphasizes teaching, coaching, and continual assessment to be important to patient care. Their concerns were similar to those

of other nurses in that they wanted better communication with occupational and physical therapists (Dowswell et al., 1999; Thorn, 2000) and more recognition for their role in helping individuals recover following a stroke (Secrest, 2002). The participants agreed with other nurses that there was not enough time or staff to provide the type of care survivors of stroke needed during their rehabilitation stay (Kneafsey & Long, 2002; Pound & Ebrahim, 1997). Moreover, they felt that the hospital administrators did not do enough to encourage the rehabilitation aspect of the nursing role (Dowswell et al., 1999; Long, Kneafsey, Ryan & Berry, 2002; Pound & Ebrahim, 1997).

The participants in my study complained about being pulled in two directions—trying to care for those individuals with other diagnoses (e.g., individuals with acquired brain injury or spinal cord injuries) while simultaneously trying to fulfil a stroke rehabilitation nursing role. Although other stroke team members and hospital managers refer to the unit as a "stroke" unit, the nurses see it operating as a general neurological floor. Each morning the nurses struggle to meet the needs of different individuals who all want to eat breakfast, toilet, and wash at the same time.

Contrary to Pound and Ebrahim (2000), who found the behaviour of the nurses who worked on a stroke unit to be detached and uncaring, I found these nurses to exude genuine warmth and concern for their patients. Although the nurses thought others often devalued their contributions on the stroke unit, they maintained a constructive outlook. This was a marked contrast to the excerpts of the interviews of ten physiotherapists working in a British Columbia rehabilitation centre. The therapists complained about evidence-based practice, research, and standardized outcome measures and made

negative comments about the allocation of resources, administration policies, and the nursing staff (Carpenter, 2005). The participants is this study appeared knowledgeable about the various prognostic factors that have an impact on stroke recovery and differed from other nurses who felt they needed more theory (Dowswell et al., 1999).

As previously mentioned, patients, and healthcare professionals seemed to have different opinions about what constitutes quality nursing care (Rieman, 1998: Sherwood, 1993; Williams, 1998). Many survivors of stroke tended to regard nurses as Florence Nightingale prototypes, expecting the nurses to do everything for them (Hill & Johnson, 1999; Jones, 1997; O'Connor, 2000). The nurses working on my unit commented on how impatient survivors of stroke became when asked to do their own care. In fact, the nurses found their efforts to promote functional recovery conflicted with the patients' preconceived notions of what they thought the nurses should be doing. The nurses reported that some individuals or their relatives became verbally abusive towards them when they did not get the type of care they thought they should receive.

In summary, some of my findings differed from the results of previous studies, especially when it came to the nurses' demeanour and their knowledge of stroke recovery. In other aspects of providing rehabilitation care, the participants had similar concerns to those of other North American and European rehabilitation nurses. The nurses wanted more time to teach survivors how to perform their activities of daily living. However, their efforts to provide holistic rehabilitative care were adversely affected by cultural stereotyping, the patients' prior expectations, and insufficient support from management.

As other factors appeared to have an effect on the way nurses provided rehabilitative care apart from their individual relationships with the patients, I decided to conduct a series of new literature searches. Although this study rests on an interpretative phenomenological framework, I agree with Porter and Ryan (1996) who maintained that "it is possible to pay attention to social structures without losing its focus on individuals" (p. 413). Kushner and Morrow (2003) contended that feminist and critical theories might play a role in extending interpretative methodologies so that we may better understand human interaction in the social world. I wanted to use a new lens to review the material by exploring (i) the influence of gender and organizational constraints on the actions of the nurses; and (ii) whether those actions maintained or transformed the existing social structures. In this way, I hope to enhance my analyses of what it means for nurses to provide care to survivors of stroke.

Exploring New Concepts Not Addressed in the Original Literature Review

Gender stereotyping.

Gender is a familiar concept in the social science and nursing literature. Briefly, Miers (2002) conceptualized gender to have the following five features: (i) a social construct where certain attributes associated with women and men have been culturally created and sustained, (ii) a binary category of male and female, (iii) relational in that conventional assumptions about masculinity and femininity cannot be understood as separate components, (iv) suggestive of inequalities in relationships and power, and (v) linked to every aspect of social life.

Nurse historians have explored the impact of gender stereotyping and discrimination on the nursing profession (Coburn, 1981; David, 2000; Miers, 2002; Warburton & Carroll, 1988). In Canada, from the late 1800s until the mid-1930s, women enrolled in apprenticeship programs where they trained to be nurses, working without pay twelve hours a days, seven days a week. Furthermore, these nurses were expected to be obedient to the male physicians and show complete deference to their nursing superiors at all times (MacPherson, 1996). Canada's first nursing school (General and Marine Hospital, 1874, St. Catharines, Ontario) had as its motto, "I see and am silent" (Coburn, 1981). Not only did this adage exemplify the subservience of women and nurses to authority, it made me pause in my writing and question the omnipresent silence that continues to surround the work of nurses. That motto could be operational today, for here I am

> "131 years later, trying to reflect the nurses' experiences without tearing the fabric of their stories. Why are their concerns not heard? Have the historical roots of obedience and silence influenced nursing behaviour and shaped society's expectations of their role?" (SB, June 10, 2005).

Throughout history, healing, caring, and looking after others have been characteristic of women's activities (Lawler, 1993; Miers, 2002). In hospitals where female nurses typically worked for male doctors, the division of labour was attributed to "culturally given, normative expectations concerning sex roles, e.g. nurses were mainly women because women were expected to perform mother-surrogate roles, providing tender loving care" (Warburton & Carroll, 1988, p. 364). The following passage describes the oppressive situation of women nurses: "The unspeakable is complex. It is

shrouded in the silence women and nurses keep. Generally nurses and women do not rock the boat by breaking the silence over personal situations and/or the way in which they are constrained by oppressive structure" (Glass & Davis, 1998, p. 45).

For this reason, some nursing researchers (David, 2000; Glass & Davis, 1998; Kushner & Morrow, 2003; Sigsworth, 1995) have suggested a feminist approach to guide inquiries into gender-based, economic, and cultural influences on the experiences of nurses in the work place. From different feminist theories, Hall and Stevens (1991) distilled three basic principles of feminism: (i) to value and validate women and their experiences, ideas, and needs; (ii) to recognize the existence of ideological and structural conditions that subjugate women; and (iii) to promote social change. Despite advances in the nursing profession, Wotherspoon (1988) stressed the importance of examining the wider context in which nursing operates and the cultural constraints that continue to have an impact on nursing.

In a series of monographs, Donner, Semogas, and Blythe (1994) have done exactly that, writing "nursing is women's work, and women's work is little valued in itself" (p. 30). Using a feminist approach, they reviewed the profession's history, the effect of gender in the work environment and the socialization of nurses into institutional life. They concluded that the nurses' inability to have control over their work was not reflective of their lack of commitment to their profession. Instead, Donner and her colleagues (1994) argued, a complex combination of gender issues, institutional policies, and socioeconomic factors influenced the quality of nurses' work life. Before looking at

the concept of power and the degree of control nurses have in their work lives, I would like to focus on one aspect of nursing, bodily care.

Although many facets of nursing could be explored within a sociological context, I feel the question of bodily care illuminates how nurses, patients, and society perceive its value differently and how these perceptions play out in broader issues of respect, entitlement, and social worth. As mentioned previously, individuals following a stroke tend to be very dependent on nurses to help them with the intimate aspects of their personal care. If they are incontinent of bowel and bladder, survivors need frequent nursing interventions to assist in toileting and cleaning their bodies.

