Nursing and policy: Nurses perspectives on ending hallway healthcare in Ontario

by

Jen Calver

A thesis submitted to the
School of Graduate and Postdoctoral Studies in partial
fulfillment of the requirements for the degree of

Master of Health Sciences in Community, Public and Population Health

Faculty of Health Sciences

University of Ontario Institute of Technology (Ontario Tech University)

Oshawa, Ontario, Canada

April 2022

THESIS EXAMINATION INFORMATION

Submitted by: **Jen Calver**

Master of Health Sciences in **Community, Public and Population Health**

Thesis title: Nursing and Policy: Nurses perspectives on ending hallway healthcare in Ontario

An oral defense of this thesis took place on April 6, 2022 in front of the following examining committee:

Examining Committee:

Chair of Examining Committee	Dr. Robert Balogh, Ontario Tech University
Research Supervisor	Dr. David Rudoler, Ontario Tech University
Examining Committee Member	Dr. Lori Schindel Martin, Ryerson University
Thesis Examiner	Dr. Manon Lemonde, Ontario Tech University

The above committee determined that the thesis is acceptable in form and content and that a satisfactory knowledge of the field covered by the thesis was demonstrated by the candidate during an oral examination. A signed copy of the Certificate of Approval is available from the School of Graduate and Postdoctoral Studies.

ABSTRACT

Drawing from elements of street-level bureaucracy this thesis examines the experiences and perspectives of six nurses (registered practical nurses and registered nurses) and their work with patients designated as alternate level of care (ALC) in an era within which policy initiatives include an end to hallway healthcare. Policies to end hallway healthcare focus on providing patients with the right care in the right location. Little attention has been focused on the impact of nursing on policy implementation. Using a descriptive qualitative approach, this study paid particular attention to the realities of everyday work in various hospitals throughout Ontario. The findings show that nurses have differing levels of awareness and understanding of policy. Further, they feel removed from policy planning and decision-making. This calls for attention of nursing institutions (education and workplace), professional associations, researchers and policymakers to help bridge this gap.

Keywords: Nursing; Policy; Hallway Healthcare; Street-level bureaucrats; Qualitative

AUTHOR'S DECLARATION

I hereby declare that this thesis consists of original work of which I have authored. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I authorize the University of Ontario Institute of Technology to lend this thesis to other institutions or individuals for the purpose of scholarly research. I further authorize University of Ontario Institute of Technology to reproduce this thesis by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research. I understand that my thesis will be made electronically

The research work in this thesis that was performed in compliance with the regulations of Ontario Tech's Research Ethics Board under **REB Certificate number 16118**

_____ Jen Calver

STATEMENT OF CONTRIBUTIONS

I hereby certify that I am the sole author of this thesis and that no part of this thesis has been published or submitted for publication. I have used standard referencing practices to acknowledge ideas, research techniques, or other materials that belong to others. Furthermore, I hereby certify that I am the sole source of the creative works and/or inventive knowledge described in this thesis.

DEDICATION

I dedicate my thesis work to my loving family and friends. A special feeling of gratitude to my loving husband, Brendan Calver who has been a pillar of strength throughout my academic journey. My children, Grayson and Adam whose energy and inquisitive nature inspire me to always persevere and to never give up.

I also dedicate this dissertation to my many friends and nursing colleagues who have supported me throughout this process. I will always appreciate all they have done, especially Nicole Molenaar for her nursing and entrepreneurial strength, Tawni Keil for helping me to navigate the delicate work/life/school balance, and Julie Vizza for the many hours of proofreading and peer support.

ACKNOWLEDGEMENTS

I cannot express in word the gratitude that I have for my thesis supervisor, Dr. David Rudoler. There were times where this work pushed outside the boundaries of our comfort zones and when I did not think that I would be able to finish, but your patience and support helped me to achieve my goals of completing my first research in the area of nursing and policy. Thank you for all of your support and guidance on health service research and public policy. I am grateful for all of the experiences I have gained through you as a supervisor.

I would like to extend a special and sincere thank you to my supervisory committee member Dr. Lori Schindel Martin for going above and beyond the call of duty. Your nursing expertise and commitment to the profession provided valuable guidance and suggestions during our time together. I am incredibly grateful to have had an opportunity to work with such an amazing person.

I cannot begin to express my thanks to Dr. Ellen Vogel, for sharing her qualitative expertise to help me gain valuable experience in qualitative research. I am extremely grateful for your time and willingness to support me through a special topics course on advance qualitative research methods during the summer months. I greatly appreciate all of your direction and guidance.

Thank you to the Gerontological Nursing Association Ontario (GNAO) and the Registered Practical Nursing Association of Ontario (WeRPN) for your unwavering support and interest in my thesis work. In particular, I would like to thank Tiff Blair, Director of Policy and Communications at WeRPN for the assistance with dissemination

of recruitment materials. I must recognize all nurses and colleagues who showed interest in my thesis work and shared recruitment materials within their professional networks.

A sincere thank you to all the nurse participants who shared their experiences working with ALC patients in hospital during an era to end hallway healthcare. Finally, to all of my fellow nurses and colleagues, I am forever grateful, and I cannot thank you enough for your on-going support and words of encouragement.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 4

CHAPTER 5

CHAPTER 6

LIST OF ABBREVIATIONS AND SYMBOLS

ALC	Alternate Level of Care
LTC	Long Term Care
LTCH	Long Term Care Home
RPN	Registered Practical Nurse
RN	Registered Nurse
WeRPN	Registered Practical Nursing Association

Chapter 1. Introduction

1.1 Background

Hospital capacity issues, prolonged wait-times, and inequitable access to health services are creating strain on Ontario's healthcare system (Premier's Council, 2019a). As a result of these care challenges, Ontario has experienced an increase in 'Alternate level of Care' (ALC) which is a construct used to refer to, most commonly, delay in hospital discharge. In 2016/17, about 4,233 ALC patients occupied hospital beds while they waited to transition into different care settings, such as long-term care homes (LTCHs) (Health Quality Ontario [HQO], 2018). On average, ALC patients are waiting more than 54 days before being admitted into LTC, costing the province an additional $500 per person each day (Financial Office of Accountability of Ontario [FAO], 2019). To alleviate these health system pressures, the Ontario government has committed to end 'hallway healthcare' and invest in 15,000 new LTC beds within the next 5 years (FAO, 2019; Premier's Council, 2019a, 2019b). Success of this commitment and related public policies, may depend on nurses to "bridge the gap" between policy directives and professional practice and work routines (Annesley, 2019).

Currently, we cannot adequately explain how front-line healthcare professionals experience and respond to government efforts to alleviate and reduce health system pressures. Nurses are one of the largest groups of healthcare professionals who work directly at the point of patient care (Canadian Institute for Health Information [CIHI], 2017; Fox et al., 2017), whose practice could influence how policy goals are implemented at the organizational and point-of-care levels. It is unclear the degree to which nurses are aware of or purposefully enact policy influence. Street-level

bureaucracy suggests that public servants such as police officers and social service workers enact public policy. However, a small body of literature has applied the street-level bureaucracy theory to explore the interconnection between nursing experience and delivery of public policies. Utilizing concepts from street-level bureaucracy may be helpful to support analysis of policy implementation from the behaviour and experiences of street-level bureaucrats in their day-to-day work (Bergan & While, 2005; Dickson & Brindis,2019; Walker & Gilson, 2004).

The current literature suggests that nurses are street-level bureaucrats, who respond to individual patient needs from within a bureaucratic structure to deliver public health services. Therefore, their work involves high workload demands, insufficient resources, and unpredictable patients which require nurses to respond with the skills, knowledge and resources afforded to them to manage and cope with work pressures (Bergen & While, 2005; Walker & Gilson, 2004). This research aims to understand how nurses experience policies to end hallway healthcare in their everyday work with ALC patients, through the lens of street-level bureaucracy.

1.1.1 Research Questions

This study aims to explore the following questions:

1. How do nurses understand the policy objective to end hallway healthcare?
2. How do nurses experience providing direct care in an era to end hallway healthcare?
3. How do the motivations of nurses align or conflict with the policy objective to end hallway healthcare?

1.2 Purpose and Significance

Exploring the experience of frontline nurses and their understanding of policies to end hallway healthcare will inform key areas of the policies that may align or conflict with motivations to deliver health services as envisioned. Street-level bureaucracy will be considered to help assign meaning to nurses described experiences and motivations to fulfill policy intentions. As such, the experience of nurses may provide valuable insight for how policy directives are understood and perceived on the frontline, which also informs how policy goals are (or are not) being translated into delivery of hospital services and programs. The significance of this study is important from a policy and health service perspective, as it will address existing gaps in the literature and highlight areas for future research, nursing, and health system reform efforts.

Chapter 2. Theoretical Concepts

2.1 Street-Level Bureaucracy

Lipsky (2010), introduced the theory of street-level bureaucracy in 1980. Street-level bureaucracies are public service agencies that employ a high number of public service workers (street-level bureaucrats) in their work force. Lipsky's (2010), street-level bureaucracy theory highlights how the discretion of public service workers, work conditions, and professional practice influence client outcomes (Lipsky, 2010). Lipsky argues that street-level bureaucrats are ultimately makers of public policy in two distinct ways. The first is the use of discretion to make decisions concerning their clients; and secondly, the way their individual actions depict the behaviour of the organizations they are employed by (Lipsky, 2010).

Faced with a heavy burden of workloads and limited access to resources, street-level bureaucrats develop their own coping mechanisms to meet what they perceive to be in the best interest of the population they serve. Oftentimes the workers' personal beliefs, desires and assumptions come into play when making these decisions. These coping mechanisms may directly contrast or conflict with their organization's goals and objectives (Lipsky, 2010). Lipsky (2010) suggests that this ambiguity and perceived conflict stems from one of three sources: (i) client centered goals conflict with the desired characteristics established by employers, (ii) client centered goals conflict with the goals of the organization, and (iii) the role expectation of the street-level bureaucrat is communicated through multiple and often conflicting sources.

A defining characteristic of street-level bureaucrats is that they cannot be fully controlled by employment agencies (Lipsky, 2010). Often the work of street-level

bureaucrats reflects professional standards rather than administrative norms. Street-level bureaucrats are bound by their regulatory standards, regulations, resource (budget) allocations, and work procedures. Thus, they are accountable for their work to the public, their peers, and the organizations where they are employed. Often street-level bureaucrats must make rapid decisions based on their client assessments and from this lens, their level of professional discretion defines how they deliver policy at the front-line.

In Lipsky's later works, he describes how the primary conclusion of his readers was that the actions of street-level bureaucrats become the public policies they carry out into practice (2010). He argues this interpretation of the street-level bureaucracy theory is too limited. Street-level bureaucrats do "make" policy through discretionary actions and behaviours, but they only do so in a broad policy context in which their decisions are a part. Overall, street-level bureaucrats do not decide the core objectives of the policy or the overarching mechanisms to achieve the policy. For this, the entire policy agency or reform needs to be taken under consideration.

May and Winter (2009), connect political and administrative influences with shaping the actions and behaviours of street-level bureaucrats at the frontline of policy implementation. Noting that the degree of influence for the delivery of policies is varied. These authors suggest that the variation of policy influence is informed by how frontline workers understand policy, their own professional knowledge, and the evaluation of policies. Lotta and Marques (2020), add that workplaces structures are central in the discretionary practice of street-level bureaucrats. The relational elements in the interactions with government officials or representatives, peers, and their assigned patient

population also contribute to variation in discretionary actions at the point of care where policies are delivered.

Figure 1.

A Conceptual Organization for the Influence of Frontline Workers to Implement Public Policy

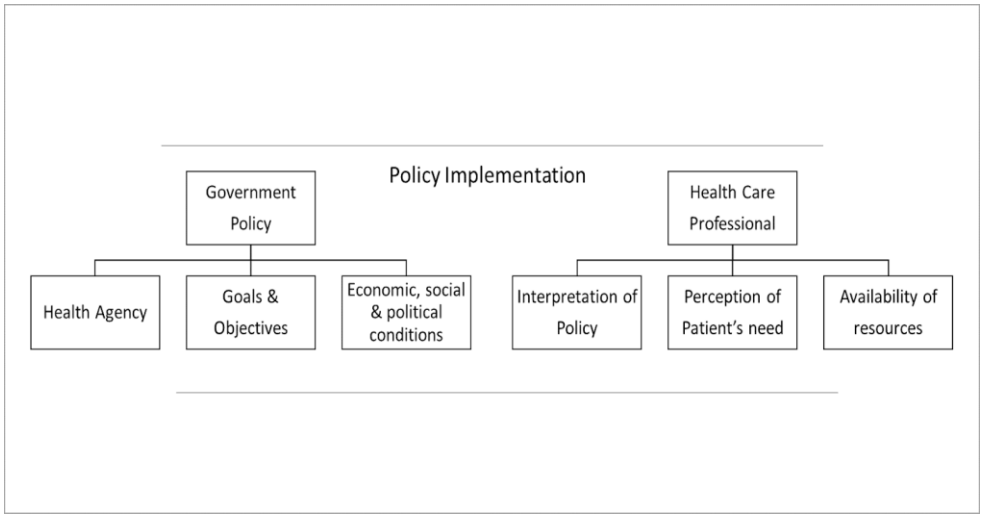


Figure 1. A conceptual organization for the influence of frontline workers to implement government policy. [Adapted from: (Annesley, 2019; Bergen & While, 2005; Lipsky, 2010; May & Winter, 2009; McConnell, 2010; Van Meter & Van Horn, 1975)].

The street-level bureaucracy theory permits us to conceptualize the influence of healthcare professionals in the translation of government policy across the continuum of care. The combined interests may be presented diagrammatically (Figure 1) to further illustrate key elements of policy making in government and on the ground of healthcare institutions, which takes the policy implementation process beyond economic, social and political conditions through its maturity where policy becomes the patient care delivered by healthcare professionals.

2.2 Selected Elements of Street-Level Bureaucracy

There are four elements of street-level bureaucracy theory that are utilized in this thesis to understand the way in which nurses implement public policy: accountability, discretion, work conditions and coping mechanisms. These elements will be used as themes in a deductive coding framework to help assign meaning to emergent findings. Exploring the central research questions of this thesis through the lens of street-level bureaucracy offers a structured approach to developing detailed descriptions (both textural and structural) of the lived experience of nurses' caring for ALC patients, and the impact they have on policy implementation.

2.2.1 Accountability

Lipsky (2010) describes accountability as when individual workers have a likelihood to respond to authority or influence. Further, accountability can be defined by the use of two distinct concepts: (i) the relationship of people or groups, and (ii) the pattrens of behaviour. For example, in their work, street-level bureaucrats are required to make decisions about other people and respond according to the patients' individual needs and their situation. These decisions may be shaped by employers, the profession and patient claims. Lipsky (2010) claims that accountability can only exist when there is a pattern of behaviour. It is these behaviour patterns that guide regulatory bodies and other stakeholders to increase level of accountability.

Nurses are held accountable through various relationships and interactions with patients, the public, work colleagues and employers. Nursing is a self-regulated profession, although in Ontario a regulatory body ensures all nurses meet expected standards for licensure, through means of a standardized exam, required for continuing

practice and renewed annually. Regulatory colleges expect nurses to hold the needs of patients above their own professional interests and be accountable to the standards of the profession and to relevant legislation (College of Nurses of Ontario [CNO], 2019). These standards may align or conflict with employing agencies, peers and/or expectations of the patient receiving care and nurses must constantly take into consideration the multi-layers of accountabilities during the course of the work day (Hupe & Hill, 2007). Interestingly, licensure by CNO is not dependent upon public-policy specific knowledge.

2.2.2 Discretion

Nurses hold a certain level of autonomy in their practice and the decisions they make on behalf of the population they serve. Employing agencies often rely on the professional judgement and experience of nurses to deliver health services in accordance with organizational goals and objectives guided by health system policy and legislative guidelines. In street-level bureaucracies, the use of discretion is expected so that professionals can make judgements and act within their specialized area of work (Lipsky, 2010). The discretion used by nurses as street-level bureaucrats may deviate from policy and organizational expectations and influence the direction of policy implementation (Hoyle, 2014).

