Goodbye to print . . .

This issue of *CJNR* marks the last time the Journal will appear in hard copy. As of March 2014, Volume 46, we will be a Web-only publication. This is a major transition after 45 years, but one that has been carefully thought through.

We would like to take this opportunity to express our gratitude to the print team at Imprimerie Lebonfon for their excellent work over the past 12 years.

We invite our loyal readers and authors to spend time with us in our virtual home as we continue our many proud traditions and initiate a number of new ones.

–The *CJNR* team

Adieu à la copie papier. . .

Ce numéro du CJNR *est le dernier à paraître en format papier. À compter du numéro de mars 2014, volume 46, la revue sera publiée uniquement en ligne. C'est un changement de taille après 45 ans d'existence, mais qui a été mûrement réfléchi.*

Nous profitons de cette occasion pour exprimer toute notre gratitude à l'équipe responsable de l'impression à l'Imprimerie Lebonfon pour l'excellent travail qu'elle a réalisé au cours des 12 dernières années.

Nous invitons notre lectorat loyal ainsi que nos auteures et auteurs à passer du temps dans notre maison virtuelle où nous poursuivrons sur la lancée de nos nombreuses fières traditions et en créerons de nouvelles.

– *L'équipe* CJNR

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EDITORIAL

Patient- and Family-Centred Care: A Long Road Ahead

More than 20 years ago, in the middle of my nursing education, a Hollywood movie starring William Hurt was released. Titled simply *The Doctor,* it is the tale of a powerful but arrogant and insensitive cardiothoracic surgeon whose approach to patient care is transformed after he encounters the health-care system at its coldest when treated for throat cancer. Critics generally loved the film, as did the public. The movie's messages were simple: first, that neither social status nor money are of much benefit when life-threatening illness strikes and one's fate lies the hands of others and of forces unknown; and second, that no health-care worker should take an officious or distant approach to their work before walking a mile in their patients' shoes. Indeed, in the closing scenes of the movie the now-redeemed lead character makes a point of exposing his trainees to the vulnerabilities of being on the other side of the bedrails, with firsthand "learning experiences" as part of their initiation to practice.

From the time I walked into my first class and stepped into the community and the hospital as a nursing student, I was socialized to be sensitive to the personal and human side of health care — even to the point of letting health-care organizations with their hierarchies and operations fade into the background. I was taught to take the responsibility of being a professional seriously but to treat the "cloak" and trappings of professionalism warily. I was required to learn about and of course attend to the diseases, treatments, medications, and procedures connected to my patients' conditions, but not to let technical details rule the way I related to patients and families. My classmates and I were reminded again and again that patients are individuals finding their way through life in spite of the challenges of illnesses and life transitions, accompanied by whomever they called their families and often in spite of the barriers and limitations imposed by the health-care system. Repeatedly, we were reminded to view negative feedback and "difficult" behaviour on the part of patients and families as an opportunity to better understand and address needs, rather than as an affront or as something to be "managed" by pushing back against expectations. I was educated to see nurses as facilitators of "safe passage" through the health-care system and, when at the bedside, to always think about the kind of care I would want my own family to receive.

This past summer, my family lived through a dramatic and heart-wrenching encounter with the health-care system alongside my mother-in-law, who ultimately died of metastatic lung cancer. We came equipped with a great deal of knowledge and experience concerning the medical decisions that she would face. We knew about how health services operate and the situations that would need to be managed. We followed her through institutions where building layouts and sometimes even faces were familiar, and where knowledgeable and dedicated friends were never further away than a phone call or a walk down the hallway. As individuals, the professionals, technicians, and other workers were, almost to a person, exceptionally kind and competent. And as someone attuned to patient-safety issues, I was pleased to see the outward attention to safety concerns and inspired to see how hard so many people in the institutions were working to do right by patients. We were very lucky in so many ways.

However, we also saw poor communication between groups of professionals and between the health-care team and us (causing much distress), a narrow focus among many members of the teams, and seemingly endless delays. Even more disturbing, we saw resignation on the part of staff (which we might have mistaken for nonchalance had we not known better) to situations that, simply, patients and families should not be expected to endure. Were there bright spots — points of connection and victories — in a very difficult set of circumstances? Were we grateful for the attention and care my mother-in-law received? Absolutely. But I did have my *The Doctor* moments — different in some ways but strikingly similar in terms of feeling that somewhere along the way we have managed to get things very wrong.

I like to think that I am a successful, albeit imperfect, product of my socialization in patient- and family-centred care. From my clinical training I went on to become a nurse researcher and educator and to study health-care systems and how they succeed and fail. I have spent most of my teaching career delivering courses on the contexts of health care that affect what nurses are able to do in partnership with patients and other workers. I had the problems in health-care across systems carefully catalogued in my head. But it took my experience this past summer to show me, in my gut, just how far we are from where we need to be as a profession and as a health-care system.

For years I had listened to the countless personal stories of my colleagues, family, and friends about huge gaps in patient- and family-centred care. I had heard for decades that only a fool would leave a loved one with a serious illness unaccompanied in the hands of the health-care system (and, indeed, at least one of us was at my mother-in-law's side from the beginning of the journey to the end). But when we lived through a crisis firsthand I realized that I have been an apologist for the system's failings — despite being involved for more than a decade in research showing how systematic and widespread those failings are. It hit me that, apart from the "points of light" (inspiring individuals and settings that keep us all from losing hope), our system of care is nowhere close to being patient-centred and that I have been overly optimistic about the prospects for improvement. In the coming years, with health-care financing expected to grow less and less secure, services are bound to shift to accommodate political and economic forces. Barring a major change in how we organize care, our health-care system will become increasingly unsafe and toxic for those who work within it and those who have no choice but to rely on its services. It is clear that we have other fundamental work to do as a health-care system and as a profession besides worrying about individuals being people-focused and humane.

It seems that we in nursing and our colleagues in the other health professions and occupations are too lost to find our first steps. Quite possibly we are just too comfortable with the status quo to seriously question what is happening in health care. Perhaps we think we have too much to lose by changing the structures and operating principles in our institutions and agencies, when keeping our heads above water consumes so much of our time and energy. However, we need to start asking ourselves why vested interests have created and continue to sustain the system we now have. Moreover, we need to determine what our next steps will be if patient-centredness is to be more than just a buzzword, and what we are willing to sacrifice as a profession and as individuals in terms of security and certainty in order to deliver better care and forge a better future for our patients and, ultimately, ourselves. The public is counting on us all to find a better path on so many fronts. And sometimes it takes a deeply personal experience to see things that our various socializations and interests prevent us from seeing.

Sean P. Clarke
Editor-in-Chief

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Commentary

Home Telehealth and an Aging Population

Debra Sheets

An aging population is driving increased demand for health services and a shift in care from hospital to home. Concerns about the high costs of acute care and the realization that hospitals are "bad places" (e.g., nosocomial infections, functional loss) for old, frail people have focused attention on treating people in their homes, which is for the most part where they prefer to be. Fortunately, technology has the potential to reduce health-care costs, enhance access to services, and improve management of chronic diseases (Center for Aging and Health, 2013).