In a series of qualitative studies with thirty-four nurses, Lawler (1993) explored the concept of the body and how the disposal of bodily waste was viewed from a societal and professional perspective. Historically, "dirty work" (i.e., jobs that involved cleaning up waste by-products) was considered to be low status work and therefore devalued. Women were deemed to be the appropriate gender to do hospital "dirty work" (e.g., clean up vomit, blood, feces and urine) as (i) they were considered unclean because of their menses, (ii) housework was regarded as menial work, and (iii) they already did that type of work in caring for their children (Lawler, 1993).

Traditionally the tasks of cleaning the body were assigned to those nurses who ranked the lowest. Lawler (1993) postulated that society's abhorrence of bodily waste products and a prudery about body sexuality have influenced nursing behaviour. As friends and family members found the work nurses did to be either distasteful or titillating, nurses soon did not talk about their work with anyone but fellow nurses.

Although patients were grateful for nurses providing such intimate help, they often were embarrassed and wanted to quickly forget that part of their care. As the subject matter of bodily functions was not a topic of legitimate social discourse, Lawler (1993) concluded that what nurses did remained concealed from the public. Her themes repeatedly pointed to the invisibility of nurses' work, linking it to the hidden aspect of women's work in general, the inability of nurses to talk about what they do because of society's distaste for such dirty work, and the silence of the patients who benefited from nursing care but preferred not to discuss it with others (Lawler, 1993). This invisibility of nurses is profound and not limited to stroke rehabilitation; it is long standing with the contributions of nurses being cited only 4 per cent of the time in over 2000 health-related news articles (David, 2000).

In summary, stereotypes of women and in particular of nurses were perpetuated and reinforced by the socialization of gender roles. Gender issues continue to permeate the health care system where nurses, as a result of male domination in medicine, still feel that they are viewed as handmaidens (Roberts, 2000). In 1999, the percentage of women in nursing remained high at 96 per cent, indicating ongoing support for a patriarchal structure where men were doctors and women were nurses (Kane, 1999). Researchers concluded that many people continued to view nursing in a subservient role which reduces its value and influence on patient care (Domino, 2005; Roberts, 2000).

Power and empowerment.

Gender stereotyping has resulted in nurses being dominated by mainly male health care administrators and physicians (David, 2000; Roberts, 2000). This authoritative control leads to oppressed groups experiencing different forms of abuse and its members becoming frustrated with the status quo (Roberts, 2000). A final report of the Working Committee of the Canadian Nursing Advisory Committee (CNAC, 2002) described Canadian nurses experiencing high rates of emotional abuse, threats of assault, and actual physical assault. For example, nurses are more likely to be attacked at work than prison guards or police officers (CNAC, 2002). Nearly 40 per cent of nurses working in Alberta reported that they had experienced at least one incident of emotional abuse during their last five shifts (CNAC, 2002). Although the majority of reported abuse incidents originated in nurses' interactions with patients and families, they also included physicians, managers, and other co-workers (CNAC, 2002). Even though I was surprised at the instances of verbal and physical abuse described by the participants in my study, I was even more astounded at the pervasiveness of the problem of violence against nurses in Canada.

As many nurses work in settings where they have borne the brunt of ongoing cutbacks in health care services, their perceptions of powerlessness have intensified (Donner et al., 1994; Finegan & Laschinger, 2001). In a national survey (CNAC, 2002), nurses expressed their frustrations at how they see themselves as well as how they believe others see them. In focus groups, nurses talked about the lack of respect they receive, giving numerous instances of how physicians were abusive and paid little

attention to what nurses thought, of how administrators and financial officers controlled nurses' lives by cutting budgets at the expense of patient care, and of how abusive some patients and families—all factors that lead to a general dissatisfaction amongst their colleagues (CNAC, 2002). Nursing is rarely recognized as valuable to patient care, with "nurse, wife, and mother being transformed into nouns that inextricably link the female gender with its sex and extend the archetype of secondary existence" (David, 2000, p. 86).

The root word of power, "*potere*," means "to be able and to have the ability to choose" (*Online Etymology Dictionary*, 2005). For nurses, power holds a negative connotation, as the term implies coercion and domination (Kuokkanen & Leino-Kilpi, 2000). Even though there are large numbers of nurses working in hospitals, they have little control over their work environment and work lives (Crose, 1999; Donner et al., 1994). A postmodern view of power suggests that the issues of who gains and maintains power are complex and present in all human relationships (Kuokkanen & Leino-Kilpi, 2000). Cohen (1994) described power as the influence one person has over others stemming from either a position in an organization, an interpersonal relationship, or from individual characteristics. Power and knowledge interact, with power being increased with the attainment of more knowledge (Kuokkanen & Leino-Kilpi, 2000). Gender role stereotypes may lead people to perceive women as having less power than they actually have and such stereotypes may even contribute to distortions of self-perceptions of power amongst women (Wilson, 1991). With respect to power and the role of nurses, much has been written concerning the need to remodel the image of

nursing so that the traditional "doctor's handmaiden" image of nursing may be transformed into a true partnership with the health care system (Cohen, 1994).

A review of reform initiatives to empower the front-line nursing staff led Donner and her colleagues (1994) to conclude that there was still a heavy reliance on leaders, an "us versus them" attitude, and unsatisfactory relationships between nurses and physicians and administrators. From a microscopic perspective, nurses working within a current rehabilitation setting continue to express sentiments of feeling estranged from management, disappointed in how their practice is regarded, and having no control over their work environment.

Another way to view institutional power is to examine the degree to which nurses feel empowered in their work place. Although the concept of empowerment has appeared in the nursing literature since the 1970s, Kuokkanen and Leino-Kilpi (2000) argued that it has not been well defined. Their analysis characterized empowerment as a positive, dynamic concept that refers to solutions rather than problems; empowerment is linked to growth and development where individuals and organizations negotiate the attainment, sharing, and letting go of power or control. The fundamental nature of power cannot be understood by simply asking who has access to power but rather it lies in the reciprocal nature of power relationships. Neither can the feelings of being empowered be attributed to certain personality traits of the nurses (Manojlovich, Laschinger, & Heather, 2002). In exploring the determinants of job satisfaction for nurses, Manojlovich and her colleagues reported that personality variables were not significant predictors. Instead, these authors maintained that the structural aspects of the work environment were more important

factors in empowering nurses in their work life than personality factors. Proponents of critical social theory would argue that as oppressed groups are maintained by social institutions, power and empowerment may be seen as being social and political phenomena (Kuokkanen & Leino-Kilpi, 2000).

A qualitative study identified five qualities of an empowered nurse as having (i) moral principles, (ii) personal integrity, (iii) expertise, and as being (iv) oriented towards the future, and (v) open-minded (Kuokkanen & Leino-Kilpi, 2001). More interestingly, these researchers described five corresponding factors that promoted empowerment in the work place (i) a shared care philosophy, (ii) delegation of responsibilities, (iii) evaluation and training, (iv) opportunities for advancement and continuity of work, and (v) collegial support and open communication. Job satisfaction, organizational commitment, and professional activity were found to correlate strongly with nurse empowerment (Kuokkanen & Leino-Kilpi, 2003).

Powerlessness occurs when people have no opportunity for growth and development and when decisions are made for them without consultation; in order for an organization to communicate effectively and promote empowerment, staff must feel a certain level of trust with the organization (Finegan & Laschinger, 2001). Nursing researchers have argued that what is required for empowerment of nurses to take place is "a low-hierarchy organization, working practices orientated toward teamwork, coherent values and strategies, personnel management that creates opportunities, and sufficient resources" (Kuokkanen & Leino-Kilpi, 2003, p.190).