In nursing, discretion is required due to the unpredictable nature of patient interactions such as sudden change or influx of patient acuity, changes in cognitive state, or hostility. The use of discretion on the job can both align with and conflict with the intent of policy decisions. Thus, through discretionary action, nurses can influence the implementation of public policy.

2.2.3 Conditions of Work

Lipsky (2010) suggests that limited involvement in policy development can leave street-level bureaucrats with a "high degree of uncertainty"; this makes it challenging to balance complex workloads, multi-level interactions and constant pressure to make rapid decisions in a limited timeframe. The workload burden and high number of patient assignments create a situation where street-level bureaucrats are unable to complete all their tasks and responsibilities. Many street-level bureaucrats will attribute their inability to perform all aspects of their role as personal failure, even when circumstances prevent them from doing so (i.e., high risk level, poor resources, ambiguous goals). Further, they may have been redeployed to an area of work where they have not been trained and expected to complete tasks as directed by their manager.

Nurses often work under conditions of ambiguous expectations, inadequate resources to deliver services (Dickson & Brindis, 2019), and conflicting goals between managers and frontline nurses (Hoyle, 2014). Further, heavy workload burdens have negative implications at a personal level for many nurses (Walker & Gilson, 2004). The conditions of work as described by Lipsky (2019) are consistent with the nursing literature that shapes nurse decisions about policy (Cuthill et al., 2019).

2.2.4 Coping Mechanisms

Faced with constant pressures to perform work expectations to provide timely high-quality of care with a lack of resources street-level bureaucrats will respond by adopting certain coping mechanisms into their practice to carry out their work in the best way they feel that they can (Lipsky, 2010). Street-level bureaucrats are expected to resolve competing and contrasting priorities to maintain a patient-centred model of care

while acting quickly, yet efficiently to meet practice expectations. Oftentimes, street-level bureaucrats will self-reflect on their own performance, recognizing that while they may not meet expected standards at an exemplary level, they are functioning at an acceptable level, doing the best they can given the constraints they face. Efforts and attempts to do a good job include adapting work modifications to limit demand, maximize resource use, and obtain patients compliance outside of procedures established by their employer (Lipsky, 2010).

When faced with high-demands and complex patient case loads, nurses may respond by safeguarding themselves from increasing pressures or limit their interactions with patients. Nurses expressed rationalizations for patient care, including using available information to make judgements, categorize patients (high need, uncooperative etc.), exercise favouritism or expressed suspicion of a patient may indicate coping mechanisms used in practice (Lipsky, 2010; Walker & Gilson, 2004).

Chapter 3. Literature Review

3.1 Introduction

Policy implementation is a multifaceted process that involves many actors and key stakeholders. Nurses may play a pivotal role in how social and health policy objectives are translated into professional practice and work routines. As health professionals, nurses draw from a specialized body of knowledge and skills to care for patients. The multi-level interactions, discretionary authority, and impact nurses have on other peoples' lives position them to influence policy at the frontline of patient care. The purpose of this literature review is to establish familiarity with the nursing and policy literature and understand the role of nurses as street-level bureaucrats with social and health policy changes.

3.2 Design

A multi-stage narrative review and synthesis of the literature was conducted to identify empirical research in the areas of nursing and policy implementation. A narrative review makes sense of complex concepts by summarizing key findings from multiple sources to draw conclusions and develop a more integrated understanding of the topic of interest (Kitson et al., 2013). This review identified both scholarly and grey literature related to nursing, street-level bureaucracy, public policy implementation, and ending hallway healthcare in Ontario.

3.3 Search Method

The preliminary search strategy for this review involved discussions with experts in the field to identify seminal works in policy implementation and Ontario health reforms. In the second stage of this review, Medline and CINAHL databases were

searched to (i) identify descriptive and empirical peer-reviewed studies published in the English Language from 1990 to 2020, and (ii) identify policy implementation concepts used to explore the area of nursing, street-level bureaucracy, and policy implementation. This search strategy included the following search strings: street-level bureaucracy AND nurs* AND (policy or policies or law or laws or legislation) AND implementation, and hallway healthcare OR hallway medicine OR Hallway healthcare AND (nurs* or nurses or nursing). Titles and abstracts were scanned and included if they spoke to nurses as street-level bureaucrats and policy implementation. Articles that focused on specific medical interventions and treatments for patient care were excluded from this review. The final stage of this review relied on customized google searches to identify grey literature (reports, government documents, news releases) discussing the Ontario policy objective to end hallway healthcare.

3.4 Search Outcome

Seminal texts in nursing, policy implementation, and ending hallway healthcare were located through a broad search of generic terms. From this, the researcher conferred with colleagues and advisors and scanned policy texts that were frequently cited. Several pieces of literature were located by which represented policy implementation and healthcare reform.

In the second stage of this review, there were no empirical studies available in the literature that have explored ending hallway healthcare from a frontline policy implementation perspective. Additionally, there were no Canadian studies which have examined nurses as street-level bureaucrats or their relationship with policy implementation. A total of 8 articles were included in this review as they spoke to nurses,

street-level bureaucracy and policy. The reference lists of these articles were scanned for additional literature in nursing, street-level bureaucracy and policy implementation and included in this review (see Appendix A).

3.5 Overview of Findings

Findings from the literature review are organized into three distinct categories: (i) ending hallway healthcare, (ii) nurses as street-level bureaucrats, and (iii) review of empirical nursing literature. The first category discusses an overview of health system issues and hallway healthcare. The second category offers insight in how nurses are street-level bureaucrats. As no studies were found to have explored nurses and the policy objective to end hallway healthcare, the final category reviews empirical literature of nursing, street-level bureaucracy, and public policies.

3.4.1 Ending Hallway Healthcare in Ontario

Hallway healthcare is defined as patients waiting for medical care in hospital hallways and other unconventional spaces (Premier's Council, 2019a). A component of this provincial policy objective focuses on investing in community and long-term care services to reduce the number of ALC stays in hospitals (Ontario Newsroom, 2018; Premier's Council, 2019a, 2019b). To adequately address the complex care needs of the population we need effective coordination of healthcare (Premier's Council, 2019b). For several decades, ALC patients have been the target population for many health strategies and initiatives to reduce strain on the health system (CIHI, 2009). The notion of inappropriate use of acute care beds by ALC patients has been in the “public consciousness” since the mid-1980s. There have been several calls for action to improve

the delivery of healthcare services in more appropriate care settings such as home and community supports (Sutherland & Crump, 2013; Walker, 2011).

Over the past thirty years, great efforts and large investments were made to build and support a more integrated health system to meet population needs. Action plans such as the 2010 *Aging at Home Strategy*, the 2012 *Action Plan for Health Care*, and the 2015 *Patients First Action Plan* were implemented to improve the capacity and flow of the healthcare system (Ministry of Health and Long-Term Care [MOHLTC], 2015; Ontario Newsroom, 2010). Yet, policy efforts to transform the health system have been largely unsuccessful, evidenced by the overcrowding of Ontario hospitals and the number of people waiting in hospitals to receive care elsewhere (HQO, 2018). By 2018, several hospitals in Ontario were regularly operating beyond 100% capacity (HQO, 2018). The current healthcare system is under strain as capacity pressures have led to hallway healthcare. In response, the provincial government committed to end hallway healthcare, claiming that patients are "waiting for care in the wrong spots" (Premier's Council, 2019a).

Often patients who are labelled ALC are frail older adults who have cognitive or behavioural conditions and present with multiple morbidities which require ongoing complex healthcare services (CIHI, 2009; Costa & Hirdes, 2010; Fox et al., 2017). The literature suggests acute care hospitals are not the most appropriate care setting to meet the ongoing and chronic patient care needs (Barnable et al., 2014; Costa et al., 2012; Kuluski et al., 2017). Research has shown that older adults experience a 3-5% functional decline each day while hospitalized (Barnable et al., 2014). Many ALC patients are occupying acute care hospital beds as they wait for care elsewhere and are unable to

access community resources to support their needs (Barnable et al., 2014). Sutherland and Crump (2013) suggest that for every ALC patient in the emergency department there are four other patients delayed from receiving emergency care.

A CIHI (2009) report claims that the health system has sufficient capacity to deliver healthcare services to meet population needs, providing that the care is delivered in the most appropriate setting. Despite the in-depth look into the multiple institutional and community-based health services and efforts to reallocate the provision of care services to the most appropriate setting, hospitals continued to see a rise in the number of ALC stays. By 2011, Ontario had one of the highest ALC rates in Canada, when 7% of hospitalizations were ALC (CIHI, 2009; Walker, 2011). Most of these ALC patients occupied acute care hospital beds while they waited for beds to become available in long-term care homes (Walker, 2011). Despite provincial and health system efforts to reduce ALC stays, the number of ALC stays have continued to increase to 14.8%, a rise from 13.9% in 2015/16 and from 14.3% in 2011/12 (HQO, 2018).

Regardless of efforts to restructure the healthcare system and increase care supports for aging populations, little attention has been paid to how frontline healthcare workers experienced these policy changes at the point of patient care. Nurses are one of the largest groups of healthcare professionals to interact directly with patients at the point-of-care (CIHI, 2017; Fox et al., 2017)..

The current provincial strategy to end hallway healthcare aims to provide the right care to the right care to patients in the most appropriate setting (Premier's Council, 2019b). How nurses understand and experience policies to end hallway healthcare could inform educators, employers and policymakers of the process of policy implementation

on the ground. Elements that underpin the motivations of nurses and their influence on how policy becomes translated into work routines and patient care can advise strategic planning and decisions to end hallway healthcare in their workplace.

More recently the Ontario government identified that the health system is difficult for patients to navigate, and patients are often receiving healthcare services in settings that are not the most appropriate to meet their healthcare needs (Fedeli, 2019; Premier's Council, 2019a). Furthermore, there are issues with access to timely care, and a lack of available beds to meet the growing complex care needs of the population (Fedeli, 2019; Premier's Council, 2019a). A component of government efforts to end hallway healthcare in Ontario focuses on investing in community and long-term care services to reduce the number of ALC stays in hospitals (Premier's Council, 2019a, 2019b).

The delay in hospital discharge is an ongoing concern for healthcare policy makers, as it is costly with estimates at about 2.5 million each day (Sutherland & Crump, 2013). Despite these calls and efforts for change, hospitals continue to experience capacity issues and overcrowding. This review found no studies which have explored nurses' experience with policies aimed at ending hallway healthcare.

3.4.2 Nurses as Street-Level Bureaucrats

In Lipsky's original work during the 1980's, street-level bureaucrats were thought to be police officers, teachers and other similar public service workers. In more recent years, studies have begun to view nurses as street-level bureaucrats (Bergen & While, 2005; Cuthill & Johnston, 2019; Walker & Gilson, 2004). Nurses as street-level bureaucrats are accountable to both the public and their peers for their professional practice and discretionary actions used to care for the population that they serve. Nurses care for a wide range of clients with various social and healthcare needs. They are not

able to select which of these clients they will serve and are often faced with a lack of resources and authority to control the quality of practice and client outcomes (Dickson & Brindis, 2019).

The nursing profession has clinical autonomy that permits them to influence the way government policies are translated into the professional practice environment (Bergen & While, 2005; Cuthill & Johnston, 2019; Dickson & Brindis, 2019; Hoyle, 2014). The position of nurses and their work is parallel with the characteristics of street-level bureaucrats and Lipsky's depiction of discretionary authority that may ultimately shape the delivery of policy at the frontline. More attention directed towards the overall structure of government policy can be useful to understand the behaviour of nurses (Lipsky, 2010).

Government policy shapes the organization of healthcare systems and services to help inform the allocation of services and patient care (Bryant, 2009), and the implementation process for policy change is the action taken to attain the policy goals set forth by the government (Deber, 2014; Howlett et al., 2009). Prior to the early 1980s, policy implementation was thought to occur automatically once a policy was adapted onto the political agenda (Howlett, 2019; Howlett et al., 2009; Van Meter & Van Horn, 1975). Over time it was realized that the implementation process needed much consideration when transitioning the policy intentions into practice environments and work routines. Evolution of policy studies have identified that competing priorities and conflicting goals among actors and interest groups can alter the application or implementation of public policy goals (Deber, 2014).

Implementation of policies to end hallway healthcare in hospitals should consider how the objectives are being understood and interpreted by nurses**,** and whether the goals of the policy are aligned with the intrinsic social and cognitive forces that motivate the action and behaviours of nurses working at the point of patient care. Discretionary acts are structured by the number of choices enabled by the policy and coping needs of the worker (Lipsky, 2010). Nurses' job preference, level of practice autonomy, wages, and work conditions are important factors that underpin the discretionary actions of nurses (Lipsky, 2010).

Street-level bureaucracy does not examine policy from government, higher executives, or a senior management lens, but rather focuses on a bottom-up perspective to policy implementation. The bottom-up perspective supports analyses of policy implementation on the ground and the common behaviours and viewpoints of street-level bureaucrats in their day-to-day work. While there is theoretical literature on street-level bureaucracy, few studies have applied the theory to explore the interconnection between the nursing profession and public policy.

3.4.3 Review of Empirical Nursing Literature

A small body of literature has found street-level bureaucracy theory useful in understanding how nurses implement policy change in clinical practice settings; these studies suggest that the interconnection between nursing and policy is complex and under researched (Bergen & While, 2005; Cuthill & Johnston, 2019; Hughes & Condon, 2016). Thus, there is a gap in our understanding of the experience of nursing practice during a time of policy change. Studies that have identified factors that shape the way nurses negotiate, adapt, or resist policy when providing patient care. These factors include: work

environment, safety and security measures, individual circumstances of patients, and availability of resources (Cuthill et al., 2019; Hoyle, 2014).

Studies that have employed qualitative inquiry to explore nurses experience with policy utilizing concepts of street-level bureaucracy theory have shown that nurses are committed to their profession and value their ability to provide high-quality of services to patients (Hughes & Condon, 2016; Walker & Gilson, 2004). However, job pressures and heavy service demands often lead them into a task-centred approach (Hughes & Condon, 2016).

Cuthill and Johnston (2019) examined the delivery of a government domestic abuse policy by public health nurses in the community setting in Edinburg. These authors determined that the discretionary actions of nurses in how they delivered the policy was largely influenced by their practice setting (family homes) and measures they had to take to ensure the safety, security and trust of their clients. This finding is consistent with other nursing literature where nurses struggle to balance the pressures required by government policy, employer expectations to instate policy changes and maintain trust with people (or groups) assigned to their care (Dickson & Brindis, 2019; Hughes & Condon, 2016).

Nurses have reported that in times of policy change they are often faced with unclear and conflicting direction and guidance from managers on how to implement government policy into work routines and responsibilities. A study of nurses working in primary care clinics in South Africa (Walker & Gilson, 2004) during the implementation of a free care policies shared similar experiences of a lack of communication and guidance from employers as nurses working within an inner-city hospital in Scotland

(Hoyle, 2014), and school nurses from the United States of America (Dickson & Brindis, 2019). Nurses from these studies were working during the implementation of new government policies, and all reported higher job stress due to a lack of communication and support from management which led them to make decisions based on the information they had to care for their patients. Practice decisions to provide public health services to their patients and clients may or may not align with policy expectation.

Individual nurses have different perceptions of how policy impacts their professional practice. Policy is viewed as a tool that impacts behaviour and workplace practices. Nurses are selective of the policies they adapt into practice; this is often based on how relevant they perceive the policy to be to their practice area (Hoyle, 2014). Nurses view policy as a set of rules and regulations that they are not in a position to disagree with (Dickson & Brindis, 2019). This view was connected to fear of reprisal or apportioned blame if nurses were unable to fulfil expectations of their employer, patients, families or team members. (Dickson & Brindis, 2019; Hoyle, 2014). The differing perceptions of policy in practice influence discretionary actions to deliver (or not deliver) the policy as intended. Further, pressures to manage patient care with limited resources available and time constraints often influence the discretion used by nurses when prioritizing work routines (Drinkwater et al., 2013).

In their roles, nurses hold both professional and administrative responsibilities and are required to make rapid decisions with the information that is made available to them (Hoyle, 2014). Elements and circumstances of work conditions contribute to how policy is carried out in practice (Hlongwa & Sibiya, 2019; Walker & Gilson, 2004). What

remains uncertain is whether the motivations to deliver policy as intended aligns or conflicts with individual preferences and practice patterns.