Home telehealth programs have documented positive outcomes, including reduced health-care costs, fewer hospitalizations and readmissions, improved quality of care, and better chronic disease management (Broderick & Lindeman, 2013; Chetney, 2008). A study of home telehealth implemented in several regional health-care systems in the United States found that health-care utilization decreased 20% for diabetes, 30.3% for hypertension, and 25.9% for congestive heart failure (Broderick & Lindeman, 2013). Another study demonstrated a 50% reduction in hospital readmissions related to heart failure and a total net savings of $8,155 per patient (Broderick, 2013); the findings indicate high levels of patient satisfaction, reduced hospitalization and readmission, decreased length of hospital stay, and decreased emergency department visits.

What, then, is holding back the wider adoption of home telehealth? Most of the home telehealth programs brought to scale have required development of software unique to each health-care organization, which limits access to data across levels of care (e.g., acute care, home care, primary care). The home health consumer market has seen a proliferation of standalone devices that address specific needs (e.g., personal medical alert systems, medication dispensing devices, blood glucose meters). Home activity sensors (e.g., Lively) that "learn" personal routines and use built-in wireless service to alert caregivers when help may be needed are the latest product to enter the market. However, the usefulness of these standalone devices is limited by the lack of common data and a secure communications platform to allow remote access. In addition, many of the devices require a separate monthly service charge to cover remote monitoring costs.

Several articles in this issue of *CJNR* provide opportunities to consider ways in which technology might improve care delivery. Remote patient monitoring (RPM) could give families the confidence and support they need to provide home care for alternate level of care (ALC) patients awaiting long-term institutionalization — and possibly even eliminate the need for placement (Cressman, Ploeg, Kirkpatrick, Kaasalainen, & McAiney). A telephone support program for dementia caregivers illustrates the use of low-cost and familiar technology in a care model (Marindale-Adams, Nichols, Burns, Graney, & Zuber). The emotional and informational needs of older adults (McInnis-Perry, Weeks, & Stryhn) might be addressed using network technologies (e.g., Tyze) that enhance communication between friends, families, and neighbours.

The wider adoption and integration of home telehealth will accelerate once a means of bridging existing data silos is found. Nurse scholars need to begin examining the implications of these technologies for nurses' workloads and roles in the future. For example, home telehealth nurses may routinely monitor up to 100 patients a day in lieu of making seven home visits. Such transformations might appear to be a logical response to resource challenges but represent a huge change in the texture of nursing practice (for instance, with respect to the nurse–patient relationship).

Growing concerns over health-care costs and access to care are intensifying interest in leveraging technology to transform the delivery of patient care and improve outcomes for Canada's older population. Nurses are uniquely positioned to influence the delivery of remote patient monitoring to older adults, because they know what clinical information is necessary for informed decision-making and they play a central role in decision-making. Nursing researchers, leaders, and clinicians need to be proactive in the development and assessment of home telehealth programs, to ensure that clinical care needs and patient concerns are addressed.

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Résumé

L'incertitude et l'autre niveau de soins : une étude narrative de l'expérience des personnes âgées malades et de leurs aidants naturels

Greg Cressman, Jenny Ploeg, Helen Kirkpatrick, Sharon Kaasalainen, Carrie McAiney

Les personnes âgées au Canada qui souffrent de multiples maladies et sont en attente d'un placement dans une unité de soins de longue durée sont très touchées par l'autre niveau de soins (ANS). La présente étude narrative vise à consigner les expériences des personnes âgées hospitalisées et de leurs aidants naturels après l'établissement de la nécessité d'un ANS. Les chercheurs ont effectué 21 entrevues avec 5 personnes âgées hospitalisées et 4 aidants naturels. Les entrevues ont été transformées en récits résumant les expériences de ces personnes et analysées pour en cerner les thèmes communs. Une des principales constatations de l'étude est que l'incertitude fait partie intégrante de l'expérience d'un ANS, comme l'expriment ces trois thèmes : *je n'ai jamais pensé que je me retrouverais dans cette situation, je ne sais pas* et *l'attente.* Pour améliorer l'expérience d'un ANS, il faudrait établir des stratégies globales à l'échelle humaine, organisationnelle et structurelle pour mieux gérer l'incertitude tout en cherchant à réduire la fréquence d'un ANS chez les patientes et les patients âgés.

Termes clés : personnes âgées, autre niveau de soins (ANS), soins de longue durée

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Uncertainty and Alternate Level of Care: A Narrative Study of the Older Patient and Family Caregiver Experience

**Greg Cressman, Jenny Ploeg, Helen Kirkpatrick,
Sharon Kaasalainen, Carrie McAiney**

Older adults in Canada who have multiple illnesses and are awaiting placement in long-term care are greatly impacted by alternate level of care (ALC). The purpose of this narrative study was to record the experiences of hospitalized older adults and their family caregivers after the patient is designated as requiring ALC. The researchers conducted 21 interviews with 5 older patients and 4 of their family caregivers. The interviews were transformed into stories summarizing the participants' experiences and analyzed for common themes. An overall finding was that uncertainty is integral to the experience of ALC as expressed under 3 themes: *I never thought I'd end up like this, I don't know,* and *waiting.* To improve the ALC experience, comprehensive strategies should be developed at the individual, organizational, and structural level to better manage uncertainty while seeking to reduce the occurrence of ALC among older patients.

Keywords: aging, clinical nursing research, geriatric, mobility, nursing interventions, transitional care

Introduction

Alternate level of care, or ALC, is a designation assigned to a patient in Canada (Canadian Institute for Health Information [CIHI], 2009) who is occupying a hospital bed but no longer requires the intensity of services provided in the hospital setting (Cancer Care Ontario, 2009). Different terms are used for the designation in other jurisdictions; in the United Kingdom it is "delayed discharge" (Glasby, Littlechild, & Pryce, 2006). There is concern in Canada that ALC is having an increasingly negative impact on an already overburdened hospital system (CIHI, 2009). The patient population most affected is older adults, especially those with multiple illnesses, including dementia (CIHI, 2009). The patient and family perspective is minimally reflected in the research literature on ALC. The main purpose of this study was to explore the experiences of hospitalized older adults and their family caregivers after the patient is designated ALC.

Literature Review

In the Canadian province of Ontario, between March 2012 and March 2013 the monthly proportion of acute-care hospital beds occupied by ALC patients ranged from 15% to 17% (Ontario Hospital Association, 2013). Older patients awaiting placement to a long-term-care home (LTCH) often spend an extended period in hospital before placement occurs (Walker, 2011). In 2008–09 older ALC patients awaiting LTCH placement in Ontario had a median wait time of 55 days (Bronskill et al., 2010).