Lastly, it would seem that advocacy and empowerment are intertwined as nurses and their professional organizations try to improve working conditions and patient care. However, it is not as straightforward as I initially thought. Like empowerment, the concept of advocacy has diverse meanings within the nursing profession (Falk Raphael, 1995). Advocacy may be seen as (i) doing good, (ii) not doing harm, and (iii) doing the greatest amount of good for the greatest number of people; in its most simplistic format, advocacy may be seen as pleading the case of another (Falk Raphael, 1995). Other forms of this concept, such as paternalistic advocacy, assume that a health care professional knows what is best for the patient while consumer or consumer-centric advocacy involves nurses giving their patients information that may cause legal complications for the nurses if what they say conflicts with the physicians' viewpoints (Falk Raphael, 1995). This controversial issue of nursing advocacy seems to depend on how the concept of advocate is interpreted. Some nursing educators prefer the idea of empowering patients in which nurses facilitate a process whereby patients may gain control over their lives (Hyland, 2002). For this type of empowerment to occur, however, nurses "need a managerial structure and educational process that supports and encourages the development of the essential attributes necessary to facilitate the empowerment of patients" (Hyland, 2002, p. 475). As nurses themselves are thought to be oppressed, nurses need to empower themselves first.

6

Implications of Linking New Literature to the Findings of This Study

As this study began over three years ago, the nurses often ask me how it is progressing. Invariably, there is a comment about how they hope that "others will listen to me, as no one has listened to them" in the past. In trying to understand what prevents their voices being heard, I am astounded to learn how endemic this issue is within the nursing profession. It is evident from the literature that what these rehabilitation nurses experienced is not unique to their situation but reflective of long-standing concerns of other nurses across Canada.

As I reread the interviews one more time, I thought about these nurses as people and as health professionals, about oppression and empowerment, about what this all means. I reflected on the personal qualities that contribute to being an empowered nurse: having (i) moral principles, (ii) personal integrity, and (iii) expertise, as well as being (iv) optimistic and (v) open-minded (Kuokkanen & Leino-Kilpi, 2001). It became apparent to me that the nurses we interviewed possess all the necessary values, skills, and mind-set to be empowered and autonomous.

Their moral principles emerged when they talked about caring for survivors of stroke as they would care for their own mother or father and wanting these patients to receive the same amount of nursing time that is given to individuals with spinal cord injuries. There was honesty in the nurses' narratives that echoed their individual

personalities, concerns, and what they considered important for me to hear. Yet there were common threads that connected their stories. The nurses' description of their role in providing care to individuals who have had a stroke matched the characteristics listed in an ideal stroke rehabilitation nursing practice model put forth by Kirkevold (1997) and O'Connor (2000). As the majority of these nurses had worked on the stroke unit for many years, their cumulative knowledge and experience made them self-assured and tolerant. And lastly, I did not sense that the nurses felt that they had all the answers, but rather they were hoping for opportunities to try out their own ideas.

At this juncture of my writing, I am struggling to make sense of the data and to understand, given what I have discovered about their practice during this process, why their voices are not heard. Despite their expertise and knowledge of stroke recovery and their aspirations to make a contribution to the rehabilitation process, they still lack control over their work-life and respect for their efforts. They possess all the attributes necessary to be empowered. I then reflected on the factors of the workplace that promote empowerment (Kuokkanen & Leino-Kilpi, 2003). An empowering environment should encompass a shared philosophy of care, foster open communication, enhance nursing skills, allow more decision making, and offer stable employment (Kuokkanen & Leino-Kilpi, 2003).

Although the hospital administration espouses a shared care philosophy for survivors of stroke, there are gaps in how that philosophy is implemented in actual clinical practice. The efficiency and effectiveness of the local stroke and spinal cord units are compared to other provincial and national stroke and spinal cord units; yet the nursing

floor really functions as a general neurological rehabilitation unit. It houses two different patient populations who require vastly different types of nursing care. Nurses state that without a doubt this splitting of their care seriously impedes the achievement of stroke rehabilitation nursing values. Furthermore, it is difficult to offer continuity of care to survivors of stroke when different nurses are assigned to different patients each day. Often the resource nurse's main concern is to get daily coverage for all three shifts, let alone schedule the same nurse to the same patients. Yet the nurses have been identified as the largest group of health care professionals on a stroke team with a pivotal role to play in helping individuals following a stroke to improve. If high incidences of stress, injury, absenteeism, or a lack of loyalty contribute to these daily nursing shortages, perhaps it is time to rethink how frontline nursing staff are employed and instead, create new ways to increase their level of work satisfaction.

When job dissatisfaction arises from limited opportunities to take on more responsibilities and a lack of shared goals, members of an oppressed group might experience hostility towards each other as some of their collective frustration becomes displaced towards each other (Roberts, 2000). When Britt was asked to talk about her experiences working on the stroke unit, she became emotional. Both her colleagues and unit manager had told her to curtail her enthusiasm for the rehabilitation nursing role.

"*It really upsets me. These last couple of weeks has been so difficult that way that I am actually thinking of applying to another unit, but it will be a rehab unit. Because it is really painful, it really hurts, you want to, you do, **you do*** [emphasized] *what you believe is the right thing, and you do your best, and I've never, never tried to give less than 110 per cent with any of my patients.*" [Britt, RPN]

When Britt tried to do more than her colleagues thought was reasonable given their resources, she experienced this type of sanctioning. Empowerment at an individual and group level involves having real decision-making power over work issues. Others must allow this to occur. I believe there is a misconception about power—that somehow the nurses need only to "go for it" and tangibly claim more control over their work lives. In reality, gaining empowerment is a process of facilitation, of others changing the policies and social structures that hinder the nurses' desire for more autonomy in their professional lives. For example more than once during the interviews, Carey expressed her frustration at the status quo on the stroke unit where the therapists work apart from the nurses.

"The upstairs-downstairs really bothers me. I mean, I find it really difficult. I just think we need to integrate together more than we do." [Carey, RPN]

Carey wants the speech, physical, and occupational therapists to do their teaching and treatments on the unit so that the nurses may have more opportunities to be part of the team. Although the future rehabilitation centre to be built in our city proposes to address this issue by developing a floor plan designed to encourage interdisciplinary relations, what is stopping the other members of the team and hospital administrators from instituting some of these changes now on our current unit? It would seem beneficial to the patients if the nurses could observe their progress in therapy and help reinforce specific therapeutic techniques. Without other health professionals and hospital administrators being willing to transform the work environment, the nurses' ideas and concerns are discounted.

The nurses clearly expressed their desire to have an open forum for voicing their opinions, challenging the viewpoints of others, and being active partners in consensus building at the various organizational levels within the rehabilitation center.

"*I think nurses should have a vehicle to express how they're feeling without the feeling of reprisal or without the feeling of belittlement.*" [Regan, RPN]

Although I do not know to what degree the current organizational systems limit opportunities for the clinical nursing staff to assume more responsibilities, it seems that more could be done to provide collegial support for the nurses and foster open communication with them. For example, the nurses find it difficult to attend team conferences not because they are uninterested but because they are unable to leave their other duties. No nurses were present at a recent stroke team retreat to give a nursing perspective on the current problems facing the unit. And if individuals who have had a stroke expect the same type of nursing they received in the acute care setting, what is being done to educate survivors and their families about the role of rehabilitation nursing?

Although the nurses possess all the attributes to be empowered, it appears premature to attribute their lack of progress in this area solely to the hospital's management style. According to the findings of Porter and Ryan (1996), it is helpful to consider the broader economic structures that have an impact on the practice of individual nurses and their unit managers. The fiscal climate within our institution has been one of financial restraint in response to the severe cutbacks in the healthcare system. One of the nurses summed it up this way:

"Well, I think sometimes because of budget issues, you get these directives from wherever they come from. They can come from all sorts of things, that's just the way it's going to have to be and we have to work with it and that makes our job very hard. Sometimes you either have to cut corners or you don't have enough time." [Loren, RN]

Deeper understandings of these issues were addressed in a final report on the benefits of a healthy workplace for nurses, their patients, and the system (Baumann, O'Brien-Pallas, Armstrong-Stassen, Blythe, Bourbonnais et al., 2001). The essence of their messages on how to retain and recruit nurses in Canada focused on (i) changing the current work environment that causes burn out amongst experienced nurses and discourages new nurses from joining; (ii) decreasing the nurses' current workloads that are unmanageable and contribute to injury, absenteeism, and stress; and (iii) respecting nursing expertise and allowing them some control over their lives.