The everyday work of nurses involves multi-layered interactions with interdisciplinary team members, patients, and their team members. Work conditions, priority of patient care, competing and often conflicting demands can influence discretionary actions of nurses in practice. Hughes and Condon (2016) found that to balance professional values with work constraints within their organization, nurses act as street-level bureaucrats in negotiating policy and the context of their professional practice. When faced with large workloads, time constraints and limited resources, nurses will develop coping mechanisms and short-cuts to complete their work (Dickson & Brindis, 2019; Hoyle, 2014; Walker & Gilson, 2004).

The coping mechanisms used to manage competing demands and workloads are often a contributing factor to the adherence or non-adherence to policy. Hoyle (2014) explored nurses' interpretation of policy and found that when nurses viewed policies as irrelevant were not fully adhered to. This finding was consistent with Bergan and While (2005) study, which found that nurses will cope with conditions of work by adopting case management practices or shifting the boundaries of the nursing role to work in a way that increased job satisfaction. Dickson and Brindis (2019) found that school nurses reported having too much to do; in the absence of appropriate supports and resources they reported not adhering to policy.

The nature of nursing is viewed as both an art and a science (Jasmine, 2009). Professional nursing practice calls on nurses to draw from theoretical and evidenced-based foundational practice and their ability to connect with others to improve, maintain,

and/or promote health, comfort, and wellbeing. This is illustrated in the literature across the health continuum where nurses balance the needs of their organization, professional practice, and service demands (Cuthill & Johnston, 2019; Hlongwa & Sibiya, 2019; Walker & Gilson, 2004). Common barriers to implementing policy goals included a lack of resources (including staff, supplies, equipment, and space), poor communication between management and staff, and lack of training in a specific area impacted by policy change (Hlongwa & Sibiya, 2019; Walker & Gilson, 2004). Communication and lack of training in areas of policy may lead to the complex and uncertain nature of the relationship between nursing and policy. Annesley (2019) suggests that nurses are often unaware of their connection and influence on policy development and processes. At the organizational and workplace level, it is also suggested that nurses feel invisible when it comes to policy decisions in the workplace (Cuthill & Johnston, 2019; Hoyle, 2014).

3.5 Summary

Efforts to address issues of hallway healthcare may be better informed through a clearer understanding the experience and perceptions of policies by the nursing profession who work at the point of patient care. The process of policy implementation relies on actors and stakeholders from policy systems, higher administrators, and frontline workers. Street-level bureaucracy has been useful in helping to understand the discretionary work practices of frontline workers and their intersection with policy implementation. Although the nursing profession is one of the largest professional workforces in healthcare, there is limited literature that examines the influence that nurses have on the implementation of public policy. The small body of literature that has

examined social and healthcare policies and how they may be translated into nursing practice have shown that the attitudes and discretionary actions of nurses' influence policy on the ground.

This review found no Canadian literature that examined nurses as street-level bureaucrats or nurses experience with policy implementation. This thesis will use the policy objective to end hallway healthcare to examine nurses' perspectives on and experience with policy implementation in their work with ALC patients, and specifically, their influence on the implementation of the Ontario government's objective to end hallway healthcare.

This study will be the first in Canada to draw from Lipsky's (2010) street-level bureaucracy theory to assign meaning to nurses described experiences working directly with patients designated as alternate level of care (ALC). This contributes to decision-making by offering some explanation of the interrelationship between policy as intended and policy as practice. The findings in this study will inform central-level planning and management procedures of how nurses experience with policy may be important in strengthening policy implementation and delivery of health services. Further, the findings may provide valuable insight for discretion used by nurses which may provide a resource, or potential barrier to, policy change.

Chapter 4 Methods and Methodology

4.1 Design

This thesis employed a qualitative descriptive approach to explore the perspectives and experiences of hospital nurses with ending hallway healthcare in their work with ALC patients. Drawing from a pragmatic paradigm (Creswell & Poth, 2018), this phenomenological approach examined the "lived" experiences of nurses and extracts meaning from nurses viewpoints to understand the combinations of subjective and objective realities of policy implementation (Creswell & Poth, 2018; Giorgi, 2009).

4.1.1 Participants

Purposive and snowball sampling was used to recruit participants (Bowling & Ebrahim, 2005; Creswell & Poth, 2018). A flyer was distributed to Ontario-based nurses who were members of the Gerontological Nursing Association Ontario (GNAO) and the Registered Practical Nursing Association of Ontario (WeRPN).

The recruitment phase for this study was open during the first and second wave of the COVID-19 pandemic, and therefore recruitment strategies were later amended to include requests to nursing colleagues and academics known to the researcher and supervisory committee asking them to share the recruitment flyer with their Ontario nursing networks. All practice nurses who responded to the initial study invitation and consented to participate in the study were asked to share details of the study with other nurses.

The inclusion criteria included Registered Nurses and Registered Practical Nurses registered in good standing with the College of Nurses of Ontario (CNO) – the

professional regulatory college. Nurse participants were eligible if they were fluent in the English language and had one or more years of front-line experience working in hospitals with patients designated as alternate level of care. There were no restrictions on the size or location of the hospitals where participants worked. Nurse managers, administrators, and nurse practitioners were excluded from this study, as the scope of the study aimed to describe experiences from the views of practice nurses who provide direct and hands-on patient care.

4.2 Data Collection

Semi-structured individual interviews were conducted using a telephone or web-based (ZOOM – audio only) platform in a private room by the student researcher between February and September 2021. I (student researcher) did not have any previous personal or professional engagements with the interview participants and therefore mitigated potential bias during the process of data collection.

Six nurse interviews were audio-recorded and ranged between 20-60 minutes with a total interview time of 253 minutes. All participants were fluent in the English language. Field notes were recorded during each interview to track how my position as the researcher evolved throughout the data collection process to account for the accuracy of data by offering transparency of myself as the researcher (Creswell & Poth, 2018).

Interview questions were developed to ascertain the factors of policy interpretation and how the reality of these policies was experienced at the organizational and practice level by practicing nurses. See Appendix B for the interview questions. With participant consent, all interviews were audio recorded and then transcribed verbatim.

The supervisory committee for this thesis work, accessed audio-recordings and transcripts to support the dependability of recorded events.

4.3 Data Analysis

Data analysis of the interviews and field notes was conducted by the researcher, under the guidance and support of the thesis supervisory committee, using a framework analysis approach (Gale et al., 2013; Ward et al., 2013).

The transcribed data of the interviews, as well as the recorded field notes were analyzed by the researcher using the five-stage framework: (i) familiarization, (ii) identification of thematic framework, (iii) charting of data, (iv) description of findings, and (v) mapping details of the findings (see Table 1). The framework approach to qualitative analysis has been shown to be useful for applied policy and health research (Bowling & Ebrahim, 2005; Gale et al., 2013). Nvivo 12 software was used to manage and organize the data.

In the first stage of analysis, I familiarized myself with the dataset by reading the transcripts and re-listening to the audio-recording and reflective thoughts from the interviews while writing down emergent thoughts and impressions. As the underlying meaning of the data was being sought, the data was first considered in the context of street-level bureaucracy theory using the four-elements of accountability, discretion, work conditions, and coping mechanisms as described in Chapter 2. The researcher used a separate document to record emergent themes and ideas. The data was then revisited by the researcher and each transcript was carefully read line-by-line, applying a descriptive label (coding) to reflect the experience expressed by nurse participants.

Consensus building was established through regular bi-weekly meetings with the student researcher's supervisory committee members. Each team member independently reviewed and coded a transcript until all sets of codes were agreed upon to be clearly defined and no additional codes emerged. Individual coding schematics were reviewed, and the preliminary coding framework was revised to reflect emergent data. The revised coding framework was applied to all subsequent transcripts.

The framework index was reviewed by the student researcher's supervisory committee during a series of consultative meetings. All feedback and suggestions were carefully reviewed and considered by the researcher. During the final stages of the analysis the data was interpreted without going beyond the data. That is, the researcher was careful to describe the data precisely as it was presented (Giorgi, 2009).

A deductive approach was used to develop a thematic framework from concepts derived from street-level bureaucracy theory (Gale et al., 2013; Lipsky, 2010). Prior to analysis, a codebook of concepts and descriptions was developed by the supervisory committee and applied to transcripts using NVivo 12 software. However, the analysis was not confined by the literature and allowed for inductive findings to further conceptualize nurses' experiences of the phenomenon (Gale et al., 2013; Ward et al., 2013).

Open-coding was used to capture new themes as they emerged from the data (Gale et al. 2013). This method of analysis is consistent with the framework approach (Ritchie & Lewis, 2003). To prevent any dominating perspectives during the coding process, the process was guided and informed by the supervisory committee during regularly scheduled bi-weekly meetings over a five-month time period.

Table 1: Five-Stage Framework Analysis Chart

Familiarization	Immerse in the data by listening to the audio recording, reading transcripts and contextual/reflective notes that were recorded. i. Re-listen to all or parts of the audio recording. ii. Have a separate document open to record thoughts and impressions while becoming familiar with the data.
Identify a thematic framework	Overview of the richness, depth and diversity of the data collected from the interviews. i. Include notes, recordings, and the range of responses to questions. ii. Identify key issues, concepts and themes that emerge from the data. iii. Capture as much detail in the thematic coding framework as possible.
Indexing	Apply thematic framework to data. i. Make judgement and meanings about data (interview responses, notes, recordings). ii. Passages from the data may include multiple themes. These themes need to be referenced.
Charting	Organize thematic findings using clear headings and subheadings. i. Headings can come from the thematic framework and/or research question
Mapping and interpretation	Reviews original research objectives. ii. Compare perceptions and experiences. iii. Review chart and research notes. iv. Search for patterns and connections.

Five-stage framework analysis chart [Adapted from: Bowling & Ebrahim 2005; Gale et al. 2013)

During these team meetings, all researchers met to review and compare the labels they applied using an iterative codebook, directional diagrams and PowerPoint presentations to help group together data into categories, which were then clearly defined. Coding was an iterative process and continued until the committee reached an agreement on themes that engaged key concepts and reduced data into understandable, but brief summaries of participants' described experience.

4.4 Validation Strategies

Evidence was corroborated through a triangulation of multiple data sources including the theory, method, investigation of data by multiple coders, and member-checking process. Creswell and Poth (2018) recommend the use of multiple validation strategies in all qualitative work. The authors define validity in qualitative research as an

"attempt to assess the accuracy of the findings, best described by the researcher, the participants, and the readers" (p. 259).

To help clarify the position of the researcher to readers, I engaged in reflexivity (Creswell & Poth, 2018), to illuminate my past experiences, biases and values that have likely shaped my approach to this thesis work (see 4.5- statement of reflexivity). Throughout the interview, transcription and analysis processes I took notes of my emergent thoughts and impressions to track my position as the researcher and to discuss connections with my past experiences and perspectives.

Frequent peer review and debriefing of the data and research process was conducted over a 5-month period with regular bi-weekly meetings, which ranged between 30 to 60 minutes each, with the supervisory committee. During these meetings I would present the preliminary findings and iterative codebooks to the supervisory committee to elicit discussion and constructive feedback on emergent meanings and interpretations from the data.

In the peer review process, the supervisory committee would discuss feelings and ideas about the research while keeping written accounts of each session. These peer review and debriefing sessions contributed to the study's validity by evoking honesty and transparency throughout each stage of the analysis process (Creswell & Poth, 2018). Additionally, a fellow graduate student (PhD candidate) with experience in qualitative methods was invited to independently code the first two transcripts to allow for multiple interpretations and a different perspective then the team who conducted and transcribed the interviews (Gale et al., 2013).

Accuracy of the data was enhanced by engaging multiple coders in the data analysis process. The researcher and each member of the supervisory committee had access to good-quality audio recordings and the verbatim transcription files. To establish a common coding platform and develop a preliminary list of themes, each member of the supervisory committee carefully reviewed and familiarized themselves with two transcripts and developed a list of concepts and ideas that emerged during this process. These documents were discussed during team meetings and then carefully reviewed and considered in the creation of the codebook of main themes and sub-themes. The consensus building among the supervisory committee helped me to develop the coded themes that were subsequently applied to each of the six verbatim transcripts.

To ensure accuracy and interpretations of the findings, participants were asked if they would like to review the preliminary descriptions and themes from their interviews that will be used in this study (Creswell & Poth, 2018). At the time of the interview each of the six participants indicated an interest to review the preliminary analysis of descriptions and themes from their interview. Participants were provided with significant statements and the formulated meaning from their interview, and invited to share any comments or suggestions on these preliminary findings, through written feedback or a virtual meeting. Further, participants were invited to contact me or the research supervisor if they had any questions or would like to request information about the study. New information emergent from the member checking process are included in the final results.

4.5 Reflexivity of the Researcher

Underlying this research is the authors' belief that addressing the gap between the realities of nursing practice and policy are critical to making health system change for patients and providers at the institutional and governmental levels. Given my own personal experience working in nursing and healthcare, I have firsthand experience with the complex nature of public policies and implications for nursing practice and patient outcomes. As such, nursing practice and policy changes are intricately intertwined, and no matter whether a nurse views themselves in a policy role, the individual actions of nurses can impact upon the direction of policy. Through research, nurses can be influencers for policy change by bridging the gap between public policy goals and realities at the frontline of patient care. In this context, I have been committed to analyzing the experiences and viewpoints at the frontline of policy rather than focusing on the top-down administrative levels of policy success. I began this research with the premise that there are disconnects between nurses and policy especially as it relates to the realities of nursing practice at the front-line of patient care. This thesis reflects my commitment and a new stage in my intellectual journey marked by my interest to understand the relationship between government policy and actions at the front-line taken to improve patient care.

Chapter 5 Presentation of Findings

5.1 Results

Nurses in this study worked in various hospital settings within Ontario. Experience working as a nurse ranged from three to fifteen years. Of the six participants, four worked as Registered Practical Nurses (RPNs) and two participants worked as Registered Nurses (RNs). Workplaces were categorized by participants to be regional (1), rural (1), urban (2), midsize (1), and large (1) hospitals. All participants were verified by the student researcher to be practicing nurses through CNO's public registry website: https://registry.cno.org/.

Significant statements were extracted from six verbatim transcripts. Table 2 includes selected examples of significant states of nurses with ALC patients and ending hallway healthcare.

Table 2. Selected examples of significant statements of nurses with ALC patients and ending hallway healthcare. (Adapted from Creswell & Poth, 2018).

SIGNIFICANT STATEMENT	FORMULATED MEANING
I think eliminating hallway healthcare is certainly important. I think that everyone who comes in needing to have a medical provision, of any kind, should get the best care possible that's available and I don't think anybody should be forced to be humiliated by using a commode in a hallway behind a curtain -Pt#4	Efforts to end hallway healthcare is viewed by nurses to be important in improving quality of patient care services.
Sometimes nurses might not realize you know that as a nurse it's also not just providing care in your clinical practice, but we can also go beyond that by providing a voice for other colleagues and kind of sharing what others have said what we think are issues within the system -Pt#6	Frontline nurses are not fully aware of the relevance or significance of public policies or the influence they have in implementing policy goals into professional practice
After them (ALC patients) working so hard all of their lives. Now they're just sitting in a room with nothing. Especially with COVID. It's been horrible -Pt#2	Frontline nurses agree with elements of policies to end hallway healthcare as hospitals lack resources to support the care needs of patients with chronic and long-term health complexities

All significant statements and formulated meanings were verified and accepted by each participant. Table 3 contains examples of one set of themes with their formulated meanings.

Table 3: Examples of Themes with Their Formulated Meanings

Example of Themes with Their Formulated Meanings (Adapted from Creswell & Poth, 2018).
Policy, provincial objective Understanding, awareness Hopeful but doubtful Agreement with policy Ending hallway healthcare Experience, Nursing Working above and beyond Shifting patients Inappropriate use of resources Lack of privacy Not wasting skills Families Don't have support Competing and contrasting demands

Following the organization of thematic findings, the data was synthesized into meanings to capture the essence of nurses' experience with ALC patients and ending hallway healthcare. Arranging the formulated meanings into themes resulted in three overarching themes and 11 sub-themes. A visualization of the final themes is conceptualized into table 4.