In their review of the literature on delayed discharge in the United Kingdom, Glasby and colleagues (2006) conclude that effective responses to the problems of ALC must be guided by evidence that includes a patient and family caregiver perspective. Such evidence (of which there is very little) is needed to guide targeted strategies for improving the patient and family experience, given that many aspects of that experience have been shown to be unsatisfactory (Doleweerd & Berezny, 2009; Kydd, 2008; Swinkels & Mitchell, 2008). Glasby and colleagues (2006) propose that the patient and family perspective be used to guide comprehensive, informed solutions at the level of the health-care and social-care systems, with the goal of reducing the occurrence of ALC.

Three qualitative studies have explored the experiences of patients or family caregivers following ALC designation. In an ethnographic study of delayed discharge with three older patients, Kydd (2008) found that patients were anxious about their future; the author includes little about the assumptions underlying the study design, provides limited description of methods, and presents a list of issues rather than a cogent summary of themes and ideas emerging from the data. In a phenomenological study using interviews with 23 patients at three hospitals in England, Swinkels and Mitchell (2008) found that patients with a delayed discharge willingly or unwillingly relinquished involvement in the discharge planning process. Doleweerd and Berezny (2009) found that family caregivers lacked accurate and timely information throughout the ALC experience and were upset about the ALC co-payment. (In Ontario, most patients awaiting LTCH placement are required to start making payments to the hospital once the patient is designated ALC. This is known as the ALC co-payment.) However, Doleweerd and Berezny's report is based on interviews that took place long after the ALC experience had ended, and neither Doleweerd and Berezny nor Swinkels and Mitchell followed their participants over time. Hence, the present study sought to better understand the experience of patients and family caregivers, including their information needs, aspects of care that were positive or negative, feelings that were part of the experience, effects of the experience, and hopes, fears, and worries concerning the future.

Method

Narrative Design

The research question was as follows: *What are the experiences of hospitalized older patients and their family caregivers after the patient is designated ALC?* The narrative design was based on Clandinin and Connelly's (2000) Three Dimensional Narrative Inquiry Space approach. The three dimensions address key aspects of the ALC phenomenon: *interactions* between the *personal environment* and the *social environment; temporality (past, present, future);* and *place*. The dimension of personal and social interactions guided inquiry into participants' feelings and values and exploration of their interactions with others, including health-care providers. The dimension of temporality helped shape understanding of the continuousness of present experiences with past and future ones. The significance of place as noted in the ALC literature guided inquiry into how place shaped participants' experiences at home and in hospital and their perception of the place they would be moving to following hospitalization.

Setting and Participants

In the fall of 2010 five patients and four family caregivers were recruited on a sequential basis over a 3-month period from the internal medicine service of a large urban teaching hospital in south-central Ontario. Patients were eligible for inclusion if they were 75 years or older, designated ALC within the last 30 days, able to speak and understand English, admitted from a private home, and likely to apply for placement to an LTCH, retirement home, or complex continuing care facility. The age criterion was chosen because the median age for ALC patients in Canada is 80 years (CIHI, 2009) and most ALC patients are over the age of 75 (Walker, 2011). LTCH was chosen as a placement destination because it is highly represented in the ALC population, at 43% of possible discharge destinations across Canada (CIHI, 2009). Retirement home and complex continuing care were included in case these possible placement destinations resulted in experiences that were different from those of LTCH. Patients were excluded if they were designated as requiring palliative care, had advanced dementia or a current delirium, or were under the order of a public guardian. Eligible patients were asked to identify a family caregiver who could be approached to participate.

Recruiters for the study were members of the professional staff involved in the patients' care. At the time of ALC assignment, all patients were divided into two groups: those who could return home (ALC-Home), and those who required placement to a setting that was yet "to be determined" (ALC-TBD). The ALC-TBD designation was retained until discussion among the patient, family, and professional caregivers in the circle of care had identified one of eight possible discharge destinations. Participants were therefore recruited from the list of patients who were designated ALC-TBD, ALC-LTCH, ALC-Retirement Home, or ALC-Complex Continuing Care. For those designated ALC-TBD, the recruiters were asked for their opinion on which patients were likely to seek one of the three destinations of interest for this study (LTCH, retirement home, or complex continuing care). In the end, a total of 13 patients qualified for the study, five of whom were eventually enrolled. Four of five possible family caregivers agreed to participate. Of the eight patients who were not enrolled, five declined to participate and three were discharged from hospital before they could be approached to participate. All those enrolled completed the entire study.

Interviews

Semi-structured interviews were conducted by the first author using an interview guide (available from the first author) based on evidence from the literature on ALC experiences and structured using the Three-Dimensional Narrative Inquiry Space approach. Given the emphasis on time as a central dimension of experience (Clandinin & Connelly, 2000), at least two interviews separated in time were obtained for most participants.

Data Analysis

The interviews were audiorecorded and transcribed. Re-storying involved a complex set of steps whereby the transcripts were analyzed using *holistic content* procedures (Lieblich, Tuval-Mashiach, & Zilber, 1998) to create one storied account incorporating the perspective of both the patient and the family caregiver for each pairing (Clandinin & Connelly, 2000). *Categorical content* analysis (Lieblich et al., 1998) was then used to identify themes that were common across participant stories. The study was guided by Kirkpatrick's (2005) suggestions for ensuring rigour in narrative inquiry.

Ethical Considerations

The study was approved by the research ethics board of the participating hospital. Given concerns about the level of physical and cognitive functioning in the vulnerable population of hospitalized older persons, the *process consent* method was employed (Dewing, 2007). This approach views consent as an ongoing process grounded in the relationship between researcher and participant. It includes efforts at each encounter to monitor the well-being of the participant to determine whether it is in any way eroded by the research process.

Findings

In total, 21 interviews were conducted, with two or more interviews taking place for seven of the nine participants. Patients ranged in age from 82 to 89 years and included three men and two women — three married, one single, and one widowed. Family caregivers ranged in age from 48 to 59 years and included three women and one man — two single, one married, and one in a common-law relationship. Patients were enrolled in the study between 3 and 30 days after being designated ALC and were interviewed approximately every 2 weeks until discharge; the longest follow-up was 8 weeks. Patients were located on five different medical wards of the hospital (ALC, Chest, Flex, Clinical Teaching, and Cardiology).

Uncertainty was found to be integral to the experience of ALC as captured under three broad themes: *I never thought I'd end up like this, I don't know,* and *waiting.* The three themes and 12 subthemes are described below. All names are pseudonyms.

I Never Thought I'd End Up Like This

The past: I was on the go all the time. In speaking about their lives before being admitted to hospital, patients viewed themselves as moving freely and engaging in meaningful activities. Reflecting on his life, Bob said,

> *I've travelled the world. I've been a lot of places a lot of people never get [to]. . . . I've done a lot, I've seen a lot. I had a good life till they took my wife [to an LTCH].*

The present: I never thought I'd end up like this. Patients and family caregivers had different perspectives on the circumstances that had led to the hospital admission. In each case, the older adult's functional status gradually deteriorated over the course of weeks or months, resulting in rising concern by the family caregiver about the person's ability to manage at home. Sudden deterioration (e.g., inability to transfer out of bed, eat, or communicate) led to the hospital admission, at times against the wishes of the older adult. This deterioration was sometimes precipitated by problems related to a chronic health condition.