This qualitative study has explored the experiences of nurses who provide care to individuals following a stroke. To my knowledge, this is the first study of its kind in Canada. The aim of the study has been to acquire a deeper knowledge of the nurses' perceptions, beliefs, and feelings about providing care within a rehabilitation setting and to understand better the factors that influence their perceptions. This journey of discovery has been unique in two ways. For the first time, the nurses have entrusted their stories to an individual who is not a nurse. This has meant breaking their silence, taking a risk, confiding in an outsider, explaining what they do, feel, and think and, most important, sharing their hopes and dreams. For me, listening to their narratives made the nurses visible. All my previous assumptions about rehabilitation nursing were displaced as I learned more about what it means to be a nurse providing care to individuals who have

had a stroke. This study has made me realize how little I knew about nursing in general. Through this process, I have come to appreciate the importance of active listening, searching for meaning, reflecting, and being more sensitive to the diverse undercurrents that surround any issue. This interpretative study has illuminated the complex interplay of historical, socio-economic, and political factors that have an impact on the context in which the nurses work. It would seem that having a person from another healthcare discipline explore another professional's experiences is a viable way to improve awareness. By asking the nurses to explain what they meant, and by not accepting vague answers such as "you know", I encouraged them to clearly articulate their values and concerns until we both were satisfied that I understood what they were trying to say.

Four major sensitizing concepts derived from the literature helped in the interpretation of analysis and reflected (i) the historical roots of nursing within an institutional patriarchal system; (ii) the stereotyping of nursing as a female-oriented job akin to the role of wife and mother, thus leading to its invisibility; (iii) societal devaluation of those nursing tasks dealing with bodily waste by-products; and (iv) the combination of all the above factors that stifle the nurses' attempts to gain empowerment and to have more control over their work life.

Opening up Heidegger's famous hermeneutical circle has allowed the research process to grow by including interpretations besides those of the researcher and the participants (Conroy, 2003). For example, my thesis committee members, as second readers, suggested reviewing the literature on bodily waste and gender to help discover what the text was showing and what was lying beneath its surface (Conroy, 2003). In

exploring the experiences of nurses providing care to survivors of stroke, I met an engaging group of knowledgeable professionals who want the opportunity to be equal partners in the rehabilitation process. Certainly gender-related issues and a traditional view of the nursing profession have combined to influence society's expectations of the nursing role and, accordingly, the degree of respect allotted to nurses in general and, more specifically, to the nurses working on a neurological rehabilitation unit.

To me, a further major outcome of this study was the realization that empowerment is a process that is influenced not only by the attributes and endeavours of individual nurses but also by the environmental factors of the workplace. I have come to realize that changes in how the rehabilitation unit operates require me and, I hope, other team members and administrators to change. This analysis has raised a number of conceptual issues relevant to understanding the implications of the social and organizational aspects of nursing within a rehabilitation setting.

At this time, the nurses are somewhat despondent that their concerns have not yet been addressed. In a way, their willingness to share their stories with me, an outsider, may be viewed as their latest and most determined attempt to achieve their goals. Does the voice of a person who is not a nurse make a difference in helping them achieve more recognition and respect? Perhaps it is a beginning if my writing fosters a greater understanding of the experiences of nurses who provide care to survivors of stroke. My intent is to encourage active reflection on what the nurses are saying rather than to be prescriptive. I do not have a solution; I have only concern and more questions. However, we may begin to crack the silence that has surrounded nurses for a long time if we all

attend to the message of Kahlil Gibran (1970): "Give me an ear and I will give you a voice" (p.12).

Future Directions

How do we address the concerns of these nurses? After my latest committee meeting (August 3, 2005), I again looked at the Canadian Nursing Advisory Committee (CNAC) website for updated reports. Although there has been some progress over the last few years, there still remain significant nursing shortages, high attrition rates, unsatisfactory work environments, violence and abuse in the work place, and a general lack of respect—issues similar to those raised by the participants. According to the website, there have been many comprehensive reports over the past eleven years that have identified these problems and made hundreds of recommendations. However, such efforts have resulted in only minor changes in educational opportunities for nurses, enhanced awareness of nursing issues with various stakeholders, and improved accountability of government-funded agencies to implement nursing plans (CNAC, 2005). My own suppositions were challenged while conducting this qualitative study, but how do I build upon my new understanding?

The CNAC (2005) concluded that the nursing profession needs the support of others to make changes to funding formulas and government policies. Similarly, members of the multidisciplinary team need to recognize the role of nurses in rehabilitation. The results of this study could be shared with the other members of the stroke team in a series of workshops where, I am optimistic they will be sensitive to the

nurses' concerns when they have time to reflect on the study's findings. However, it is far more difficult to foster an attitude that builds trusting and workable relationships amongst all health care professionals when the setting is far removed from the actual clinical practice. Apparently past attempts to advocate for greater interprofessional collaborations that decrease discipline-specific prerogatives at the university level have been unsuccessful (H. Arthur, personal communication, August 3, 2005). Van Manen (2001) wrote about the critical importance of not losing the essence of the phenomenon—of keeping it real to remind educators, academics, and researchers why they study, teach, or explore. One possible way to make the nurses' concerns meaningful to others is to produce a fifteen-minute teaching video based on the thick descriptions found in this study. Scenarios could be scripted that highlight the themes along with questions to encourage group discussion. The visual medium is a powerful tool for translating knowledge; the voices of nurses as the front-line staff providing care to survivors of stroke are powerful in the message they delivered. I hope the video would cause others to pause in their busy lives as clinicians, students, professors, or policy makers and reflect on the issues facing the nursing profession.

It would also be interesting to focus on the area of healthcare expenditures. The nurses want to conduct a study where an additional staff person would be employed every morning in order to allow them more time to provide rehabilitation nursing to individuals who have had a stroke. A mixed qualitative and quantitative design could explore this question. A randomized controlled trial could evaluate whether extra nursing staff in the mornings translates into more efficiency for the unit as measured by the length of stay in

hospital and changes in the patients' Functional Independence Measure (FIM) scores. Focus groups could explore the satisfaction of the nursing staff, team members, and survivors of stroke and their families. Such a study would directly speak to the bottom line of health care analysts.

Limitations of the study

The implications of this small study may not be generalizable to other facilities, as it was carried out (i) in a stroke rehabilitation unit housed on a mixed neurological ward, and (ii) with rehabilitation nurses who, on average, had considerable experience working with survivors of stroke. Moreover, as the researcher was a novice in conducting interviews, although there a more experienced interviewer was also involved, perhaps additional or different data would have been obtained. My interpretation was one of several possibilities, thus reflecting the creative, constructive component of qualitative research and my understandings as a physiotherapist and research clinician working with survivors of stroke. However, I do believe that this study offers a basis for further reflections.

Summary of Possible Implications for Various Stakeholders

The validity of this study rests with the reader who must decide whether my findings resonate with "a ring of truth." If that is the case, then there are some possible implications for the various stakeholders (i.e., survivors of stroke and their families, the

nurses, members of the stroke team, the nursing profession, hospital administrators, and policy makers).

The relationships nurses form with their patients and family members are fundamental to the work of nursing. If survivors of stroke and their relatives hold different expectations about the role of nurses (i.e., nurses are there to "do for" the patient), then misunderstandings may easily arise. Before their admission to the stroke unit, it would seem advantageous to inform survivors of stroke and their families about the new role nurses will play in their recovery. The nurses may find it helpful to discuss and form specific nursing goals with these patients and their families. Developing these mutual interactional goals may help clarify the role of rehabilitation nurses that can be further augmented with written material and verbal support from other health care disciplines.