Table 4. Thematic Framework of Findings and Composite Descriptions

No.	*Theme*	*Composite Description*
1	**Minimizing application and awareness of policy** i. Needing to end hallway healthcare ii. Feeling removed from policy iii. Addressing the gap between policy intention and reality of nursing practice iv. Hoping for change, but cautious	The relationship between policy and nursing is not clear to frontline nurses whose practice is shaped by policy and who influence policy on the ground *I haven't had a lot of direction with ending hallway healthcare ... I do feel, you know I do feel the effect of patient's kind of stuck in limbo waiting in the hospital – Pt#5*
2	**Motivating the behaviour or actions of nurses** i. Discretion is required to manage workloads ii. Reality of practice falls short of expectations iii. Health system issues challenge professional nursing values iv. Beyond the call of duty	Nurses need to take discretionary actions to manage heavy workloads and demands of patient care with the resources available *I've got as much knowledge as how to mobilize the patient as the majority of anyone in the hospital, so I'm not going to take any risks -Pt#1*
3	**Concern for ALC patients** i. Prioritizing ALC patients with low-acuity ii. Cognitive impairment creates challenges in acute care hospitals iii. Needing more public awareness for accessing health services	Priority of care is given to acute and critically ill patients which may lead to a lack of available resources for ALC patients. *I find that really challenging. That they're (ALC patients) not as important as somebody that is on an acute level or if their health... some of their health needs change they don't seem to be priority - Pt#2*

The first main theme, minimizing application and awareness of policy, explored how nurses understand policy in the workplace and has four sub-themes: (i) needing to end hallway healthcare, (ii) feeling removed from policy, (iii) addressing the gap between policy intention and reality of nursing practice, and (iv) hoping for change, but cautious. These sub-themes are associated with the essence of nurses' experience in terms of policy context, patient care, and the conditions of their work.

The second theme, motivating the behaviour or actions of nurses, explored the objective and subjective experience of participants and their work with ALC patients during the implementation of policies to end hallway healthcare. Within this primary theme, four sub-themes also emerged as (i) discretion is required for nurses to manage

workloads, (ii) reality of practice falls short of expectations, (iii) health system issues challenge professional nursing values, and (iv) beyond the call of duty. These sub-themes highlight personal, professional, and social experiences that shape the decisions and behaviours of nurses in their work. These sub-themes could be further categorized as many of the experiences overlap or interconnect, however they are categorized accordingly to where they were found to be most appropriate.

The third main theme, concern for ALC patients, describes nursing concerns about workload burdens and the implications for patient care. Three sub-themes include (i) prioritizing ALC patient with low acuity, (ii) cognitive impairment creates challenges in acute care hospitals, and (iii) needing more public awareness for accessing health services. These sub-themes spoke to the essence of the participant experience involved in prioritizing patient care, challenges of the work environment, and level of public awareness.

5.2 Reporting and Presentation of the Findings

Interview quotes displayed in this chapter have been cleaned for clarity and readability. Repetition of words, vernacular and language patterns such as “like”, and “uh” have been removed.

Theme 1: Minimizing application and awareness of policy

Nurses experience with policy was largely considered in the context of clinical application. Some nurses in the study explained that they were not familiar with policies to end hallway healthcare, then provided rich descriptions of caring for patients in hospital hallways and other unconventional spaces. Nurses spoke of work pressures

around patient flow for admissions and discharges from hospital. The main components of Theme 1 are illustrated here.

> No…Well I've heard it [ending hallway healthcare], but I guess we didn't really call it that, and I know we had a family room where we had to put beds in at one time and we have a treatment room that we've had to put beds in. - Pt#2

Another nurse identified that their awareness of policy was informed by the media and thought that although a lack of support existed within their workplace, the policy was experienced in their everyday work environment.

> Like vaguely. You know like I see it in the news, it's not something that I learned a lot like through work ... I haven't had a lot of direction with ending hallway healthcare ... I do feel, you know I do feel the effect of patient's kind of stuck in limbo waiting in the hospital. - Pt#5

This was in comparison to those who felt they understood policy yet did not possess complete confidence when elaborating upon their understanding of hallway healthcare.

> From what I understand about what hallway healthcare means, I think it's quite a recent initiative ... I think it's the initiative to really speed up that process and provide you know enough long-term care beds for example, so that people can meet their goals a little more faster. I think it also has to do with the increase in emergency service uses … to make sure that people are accessing those services when they do you really need that and that it's more efficient that they're not staying in emergency you know for long periods of time, and that they have the

next bed available to them whether that's in hospital or you know a more specialized unit. - Pt#6

Nurses demonstrated a capacity to understand policy initiatives at multi-levels of the health system yet remain reserved when sharing their views and insights about current policy. One nurse elaborated upon their understanding of policies aimed to end hallway healthcare to include more specific details of their awareness, citing pressures of nursing accountability amongst members of the health team.

My understanding is that it in general most hospitals across the province of Ontario function anywhere from 20 to 60% over capacity and those patients have to go somewhere. You can't turn them [patients] away they [doctors] are very liable ... Well, a lot of times they ended up in a hallway or inner room that was only designed to have two beds in it or four beds in it … there's disagreements amongst the staff and yet they'll discharge them and sure enough come Saturday morning oh so and so is in emerg. Yeah, we called that, so it … you feel like your input sometimes isn't being openly respected … some nurses will see that as look at negative reflection on how they weren't doing their job right. - Pt #4

A second nurse also describe pressures of accountability on nurses and their position where they believe they cannot refuse to admit or discharge patients

If there are too many people in emerg oftentimes will hear about you know there's patients waiting and stretchers still in the paramedics are still with them because there's no other place to put them in a room for example in the emergency room so we do hear about that and you know we want to be as helpful as we can to

ensure that everyone has a bed. So obviously we will we can't refuse the discharges and the new admissions. - Pt#6

Nurses minimized awareness and understanding of hallway healthcare from a policy perspective, but shared common experiences of hallway healthcare and implications on their work experience.

Sub-theme (i): Needing to end hallway healthcare

Nurses highlighted some of the challenges they have experienced related to prolonged hospital stays by ALC patients and shared views on why ending hallway care is important. A common perception is that hospitals are not the most appropriate setting to meet the healthcare needs of ALC patients. This sentiment is summed up in the following comments from nurse interviews:

> I think eliminating hallway healthcare is certainly important. I think that everyone who comes in needing to have a medical provision, of any kind, should get the best care possible that's available and I don't think anybody should be forced to be humiliated by using a commode in a hallway behind a curtain… Whatever it is you're going to the hospital for you should feel like you're going to have the utmost dignity and at the best care as possible. I don't think hallway healthcare is one of the ways to do that and I don't know what the answer is we can't just keep Lego blocking on top of our system. - Pt#4

One nurse describes the more complex care needs of ALC patients as follows:

> [ALC patients are] complex behaviourally and medically. I find they have higher care needs … twelve patients on a night shift is pretty near impossible. - Pt#5

Fundamental nursing training and education was thought to be inadequate to help nurses prepare for the realities of nursing practice and applications in hospitals. Two nurses described the following: “I don’t think any of us were taught in school you might actually end up taking patients in a dining room in a common area.” – Pt#6, and “Some [employees] need specialized training and patients aren’t getting it.” - Pt#2.

The government’s objective to end hallway healthcare “puts patients to be where they need to be.” Pt#2, and “its not the right place for them to be in hospital. You know, you know to be in hospital is to be in limbo.” -Pt#1.

Hallway healthcare was noted to have negative impacts on patients, families and all healthcare providers which added to nurses’ views in support of policies to end hallway healthcare as follows:

> I think that's why it's really important to end this hallway healthcare so that people are not you know waiting for their next location in that it's a lot faster and I think it would benefit not only you know patients and families, but also healthcare providers so that they are also tailoring care and meeting the cares based on their skill levels, and you know what they're supposed to be doing as well based on that area and also improve the efficiency of systems in general … to make sure that people are receiving care at the right places and not because there's nowhere else for them to go to. - Pt#6

Nurses in this study all shared insights for why ending hallway healthcare is important and needed to improve health services. Decision making authority and role clarity for who will translate policy into practice were not quite as clear.

Sub-Theme (ii): Feeling removed from policy

Two key factors were raised by nurses as central to their experience with efforts to end hallway healthcare. Responses to streamline patient hospital admissions and discharge processes were challenged by a lack of available resources within the hospital (i.e., beds and staff) and external factors (i.e., individual systems of support, shortages of acceptable bed-placements). Nurses reported feeling a sense of powerlessness and that oftentimes their recommendations went unheard by managers and other members of the care team. One nurse describes that their attention is task-focused and too occupied with the mundane, everyday activities of the nursing role to have policy influence.

> … to be honest I don't feel like I have the biggest hand in them [policy strategies] as the nurse … my day entails making sure they get their medications and their care … participate in rounds with the healthcare team, make any sort of suggestions that I can at that point … go speak to the doctors speak to their family, if need be, but I guess because it's the you know a whole team approach that participates in it I don't feel like I directly … Maybe I do more than I realize. I don’t know. - Pt#3

Decisions about patients were often made without including input from the nurses attending to their care needs.

> As my role as a nurse. I'm, you know I'm involved [in the policy directive to end hallway healthcare] smally. Like not a lot in discharge planning. Typically, when they come down to our floors, they they've been through like a social work process where they determined that they cannot go home ... there's already a plan set in place for them. I'm not, too involved with that side of the process of it. -Pt#5

Nurses observed the effects of policy changes to address hallway healthcare; however, they did not perceive a connection between their role as a nurse and policy influences. One nurse stated "I think we have been noticing that there has been more initiative throughout our hospital trying to make more room for patients." – Pt#6, another nurse remarked, "I feel like I make my recommendation, but ultimately I don't make those final decisions" -Pt#3.

One nurse noted that creating opportunities for nurses in research studies would enhance awareness of frontline nurses and prepare them to have a stronger influence when addressing health system issues.

> It's great Jen that you're focusing on this area and getting the nursing experience 'cause I think sometimes we kind of get left out from these types of studies… Yeah I think sometimes nurses might not realize you know that as a nurse like it's also not just providing or working or providing that care in your clinical practice, but we can also go beyond that by providing a voice for other colleagues and kind of sharing what others have said what we think are issues within the system. -Pt#6

Nurses expressed uncertainty in their role to influence policies to end hallway healthcare. Frontline nursing was viewed primarily as clinically focused and policy planning and decision-making was commonly viewed to be the responsibility of other members of the health team.

Sub-Theme (iii): Addressing the gap between policy intention and reality of nursing practice

Many nurses reported that pressures of work forced them to prioritize responsibilities and tasks, knowing there was a low-likelihood of addressing the full extent of care needs and performance expectations. Time constraints and high workloads can inhibit proactive approaches to improving the delivery of health services envisioned by overarching policy goals (Hughes & Condon, 2016). This was supported by nurses in this study, as many described themselves as being pulled between the responsibilities for individual patient care needs and ensuring safety for all within the hospital environment. As one nurse commented: "It puts pressure on everybody and its the dignity of the patients when they are sitting in the hallway for two, three, five or whatever many of hours it takes to get them into a room". - Pt#1

The nature of work for frontline nurses positions them to hold patient-related information that may not be as transparent to formal leaders. A disconnect between policy goals for admission and discharge risks compromising safety of patients and staff. One nurse describes a disconnect between frontline nursing and nurse managers in the following comment:

> Sometimes our managers … might not be aware of the complex needs that these patients have, if they are not appropriate for ALC unit most of the time nurses will advocate for that patient not to come to our unit ... because it wouldn't be a safe

way to meet [patient] needs and for us to be able to meet the needs of the rest of our patients … - Pt#6

Another nurse shared their insights about challenges to transition some patients from hospital

> I think the hardest transitions that we are having are people who need a monitored facility. Whether they are in a locked down facility of some sort. Because they are the ones that we don't have the beds in the community for and they take the longest time to actually find and transition into a new facility. -Pt#1

Nurses described the delicate balance of caring for ALC patients in an hospital where patients with higher levels of acuity or who are in critical conditions are placed higher on the priority list. Furthermore, patients ready to be discharged are delayed due to factors beyond the hospital's control, such as a lack of beds in specialized care settings within the community, dynamics of patients social and family support systems, and readiness of patients for discharge.

Sub-theme (iv): Hoping for change, but cautious

All nurse participants expressed hope to end hallway healthcare. Yet, they were also unsure whether the current policy goals could be attained given the state of the health system and ALC population care needs. Nurse viewpoints were marred by past experiences of shortcomings with past improvement plans for the health system.

> It was a pretty poor state for a while. The hospital had recently shut down their waiting for ALC floor and those patients have all been shipped out to other floors. So, it was difficult to move them into other areas. So at one point though we did

> have quite a relief button on the system as a new nursing home opened up in the area and that helped to move a lot of patients out and into alternative levels of care, but unfortunately that effect was very short lived and I'd have to say that within a year, not much longer than that, that our beds were filling up again with patients waiting to get care elsewhere. - Pt#1

High financial costs and competing priorities within the health system were a concern for the successful implementation of policies aimed at ending hallway healthcare.

> I'm very interested to see where (the government) think they're going to … be cutting? Are you going to be cutting like robbing from Peter to pay Paul, to ensure that this patient is getting discharged? And are they getting discharged, sacrificing their quality of care? Or they just going to bounce back and end up being more expensive in the long run because you picked up those extra few days? Who decides how long it takes one patient to recover from the same injury compared to the other patient? What are the other associated socioeconomic contingencies? Where do they live what resources do they have? Are we looking are we comparing apples to apples or are we comparing apples to oranges" - Pt#4

A nurse described the disconnect between policy decision makers and what they perceived to be in the best interest of health as follows:

> When I think of politics, I don't always think that they have the best health interest in mind. The two aren't ... really unified. They are like separate entities.

> You know, like the politics side is trying to dictate how healthcare should operate, but without really considering how it does operate. - Pt#3

Some nurses felt that governments were more focused on the business of running hospitals or on political concerns, than population health. One nurse shared that the government wants to end hallway healthcare because of "bad press" – Pt#3, another nurse commented: "I don't think [government] want to end [hallway healthcare]. I think they want to keep hospitals at over capacity, but I think they don't want it to look bad to the public". – Pt#4

In contrast, some nurses expressed hope that government interest was to "have more permanent housing that is suitable to [patients] lifestyles." – Pt 5, and that the government "wanted to make the healthcare system more efficient by reducing wait times … and making sure families and patients are receiving the quality of care." - Pt#6. The nurses who perceived governments interest to be in the best interest of healthcare find it hard to say if the policies will be successful, "It's hard to say what this will be the outcome until we actually see the evidence". – Pt#6. The majority of nurses described competing and contrasting interests between politics, policy, and population health needs.

Theme #2: Motivating the behaviour or actions of nurses

Nurses reported a need to rapidly adjust to situations based on the level of experience and skill set of fellow members of the care team. One nurse described a team's approach to caring for a dementia patient who was being uncooperative for care.

> Five or six of them [nurses] had to change this fella or whatever. And I'm like wow. That is just so freaky for him…. But they just don't sometimes because they

don't have to always deal with that situation so they were trying to keep safe. Where I would just say a couple of you go in and be quiet and just deal with the patient and we'll stand behind the curtain if you think you need me. You know. Just be calm and stuff until it works out calm and it does. - Pt#2

The differences in nurse's discretionary actions and decision-making in practice is apparent in the experience described by the nurse above, and the detailed events for how a different nurse (with more specialized training or experience) would respond differently to the same situation. Personal and professional belief and value systems are a competing factor for the underlying motivations of nurses when addressing workload pressures and policy expectations as demonstrated by this nurse in the following quote. "We're trying to put yourself in their shoes or not always think of them like how you would want your family member treated, but keep that at the back of your mind as well". - Pt#3

One nurse felt this ALC patients would receive better care in a long-term care home setting and stated "I think that getting them (ALC patients) into long term care where their goal is to maintain their lifestyle and their functionality". - Pt#5

Another nurse articulated the position of individual or groups of nurses when choosing which patients to advocate for and when they will advocate with the statement "we often will advocate for whether certain patients who are supposed to come to our unit whether they are appropriate for our unit". - Pt#6

Nurses practice decisions were based on their level of comfort, background experience, and resources that are available. One nurse remarked that they take greater initiative than some other nurses to support patient recovery and discharge from hospital

with the statement “I’ve got as much knowledge as how to mobilize the patient as the majority of anyone in the hospital, so I’m not going to take any risks, but I’m certainly going to get a walker for my patient”. - Pt#1

In one interview a nurse explained that their assessment reports regarding patients concerns often went unheard by the health team “nobody really wants to listen” – Pt#4, which motivated this nurse to ensure “a lot” of documentation was completed, to get “to the point that they have to listen”. Another nurse shared that nurses are motivated by their desire to help others in their personal and professional lives “…always the one that would help other people, it’s a lot of self sacrifice and most of the time I don’t even think you notice that you do it.” Additionally, financial benefit was noted to not be the primary driver of a career in nursing “I legitimately love what I do, but I’m not in it for the money.” - Pt#4. Nurses shared a number of personal and professional motivating factors which influenced how they approached their work.