Most patients described their present situation — hospitalized while designated ALC — as discontinuous with their past experience and their previous notions about their future. They expressed an uncertain, almost bewildered, concept of self, struggling to come to terms with their recent decline in functional ability and to imagine themselves living in the new place. On the morning of his transfer to an LTCH, Dan's resigned tone stood in marked contrast to his usual assertive and direct manner: "I never thought I'd end up like this." Teresa's second interview, filled with a litany of complaints about her situation, included the following reflection:

> *When you think of people throughout the world starving . . . I think, "What must God think of you?" He put me on this earth for a purpose. This is the way He wants things to be. [So] why don't I say, "Thank you, God, I accept it," instead of carrying on like an idiot . . . I don't like that part of me, because I never thought in my life I would be one to complain.*

The future: At my age, what is there to hope for? Patients had a mostly negative view of their future. When they were asked what they hoped for, their responses ranged from tentative hopefulness (Dan and Frank), to trust in the face of uncertainty (Teresa), to resignation — "At my age, what is there to hope for?" (Nancy), to a conviction that there was no future (Bob). Because of their age and recent health decline, most patients were pragmatic and frank in speaking about their own mortality and the possibility that the end of their life was near. However, this view of the future did not preclude their expressing modest hopes for a better future. About the uncertainty she was feeling regarding her future and the challenges she was facing, Teresa said, "I think you get accustomed to things and you adjust or you go crazy." Bob had a pragmatic view of his future: "I don't have a future . . . I've been [in bed] for 2 months. That's no good." Given Bob's past experience with chronic illness and cycles of exacerbation and recovery, his inability to rebound from this acute phase caused him grave concern.

I Don't Know

I don't know the right questions to ask. Several family caregivers identified concerns related to poor communication. Barb, for example, was uncertain about how to obtain the information she needed to guide planning and decision-making for her mother's care:

> *I think the information could have been explained a little more clearly, because I don't . . . understand the system . . . maybe I just didn't know the right questions to ask.*

Similarly, Alan said,

> *The degree of communication is terrible . . . It's rare that someone will come to me and say, 'This is what's going on.' . . . It seems unprofessional and it makes me wonder — I mean, not the abilities but . . . the coordination.*

I don't know about hospital processes. Participants described not knowing about important processes of care. This included not knowing the meaning of "alternate level of care," the roles of different staff members, processes related to patient isolation, the availability of day passes, or why the patient was being moved. For example, patients and family caregivers tried to read meaning into unexplained moves that occurred in the hospital. After the unexpected move of her father to the ALC ward, Sarah declared, "They didn't even explain to us . . . I thought they were going to start those musical beds again like they generally do."

I don't know about the placement process. In the midst of the experience, participants had many unanswered questions about the placement process. This uncertainty lingered right up to the moment of discharge. Participants reported not knowing about crucial aspects of the plan for placement, not being included in the planning and decision-making processes, not knowing about financial aspects of the placement process, not having basic information about the features and services of retirement homes and LTCHs, and not understanding the overall process for arranging placement. Bob was extremely upset about not being present at a crucial discharge planning meeting: "How they can hold a meeting like that and not have the person you're talking about and discussing have an opinion!" Teresa was just 3 hours from discharge:

> Teresa: *I'm being moved to [the Assess and Restore Program] for therapy . . . I don't know what it involves . . . and I don't think they told my niece any more than they told me.*
>
> Interviewer: *Do you have any idea what the plan is?*
>
> Teresa: *Not a whit.*

I don't know about medical assessment, diagnosis, and prognosis. Patients and family caregivers felt they were not provided important medical information related to assessment, diagnosis, and prognosis. On the morning of her transfer to a retirement home, Nancy was so angry about not receiving adequate medical information that she held a protest, refusing to get dressed until a doctor came to assess her. Her daughter, Barb, commented,

> *I don't know if assessments were ever done. Well, I do know one was done but you don't know when, where, what are the results? What do they say? What does that mean?*

Waiting

Waiting to be more mobile. Patients expressed a desire to be more mobile and to receive more physiotherapy and assistance with exercise. Several were waiting for assistance so they could start walking and lamented the unavailability of physiotherapy on weekends. Teresa complained to the physiotherapists about the uncertain weekday scheduling: "There's really no purpose you coming if you don't come on a regular basis." Sarah was very disappointed because of the lack of attention paid to her father's walking. Having seen remarkable improvement in her mother's mobility after 3 months in an LTCH, she said, "The nursing home will probably have my dad up more . . . than the hospital."

Longing for meaningful activity. Patients described the challenges they faced waiting for time to pass. They attributed the lack of meaningful activity to this waiting. Nancy described herself as "whining" because of the inactivity: "It's boring . . . I mean, I'm lying there all the time . . . they get mad at me because I'm whining . . . but there's nothing else." Teresa poignantly conveyed her longing for meaningful activity using the image of a clock:

> *The days are long, the nights are longer, and of course in every room they have a great big clock that tells you exactly to the minute. So your life is passing . . . by and you're not going anywhere.*

Waiting for care. Patients were pleased with many aspects of the physical care they received while designated ALC. However, they reported having to wait, often for long periods, for assistance with activities of daily living, such as eating, toileting, and personal care. In observing other patients on the ALC ward who were physically and cognitively more impaired than she was, Teresa commented,

> *I was wishing people could be more helpful to them, because . . . if you're [among] the more disabled, to me you always have to wait till everybody [else] is looked after.*

Waiting for placement. Family caregivers and patients were frustrated by the protracted and uncertain wait for placement, which led to firm action in some cases and resignation in others. A particularly contentious aspect of waiting for placement was the ALC co-payment. Alan stated that it caused his parents great financial difficulty since they were simultaneously paying for their house and its expenses and his mother's LTCH placement:

> *Somebody who worked 50 to 70 years and, you know, accumulate this and have it depleted while in the hospital . . . I want it to go for life, not for existence . . . He's existing — he's not living.*

Waiting for couple reunification. Three of the five patients were separated from a spouse with dementia and the placement they were waiting for would reunite them. Bob had been waiting 15 months, ever since his application to be placed in the same LTCH as his wife had been accepted: "Especially in these years, not that much time left, they could be a little more careful about splitting couples up." His son, Alan, exclaimed, "If someone tells me one more time that that is the way the system works — the system is broken; it needs to be fixed!"

Discussion

Uncertainty and the Experience of ALC

The main finding of this study is that *uncertainty* is integral to the experience of ALC for patients and family caregivers. Uncertainty was apparent across the three dimensions of experience described by Clandinin and Connelly (2000), including *uncertain self-concept* in the personal dimension as reflected in the theme *I never thought I'd end up like this, uncertain knowing* in the dimension of interactions in the social environment, and *uncertain waiting* in the dimensions of temporality and place. Other studies of patient experience of ALC have reported themes that resonate with the findings of this study, such as lack of information and anxiety about the future (Doleweerd & Berezny, 2009; Kydd, 2008; Swinkels & Mitchell, 2008). No other studies, however, have reported the combination of findings that result in the view that uncertainty is a central part of the ALC experience.