As the population ages, more people are likely to need rehabilitation services at some time in their lives. It seems an opportune time for hospital administrators to rethink ways to increase the job satisfaction of nurses, who make up the largest group of health professionals working within a rehabilitation setting. Empowering the nurses may enhance the delivery of quality and cost-effective care. In particular, it would seem beneficial to review the current rehabilitation care philosophy of the stroke unit to try to meet some of the nurses' concerns. Second, fostering more collegial support and open communication with the rehabilitation stroke nurses would assist in creating a more interactive and respectful work environment.

At present there appears to be a mismatch between the way in which nursing care to survivors of stroke is envisioned and the resources available. The current arrangement appears to erode the nurses' self-esteem, while past attempts have decreased their willingness to trust team members, managers, and administrators. These are serious factors that feed into a cycle of frustration, isolation, and hopelessness for the nurses. To help the nurses reach their professional actualization, a climate of trust that encourages honest communication is of utmost importance. To accomplish this, it might be helpful to appoint an ombudsperson to facilitate meaningful dialogue between management and the nurses and to help examine relevant issues that could be addressed within the current fiscal restraints.

The nurses have demonstrated that they have all the qualities to be empowered as equal partners in caring for individuals following a stroke. What is needed is a working environment that helps this happens. While stroke team members theoretically recognize the contributions of nurses to the rehabilitation care of survivors of stroke, a number of issues still remain that negatively affect effective team functioning. From the nursing perspective, this includes a lack of time and staff shortages owing to the needs of individuals with spinal cord injuries that limit nurses engaging in therapeutic activities with survivors of stroke. If the stroke team is to focus on providing goal-directed patient and family-centred rehabilitation care, then each stroke team member needs to think about how they can help nurses be part of the team. If the therapists were to spend more time on the ward, there would be increased opportunities to interact with the nurses and

exchange information; not only would these actions better serve survivors of stroke but they would also help build a cohesive, functional stroke team.

The stroke team, unit managers, administrators, and nurses have an opportunity to model an environment of empowerment to the nursing profession. In turn, the nursing academic community also has an opportunity to support these rehabilitation nurses and help them articulate the issues facing their profession. This type of interaction may possibly demonstrate to nurses working in other areas of the hospital the importance of persisting in having their voices heard.

At a macroscopic level, in order to counteract the stereotypical image of nurses cast by television programs, movies, advertisements, and books, I believe we all need more education about what nurses really do. Perhaps nurses presume that it is redundant to articulate the different aspects of their profession to other health care providers while members of the stroke team believe they already understand the role of nurses. However, I started this study with incorrect presuppositions about the role of rehabilitation nurses. Through our journey, the nurses have broken their silence and described how they provide care to survivors of stroke. Their stories have made me aware of the challenges facing the nursing profession. I hope my story will make all who read it think about their own assumptions and by doing so, become more aware of the nurses' concerns and more receptive to changing some part of the system that limits the quality of their work life in providing care to survivors of stroke.

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Appendix 1. Information Letter on Facility Letterhead

"Exploring the Experiences of Nurses Who Provide Care to Survivors of Stroke Within a Specialized Stroke Rehabilitation Unit"

Susan Barreca, XXX & YYY University
Prof. Seanne Wilkins, YYY University

Dear Participant,

You are being invited to take part in a research project called "Exploring the Experiences of Nurses Who Provide Care to Survivors of Stroke." This study wants to better understand your feelings, beliefs, and thoughts about providing care to individuals following a stroke. The research team is made up of a trained interviewer and researchers from XXX and YYY University.

This qualitative study is important, as nurses have not been asked before about what it is like to work with survivors of stroke. When we better understand your experience as a nurse, we will be better able to increase awareness around the role you play in caring for survivors of stroke. More importantly, by listening to your voices, we hope to capitalize on this deeper understanding to create a willingness to change and improve clinical practice within the stroke rehabilitation unit.

Your comments and experiences will be gathered during an interview that will take 1 and 1/2 hours to complete. Your interview will be recorded so that your comments may be transcribed accurately. You may be contacted again to clarify anything you said and to make sure what you said was understood correctly.

Information such as your age, level of education, and employment status will be collected in order to ensure a good representation of nurses.

We have attached a copy of the Study Consent Form for you to read over.
Please call Susan Barreca, Principal Investigator, RRR Division, XXX at (111- 222-0000, Ext. 5555) if you have any questions about the study.

Thank you for reading this.

Susan Barreca, Principal Investigator, XXX
Client information letter (05/03/04)

Appendix 2. Consent Form on Facility Letterhead

"Exploring the Experiences of Nurses Who Provide Care to Survivors of Stroke Within a Specialized Stroke Rehabilitation Unit"

Susan Barreca, XXX and YYY University, Prof. Seanne Wilkins, YYY University

Consent Form

I agree to take part in a study called "Exploring the Experiences of Nurses Who Provide Care to Survivors of Stroke Within a Specialized Stroke Rehabilitation Unit." This research is being done at the RRR site of XXX. Susan Barreca or someone appointed by Susan Barreca has explained the study to me.

I understand that I will be asked about my thoughts, feelings, and beliefs in providing care to survivors of stroke. My interview will be tape recorded and studied in order to gain a deeper understanding of my experience in providing care to individuals following a stroke

The interview will take about one and 1/2 hour. The interview will be arranged at a time that is convenient to me. I understand that I may be contacted again at a later date to clarify what I said and to make sure that what I said was understood correctly.
I understand that there is no direct benefit from taking part in the study. Also there are no known risks. I understand that I may withdraw from the study at any time even after I sign this form. This withdrawal would in no way affect my position at XXX. Should I decide to withdraw, the tape recording of my interview will be destroyed at that time.

The results of the interview will be kept confidential. For transcription, audit and publication purposes, I will not be identified in any way. The tapes will be kept in a locked file only accessible to the researcher. Approximately 15 nurses will be asked to take part in this study.

Any questions about the study may be directed to Susan Barreca, Principal Investigator, RRR campus, XXX at (111) 222-0000 ext. 5555. If I have any questions regarding my rights as a research participant, I may contact XXX Patient Relations Specialist at (111) 222-0000 ext. 77771.

I will receive a signed copy of this form.

Name (please print)	Signature	Date

I have explained the nature of the study to the client and believe he/she has understood it.

Name of Witness (please print)	Signature	Date

XXX Consent form 03.03.04

Appendix 3. Interview Guide

Interview Guide

The interview will begin by asking the participants:

1. Tell me a little bit about yourself -your nursing experience and how you came to work on this unit?

2. When you first came here, what were your impressions of the nursing role on a unit dedicated to providing care to survivors of stroke? Has your thinking changed after working here for a while? If yes, how?

Once the participants appear comfortable with the interview process, they will be asked to:

3. "Think about the last day you worked here and the interactions you had with the people who have had a stroke. I am interested to hear about your thoughts and feelings when you were providing care to them."

If the participants appear to be focusing more on the instrumental nursing activities they perform each day (e.g. I gave them their medication, put the head of their bed up, and so on), then the following probes will be used to explore their beliefs, feelings, and perceptions of providing care to individuals following a stroke.

4. What do you perceive to be the key roles in looking after people who have had a stroke?

5. Pretend that I know nothing about people who have had a stroke. Can you tell me a little about the joys and challenges of your job?

6. From your experience providing nursing care on this unit, I am interested to hear your thoughts about how you see people recovering from a stroke?

7. Is there anything that I have missed that you would like to add

Thank you ever so much for sharing your experiences with me. If I were to say to you:

*Providing care to survivors of stroke is **like** ... how would you complete that sentence?*

Please take a few moments to complete this demographic sheet.