Sub-theme (i): Discretion is required for nurses to manage workloads

Safety of self, staff and patients was a factor in how nurses responded to policy and performance expectations in the workplace. Availability of resources, skills and work habits of fellow team members and complexity of patient care needs were common considerations of nurses when prioritizing their work schedules and shaped discretionary actions used to care for patients. According to Hoyle (2014), nurses will draw on personal and professional belief systems and will make “extra allowances” for patients they feel are more deserving or behaviours that are more desirable. This view was expressed by one nurse.

> When we have the patients there that are confirmed wanders that there uh, how do you say it. It's a group project. Everybody's trying to keep an eye out for [the confused patient]. At some points during the night if it becomes to much for us to keep running after them or whatever it might be, that's when you are going to have them end up in a Broda chair at the nursing station with a tray on it so we can keep a closer eye on them. - Pt#1

Another nurse described,

> Sometimes, because we're an ALC unit and we have 13 to 14 patients we cannot accept patients who are still under the medical team for example who are still receiving you know blood work twice a day kind of thing, and that are requiring X amount of test and they're on like 5 different IV medications. We have to be very careful with the type of patients we do admit. - Pt#6

One nurse explained that "strategies are only as good as the people who are willing to work to implement them" and "you can write it down on paper, but it's only going to be as good as the people who can help make it happen" – Pt#4. Another nurse described that heavy workloads and high patient demands require nurses to "adjust to situations where we think oh man. So, it's not good. Just because they're [staff] inexperienced I'm just trying to be safe with everybody." - Pt#2. These moments which require discretionary actions were also shared by this nurse who describe a need for nurses to "learn how to do things creatively …" – Pt#6.

Because workloads, unique patient care needs, and team dynamics are constantly shifting, nurses must constantly assess their environment, access resources available and consider safety precautions for themselves and others. Here, nurses must use individual

discretion which draws from their foundational nursing knowledge, experience and judgements to make decisions about other people while also managing high workload demands and prioritizing patient care

Sub-theme (ii): Reality of practice falls short of expectations

According to CNO's professional standards (2018), nurses must practice with integrity, honesty, and professionalism, in part, by identifying ethical issues and options to resolve any conflicts. Nurses in this study expressed that they are facing increasingly heavy workloads and lack the resources to deliver care that meets their personal and professional standards. One nurse commented as follows:

> You go and go to work and you just do the best you can do throughout the day and then you go home at the end of the day, and I mean sometimes … if something's going on you're thinking maybe it's not that bad, let's see what happens tomorrow. Just make it through the day. Like I don't know. It's hard to explain - Pt#2

Nurses in this study noted that some doctors felt that ALC patients no longer required their services. "I think the biggest problem that I have is that once they (ALC patients) come over to our unit the doctors don't feel like they need to be watched anymore." Pt#2. Another nurse described conflict and tension within the health team about pressures to admit and discharge patients.

> Sometimes it just depends on what team working with. Some doctors are like, yep no problem and its systemic amount of pressure so emerg is pressuring the floors to get patients out there's patients like our managers are pressuring us to make

sure it just becomes there's only so much room at the end aside from putting bunk beds in the hospital. - Pt#4

Another nurse agreed that there are systemic pressures but felt that their "hospital is doing the best they can and trying to maximize their resources." - Pt#3. This sentiment was shared by another nurse who demonstrated empathy for managers and other members of the health team "you really recognize why people are pushing for increased admissions and our managers will tell us we really have to admit…." - Pt#6.

This nurse also commented that they have experienced an excess of patient discharge from hospital as "there's no other room in the hospital right now". This leads to less time for nurses to be available to be spend with patients.

With increased work demands nurses are working harder to try to take pressure off from other areas within the hospital. One nurse shared "I think we all just work harder. We know when the hospital is in surge, we hope that we can take the pressure off." -Pt#1, and pressures are worsening for some nurses and they work to support patients with cognitive impairments and associated responsive behaviours. "…The patients' behaviours are getting worse and worse, because if [nurses] are not dealing with the medication part … it's frustrating". This view was shared by another nurse who remarked that "it's difficult to support [ALC] patients, some of them can be quite confused as well, so it's hard for them …" – Pt#3.

Caring for ALC patients who no longer require acute hospital care is "confusing" -Pt#3, and nurses feel they cannot "give [ALC patients] the full attention that they require, sometimes even something as much as going to the bathroom." - Pt#1.

Nurses experienced feelings of confusion, frustration, and pressure to carry out work tasks and responsibilities according to the best way they feel they can. Nursing judgements and decisions are affected by the unique needs of patients, resources that are available, and the direction they receive from superiors and other members of the health team.

Sub-theme (iii): Health system issues challenge professional nursing values

Nurses enter the profession because the want to help others. An overarching goal of nursing is defined by CNO's professional standards (2018), is to "obtain the best possible outcome for clients, with no unnecessary exposure to risk of harm". In the current health system environment, nurses shared a common experience of being unable to fulfill their duties and responsibilities of a nurse. There was consensus amongst participants that time constraints jeopardized the well-being and recovery of patients, particularly patients with lengthy hospital stays. Because of this, many nurses also felt that problems and attempts to balance the care of acute or critically ill patients with the care needs of more stable ALC patients challenged their values of giving tailored, patient-centred care. Simple statements such as "I just don't feel like I'm doing my job" (Pt#2) and "Sometimes you leave work and you feel like wow I did the bare minimum almost," (Pt#3) were provided. Other respondents provided greater detail:

> I'm like dear Lord this person this is outside of the alternative level of care. This is someone who's just been admitted in there with say a bowel obstruction and this person has a bowel obstruction. They've gotten NG Tube hooked up in the hallway and you're asking them to take prep to clear a black or blocked bowel and

> they're using a commode chair in the hallway. Like how humiliating for someone. This isn't a war zone this is hospital. - Pt#4

Another nurse felt challenges to provide holistic nursing care for dementia patients, while trying to address the care needs of other patients and stated "… you try to make it more like a home atmosphere for them, but that's very hard to do when you're dealing with um like acute patients at the same time." - Pt#5

Gaps in nursing training and education about the realities of the health system were identified by one nurse to be a major contributor for the level of preparedness nurses feel they have when faced with unprecedented situations.

> I don't think any of us were taught in school you might actually end up taking patients in a dining room in a common area… it's definitely something that's, well I wouldn't say shocking, but it's just not something that you don't expect to happen. And a little less shocking for nurses because we understand how the system works and how there is a need to ensure that everyone needs care. - Pt#6

In-depth interviews were conducted during the first and second wave of the Coronavirus Disease 2019 (COVID-19). Nurses shared common experiences of "staffing shortages", and pressures to "work harder". One nurse who worked in a large hospital within Ontario commented:

> Nursing has been particularly hard hit we've gone the pandemic has been phenomenally hard on all of the nurses or front care workers in general but the nurses that I talked to are just it's one day you're the heroes and the next day you're your poop on a boot. Like just they (nurses) can't work any harder than

> they are working and the public backlash that's come and the political backlash that's come and then the slap to the face when they didn't get any sort of pay equity with regards to how hard they're working and I mean that's ongoing. And everyone's like Oh gosh the hospitals are over capacity and the COVID and I'm like you realize that's a political situation right like our hospitals have always been over capacity. It's not new - Pt#4

Another nurse also discussed that issues highlighted by the COVID-19 are not new, but exacerbated by the pandemic and stated "the biggest stretch right now is not having enough people to go around and so yeah it's a strain … The pandemic has really exhausted that". - Pt#3

Time constraints, staffing shortages, and lack of resources lead to increased pressures and strain on nurses which has only heightened since the onset of the COVID-19 pandemic. Nurses felt they cannot work any harder than they are working, yet job pressures continue to rise.

Sub-theme (iv): Beyond the call of duty

When nurses discussed their roles and responsibilities, they recognized nursing as a profession that extends beyond the brick and mortar of the hospital walls and prescribed work schedules. In this context, nurses asserted that they are pressured to work beyond paid and scheduled hours to complete work tasks and responsibilities. One nurse described that during a workday "it's hard to get breaks" – Pt#1. Another nurse described job pressures and heavy workloads lead to nurses needing to stay past their schedule shift to get their work completed.

> Lots of us have been staying over later in the day because of the increased discharges and admissions and sometimes during these discharges we do if we have a patient who falls acutely ill unfortunately, we are spending more time with that patient on top of admission and discharges. - Pt#6

While nurses understood the pressures faced by the profession, they remained committed to their role in helping others both within formal professional settings and personal networks.

> If we are being honest. I could have been a dentist. Nursing literally, it's your whole life. I don't think you just oh gosh I retired I'm not going to be a nurse anymore. Cause you're the one that your best friend calls and their kids calls or you're the one that your mom calls when she's feeling this way or you're the one that whether you're at an OB nurse whether you're a psychiatric nurse whether your geriatric nurse or your somebody who specializes in any number of aspects of nursing. At the core you are still a nurse. - Pt#4

Many nurses described feelings of accountability and pressures to work beyond work schedules to care for other people in both their personal and professional lives.

Theme #3: Concern for ALC patients

While public policy intentions have committed to ending hallway healthcare and support ALC patients to transition into more appropriate care settings (Premier's Council, 2019a, 2019b), it was clear from the narratives from the interviews that nurses continue to view ALC patients as recipients of suboptimal care. Sutherland and Crump (2013) suggest that hospitals cannot be held solely responsible for those patients who are “stuck”

in hospital. Policy actions to end hallway healthcare acknowledge that the hospital backlog is more of a systemic issue. Bergan and While (2005), characterize the relationship between policy and practice by “ambiguity of intent and unpredictability of response”. This is consistent with the nursing narratives that highlighted the existing challenges that contrast with policy goals to end hallway healthcare. One example of this is described as “[Hospitals] are supposed to be helping them to feel better, and I always feel like they're going to get worse, and it usually does happen”. – Pt#2

Additionally, nurses describe patients as being stuck in limbo with safety of staff and patients being a consistent concern. Patients designated “ALC for home” was defined by one nurse as “a catch phrase … even though we know there is no chance for them ever going home.” Pt#1. Given resource constraints and high workloads, the complexity of care for ALC patient is considered to not be conducive for hospital settings.

> It’s not safe and it’s not a good level of care for anyone. It’s hard on patients, it’s hard on staff who work in the facility. It’s not a level of care that you would want anyone to be to be subjected to in the long term. - Pt#1

One nurse shared that in their experience, ALC patients want to get back to the comfort of their own home, “They are ready to go home, but nobody wants, well I shouldn’t say that.” Pt#4. Another nurse described lengthy hospital stays for ALC patients to lead to health declines due to absence of care. “Mentally they are unwell. Physically there are unwell. Just because they’re not exercising. Mentally you don't have the time to go and sit to chat with them.” – Pt#2.

Nurses shared devastating impacts of COVID-19 in their workplace which negatively impact patient care. Statements included “It’s so tough. We don’t always have the resources right, and especially during the pandemic. It is complexly evident that we don’t have the resources”, Pt#3, “patients are received substandard care” – Pt#2, and “it was such a rush to hire as much nurses as possible to fill the gap to meet the demand in needs and the increase patient load.” – Pt#6.

The negative impact of the pandemic was described by one nurse to be the hardest for ALC patients as follows:

> The last year, it's been really hard I think the most on ALC patients, just because a lot of … times the families are really involved in their family members care … I’m definitely seeing like a lot of patients decline because of that. Because I can't meet all of those roles and twelve times over. I’d say there are ton of negatives that’s for sure. - Pt#5

Expressions of empathy and feelings of compassions for ALC patients were shared by nurses when speaking about patients. One nurse explained “After [ALC patients] working so hard all of their lives. Now they’re just sitting in a room with nothing. Especially with COVID. It’s been horrible. They can't have visitors”. – Pt#2

Implementation of policies to shift non-medical patients to more appropriate settings within the community were seen to have a positive impact for the care of hospital patients. Two nurses shared a glimpse of what patient care could be in their experience with lower resident assignments. Both nurses experienced a mass discharge of hospital patients as the province pushed to open more beds in the community setting.

> I don’t have a lot of knowledge of how they did it, but we saw a lot of patients out of hospital. Particularly our floor. We went from a floor who have 37-39 patients then went down to as low as 19 high 20’s for a short time there – Pt#1

> There has been a lot more empty rooms which I have never seen. Even on my unit, we’re putting x’s on the doors because there is no one in that room just to keep track of how many empty rooms we have. And so yeah. It’s just been very strange. - Pt#6

With a reduced number of patients on the ALC hospital unit, nurse Pt#6 described the work experience as “lovely” and explained how the health team were in a better position to support the specialized care need of the ALC sub-patient population, and a healthier work environment for staff.

> The same amount of staff which is actually really quite lovely. And with the type of patients that we do care for it's actually really important to have lots of staff to keep them stimulated and also to be able to deal with the day today kinds of things, you know family questions and if you know we can also intervene a lot faster if we do see behaviors sort of escalating and we can actually provide a little bit more of that special individual for those ALC patients. Not saying that we didn’t do that before, but we are doing it in a way that is much healthier now for the work staff that are on the floor. – Pt#6

This nurse shared hope that efforts to end hallway healthcare will better support patients with more chronic health complexities from the lessons learned from COVID-19.

One nurse described a past program to shift ALC patients from hospitals into community care settings as follows;

> [There was a] relief button on the system as a new nursing home opened up … unfortunately the effect was very short lived, and I'd have to say that within a year … our beds were filling up again with patients waiting to get care elsewhere. To the point where we knew some of the families so well that they have been there for two years. - Pt#1

With words of hope nurse Pt#6 shared that they believe that experiences through COVID have shed light to "create new facilities nearby and cater to patients who are no longer requiring hospital care in a safe environment, and that this is actually probably ideal and best for the patient, but also the family". Further, this nurse stated an intention to watch to see if policy decision makers will "re-evaluate their strategy or think ... differently".

Hospitals are not the most appropriate setting to care for medically stable ALC patients for prolonged periods of time. Some nurses have seen short-term relief with past policy efforts to shift patients from hospitals into home and community settings. Yet, past efforts have not been sustainable. The presence of the COVID-19 pandemic has shed a spotlight on two important areas for ALC patients. Family involvement is important to sustain optimal patient health, and staff to patient ratios must be considered to develop a healthy workforce with the capacity to meet patient care needs.

Sub-theme (i) Prioritizing ALC patients with low-acuity

Nurses in this study described the way patient care is prioritized and how it must

be considered in terms of acuity. Prioritizing patient acuity intensified risks for unmet basic care needs of ALC patients due to heavy workload burdens, available resources and time constraints. This contrasted with the personal beliefs of individual nurses and the overarching values of nursing profession. One nurse stated “I find that really challenging. That they’re (ALC patients) not as important as somebody that is on an acute level or if their health... some of their health needs change they don’t seem to be priority”. - Pt#2

This idea of providing care to ALC patients with a lower priority was a strong narrative thread interwoven in the accounts nurses gave of their daily work in hospital. The mounting pressures and strain felt by nurses was elevated by pressures to choose which patients may or may not receive care.

> Like basic human things that you would like to be able to provide to everyone in a timely manner, but you’re stretched quite thin and ahh because the variation of patient acuity that’s kind of in the mix, but like I said you might have to prioritize somebody who’s a little less stable umm and that might mean that you forgo giving somebody a bed bath that day or something, right? - Pt#3

Although all hospital patients are entitled to treatment, nurses in this study used discretion in their decision of whether to intervene in patient care. This aligns with Hoyle (2014), who suggests that frontline nurses will develop coping mechanism to manage unreasonable workloads which may influence the direction policy implementation.