The findings of this study are consistent with Clandinin and Connelly's (2000) perspective that the dimension of place has a significant impact on experience. For example, three of the five patients were waiting for LTCH placement. The uncertainty and distress shown by these participants support Sussman and Dupuis's (2012) finding that transition from hospital to LTCH is a more difficult experience than transition from, for example, home or retirement home to LTCH. In the hospital setting, the transition to LTCH is intertwined with the process of ALC designation and is therefore shaped in significantly different ways compared to the transition to LTCH from, for example, home or retirement home.

Several aspects of this study may have contributed to the novel findings. First, the temporal design, with multiple interviews for each participant, allowed both a stronger relationship to evolve between participant and interviewer and time for participants to reflect and expand on themes that re-emerged in subsequent interviews. This generated deeper and richer insight, which included negative aspects of the experience. Second, the pairing of patient and family caregiver perspectives elicited a rich narrative of the shared experience of ALC designation. Finally, participants noted that reflecting in the midst of the experience allowed them to comment on details they might otherwise have forgotten.

Uncertain Self-Concept

The theme *I never thought I'd end up like this* conveyed patients' uncertainty about their self-concept. The research literature on the ALC experience does not report on uncertain patient self-concept. The literature on self-concept related to chronic illness, however, does discuss uncertainty — for example, in relation to Alzheimer's disease (Parsons-Suhl, Johnson, McCann, & Solberg, 2008; Pearce, Clare, & Pistrang, 2002). Charmaz (1995) points out that chronic illness disrupts the unity between a person's concept of their body and their sense of self. She describes a process whereby some people with chronic illness go through stages of adapting to impairment. The present study identifies relocation as an added challenge in learning to live with chronic illness.

Uncertain Knowing

The findings under the theme *I don't know* are congruent with those reported by previous studies of ALC experiences (Doleweerd & Berezny, 2009; Swinkels & Mitchell, 2008). Concerns about not knowing also reflect problems documented in the larger research literature on hospitalization of older adults (Flacker, Park, & Sims, 2007; Huber & McClelland, 2003) and family caregivers (Higgins, Joyce, Parker, Fitzgerald, & McMillan, 2007).

Participants expressed frustration at not knowing about the discharge plan, which is consistent with the ALC literature in that disempowerment related to poor communication is a barrier to full participation (Swinkels & Mitchell, 2008) and patients had little say in their discharge plan (Kydd, 2008). This study provides evidence of more active exclusion from the discharge planning process. For example, Bob was extremely upset at being excluded from a crucial discharge planning meeting. Hence, the word "disenfranchisement" might better characterize the experience of ALC patients in relation to the discharge planning process than "relinquishment," as proposed by (Swinkels & Mitchell, 2008).

Uncertain Waiting

The theme of *waiting* illustrates how uncertainty in the dimensions of time and place contributed to participants' global experience of uncertainty. The length of the wait for placement proved to be very uncertain. The ALC stay for the patients in the study ranged from 11 to 85 days. In all cases, discharge occurred suddenly, with little notice — less than 24 hours in two cases. Doleweerd and Berezny (2009) also report uncertain waiting for discharge and note that lack of accurate information about wait times contributed to the uncertainty.

Participants were concerned about the lack of mobilization assistance, especially on weekends, and the uncertain scheduling of physiotherapy. Swinkels and Mitchell (2008) also report *immobility* as a theme. In the larger body of research with hospitalized older adults, Callen, Mahoney, Grieves, Wells, and Enloe (2004) report that few older patients on the medical units of a teaching hospital who were evaluated as capable of walking actually did walk. The detrimental effects of lack of mobility among older hospital patients are well documented (Brown, Friedkin, & Inouye, 2004; Fisher et al., 2011; Inouye, 2006; Zisberg et al., 2011).

Participants spoke eloquently about the lack of meaningful activity. In the ALC literature, the lack of meaningful activity is associated with mood changes, frustration (Swinkels & Mitchell, 2008), and boredom (Kydd, 2008). Other literature on hospitalized older adults reflects this same concern (McKee, Harrison, & Lee, 1999; Nolan, Grant, & Nolan, 1995).

Some of the participants' narratives display evolution of the themes over time. For example, at the first interview Teresa (who had the longest ALC stay: 85 days) was quite brief in her responses and spoke in mostly positive terms about her experience. Subsequent interviews yielded much more content, including many complaints about her situation, which centred on the theme of uncertainty as expressed across all three themes (uncertain self-concept, uncertain knowing, and uncertain waiting) and even led her to apologize for being "a complainer." The fourth and final interview continued to yield this richness but included positive reflections on initiatives she had taken to address her concerns, such as becoming more mobile and pursuing meaningful activity. Uncertainty about the plans for her discharge emerged most intensely during this last interview, just hours before her discharge. Overall, it is difficult to characterize the factors that might have influenced the evolution of the narratives. As well, the nature of the relationship between the themes and the passage of time is variable, with some aspects amplified and others diminished, depending on the particular experience being described by the participant.

Uncertainty and the Challenge of ALC Research

A number of challenges were encountered doing research related to ALC, which were impacted by the uncertainty associated with the phenomenon. For example, uncertainty about the timing of discharge meant that the researchers were given little time to arrange final interviews (less than 24 hours in two cases). As well, the physical and/or emotional vulnerability of participants coupled with the complexity of the acute-care environment made it difficult to initiate timely engagement with participants (the first interviews with patients ranged from 8 to 32 days following ALC designation), to sensitively and flexibly negotiate appropriate interview times (e.g., many family caregiver interviews were dovetailed with scheduled visits to the patient), and to find private, accessible interview locations.

Implications for Practice and Policy

Glasby (2004) proposes a framework for understanding and responding to problems associated with ALC. Problems fall into three concentric and expanding circles or levels of concern: individual, organizational, and structural. The individual level refers to the way in which health-care providers interact with patients and families and to issues such as effective communication. The organizational level encompasses the effectiveness of care practices and policies within and between organizations. The structural level highlights the need for government action in order to address financial, legal, and administrative obstacles to inter-organizational collaboration. The implications of the findings of uncertain self-concept, uncertain knowing, and uncertain waiting are examined using the lens of Glasby's framework.

Individual level. The finding of uncertain self-concept suggests the need to provide support to patients in the midst of the ALC experience. Penrod (2007) argues that when the mode of uncertainty is existential in nature and related to learning to live with prolonged uncertainty, intervention strategies should focus on helping patients to be introspective and to seek personal growth. In her examination of older adults' perceptions and experience of time when institutionalized (specifically, in LTCHs), Wiersma (2012) observes that institutional living tends to create a culture of time that is focused solely on the present. She argues that institutional staff would do well to resist this cultural tendency and seek ways to recognize the rich and varied past of residents along with the challenging future they face. This prescription might apply equally to staff caring for older patients designated ALC.