Appendix 4. Demographic Information Sheet for the Nurses

Demographic Information Sheet

"Exploring the experiences of nurses who provide care to survivors of stroke within a specialized stroke rehabilitation unit"

Age ☐ **Sex:** **1**=Male **2**=Female ☐

1- Full time **2**-Part-time ☐

Discipline ☐ **1**- RN (Diploma) **2**- RN (Degree) **3**- RPN

Number of years of experience in your profession ☐

Number of years of experience working with survivors of stroke ☐

Number of speciality courses

Geriatric courses ☐ Rehabilitation courses ☐ Neurology-based ☐
courses

Number of hours of daily contact with survivors of stroke ☐

Education ☐

1- College **2**-University **3**-Post Secondary University Credits

Thank you for completing this form.

Appendix 5. Confidentiality Agreement with the Transcriber

Confidentiality Agreement with the transcriber

For the period beginning May 15th, 2004, [name of individual] is responsible for transcribing audiotaped interviews that are generated through the YYY University research study entitled "Exploring the Experiences of Nurses who Provide Care to Survivors of Stroke Within a Specialized Stroke Rehabilitation Unit." Each interview may be up to 2 hours long. Transcription will follow the guidelines attached.

As part of the research protocol, I understand that strict confidentiality must be maintained at all times. I will not discuss information about study participants with anyone other than the identified members of the research team. When transcribing, I will remove information that could be used to identify the participant (e.g. names, staff members, patients). When in my possession, audiotapes will be stored in a locked area and safeguarded against potential harm. Audiotapes will be returned to the project coordinator once they have been transcribed. Transcripts with identifiers removed may be emailed to the PI (barreca@hhsc.ca) and other interviewer [molls@mcmaster.ca]. The transcriber will keep a backup copy of each transcription, but these files will be deleted upon completion of transcription services for the project.

All transcripts should be completed within one week of receiving the audiotaped material. Payment for transcribing services will be a flat rate of $50 per hour of taped material. The transcriber is responsible for generating an invoice at regular intervals. Invoices can be submitted through Susan Barreca, Principal Investigator

[Name]	Susan Barreca
Transcriptionist	Principal Investigator
Date	Date

Appendix 6. Transcription Guidelines

Transcription Guidelines

- Title: Interview 1A, 1B, 2A etc. Please label the date of the interview as well.
- Interviews should take place between Sandra (SM), Susan (SB) and one participant.
- Identify each speaker (see below). SB is me, SM is Sandra & use initials to identify respondent.
- Separate each speaker with a double space.
- Everything on the tape should be transcribed verbatim. Do not correct grammar. If the person repeats himself or herself, write out each time. If the participant does not finish a sentence, you can use a dash (—). If someone pauses, identify this by indicating "pause" in square brackets, or if they laugh, identify "laughs" in square brackets.
- Square brackets can be used for anything that is not verbatim transcription.
- If you cannot make out something that a person has said, highlight in yellow, then I can go back over the tape & try to decipher it later!
- Information that might identify the participant should be disguised or removed. Use initials instead of names. Instead of names of patients, staff, or managers, put [patient] or [staff member] or [manager] instead.
- Please use page numbers.
- Save your work at regular intervals!

- Email the transcripts to me once complete. Save one copy to disk as well & return with the audiotape when complete. If you have any questions, email barreca @xxx.ca (905) 521-2100 ext. 73654.

- **Sample Transcript:**

[Interview conducted on Dec 10 in home of respondent. YG has a 6-year-old son C who has DCD.]
[Initial discussion regarding consent for videotape of screening done with C. Initial interaction with younger son D about Christmas coming. Copy given of screening assessment results—mom reviews the scores.]
YG:
Okay, so with the, uh, the movement one, you can definitely see [the problems].
SM:
Mmm hmm. Yeah, so that just means that he does have significant coordination difficulties, but he's very bright. There were just a few things he couldn't do.
YG:
Yeah, we knew that (laugh)
SM:

No surprise. You can choose to do with the report whatever you like.
YG:
Yeah. All right. (pause as reads over results) Alrighty, so I get a copy of this one, like the entire thing?

Appendix 7. Process of Developing the Codes

Codes after initial 2 interviews, July 15, 2004

- **Joys – the what**
- **Reasons for joy –the why**
- **Joys being a nurse on the stroke unit:**
- **Challenges**
- **Strategies to deal with challenges**
- **Nurses' feelings**
- **How nurses feel stroke survivors perceive them**
- **Perceived role of nurse**
- **How nurses perceive providing care to survivors of stroke**
- **Prognosis (including factors that contribute to successful or 'unsuccessful' outcomes**
- **Generating research ideas (advocate)**

Appendix 7 (continued) Process of developing the Codes

Codes as of September 24, 2004

- **Feelings**
  a. **Joy—the what**
  b. **Reasons for joy—the why**
  c. **Sadness**
  d. **Frustration**
- **Challenges**
- **Strategies to deal with challenges**
- **How nurses feel stroke survivors perceive them**
- **Perceived role of nurse**
- **How nurses perceive survivors of stroke**
- **Values and Beliefs**
- **Prognosis (including factors that contribute to successful or "unsuccessful" outcomes**
- **Generating research ideas (advocate)**

Codes with Descriptions October 14, 2004

- **Positive feelings of being a nurse on the stroke unit**—includes descriptors (verbs such as like, love, enjoy or adjectives such as happy, excited, thrilled) that describe affirmative outlook about survivors, the unit, the nursing role
- **Reasons for positive feelings**—includes explanations, instances of having positive feelings; absence of negative examples
- **Sad feelings of being a nurse on the stroke unit**—includes descriptors (verbs such distress, upset or adjective such as bad, unhappy, shame, sad, wistful) that describe negative outlook about survivors, the unit, the nursing role
- **Reasons for sadness**—includes explanations, instances of having negative feelings; absence of positive examples
- **Feelings of frustration of being a nurse on the stroke unit**—includes descriptors (verbs such as 'frustrate, annoy, bother or adjectives a such as frustrating, exasperating) that describe dissatisfaction with survivors, the unit, the nursing role
- **Reasons for frustration**—includes explanations, instances of being frustrated
- **Challenges to being a nurse on a stroke unit**

  (a) **challenges from providing care to survivors**—instances where nurses attribute the nature of the difficulties directly to the survivors of stroke or their family members; difficulties dealing with individuals with severe motor

  b) **challenges from how the unit is managed**—instances where nurses attribute the nature of the difficulties directly to how the unit is managed; difficulties with lack of medical coverage; difficulties with laboratory coverage; difficulties with patient mix; difficulties with work-load requirements; relationship with other team members

  (c) **other challenges**—includes instances of other challenges to being a nurse on the unit that are not included in (a) and (b).

- **Strategies for dealing with challenges**—ways nurses have developed to cope with the various challenges including humor, walking away, repetition, team work
- **How nurses feel survivors perceive their nursing role**—positive and negative descriptions of what nurses believe survivors think about the care they receive from nurses; examples of stereotypical thinking from survivors; nursing viewpoint about the value survivors place on their nursing care
- **How nurses perceive their role on the stroke unit**—descriptions to the interview guide question as to what nurses perceive their role to be; metaphorical response to finishing the sentence 'Providing care to survivors of stroke is like....'

- **Nursing perceptions about survivors**—attitudes and beliefs about survivors' interactions with nurses; presence of absence of labeling of survivors
- **Values and beliefs of nurses**—expressed values and beliefs of nurses that reflect an ethical stance, a set of morals or principles for providing care to survivors; use of words such as 'my belief, I believe, I want"
- **Factors that contribute to "successful" patient outcomes**—awareness of the nurses of positive physical, cognitive, social factors or prognostic indicators that may impact on how well survivors of stroke will do during their stay in the rehabilitation unit
- **Factors that contribute to "unsuccessful" patient outcomes**—awareness of the nurses of negative physical, cognitive, social factors or prognostic indicators that may impact on how well survivors of stroke will do during their stay in the rehabilitation unit
- **Ideas for change**—suggestions, ideas, research proposals for improving, changing how nursing care is delivered within the unit, to the survivors.