Sub-theme (ii): Cognitive impairment creates challenges in an acute care hospital

Ending hallway healthcare relies on an integrated health system in addition to

effective and efficient tools and resources to connect patients access the appropriate services throughout our health system (Premier's Council, 2019b). Unfortunately, some nurses in this study described the institutions they worked in as a ‘dumping ground’ or place to ‘off load’ difficult family members with behaviour problems. The increasing number of patients presenting with cognitive and behavioural challenges comprise the effectiveness and efficiencies of hospitals designed to treat acute care patients.

> Just when you’re dealing with the patient who is really ready to go to a nursing home or to a lock down memory unit and at the same time you’re trying to provide care to the new patient who has just come up from the PACU having had a craniotomy or a spinal surgery or a brand new stroke and just getting out of the ICU and coming to the floor and yet your constantly listening for the next bell and whistle to go off to find out. Well ok. Is the Wanderguard [elopement security tracker] going off because my patient and blah blah blah is trying to leave the floor? - Pt#1

Additionally, the level of preparedness and training nurses receive to support ALC patients exhibiting responsive behaviours was described to be inconsistent in nursing and health teams. This affected nurse decision making, as they could not establish a baseline of care, and they described mounting frustrations within the care teams.

> The patients of course, the patient’s behaviours are getting worse and worse. Because if they (nurses) are not dealing with the medication part you know like it's just not really paying attention. Like it's really frustrating. Like I do. I pay attention to what time I give them their medications. If they’re trialling something

> new, I'm paying attention. Like okay, I've tried Trazadone at noon, I'll try it again at four so they won't get agitated. This is what I did. I try to pass this onto the next people. Can you try this? To see if we can get something going here? But nobody is really listening, there are so many different patients. It's really hard. I don't know. We're working on it. We're working on it - Pt#2.

Furthermore, one nurse described a fear of reprisal or that negative judgement existed for some nurses if patient care goals were not achieved within a specific timeframe.

> It's heartbreaking because you know how badly that patient just wants to go home. Sometimes it is a cognitive issue where they don't understand why they can't go home. Sometimes they're not even sure why they're at the hospital to begin with … some nurses will see that as look at negative reflection on how they weren't doing their job. We didn't get the [patient] ready in the time frame … - Pt#4

Acute care hospital nurses' range in their level of experience and training in the care of patients with chronic and long-term care needs. Hospital nurses are trained to respond to higher levels of acuity and lack specialized training to support patients with responsive behaviours connected to degenerative brain disease and impairment. One nurse said that "[the staff are] inexperienced. I'm just trying to be safe with everybody" – Pt#2. Nurses found the increasing prevalence of cognitive decline in patients to be challenging to navigate in a hospital environment. Especially, when balancing a mix of acutely ill, critically ill, and medically stable patients.

Sub-theme (iii) Needing more public awareness for accessing health services

Nurses discussed how the public is uneducated about the appropriate use of hospital services. A nurse stated that they would like to see "more of the outcomes be public with the increase in beds." – Pt#6. Another nurse explained that information was not made available to the public which led to people not fully understanding the strain on Ontario hospitals.

> There's not like a great big no vacancy sign at the front door. We don't have one of those. It might be good if we did, but we don't. They [government] don't tell people that they just continue to see people they continue to bring in the influx of patients in the sickest of the sick and I don't think I think the public is ignorant to the fact that's happened, but I don't think it's on the forefront or their mind that are hospitals have been running at additional 30 to 60% over the number of beds they have for years. - Pt#4

Nurses found family members struggled to care for and support their loved ones. One nurse explained that "[they thought] it's a lot of anxiety for them" – Pt#4, and that this anxiety contributed to inappropriate use of hospital services. One nurse commented that "it could just be family members not being able to meet the care needs of their loved ones at home or feeling overwhelmed or burned out." Pt#6. Another nurse described a sense of apprehension from families who did not feel prepared to support the basic care needs of their loved one as follows: "all of a sudden [their family] will have to learn how to use a lift and they are going to do this and they're going to do that" Pt#2. This nurse shared that an early intervention to educate families may support some ALC patients to

return home. “… if I was the family member, I would be taking them home, 'cause there is no work. There is nothing to it.”

Many nurses in this study felt that more public education and supports for families would help to end hallway healthcare. Hospital capacity pressures and overcrowding was described by Pt#4 as “It’s not common knowledge ... to know we’ve got this many people in emerg.” Another nurse shared that they would like to see more public information about patient admissions and discharges by asking “how fast has the turnover been? How long are people in hospital until they actually receive a bed in long-term care ... what is the average length of stay?” - Pt#6.

Increased public awareness and education to help families to attend to basic care needs of their loved ones was considered needed to address issues of hallway healthcare.

Chapter 6 – Discussion

The emergent findings of this thesis addresses each of three guiding research questions. The lived experiences of nurse participants provide valuable insight into (i) how nurses understand policies to end hallway healthcare, (ii) how nurses experience providing direct care in an era to end hallway healthcare, and (iii) how the motivations of nurses align or conflict with the policies to end hallway healthcare. In this chapter, I discuss how the findings influence the implementation of public policies, specifically policies aimed at ending hallway healthcare.

6.1 Nurses understanding of policies to end hallway healthcare

Nurses in this study demonstrate various levels of awareness and understanding of policies to end hallway healthcare; however, they often minimize, or underestimate their level of knowledge in this specific corner of the policy arena. When describing their work, nurses provide in-depth information about the clinical impact of hallway healthcare, capacity pressures and overcrowding. Although nurses had first-hand experience with hallway healthcare, they did not always link these experiences with policies to end hallway healthcare. This disconnect between frontline nursing and policy has been previously reported in the literature (Annesley, 2019; Bergan & While, 2005; Cuthill & Johnston, 2019; Rasheed et al., 2020; Taylor, 2016). These findings suggest that nurse's awareness and understanding of public policy have not improved overtime.

The interrelationship between nursing and policy has been undervalued and underappreciated in the workplace and by nurses themselves (Rasheed et al., 2020; Taylor, 2016). Policy is rarely a topic for discussion in the everyday work of nurses at the

front-line of patient care, yet nurses play a primary role in the translation of policy intentions into practice realities. Thus, the findings of the current study align with those of Rasheed et al., (2020) who argued that nurses perceive that they have little contributions to make to the development, evaluation and refinement of existing policy initiatives. Therefore, they often do not surpass beyond the level of basic understanding of policy and cannot be considered as conscious actors in the application of policies to end hallway medicine (Adams, 2015; Annesley, 2019; Dickson & Brindis, 2019). However, as nurses work at the frontline of policy delivery, they have an important role in the leadership, governance and implementation of policy (Canadian Gerontological Nursing Association [CGNA], 2020; Rasheed et al., 2020).

The gap between nursing and policy is supported by literature that suggest nurses are not trained to understand their role in policy or how policy shapes their work (Annesley, 2019). Nurses have been shown to lack knowledge and awareness of policies deemed essential to their work (Dickson & Brindis, 2019). Participants' awareness of policies to end hallway healthcare generally stemmed from outside sources (e.g., media) rather than within their workplace. Without a clear awareness or understanding of policy, nurses may selectively choose to disregard policies they view as irrelevant to their work (Hoyle, 2014). Those differences in behaviour can influence the direction of public policies through interactions with patients and health networks (Lotta & Marques, 2020).

6.2 Nurses experience with policies to end hallway healthcare

Nurses in this study felt removed from organizational decisions and strategic planning concerning patient flow and movement throughout the hospital. Work routines and responsibilities were described by nurses in terms of mundane tasks such as

medication administration, attending to patient care needs and documenting patient records. Continuous engagement with patients, families and health networks equipped nurses with unique insight, yet many of them felt their recommendations to improve patient care and work conditions were unheard. The frustration with the lack of consultation in policy planning and processes were also reported by Walker and Gilson (2004) in their study of nurses working in urban primary care health clinics.

Nurses must adapt their roles to keep pace and ensure high-quality patient care (Annesley, 2019). However, unclear policy guidance and ambiguous expectations have been associated with struggles to uphold policy expectations while managing challenging work conditions (Hughes & Condon, 2016; Walker & Gilson, 2004). Aware that demands for hospital admissions exceeded the number of available beds, nurses often worked harder to offset pressure in other areas of the hospital. This included working through breaks and beyond scheduled work hours in an effort to catch-up. Work pressures were further exacerbated as nurses perceived that manager's sometimes make decisions without truly understanding the complexities of patient care or what resources are needed to tend to certain patients. Staffing ratios, skill mix for level of patient acuity, and availability of equipment or supplies were of most concern.

When nurses perceived the direction of management compromised the safety of patients or staff, they would act to resolve the issue in the best way they knew how. Poor communication and guidance from managers and other leaders have been previously identified within the literature as a challenge to integrate policy into practice (Hoyle, 2014; Hlongway & Sibiya, 2019; Johannessen et al., 2018). Conflicting goals and direction between managers and nurses can effectively alter the direction of policy

implementation (Deber, 2014; Hoyle, 2014; May & Winter, 2009), as nurses will act according to what they believe is appropriate for the given situation. These actions may deviate from policy implementation as intended. The key insight here is that management authority and the amount of direction provided to nurses influences the knowledge and perception of policy by nurses, which can ultimately shape actions in the implementation services delivered (May & Winter, 2009).

Issues of nursing shortages are long-reported in the literature (Cuthill & Johnston, 2019; Fox et al 2017; Rasheed et al. 2020) and were repeated by participants in this study. Nurses shared that staffing shortages have always been a concern and the onset of COVID-19 has further compounded this issue. With low staffing numbers, nurses are experiencing greater job demands and stress which leads to feelings of moral distress, job fatigue and burnout.

Participants stated that in some situations they will resist or adapt to pressures to hasten patient admission or discharge to and from hospital. These actions are made through increased advocacy efforts, documentation of patient records, and social interactions as an attempt to alleviate work stressors for themselves and for other areas within the hospital (e.g., emergency department). This is consistent with Cuthill and Johnston (2019), who found that nurses will adapt their practice to achieve policy outcomes while managing threats and challenges to their workplace and professional and personal identities. Individual interpretation for the provision of resources may present obstacles to policy goals and should be considered when introducing new policy.

6.2.3 Caring for ALC hospital patients

Nurses are trained to focus on disease and symptom management, but trends in patient and population health have shifted to a broader approach to consider longer-term complexities of patient care (Annesley, 2019). In this study, nurses had first-hand experience with the increasing number of ALC patients, who are at the forefront of policy efforts to end hallway healthcare (Premier's Council, 2019a, 2019b). Nurses noted that with the influx of ALC patients, there has also been a rise in responsive behaviours in patients living with neurological disorders (i.e., dementia). Responsive behaviours are often exhibited through expressions of agitation, aggression, and other disruptive or distressing actions that are challenging for caregivers and other patients (Alzheimer Society, 2022).

Not all nurses in this study felt that hospitals, or the nurses that worked there, were equipped to support the higher complexity of patient care needs. Prolonged hospitalizations of ALC patients have been associated with avoidable adverse events (Sutherland & Crump, 2013), such as poorer cognitive status, decline in functional mobility, and more depressive symptoms (Costa & Hirdes, 2010). Fox et al. (2017), argue that more training is required to support geriatric nursing practice to improve the quality of care for older people in hospital. Further, these authors suggest that policy and decision makers need to understand the different scopes of practice for RPNs and RNs, to advance the care of older people admitted to hospital. Specialized geriatric nursing training, more awareness and education about policies to end hallway healthcare could potentially support nurses to effectively contribute to discussions about patient care planning and inform health system improvement efforts.

6.3 Nursing motivations to end hallway healthcare

Nursing motivations stem from different healthcare objectives compared to those of governmental or organizational policy makers. Nurses are motivated to end hallway healthcare if it advantages the care of the patient. When nurses do not agree with policy goals, or view policy to conflict with professional values, they may deviate to act accordingly to what they perceive is in the best interest of patients while preserving feelings of job satisfaction (Annesley, 2019; Hoyle 2014).

Conflict between policy ideals and clinical nursing practice is consistent with current literature (Johannessen et al., 2018). Nurse participants considered the end to hallway healthcare as important for health system improvement and patient outcomes. However, some of these nurses expressed doubt that governments and policy-makers interests considered patients at the heart of these initiatives. Concerns were brought forward that the true organizational and governmental drivers for policies to end hallway healthcare are reputation, political gain, and cost savings. In contrast, other nurses shared a more optimistic perception that hallway healthcare was adapted onto the political agenda to address safety risks, work conditions and improve patient care. These findings show that nurses are hopeful for effective policy solutions to end hallway healthcare, yet are divided in their beliefs that these policy aims represent the best interest of the patient population.

For change to occur, involvement from frontline nurses and other stakeholders is important to leverage support and mitigate resistance (Villeneuve et al. 2019). Nurses in this study provided insight into how formal managers, patients, families, and co-workers might influence their motivation to adhere to or disregard policies to end hallway

healthcare. These findings support the importance of nurse involvement in strategic planning and policymaking at the local and provincial levels. The specialized scope of practice and unique insight by nurses is critical to tackle challenges of hallway healthcare in a time when resources are limited and time is constrained (Rasheed et al. 2020). Further, collective action is important to effectively deliver health services that align with policy goals (Currid et al., 2012).

6.4 Extending the theoretical framework

The findings from this study are consistent with the theoretical concepts of street-level bureaucracy, specifically the four elements of street-level bureaucracy through which the data were analyzed (Lipsky, 2010). Accountability, discretion, conditions of work, and coping mechanisms of street-level bureaucrats are helpful to better understand how nursing practice influence patient outcomes, thus essentially (in some form) shape public policies. Table 5 provides a visual representation of participant responses that are thought to be consistent with Lipsky's (2010) description of street-level bureaucrats.

Table 5: Concepts from Street-level Bureaucracy and Examples of Nurses Lived Experience

	Street-Level Bureaucrats and Theoretical Concepts (Lipsky, 2010)	Examples of Nurse Responses Consistent with SLB	Quotes from Participants
Accountability	Accountability is: i. The relationship of people or groups ii. Patterns of behaviour	• Accountability to patients, interdisciplinary team members, consideration of social circumstances • Roles and responsibility of the nurse	Like that pressure comes down to the nurses that you know you get so and so ready yet and sometimes it's you know it could be a rehab issue. It could be a physiotherapy issue. it could be for so many other key components that when a nurse is given a patient in the expectation is that you're going to get them ready for discharge very concise period of time. - Pt#4
Discretion	The use of discretion is expected so that professionals can make decisions and judgements within their specialized area of work. Discretionary actions may either align or conflict with the intent of policy decisions.	• Discretionary action with ambiguity and role uncertainty in the workplace • Flexible decisions on which patients receive care, and how tasks are completed	as a nurse I have to prioritize tasks. Sometimes, the needs of the ALC patient just have to be less on the priority list than an acute patient - Pt#5
Conditions of	Characterized by high degree of uncertainty which leads to challenges to balancing complex workloads, interactions, pressures within a limited timeframe	• Limited resources, tight timelines • Complex workloads • Users of health services will continue to increase to match or exceed availability of resources	I mean anything from hospital bed to staff being available. Umm I don't always feel like the resources are there. Some people are given subpar healthcare because of that -Pt#3
Coping	Efforts and attempts to do a good job include adapting work modifications to limit demand, maximize resource use, and attain compliance outside of procedures established by employers	• Shortcuts and simplifications made to manage work tasks within limited timeframe • Ethical conflicts shape actions to cope with conditions of work • Personal resources (training) influence organization and prioritization of skills	There is and you're hoping that your patients become you know, want to rest and sleep over night, but uh there are nights when you'll come up to the nursing station and there will be 5 or 6 people in Broda chairs all lined up at the front nursing station because some point you have to get your work done. - Pt#1

Characteristics of street-level bureaucrats aligned with the experience of nurses who participated in this study. Nurses described many aspects of their work where they had to make rapid decisions about patients that could not be predicted or governed by administrative programs or processes. With heavy workloads, resource constraints and time pressures, nurses shared their use of discretion when providing services to ALC patients in accordance with their unique situations and circumstances. Creative thinking

and flexible actions by nurses were necessary to manage and cope with their conditions of work and individual patient care needs.