Organizational level. The finding of uncertain knowing implies that hospitals should provide timely and accurate information to patients and families in order to manage uncertainty during the ALC experience. Although the care processes related to information provision were not examined in this study, patients and family caregivers were clear about their experience on the matter. The literature on managing uncertainty in chronic illness (Bailey, Wallace, & Mishel, 2005; Penrod, 2007) includes work based on Mishel's (1988) Uncertainty in Illness Theory. A key insight of this theory, as applied to chronic illness, is that patient uncertainty can be mitigated by education and social support offered by health-care providers (Mishel & Clayton, 2003). However, this alone is not sufficient to address information needs during discharge planning (Flacker et al., 2007). Best practices suggest that a comprehensive approach is needed to ensure the full participation of patients and families in the discharge planning process and that it should include better, earlier, and more frequent education and communication (Bauman et al., 2007). A multidisciplinary team member designated as discharge advocate might be one means of improving the discharge planning process (Jack et al., 2009; Naylor et al., 1999).

The findings on uncertain waiting suggest that hospitals should encourage meaningful activity for older adults, including the promotion of mobility. In Ontario, the Senior Friendly Hospital strategy (Wong, Ryan, & Liu, 2011), building on the work of Parke and Stevenson (1999), includes care processes that preserve the independence of older adults by optimizing physical, cognitive, and psychosocial function. Hospitals need to implement goal-directed plans for physiotherapy and recreation, ensure reliable scheduling of such services, especially on weekends, and educate all staff members in the value of meaningful activities for older adults, including nursing assistance with mobilization (Callen et al., 2004; Kalisch, 2006).

Structural level. Uncertain waiting could be reduced by revising regional, provincial, and national policies in order to address problems related to LTCH wait-list management, couple reunification, and the ALC co-payment. Doleweerd and Berezny (2009) raise similar concerns about LTCH wait-list management in Ontario. Policies should focus on developing comprehensive strategies for reducing the occurrence of ALC among older patients by providing options for care in more appropriate settings (Costa, Poss, Peirce, & Hirdes, 2012). In general, hospitalization can compromise the health of older patients and every effort must be made to reduce hospital stays when they become unnecessary (Callahan, Thomas, Goldhirsch, & Leipzig, 2002). Glasby and colleagues (2006) report that evidence on solutions is limited but that comprehensive strategies simultaneouly addressing all three levels of the Glasby framework hold some potential.

Limitations

Narrative inquiry acknowledges the tentative nature of any findings concerning the human experience. "The attitude in a narrative perspective is one of doing 'one's best' under the circumstance, knowing all the while that other possibilities, other interpretations, other ways of explaining things are possible" (Clandinin & Connelly, 2000, p. 31).

Although the number of patients would be quite small, the findings of the present study could likely be generalized to patients awaiting placement but not designated ALC (e.g., those for whom the ALC designation is suspended while a new acute medical issue is being treated). In addition, the transferability or generalizability of the findings is limited by the study design. For example, given the narrative approach of exploring through in-depth interviews the experiences of participants over time, the number of participants in the study was small and only one acute-care setting was used. As well, the perspective of patients with advanced dementia was not included, and since this population is significantly impacted by the phenomenon of ALC the absence of such a perspective precludes a full understanding of the range of ALC experiences. In addition to the problem of generalizability, the study's design made it difficult to differentiate the multiple factors that might have contributed to the patients' uncertainty. These factors could include the following: the implications of the process of ALC designation for type, quantity, quality, and location of care in the hospital; implications of the life crisis precipitated by the need to seek placement in an LTCH or retirement home; factors specific to the setting to which the patients were being transferred (e.g., LTCH vs. retirement home); and the total length of time the patients spent in hospital before and after ALC designation. Finally, given that the overall tone of the findings is negative, especially in relation to experiences with the discharge planning process, it is important to note that the study did not include the perspectives of health-care providers, whose views on the processes of care and discharge planning might have differed from those of patients and family caregivers.

Conclusion

The main contribution of this study is the finding that uncertainty is an integral part of the ALC experience. This finding implies two basic approaches to improving the patient and family caregiver experience. The first is to identify strategies for better managing uncertainty in this situation. Given the findings with respect to uncertain self-concept, health-care providers should be better prepared to offer support to patients during difficult life transitions. At the organizational level, the findings regarding uncertain knowing and waiting should prompt hospitals to develop comprehensive approaches to discharge planning while better aligning processes of care to promote physical, cognitive, and psychosocial function among older patients (Wong et al., 2011). At the structural level, the findings with regard to uncertain waiting suggest the need for regional, provincial, and national policies addressing LTCH wait-list management, couple reunification, and the ALC co-payment. The second approach is to develop regional, provincial, and national policies that result in comprehensive strategies (Glasby, 2004) for reducing the occurrence of ALC among older patients in order to minimize exposure to the uncertainty and distress associated with this experience.

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Résumé

Un essai sur le soutien téléphonique aux aidants de personnes souffrant de démence

Jennifer Martindale-Adams, Linda O. Nichols, Robert Burns, Marshall J. Graney, Jeffrey Zuber

La présente étude vise à déterminer si les groupes de soutien téléphonique pour les aidants de personnes souffrant de démence ont un effet sur les ennuis liés aux comportements des patients, l'accablement, la dépression et le bien-être général. L'essai clinique aléatoire a comporté la comparaison de groupes de soutien téléphonique (16 groupes composés de cinq ou six aidants) avec des groupes témoins (documents imprimés). Les groupes se sont réunis à 14 reprises au cours d'une année. Les séances d'une heure ont porté sur la formation, les habiletés d'adaptation et le soutien. Les données ont été recueillies au niveau de base puis après 6 mois et après 12 mois. L'échantillon a comporté 154 aidants et aidantes, 77 par bras, qui fournissent des soins à des vétérans souffrant de démence ou à un aidant vétéran. Il a été constaté que les ennuis variaient grandement au niveau de base. Il n'y avait pas de différences importantes dans l'effet thérapeutique entre les bras. Les participants et participantes ont dit avoir constaté une amélioration. Il a été conclu que les groupes de soutien téléphonique sont un moyen efficace d'interagir avec les aidants. D'autres études devraient toutefois examiner différents modèles de soins. Les interventions fréquentes ou portant sur des besoins particuliers pourraient être plus efficaces pour soutenir les aidants de personnes dont l'état s'aggrave.

Mots clés : groupe de soutien téléphonique, personne souffrant de démence, aidant, habiletés d'adaptation

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A Trial of Dementia Caregiver Telephone Support

Jennifer Martindale-Adams, Linda O. Nichols, Robert Burns, Marshall J. Graney, Jeffrey Zuber

The purpose of this study was to determine if telephone support groups for dementia caregivers have an effect on bother with patient behaviours, burden, depression, and general well-being. The randomized controlled trial compared telephone support groups (15 groups of 5 or 6 caregivers) with control groups (print materials). Groups met 14 times over 1 year. The 1-hour sessions included content on education, coping skills, and support. Data were collected at baseline and at 6 and 12 months. The sample comprised 154 caregivers, 77 per arm, providing care to veterans with dementia or a veteran caregiver. Bother was found to differ significantly at baseline. There were no significant treatment effect differences between study arms. Participants anecdotally reported improvement. It was concluded that telephone support groups are an efficient way to interact with caregivers. Further research should test different models of care. Interventions that are targeted to specific needs or occur frequently may provide better support for caregivers of individuals with a worsening condition.