Description of Codes with Categories January 20, 2005

- **Positive feelings of being a nurse on the stroke unit**—includes descriptors (verbs such as like, love, enjoy or adjectives such as happy, excited, thrilled) that describe affirmative outlook about survivors, the unit, the nursing role; includes reasons, explanations, instances of having positive feelings; absence of negative examples

- lots of interaction with different team members and families
- lots of autonomy
- uses lots of their nursing skills
- gets to know the survivors and their families, but see them move on e.g. go home
- fast paced unit
- seeing survivors get better
- seeing survivors go home
- seeing friendships formed amongst patients
- from seeing survivors become less frightened
- nursing being the number 1 field
- likes looking after patients
- seeing patient walking down the hall
- confident in nursing role
- respect from the attending physician
- survivors remembering their name

- working with other groups
- working all together- one person can't do it all
- like working with other nurses (the team)
- able to solve problems (e.g. understand an individual with aphasia)
- nice physical environment (green, near malls,)
- closeness at Chedoke
- rewarding
- seeing patients improve
- opportunities to learn
- credit for using their brains
- recognized by the physicians
- always fresh
- something to learn everyday
- good relationship between the RNS and RPNS
- autonomy to put best foot forward
- seeing patients learn how to do their daily activities
- seeing patients' pride coming back
- seeing them go home
- seeing how people deal with such losses with dignity and strength
- making a nurse appreciate of their own life

- **Negative feelings of being a nurse on the stroke unit**—includes descriptors (verbs such distress, upset or adjective such as bad, unhappy, shame, sad, wistful) that describe negative outlook about survivors, the unit, the nursing role; includes reasons, explanations, instances of having negative feelings; absence of positive examples

- Sad if survivors do not get home
- wistful about wanting to be a stroke nurse but not wanting patients to hate her
- feel families of the patients should be more patient, including the patient themselves about recovery
- young patients
- number of medical tests
- patients land up in chronic care where they will not be able to practice their newly learned skills
- upset because told by others not to work through lunch
- painful because told to do less
- wistful that people had more time and desire for education
- To see that patients do not feel that they can ask for help when they are unable to do the task

- **Feelings of frustration of being a nurse on the stroke unit**—includes descriptors (verbs such as 'frustrate, annoy, bother or adjectives a such as frustrating, exasperating) that describe dissatisfaction with survivors, the unit, the nursing role; includes reasons, explanations, instances of being frustrated

- when patients are obese and not enough help to get them practising
- dealing with aphasic patients
- not being able to be the stroke nurse
- difficult to watch them struggle
- upstairs/ downstairs phenomenon where nurses and therapy staff don't mingle
- not knowing if the individuals who have had a stroke will become ill
- not knowing whether new survivors of stroke are "stable" as "stable" in acute care vastly differs from stable in rehabilitation

- **Problems with being a nurse on a stroke unit**

(a) **problems arising from providing care to individuals following a stroke**—instances where nurses attribute the nature of the difficulties directly to the survivors of stroke; difficulties related to the nature of stroke i.e. severe motor impairments, aphasia, obesity, depression, cognitive deficits; difficulties dealing with the attitudes and expectations of survivors

- that survivors do not see the rehabilitation role of nurses as important
- dealing with violent survivors
- teaching how to use ventalin to a survivor with aphasia
- working with patients who are apraxic
- working with overweight survivors
- unpredictable patients
- stroke survivors can't walk, can't sit up, balance bad
- the length of time it takes a stroke survivor to learn how to dress
- stroke survivors getting easily depressed
- getting them back as well as possible after the stroke
- aphasic patients who can't get their meaning across
- educating survivors about diet and nutrition
- keeping stroke survivors happy and getting them to program
- keeping hands in the pockets
- keeping stroke survivors happy and getting them to program
- keeping hands in the pockets
- never know with survivors as to how well (medically) they will be
- when you are run off your feet and not getting anywhere

- nurses are there to get them ready for PT/OT
- to get patients to understand that nursing is part of the team and work together with PT and OT
- that treatment is a matter of degree (get more intensity with OT/PT but still practice with nurses
- scared about how to manage the heterogeneity of the stroke population
- patients are heavy care and may be inconsistent in their transfers
- dealing with impulsive patients
- bladder retraining
- difficult to let patients struggle
- dealing with heavy patients when energy level of nurse may be low or the repetition of the activity is difficult

(b) **problems arising from interacting with survivors of stroke's families**—instances where nurses attribute the nature of their difficulties directly to interacting with family members of survivors of stroke; difficulties dealing with the attitudes and expectations of family members

- dealing with families of violent survivors who accuse nurses of improper behaviour and whose expectations are unreasonable
- families' expectation of recovery
- families expectation of what nurses should do
- families yelling at nurses
- families getting upset with nurses

c) **problems related to how to the administration of the stroke unit**—instances where nurses attribute the nature of the difficulties directly to how the unit is managed, their jobs, and conditions of work; difficulties with lack of medical coverage; difficulties with laboratory coverage; difficulties with patient mix; difficulties with work-load requirements; difficulties with increased technology and newer methods

- no backup for nurses when patients are sick (labs, crash cart, doctors)
- nursing caseload is made up of three clients with different diagnoses so survivors do not get enough time
- changing the client mix on the floor all the time
- other nurses have to pick up the rest of the work for the nurse who does rehab aspect
- time to do rehab nursing
- staffing model of the unit
- patients with spinal cord injuries take more of the nurses' time

- lack of management support and education about the importance of the rehab role with survivors
- other nurses who are doing their own work and picking up hers
- different nurses doing things differently (being a relief)
- the needs of the patients with spinal cord injuries vs. those of survivors of stroke
- level of care needed amongst patient mix
- keeping the staff happy because of the patient mix (staffing resources)
- residents not coming to deal with sick patients
- newer staff struggling with the workload
- newer staff learning procedures such as catheterization, internal feeds, transfers
- difficulty because survivors do not know how to do any of the basic tasks
- dealing with heavy patients (in terms of care)
- politics of the hospital, not nursing
- budget cuts—no consultations
- no physician support
- can't do all that is possible from a nursing point of view for acutely ill patients
- nurses not communicating with each other
- shift work so not sure what the patient is capable of
- escalation of patient load
- not enough time with increased nurse: patient ratio
- GRASP number changed
- nurses let go
- not enough staff
- given lip service to input
- not being consulted by management
- having the wind knocked out of their sails
- being able to express how they are feeling with belittlement
- many situations and challenges where nurses feel they are losing control
- relief nurses coming in with expectations, becomes frazzled, disturbs the working environment, and then everything straightens itself out

(d) **problems related to relationships with other stroke team members**—instances where nurses attribute the nature of the difficulties directly to their relationship with other members of the stroke team; difficulties dealing with the attitudes and expectations of other team members

- two levels—don't see what is happening in physiotherapy
- physiotherapy doesn't sign off on the ward what patients can do
- general communication
- difficulty with fellow nurses who are not sensitive to the needs of stroke survivors leading to a strained relationship

- degree of negativity of the floor due to some nurses' approaches to clients
- nurses being consistent between themselves as to how they approach the client in encouraging independence
- fragmentation of nursing care due to lack of communication with each other
- nurses supported their practice with the evidence

(e) **other problems**—includes instances of other problems to being a nurse on the unit that are not included in (a)–(d).