Adopting Lipsky's (2010) definition of accountability, nurses are likely to respond to higher authority and influence. Relationships described by the nurses in this study were interconnected and somewhat complex. Nurses were responsive to the people they served and worked alongside. Individual nurse experience, training and unique circumstances shaped their attitudes, decision-making and actions which ultimately represents the organization in which they work. The verifiable differences in discretionary actions can been seen to influence the services provided, systemic processes, and allocation of resources which may or may not align with policy intentions to end hallway healthcare. Discretion used by nurses can have implications for how policies are translated into clinical practice (Walker & Gilson, 2004).

Nurses are street-level bureaucrats who will develop routines that are most favourable for controlling patient behaviours and maximizing utilizations of available resources to discourage disruptive or challenging circumstances before it emerges (Lipsky, 2010). These non-prescriptive routines may act as either a conduit or become a barrier to policy implementation as intended. In practice, nurses coped with work pressures and challenges by moving the boundaries of the nursing role (Bergan & While, 2005) to manage their workday and respond to capacity pressures, overcrowding, and the pull between acute and ALC patient care needs. Existing literature has accepted that street-level bureaucrats influence policy on the ground (May & Winter, 2009).

Strengths and Limitations

This novel study is the first to explore policy and governmental efforts to end hallway healthcare care through the lens of frontline nurses in their role as street-level bureaucrats. Extending the theoretical framework of street-level bureaucracy in future research may be useful to bridge the gap between nursing and policy, and to inform policy change within organizations and the broader health system.

In conceptualizing nurses' understanding and experience with policies to end hallway healthcare, this study suggests that decision-makers and hospital leaders need to develop a clear understanding of nurses' involvement with policies that become the health services delivered. The lived experience of nurse participants is described in their ambiguity, complexity and diverseness of individual experiences (Coombes & Wratten, 2007; Karimi et al., 2020), working with ALC patients and policies to end hallway healthcare. Thus, draws attention to an important area of research that has been previously underexplored and underutilized.

This study had some limitations. This descriptive study was conducted in one Canadian province and included a sample of hospital nurses (RNs and RPNs) who worked with ALC patients. Provincial policy efforts to end hallway healthcare extend beyond the care of ALC patients to broader health system context, however this study concentrated on nurses with expertise in the care of ALC patients. As such, the findings may not be generalized to other nurses' experiences in managerial or educator roles or to other provinces. The study was dependent upon the viewpoints and experiences of nurses who participated in the study. Nurse representation from both categories of nurses who each worked in different hospitals across the province was a strength of this study. Many

common themes emerged from nurses described experience working with ALC patients and policies to end hallway healthcare

Recruitment for this study was open during the first and second wave of COVID-19, and may have resulted in a lower response rate as nurses worked at the frontline of the pandemic during the data collection period. The findings represent the experience of nurse participants and may not be generalizable to the experience of all nurses. Future research would benefit from a larger sample of hospital nurses, as well as from other areas of the health sector to inform policy makers, health administrators and nurse leaders about the interconnection between efforts to end hallway healthcare and nurses as street-level bureaucrats. However, this was beyond the scope of this study, which attempted to understand how nurses perceive and understand public policy.

6.5 Implications for Future Research

Nurses in this study support the idea of ending hallway healthcare, but express low confidence that public policies will be implemented as envisioned. This suggests a dissonance between policy intentions and clinical practice realities. Here, nursing leaders, and policymakers can play a key role to bridge this gap between policy intentions and what can be reasonably enacted through clinical nursing practice. This will require nurses to become more aware of why policy matters, and the importance of policy for the nursing profession (Annesley, 2019), to strengthen professional commitment, competencies and confidence for contributing to policy at all system levels. These pathways need to reflect and be sensitive to the local practice level and integrate specialty practice areas. This includes, principles of geriatric nursing that accounts for the difference in the scope of practice between RPNs and RNs.

The work of nurses included many mundane, routine tasks that risk minimalizing their role and engagement in professional and policymaking environments. These factors may underpin nurses described understanding of policy as vague or distant in their role as a nurse. As street-level bureaucrats, nurses enact policy through their interactions with patients and health networks, but are not always aware of their involvement with policy (Dickson & Brindis, 2019). Nurses need to understand policy that informs their practice. It seems important to recommend here that nursing institutions (education, and workplaces), and nursing associations should prioritize mandates that prepare nurses as confident and competent leaders, and to move beyond heightened levels of awareness of public policy through sustained involvement in policy development (Taylor, 2016). Rasheed et al. (2019) argue that it is essential to include nurses at the graduate and bachelor's levels in policymaking. This argument is supported by the findings in this study, and suggests to expand nurse involvement in policymaking to include all categories of nursing.

The reviewed studies of nurses as street-level bureaucrats captured nurses experience, understanding and potential influence for policy change at the local level outside the context of the Canadian healthcare system. Application of street-level bureaucracy, specifically accountability, discretion, coping mechanisms and conditions of work may be useful to better understand the actions and motivations of nurses influencing policy change. Further research is needed to explore nurses' impact and involvement in policymaking at the local level of the Canadian healthcare system. Frontline nurses can provide valuable insight and experience to inform decision-makers and institutions of any potential gaps between policy intentions and realities of practice. This will help policy

implementation and fidelity, including, but not limited to, policies to end hallway healthcare.

Managers influence how nurses' approach and respond to work conditions (May & Winter, 2009), such as the hospital capacity pressures and issues of overcrowding underpinning efforts to end hallway healthcare. Nurses perceived managers to make decisions without fully being aware of the implication these decisions have for frontline nurses. Problems with nurse and manager conflicts that were demonstrated in other studies (Hoyle, 2014; Hughes & Condon, 2016; Walker & Gilson, 2004), including a lack of communication, limited consultation concerning policy change, rushed implementation, and insufficient resources. Because managers are key to inform and motivate nurses understanding and experience with policy, these challenges need to be addressed when considering local levels of policy change, including efforts to end hallway healthcare.

6.6 Conclusion

The findings of this thesis suggest that nurses continue to feel disconnected from policymaking at the local and provincial levels of the healthcare system. This is consistent with literature reviewed in this paper that suggest nurses lack awareness, and therefore confidence in their role with policy (Annesley, 2019; Dickson & Brindis, 2019; Hlongwa & Sibiya, 2019; Rasheed et al., 2020; Walker & Gilson, 2004).

Much of the information nurses received about policies to end hallway healthcare stemmed from outside academic and institutional training. This may speak to why some nurses felt only vaguely familiar and not engaged in policy. Yet, from their clinical

experience nurses spoke confidently about their work with ALC patients, and challenges of hospital capacity pressures and overcrowding. Some nurses described in detail the stressors of caring for patients in hospital hallways and other unconventional spaces, such as sunrooms. The important voice and experience of frontline nurses is critical in influencing policy that guides their professional practice and shapes patient outcomes.

Application of street-level bureaucracy framework may be useful in future research to inform government leaders and nurse managers on how the considerable discretion of nurses' shape government policy through the services nurses deliver. This research will be important for the development and implementation of strategic programs to end hallway healthcare. Further, generating an understanding for how policy is perceived and interpreted by frontline nurses is important to bridge the gap between nurses' roles and involvement with public policy. Nurses' involvement at all levels and systems of policy are essential to the nursing profession and to the future of healthcare. Collective efforts and activities that include nurses are required to deliver public policies as envisioned.

References

Adams, N. E. (2015). Bloom's taxonomy of cognitive learning objectives. *J Med Libr Assoc, 103*(3), 152-153. doi:10.3163/1536-5050.103.3.010

Alzheimer Society (2022). *Responsive and reactive behaviours*. Alzheimer Society of Canada. https://alzheimer.ca/en/help-support/im-caring-person-living-dementia/understanding-symptoms/responsive-reactive-behaviours

Annesley, S. (2019). The implications of health policy for nursing. *British Journal of Nursing, 28*(8), 496-502. https://doi.org/10.12968/bjon.2019.28.8.496

Barnable, A., Welsh, D., Lundrigan, E., & Davis, C. (2014). Analysis of the influencing factors associated with being designated alternate level of care. *Home Health Care Management & Practice, 27*. https://doi.org/10.1177/1084822314539164

Bergen, A., & While, A. (2005). 'Implementation deficit' and 'street-level bureaucracy': policy, practice and change in the development of community nursing issues. *Health Soc Care Community, 13*(1), 1-10. https://doi.org/10.1111/j.1365-2524.2005.00522.x

Bowling, A., & Ebrahim, S. (2005). *Handbook of health research methods: Investigation, measurement and analysis*. Open University Press.

Bryant, T. (2009). *An introduction to health policy.* Canadian Scholars' Press Inc.

Canadian Institute for Health Information [CIHI]. (2009). *Alternate Level of Care in Canada*.https://secure.cihi.ca/estore/productFamily.htm?pf=PFC3264&lang=en&media=0

Canadian Institute for Health Information [CIHI]. (2017). *Regulated Nurses, 2016*. https://secure.cihi.ca/free_products/regulated-nurses-2016-report-en-web.pdf

Canadian Gerontological Nursing Association [CGNA]. (2020). *Gerontological nursing standards of practice and competencie*s. In 4th ed. CGNA. https://cgna.net/standards

College of Nurses of Ontario [CNO]. (2018). *Professional Standards*, revised 2002. https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf

College of Nurses of Ontario [CNO] (2021). *Find a nurse. Registry*. 2021 College of Nurses of Ontario

Coombes, L., & Wratten, A. (2007). The lived experience of community mental health nurses working with people who have dual diagnosis: a phenomenological study. *Journal of Psychiatric and Mental Health Nursing, 14*, 382-392. https://doi.org/10.1111/j.1365-2850.2007.01094.x

Costa, A., & Hirdes, J. (2010). Clinical characteristics and service needs of alternate-level-of-care patients waiting for long-term are in Ontario hospitals. *Healthcare Policy = Politiques de Sante, 6*(1), 32-46.

Costa, A., Poss, J., Peirce, T., & Hirdes, J. (2012). Acute care inpatients with long-term delayed-discharge: evidence from a Canadian health region. *BMC Health Services Research, 12,* 172-172. https://doi.org/10.1186/1472-6963-12-172

Creswell, J., & Poth, C. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Sage.

Cuthill, F., & Johnston, L. (2019). Home level bureaucracy: moving beyond the 'street' to uncover the ways that place shapes the ways that community public health nurses implement domestic abuse policy. *Sociology of Health & Illness, 41*(7), 1426-1443. https://doi.org/10.1111/1467-9566.12968

Currid, T. J., Turner, A., Bellefontaine, N., & Spada, M. M. (2012). Mental health issues in primary care: Implementing policies in practice. *British Journal of Community Nursing, 17*(1), 21-26

Dickson, E., & Brindis, C. D. (2019). The double bind of school nurses and policy implementation: intersecting the street-level bureaucracy framework and teaching sexual health education. *The Journal of School Nursing*, 1059840519868764. https://doi.org/10.1177/1059840519868764

Deber, R. M., C.,. (2014). *Case studies in Canadian health policy and management* (2nd ed.). University of Toronto Press.

Drinkwater, J., Salmon, P., Langer, S., Hunter, C., Stenhoff, A., Guthrie, E., & Chew-Graham, C. (2013). Operationalising unscheduled care policy: A qualitative study of healthcare professionals' perspectives. *Br J Gen Pract, 63*(608), e192-199. https://doi.org/10.3399/bjgp13X664243

Fedeli, V. (2019). *2019 Ontario budget: Protecting what matters most*. Queen's Printer for Ontario, 2019.

Financial Office of Accountability of Ontario [FAO]. (2019). *Long-term care homes program*. https://www.fao-on.org/en/Blog/Publications/ontario-long-term-care-program

Fox, M., Sidani, S., Butler, J., & Tregunno , D. (2017). Nurses' perspectives on the geriatric nursing practice environment and the quality of older people's care in Ontario acute care hospitals. *Canadian Journal of Nursing Research, 49*(2), 94-100. https://doi.org/10.1177/0844562117707140

Gale N, Heath G, Cameron E, Rashid S, & Redwood S. (2013). Using the framework method for analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*

Giorgi, A. (2009). *The descriptive phenomenological method in psychology : a modified Husserlian approach*. Duquesne University Press.

Health Quality Ontario [HQO]. (2018). *Measuring up 2018: A yearly report on how Ontario's health system is performing*. Queen's Printer for Ontario, 2018

Hlongwa, E. N., & Sibiya, M. N. (2019). Challenges affecting the implementation of the policy on integration of mental health care into primary healthcare in KwaZulu-Natal province. *Curationis, 42*(1), 1-9. https://doi.org/10.4102/curationis.v42i1.1847

Howlett, M., Ramesh, M., & Perl, A. (2009). *Studying public policy: Policy cycles & policy subsystems* (3rd ed.). Oxford University Press

Howlett, M. (2019). Moving policy implementation theory forward: A multiple streams/critical juncture approach. *Public Policy and Administration, 34*(4), 405-430. https://doi.org/10.1177/0952076718775791

Hoyle, L. (2014). 'I mean, obviously you're using your discretion': Nurses use of discretion in policy implementation. *Social Policy and Society, 13*(2), 189-202. https://doi.org/10.1017/S1474746413000316

Hughes, A., & Condon, L. (2016). Street-level bureaucracy and policy implementation in community public health nursing: A qualitative study of the experiences of student and novice health visitors. *Prim Health Care Res Dev, 17*(6), 586-598. doi:10.1017/s1463423616000220

Hupe, P., & Hill, M. (2007). Street-level bureaucracy and public accountability. *Public Administration, 85*(2), 279-299. doi:10.1111/j.1467-9299.2007.00650.x

Jasmine, T. (2009). Art, science, or both? Keeping the care in nursing. *Nurs Clin North Am, 44*(4), 415-421. doi:10.1016/j.cnur.2009.07.003

Johannessen, A. K., Tveiten, S., & Werner, A. (2018). User participation in a municipal acute ward in Norway: Dilemmas in the interface between policy ideals and work conditions. *Scand J Caring Sci, 32*(2), 815-823. https://doi.org/10.1111/scs.12512

Kuluski, K., Im, J., & McGeown, M. (2017). "It's a waiting game". A qualitative study of the experience of carers of patients who require an alternate level of care. *BMC Health Services Research, 17*, 1-10. https://doi.org/10.1186/s12913-017-2272-6

Karimi, Z., Fereidouni, Z., Behnammoghadam, M., Alimohammadi, N., Mousavizadeh, A., Salehi, T., Saeed Mirzaee, M., & Mirzaee, S. (2020). The lived experience of nurses caring for patients with COVID-19 in Iran: A phenomenological Study. *Risk Manag Healthc Policy, 13*, 1271-1278. https://doi.org/10.2147/RMHP.S258785

Kitson, A., Marshall, A., Bassett, K., & Zeitz, K. (2013). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *J Adv Nurs, 69*(1), 4-15. https://doi.org/10.1111/j.1365-2648.2012.06064.x

Lipsky, M. (2010). Street-Level Bureaucracy: Dilemmas of the Individual in Public Services. Russell Sage Foundation.

Lotta, G. S., & Marques, E. C. (2020). How social networks affect policy implementation: An analysis of street-level bureaucrats' performance regarding a

health policy. *Social Policy & Administration, 54*(3), 345-360. https://doi.org/10.1111/spol.12550

May, P. J., & Winter, S. C. (2009). Politicians, managers, and street-level bureaucrats: Influences on policy implementation. *Journal of Public Administration Research and Theory, 19*(3), 453-476. https://doi.org/10.1093/jopart/mum030.

Ministry of Health and Long-Term Care [MOHLTC]. (2015). *Patients first: Action plan for health care.* Queen's Printer for Ontario 2015.

Ontario Newsroom. (2010). *Aging at home strategy*. Queen's Printer for Ontario 2012-2022

Ontario Newsroom. (2018). *Ontario's government for the people taking immediate action to end hallway health care*. Queen's Printer for Ontario, 2019

Premier's Council. (2019a). *Hallway health care: a system under strain*. 1st Interim Report from the Premier's Council on Improving Healthcare and Ending Hallway healthcare. Government of Ontario. http://www.health.gov.on.ca/en/public/publications/premiers_council/docs/premiers_council_report.pdf

Premier's Council. (2019b). *A healthy Ontario: Building a sustainable health care system.* 2nd Interim Report from the Premier's Council on Improving Healthcare and Ending Hallway healthcare. https://files.ontario.ca/moh-healthy-ontario-building-sustainable-health-care-en-2019-06-25.pdf

Rasheed, S. P., Younas, A., & Mehdi, F. (2020). Challenges, Extent of Involvement, and the Impact of Nurses' Involvement in Politics and Policy Making in in Last Two

Decades: An Integrative Review. *J Nurs Scholarsh, 52*(4), 446-455. doi:10.1111/jnu.12567

Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. Sage.