Keywords: caregiving – informal, Alzheimer's disease, caregiver stress

Almost 11 million US caregivers provide 12.5 billion hours of care annually to Alzheimer's patients, at a value of almost $144 billion (Alzheimer's Association, 2010). Caregiving can be all-encompassing. It includes assistance with personal care and activities of daily living, supervision, and monitoring (Schoenfelder, Swanson, Specht, Maas, & Johnson, 2000). Caregivers experience physical and psychological morbidity (e.g., depression, anxiety, sleep disturbance, increased hospitalization and mortality, increasing care recipient institutionalization) (Mahoney, Regan, Katona, & Livingston, 2005; Schulz & Beach, 1999). Dementia caregivers have more serious adverse events, such as morbidity and stress, than non-dementia caregivers (Schulz & Martire, 2004).

Caregiving interventions can ease the burden. One of the most successful interventions for a diverse caregiving population was the multisite National Institute on Aging/National Institute of Nursing Research randomized controlled trial Resources for Enhancing Alzheimer's Caregiver Health (REACH II). This intervention provided education, support, and skills-building through 12 individual sessions in-home and by telephone plus five support group sessions by telephone. It was targeted to risks identified by a caregiver risk appraisal. Intervention caregivers showed significant improvement in terms of burden, depression, health and self-care, social support, and management of patient behaviours, and they gained 1 extra hour per day not spent on caregiving tasks (Belle et al., 2006; Nichols et al., 2008). There have been several adaptations of REACH II, including REACH VA (Nichols, Martindale-Adams, Burns, Graney, & Zuber, 2011), which was very similar to the original REACH II, REACH OUT (Burgio et al., 2009), and the Scott and White Family Caregiver Program (FCP) (Stevens, Smith, Trickett, & McGhee, 2012), both of which are shorter interventions.

Despite caregivers' need for education and assistance with tasks, caregiving is an obstacle to participation in interventions. To circumvent obstacles such as a dearth of local services, lack of access, and the need to travel (Salfi, Ploeg, & Black, 2005; Smith, Toseland, Rizzo, & Zinoman, 2004), non-face-to-face interventions have been developed and do show promise. In a Canadian study (Marziali & Garcia, 2011), both Webchat and video-based groups showed improvement in self-efficacy and a decline in distress related to caregiving tasks and the video group showed improvement in mental health.

We developed telephone support groups. With group leaders trained to manage a lack of verbal cues (Smith et al., 2004; Toseland, Naccarato, & Wray, 2007), telephone groups can have similar advantages to face-to-face groups. Participants can interact, obtain factual/current information (Toseland et al., 2007), share expertise and experiences, exchange social support, learn and practise skills, and seek assistance in addressing their own problems.

Caregivers can benefit from telephone support groups (Toseland & Rivas, 2005). Dementia caregivers have shown satisfaction and increased knowledge, skills, and support (Bank, Argüelles, Rubert, Eisdorfer, & Czaja, 2006; Martindale-Adams, Nichols, Burns, & Malone, 2002; Salfi et al., 2005). A telephone group for caregivers of frail older persons, compared to usual care, showed improvement with regard to burden, depression, social support, and pressing problems, and also increased knowledge and use of community services for adult children (Smith & Toseland, 2006).

The strategies of telephone support groups for reducing caregiving stress may best be understood through a stress/health process model. Caregivers experience stress if they perceive that the demands placed on them exceed their resources and their capacity to manage (Lazarus & Launier, 1978). Action-oriented management of environmental demands depends in part on information and skills directed towards diminishing, tolerating, or meeting the demands. The support groups focus on the management of patient behaviours and activities of daily living/instrumental activities of daily living (ADLs/IADLs), a major demand placed on dementia caregivers.

Perceptions of demands and coping are individualized (Belle et al., 2006) and an individual's internal efforts to manage demands that cannot be changed are critically important (Folkman, Schaeffer, & Lazarus, 1979). While caregivers in this study were taught strategies for managing patient behaviours, they were also taught skills to reduce distress over behaviours and circumstances that are not amenable to change. Dementia caregivers who are provided with behavioural interventions alone, with no attention paid to intrapersonal coping, have poorer affective outcomes (Burns, Nichols, Martindale-Adams, Graney, & Lummus, 2003), which can lead to decreased quality of care or to institutionalization. Therefore, caregivers' internal responses were also targeted. Under this theoretical framework, the intervention had several components, including those shown to be successful in caregiving studies such as REACH II: education; support; and the building of practical skills, including problem-solving, communication, and stress reduction (Belle et al., 2006; Gottman, Gottman, & Atkins, 2011; Schulz et al., 2003).

The study was funded by the Department of Veterans Affairs (VA) and was focused on a VA medical centre. Although caregiving is a challenge for community health- and social-service agencies, in many ways the VA is at the leading edge in dealing with dementia. VA's patient population is reaching an all-time high in terms of advanced age, and veterans diagnosed with traumatic brain injury have more than twice the risk of developing dementia within 7 years of diagnosis (Spotswood, 2012). Also, caregivers of veterans show greater emotional stress, physical strain, financial hardship, and work stoppage/early retirement, although these results are not specific to dementia caregivers (National Alliance for Caregiving, 2010).

We hypothesized that caregivers in a telephone support group, compared to those in a control condition who received a packet of printed information, would show improved bother with patient behaviours, burden, depression, and general well-being.

Method

Overview

CONNECT – Telephone Support for Dementia Caregivers was a 3-year randomized controlled trial, from October 2004 to September 2007, sponsored by VHA (Veterans Health Administration) Health Services Research and Development and the Veterans Affairs Medical Center in

Memphis, Tennessee (VAMC Memphis). CONNECT caregivers were family members reporting stress or difficulty with care, living with care recipient, providing 4 or more hours of supervision or care per day for at least 6 months. Care recipients had a dementia diagnosis or mini-mental state examination (MMSE) (Folstein, Folstein, & McHugh, 1975) score of 23 or less and at least one ADL or two IADL limitations (Katz, Ford, Moskowitz, Jackson, & Jaffee, 1963; Lawton & Brody, 1969). One member of the dyad had to be a veteran receiving services at VAMC Memphis. Planned nursing home admission within 6 months was an exclusion criterion. Caregivers were recruited through brochures placed in the medical centre and mailed to VAMC patients receiving cognitive enhancers and through clinician referral.

The study was overseen by the VAMC Memphis Institutional Review Board. Informed consent was collected in-home before baseline data collection. Privacy and information security procedures included identification numbers on all analytic files, secure paper and electronic files with access limited to study personnel, and password-protected secure servers. Identifying information was kept separate from study data.