- stressors when patients become acutely ill requiring **24 nursing care**
- nurses getting older
- need fresh nurses to do things differently
- when other nurses are not sensitive

- **Strategies for dealing with problems**—ways nurses have developed to cope with the various problems including humor, walking away, repetition, team work; includes explicit statements by nurses.

- Getting good at guessing what a survivor wants
- Ignoring yelling by patients and families
- Keeping it brief and documenting incident of yelling
- Trying different ways
- repetition and consistency
- working in groups to share workload
- telling the patients that walking to the bathroom is a form of physio
- listening
- being kind and gentle
- humour
- never going in alone to do "heavy" patients
- patience in dealing with aphasic patients
- go slower with those who are not ready for rehab
- talking to co-workers
- referring to Cardex
- having fun—getting to know their personalities and joking with patients
- able to change patient without putting her to bed (working alone using the bed rail)
- learning to read little clues
- combing gestures with words
- being patient
- being open minded
- never judge the present day on the previous one

- side-stepping anger in patients

a. trying to nurture a constructive use of anger in patients

b. **How nurses feel survivors of stroke perceive their nursing role**—positive and negative descriptions of what nurses believe survivors think about the care they receive from nurses; examples of stereotypical thinking from survivors; nursing viewpoint about the value survivors place on their nursing care and how they understand and/or perceive this evaluation

- not held in high regard because of the type of care nurses provide—washing private parts
- feeling of stroke survivors that nursing work is not important
- present differently downstairs with the therapists
- abusive at times (screaming for toast)
- treat them as a servant
- stereotyping nurses
- hate nurses when they make them do things for themselves
- feel physio is the most important
- have been told that physio is the most important
- patients are frustrated because they have been led to believe that they will get better sooner
- patient expect nurses to be at their beck and call
- when they leave the patients to do things on their own, they feel that the nurse hasn't done anything for them
- patients think that the nurses are lazy when they let them struggle to do their ADLS
- some of the population think nurses are wonderful
- patient commented patient commented on "not having much of a nurse today"

- **How nurses perceive their role on the stroke unit**—descriptions to the interview guide question as to what nurses perceive their role to be in providing care to survivors of stroke

- important role—should know how to transfer and toilet survivor and know how the patient acts
- big role as it includes PT, PT, speech, doing all that with morning care
- nursing role has changed with more autonomy and more responsibilities
- improved technology that calls for increased skill set needed involving new learning (e.g. knowing how to regulate ventilator, doing their lab work)
- no backup—feelings of isolation—no x-ray after 4, no ECG tech, do not feel this will change at the new site
- more complex patients with more unresolved medical issues

- importance of bladder training
- teaching and reinforcing the steps for dressing, transferring, walking
- physical care
- interactions with families and other disciplines
- teaching them some of the things that will help get them home ++
- dealing with survivors who are unsafe
- dealing with survivors who are violent
- nursing role where you just got them washed and sent off to program-has not changed in 9 years
- few dedicated to the rehab role
- what the rehab nursing role is and that only a few really good nurses do it
- rehab role very time consuming
- assessment and deciding which approach to take (bladder, meds, depression, for example)
- working with the therapy staff to gain consistency
- role of a coach
- benefits of rehab nursing role to lead to earlier discharges for patients
- advocate for the survivor of stroke
- have to put hands in the pocket because I was always helping the patient
- every aspect of nursing from feeding, to getting them up in their chair to doing their bowel and bladder programs
- educate patients that there is more to life than physio
- we do a lot of education "24/7"
- role has not changed much
- newer equipment and methods
- being assertive to get the resident to see a sick patient
- a nurse is a sort of PT, OT , dietician, speech therapist all rolled into one
- jack of all trades, master of none (even fixing the TV)
- part of the nurse's job to teach
- explaining the reasons for all the tests
- starting IVs
- elsewhere
- role of assessment, especially when patient is ill
- leaders
- on the job "24/7"
- teaching
- direct patient care
- communication with patients
- helping patients can control of their bowel and bladder
- developing a strong rapport with the patients
- respecting their person

- helping them with bowel and bladder issues
- communicating with patients
- emotional support "give a hug"
- sensitive to the individual's needs
- advocate
- helping stroke survivors get back their self esteem
- health teaching
- reinforce teaching from other disciplines
- staff are goal orientated, focused and know how to get the job down
- give information and explanation why something is done
- teaching to keep nursing profession vibrant
- to become better educated so as to be able to teach
- to be a shadow and observe
- being sensitive to patients' pain
- helping patients to become motivated to gain independence
- helping patients gain acceptance of the stroke
- listening to their needs
- identifying their needs
- being a whipping post if necessary
- mentor
- watching to see if their help is needed

- **Nursing perceptions about survivors**—attitudes and beliefs about what nurses think about survivors of stroke; presence of absence of labeling of survivors of stroke

- Trying different communication strategies but sometimes unsuccessful in knowing what the client wants (experience helps you guess better)
- Difficulty dealing with survivors who are younger
- Empathy for all ages, including elderly but young patients are the hardest and affect nurses the most personally
- Talking to patients, even when they are unconscious
- Like the connection—getting to know survivors and their families
- Strong teaching role
- Reinforcing the teaching of the therapists
- survivors of stroke are a bit lighter care
- demanding
- patients won't tell nurses what they are doing in therapy
- trying to pull the wool over the nurses' eyes
- patients don't see the importance of practicing going to the washroom at night
- women tend to keep things from nurses more than men

- patients are frustrated with the number of medical tests
- patients' feelings (a little angry, aggravated) when they lose their independence
- patients and families don't want to practice nursing tasks (wait until they get home)
- like the patients and their different personalities
- survivors are excitable and get upset easily
- patients expect nurses to do that type of care
- pushy with nurses to get to therapy
- patients struggling with a lack of control of their lives and bodily functions (being able to go to the washroom by themselves)
- having to submit to some "humiliating" procedures
- stroke survivors experience some form of pain, physical or mental or emotional
- stroke survivors have a lot of anger

- **Values and beliefs of nurses**—expressed values and beliefs of nurses that reflect an ethical stance, a set of morals or principles for providing care to survivors; use of words such as "my belief," "I believe," "I want"

- treating patients as you would your family members
- treat patients like I would like to be treated
- let the survivor struggle a bit as they have to learn to do this for themselves
- empathy for survivors
- everyone is an individual
- holistic approach to care
- going the extra mile
- not here to punch a clock
- want to learn to do better
- challenging survivors for quantity and quality in their lives
- should not challenge something just on your opinion but importance of sitting down and getting information
- putting yourself (as a nurse) in their shoes and understand their losses

- **Determinants of patient outcomes**—awareness of the nurses of positive, negative, or unclear physical, cognitive, social factors or prognostic indicators that may impact on how well survivors of stroke will do during their stay in the rehabilitation unit

- type of stroke
- motivation—positive factor
- level of impairment
- incontinence of bowel and bladder—negative factor

- impulsiveness—negative factor
- recovery of the arm, leg, speech, swallowing, bladder control
- knows difference between hemorrhages and infarcts—positive for bleeds
- FIM score
- Multi-infarct dementia—negative factor
- family support—positive
- heavy patients—negative for obesity
- stroke patients are easier to get going provided they get their limbs back and not too much brain damage
- not sick but an alteration in how the body functions and needing to learn how to get around it
- some patients not ready to deal with the fact that they have had a stroke
- recovery over time
- role of depression and medication
- risk for depression
- positive sign when they start to think about others

- **Ideas for change**—suggestions, ideas, research proposals for improving and/or changing how nursing care is delivered within the unit, to the survivors

- Doing a study where extra staff were on mornings and then evaluating length of stay of stroke survivors
- OT and PT to put up sheets on each patient
- OT to teach dressing skills
- nurses spending time with the physios learning transfer techniques
- OTAs helping on the ward
- research on how to help approach intimate relations with clients
- physios working on the week-end
- more nursing care hours