Sutherland, J. M., & Crump, R. T. (2013). Alternative level of care: Canada's hospital beds, the evidence and options. *Healthcare Policy = Politiques de sante, 9*(1), 26-34.

Taylor, M. R. (2016). Impact of advocacy initiatives on nurses' motivation to sustain Momentum in Public Policy Advocacy. *J Prof Nurs, 32*(3), 235-245. doi:10.1016/j.profnurs.2015.10.010

Van Meter, D., & Van Horn, C. (1975). The policy implementation process: A conceptual framework. *Administration & Society, 6*(4), 445-488. https://doi.org/10.1177/009539977500600404

Villeneuve, M., Skelton-Green, J, & Shamian, J. (2019). Inflencing policy and leading change: essential steps in successful transformations. In A. McDonald, C & McIntyre, M (Eds). Relatities of Canadian Nursing professsional, practice, and power issues (5th edition, 230-257). Wolters Kluwer.

Walker, L., & Gilson, L. (2004). 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Soc Sci Med, 59*(6), 1251-1261. https://doi.org/10.1016/j.socscimed.2003.12.020

Walker, D. (2011). *Caring for our aging population and addressing alternate level of care*. Report Submitted to the Minister of Health and Long-Term Care. Queen's Printer for Ontario. ISBN 978-1-4435-7092-3

Ward, D. J., Furber, C., Tierney, S., & Swallow, V. (2013). Using Framework Analysis in nursing research: a worked example. *Journal of Advanced Nursing*, *69*(11), 2423-2431. doi:10.1111/jan.12127

APPENDICES

Appendix A

Synthesis of Literature. Nurses as Street-level Bureaucrats & Policy

Source	Key Concepts/Assumptions	Theoretical Base	Focus	Findings	Overall Contribution
Wells, J. S. G. (1997)	Pressures on mental health professionals in the community exacerbate challenges to policy implementation	Street-Level Bureaucracy	Using concepts of street-level bureaucracy to examine implementation of individual care programs by community health workers (including nurses).	The high levels of accountability may influence practitioners care decisions and discretionary actions to help the cope with the stresses of their work and the reality of policy in practice.	Contributes to the implementation literature in the area of health care practitioner's role and the reality of policy in practice.
Walker, L., & Gilson, L. (2004)	Examining the perceptions and perspectives of nurses as street-level bureaucrats regarding the process of policy implementation	Street-Level Bureaucracy	Nurses experience implementing health policy in South Africa	Implementation of health policy is informed by the views and values of nurses. Nurses feel excluded from policy change and the implementation process.	Policy Change should be viewed through the lens of street-level bureaucrats
Bergen, A., & While, A. (2005)	Policy implementation and nursing practice is complex and problematical.	Implementation Theory Street-level bureaucracy	Retrospective analysis of tension between policy and nursing practice focusing on Community Nurse Case Managers	Community nurse case management model embraces concepts outlined in street-level bureaucracy and implementation theory.	Framework combining street-level bureaucracy and implementation theory that may be useful to explain the link between nursing and policy implementation.
Sorensen, R., Iedema, R., Piper, D., Manias, E., Williams, A., & Tuckett, A. (2010)	Limited evidence to inform implementers of which base-model to use in patient-clinician communication and policy development	Grounded Theory	Patient and health professionals experience of Open Disclosure policy and how practice can inform policy	Experience with open disclosure was influenced by initiation of the disclosure, apologies, patients' perspectives, communication and cultural awareness	Elements to training standards and assessment of policy implementation progress.
Scott, V., Mathews, V., & Gilson, L. (2011)	Resistance to policy may delay implementation. Lack of trust underpin nurse oppositions, rather that equity goals. Relationships between various actors is key to implementation.	Policy Analysis Theory Implementation Theory	Views and reactions of district health managers and clinic nurses on implementation of staff reallocation strategies.	Lack of trust between mid-level managers and nurses influenced policy implementation	Contributes to implementation research and the perspectives of implementers

Source	Key Concepts/Assumptions	Theoretical Base	Source	Findings	Overall Contribution
Motsosi, K. S., & Rispel, L. C. (2012)	Inadequate planning leads to variations of and inconsistencies in policy implementation	Walt/Gilson Health Policy Triangle for analysis	Nurses understanding and perceptions of the Occupational Specific Dispensation (OSD) policy.	remuneration of health workers affects their motivation, performance and morale and attraction and retention of staff	Differing interpretations of detailed policy guidelines and unintended consequences.
Ditlopo, P., Blaauw, D., Rispel, L. C., Thomas, S., & Bidwell, P. (2013).	There are unintended negative consequences in policy implementation.	Hogwood and Gunn's Framework (1984)	Implementation of the occupation-specific dispensation (OSD) policy for nurses.	Conditions for OSD policy implementation were unmet related to incomplete data entry, insufficient attention paid to time and resources, relationships, communication and coordination.	Contributes to the implementation literature and identifies focus areas for planned implementation of healthcare reforms.
Drinkwater, J., Salmon, P., Langer, S., Hunter, C., Stenhoff, A., Guthrie, E., & Chew-Graham, C. (2013)	Healthcare professionals play a role in policy implementation	Street-Level Bureaucracy	Understanding why patients are using unscheduled care and how healthcare professions understand their role in reducing the use of unscheduled care	Nurses and other healthcare professionals take actions to negotiate or bypass the system to help patients.	Perceptions of healthcare professionals and work conditions are not taken into account in the policy to reduce the use of unscheduled care
Hoyle, L. (2014).	Nurses are street-level bureaucrats and the discretion they use in their day-to-day work influence policy implementation.	Street-Level Bureaucracy	The utility of street-level bureaucracy theory to demonstrate the importance of nurses discretion in their day-to-day work.	Nurses are street-level bureaucrats who use discretion in their work and can influence policy implementation	Contributes to the policy implementation literate on the use of discretion and translating policy to practice
Oliveira, E. S., Oliveira, C. R., Oliveira, R. C., Souza, F. S., & Xavier, I. S. (2014)	Progress has been made in Brazil to create a unified health system, yet there remain challenges to create a public health system to achieve quality	NA	Analysis of the literature about the National Policy on Health Promotion and implementation in nursing practice	Nurses play a role in policy implementation	Identify implementation challenges at the education, technology and user level of nursing practice.

Source	Key Concepts/Assumptions	Theoretical Base	Source	Findings	Overall Contribution
Hughes, A., & Condon, L. (2016).	Public health nursing has undergone major policy reform. Nursing viewpoints of new nurses offers unique perspective on policy implementation	Street-Level Bureaucracy	Student and new health visitors (nurses) experiences in policy implementation.	Nurses are street-level bureaucrats who negotiate demands of policy and practice.	Contributes to the utilization of street-level bureaucracy in nursing and policy research.
Johannessen, A. K., Tveiten, S., & Werner, A. (2018)	Legislation does not consider the need for clear guidance for professionals in practice	Street-level bureaucracy theory	The experience, perceptions and performance of healthcare professionals with user participation in a Municipal Acute Ward	There is a gap between the clinical work of health professionals and implementation of user participation policy	Contributes the need to acknowledge the clinical work of health professionals and valued in the policy process.
Annesley, S. H. (2019)	Policy provides context to nurses practice, roles, and patient care. Nurses do not always recognize the role in policy.	NA	Why nurses need to understand policy.	Nurses' play an important role in the leadership, governance, and decision-making of clinical commissioning groups to shape the context of care	Demonstrates the importance for why nurses need to understand policy and the role they play as implementors of policy.
Cuthill, F., & Johnston, L. (2019)	Street-level bureaucracy is useful to understand policy implementation in health and social care practices.	Street-level bureaucracy	Implementation of government domestic abuse policy by public health nurses in the family home environment	The physical environment influences the use of discretion nurses use to negotiate, adapt and resist elements of the policy.	The workplace is a factor in influencing home visitors (nurses) discretion to adopt or resist policy.
Dickson, E., & Brindis, C. D. (2019).	South Africa faces several challenges to implement health policies.	Street-level bureaucracy	The role of school nurses in the implementation of sexual health education.	Nurses acted as street-level bureaucrats in their use of discretion to manage challenging work conditions, unclear policy expectations and ambiguous policy goals.	Contributes to literature in the area of nurses as street-level bureaucrats and challenges with policy implementation in practice settings.
Hlongwa, E. N., & Sibiya, M. N. (2019).	Adherence of primary health care nurses of policy in South Africa. Nurses may be experiencing some of these challenges to implement the policy on integration to mental health care into primary health care.	Street-level bureaucracy	Challenges affecting implementation of the policy on integration of mental health care into primary health care.	Nurses experience a lack of training and resources, poor communication to address patient needs in alignment with the policy goals.	Contributes to the literature of the barriers experienced by nurses to implement policy into practice.

Appendix B

Interview Guide

Thank you for agreeing to participate in this interview.

The purpose of this research is to understand your experience caring for ALC patients in an era to end hallway health care. The provincial government defines hallway health care as medical care provided to patients in unconventional spaces. This policy objective aims to alleviate capacity pressures and overcrowding of hospitals by investing in long-term care and community health services to transition non-acute care patients from hospital into a more appropriate setting.

Your participation is completely voluntary and you can choose to withdraw at any time for any reason. If at any time you are uncomfortable with any of the questions you can choose not to answer. Any information you provide will be kept confidential; this means no personal identifiers will be used in the data. The de-identified information will be shared with my research team who will be required to sign a confidentiality form. I have received your consent form. Do you have any questions before we begin?

Is it ok to begin the audio recorder?

Demographics

Education level

Years of experience total

Years of experience in a hospital setting

Hospital type rural, urban, regional

Area of the hospital you work (transitional unit, ER, etc.)

Preliminary Question(s)

1. Would you tell me a little bit about yourself and your experience caring for ALC hospital patients?

Main Questions

1. Based on the definition of hallway health care, can you tell me a little about your experience with the care of ALC patients?

2. Why do you think the government has this objective to end hallway health care?

- What do you think of the guidance or directives you have received to transition ALC clients out of hospital?

3. From your perspective, is this policy objective important and needed? Please explain.
    - From your perspective, is there a need to move ALC clients out of hospital more efficiently to free up spaces for other patients?

4. What does the policy objective mean to you and how has it impacted your nursing practice and work routines?
    - Has the guidance of these directives had an impact on the way you provide care?
    - Has your views about the importance of moving ALC clients out of hospital impacted the way you provide care?

Conclusion

Is there anything else you would like to comment on the policy objective and your experiences providing direct patient care to ALC patients?

Is there something I haven't asked that you think is important for me to know, ALC patients and the policy priority to end hallway health care that we haven't discussed yet?

Thank you very much for taking time to participate in this study. We have come to the end of the interview. As we wrap up, may I contact you in the future if I require additional clarification on your responses? Would you like to review the themes or descriptions used from this interview?

Appendix C

Letter of Invitation

Qualitative Research Study

Dear Ontario Nurses:

I am requesting your participation in a research project titled, '*Nurses' Perspectives on Ending Hallway Health Care in Ontario to Address Alternate Level of Care in Hospitals'*. Your participation will involve a 45-to-60-minute interview that will ask about your experiences working with patients identified as alternate level of care (ALC). Your participation will support the successful completion of my Master of Health Science in Community, Public and Population Health at Ontario Tech University. This study was reviewed and approved by Arizona State University's Institutional Review Board on January 14, 2021 (file #00013177) and Ontario Tech University's Research Ethics Board on January 20, 2021(file #16118).

What to Expect

At a time of your convenience, we will schedule a telephone call or web-based (ZOOM) platform to complete the interview. The questions will ask about your experience providing care to ALC patients, as well as some general demographic questions. With your permission the interview will be audio recorded for analysis and accuracy of data purposes. The information provided during the interview will be held in strict confidence and no identifying information will be shared or attributed to your comments.

Next Steps

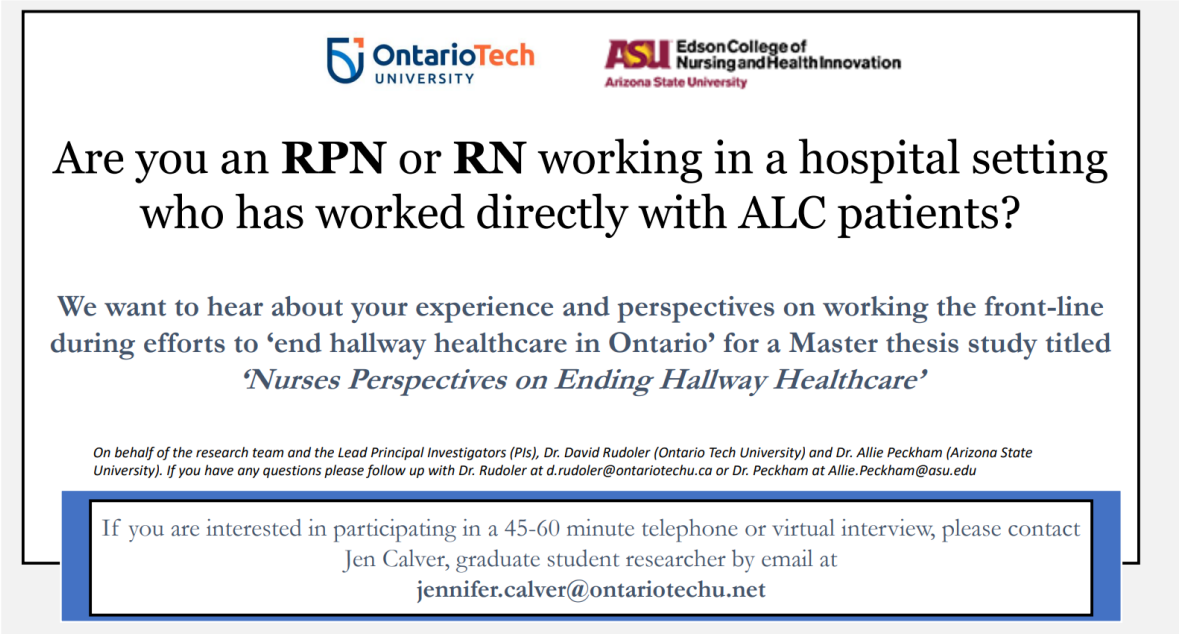
If you would like to participate in this research study or would like to request more information, you can email me at **jennfer.calver@ontariotechu.net**. If you are interested in participating, please email me with dates and times of convenience in order to schedule the interview.
Thank you for considering to participate in my Masters Thesis research, I look forward to hearing from you.

Sincerely,

Jen Calver, RPN, GPNC(C), BAHSc (Hons), MHSc(c)
Student Researcher, Ontario Tech University

On behalf of the research team and the Lead Principal Investigators (PIs), Dr. David Rudoler (Ontario Tech University) and Dr. Allie Peckham (Arizona State University). If you have any questions please follow up with Dr. Rudoler at d.rudoler@ontariotechu.ca or Dr. Peckham at Allie.Peckham@asu.edu

Appendix D


OntarioTech UNIVERSITY
ASU Edson College of Nursing and Health Innovation
Arizona State University
Are you an RPN or RN working in a hospital setting who has worked directly with ALC patients?
We want to hear about your experience and perspectives on working the front-line during efforts to 'end hallway healthcare in Ontario' for a Master thesis study titled
'Nurses Perspectives on Ending Hallway Healthcare'
On behalf of the research team and the Lead Principal Investigators (PIs), Dr. David Rudoler (Ontario Tech University) and Dr. Allie Peckham (Arizona State University). If you have any questions please follow up with Dr. Rudoler at d.rudoler@ontariotechu.ca or Dr. Peckham at Allie.Peckham@asu.edu
If you are interested in participating in a 45-60 minute telephone or virtual interview, please contact Jen Calver, graduate student researcher by email at
jennifer.calver@ontariotechu.net