Intervention

Content and structure of the intervention were based on the 6-month REACH II intervention of 12 individual in-home and telephone sessions and five telephone support group sessions (Belle et al., 2006). The CONNECT treatment arm comprised 15 support groups, each with five to six caregivers and a trained group leader. There were three group leaders, each with a caseload. The support groups met bi-weekly for 2 months and monthly thereafter for 1 year, for a total of 14 hour-long sessions. Each participant received a one-on-one introductory telephone call.

Training in group work and theory and motivational interviewing (Miller & Rollnick, 1991; Toseland & Rivas, 2005) as well as certification ensured consistency across the master's-prepared group leaders. Certification involved readings, videos, and practice sessions. During the certifying role play, each group leader led the first session and made two additional educational presentations. Study investigators evaluated behaviourally anchored ratings of specific procedural techniques (e.g., correct use of forms) and clinical skills (e.g., active listening).

Session materials consisted of a Caregiver Notebook and commercially available pamphlets. The Notebook, initially developed for a primary care intervention (Burns et al., 2003), comprised 29 behaviour-management chapters of five to eight pages each (e.g., bathing, repeated questions) and 17 caregiver stress/coping chapters (e.g., assertiveness, communication, grief) based on research and practice, written in large print and at a fifth-grade reading level.

Like REACH, the multi-component intervention targeted caregiving risks, including risks associated with emotional and physical well-being, safety, burden, social support, and patient behaviour management. To ensure that components of caregiving interventions shown to be successful (Belle et al., 2006; Gottman et al., 2011; Schulz et al., 2003) were addressed, the first six sessions were standardized to include an introduction, basic information about dementia and financial and legal issues, safety, caregiver health and well-being, communication, and problem-solving — all Caregiver Notebook chapters. The remaining eight topics were chosen by each group from the behavioural and stress topics in the Notebook, because interventions that are most effective are targeted to the specific needs of the dyad (Goy, Kansagara, & Freeman, 2010).

The sessions were semi-structured telephone calls with education, skills-building, and support. Each session began with a relaxation exercise, caregiver updates, review of strategies tried from the preceding session's topic, and the group leader's presentation on a behaviour management or stress and coping topic. The rest of the session included discussion and practice by the entire group on the session's topic, selection of individual strategies to try, selection of the next session's topic, and closure, including another signal breath relaxation exercise.

Control caregivers received pamphlets on dementia and safety as well as telephone numbers for local resources. At the end of the study they received the Caregiver Notebook and a workshop focusing on knowledge, safety, health, well-being, behaviour management, and stress.

Data Collection

Measures used in REACH II (Belle et al., 2006) were collected in-home by trained research associates at baseline and at 6 and 12 months; each session lasted approximately 1.75 hours. Outcomes (patient behaviours, burden, depression, general well-being) and non-VHA health use and health costs were collected by telephone at 3 and 9 months, each call lasting approximately 20 minutes.

Measures

Caregiver data. Demographic data included age, gender, race, work status, marital status, education, and income. Caregiving data included relationship, social support, number of years providing care, time on duty, and time providing care. Nineteen social support items measured received support and negative interactions (Krause, 1995), satisfaction (Krause, 1995; Krause & Markides, 1990), and social networks (Lubben, 1988).

The first three social support domains use a scale of 0 (*never, not at all*) to 3 (*very often, very*). Social network items use a scale of 0 (*none*) to 5 (*9 or more*). Social support items sum to 0 through 69; higher scores indicate more support. A US study with 1,103 older people yielded Cronbach's alphas of .84 for received support (Krause, 1997), .71 for support satisfaction (Krause & Shaw, 2002), and .83 for negative interactions (Krause, 1999). In a European validation study with 7,432 older people, social networks had a Cronbach's alpha of .83 (Lubben et al., 2006). Two Caregiver Vigilance questions (Mahoney et al., 2003) asked hours and minutes per day spent on duty and on care activities. Cronbach's alpha for the four-item scale is .66 (Mahoney et al., 2003).

Clinical data were health, self-care, burden, depression, general well-being, and number of and bother with care recipient behaviours. Health was assessed from 1 (*poor*) to 5 (*excellent*) with one question from the Medical Outcomes Study 36-item Short-Form Health Survey (SF-36) (Ware et al., 1995). Caregiver's self-care and preventive health measures (e.g., getting enough rest, keeping medical appointments) were assessed using four REACH II questions (Belle et al., 2006). All self-care items are scored 0 or 1 (*no* or *yes*), summed 0 to 4.

The 12-item Zarit Burden Interview (ZBI) (Bédard et al., 2001; Zarit, Reever, & Bach-Peterson, 1980) assessed caregiver burden. Scoring is 0 (*never*) to 4 (*nearly always*); a higher score indicates greater burden. Cronbach's alpha is .85 for a representative sample of 1,095 Canadian dementia caregivers (O'Rourke & Tuokko, 2003). The 10-item Center for Epidemiological Studies Depression Scale (CES-D) (Irwin, Artin, & Oxman, 1999; Radloff, 1977) assessed depressive symptoms within the past week. Scoring is 0 (*rarely, none of the time*) to 3 (*most, almost all the time*), for a score of 0 to 30; higher scores indicate greater symptoms. Cronbach's alpha is .92 (Irwin et al., 1999). The 22-item General Well-Being Scale (Brook et al., 1979) assessed well-being, anxiety, general health, vitality, depression, self-control, and mental health. Scoring is 1 (*definitely true, all of the time*) to 5 (*definitely false, not at all*) and summed; higher scores indicate greater well-being. Cronbach's alpha is .94 (Brook et al., 1979).

The 24-item Revised Memory and Behavior Problems Checklist (RMBPC), with a Cronbach's alpha of .78 (Teri et al., 1992), assessed frequency and bother of dementia behaviours. Each behaviour is rated 0 (*not in past week*) to 3 (*daily or more often*) and summed (0 to 72); higher scores indicate greater frequency. Bother is rated for each behaviour reported, from 0 (*not at all*) to 4 (*extremely*). Scoring is 0 to 96; higher scores indicate more bother.

Care recipient data. All data except cognitive status were collected via caregiver report. Demographics included age, gender, and education. For clinical data, cognitive status was assessed using the MMSE, a 30-point scale determining orientation, short-term memory, visual construction, and language skills (Folstein et al., 1975). Higher scores indicate better cognitive functioning. Across multiple studies, Cronbach's alphas range from .54 to .96 (Tombaugh & McIntyre, 1992). Use, but not dosage, of cognitive enhancers was collected. Care recipient health was assessed using the same SF-36 question used for caregiver health (Ware et al., 1995). Care recipient function was assessed using the six-item Katz ADL Scale (Katz et al., 1963) and the eight-item Lawton and Brody IADL Scale (Lawton & Brody, 1969). Each item is scored 0 (*no help needed*) or 1 (*help needed*). ADL and IADL items are summed separately, with higher scores indicating greater impairment. Cronbach's alpha is .75 across three studies for ADL (Spector, Katz, Murphy, & Fulton, 1987) and averages .84 for IADL in a review of multiple studies (Sikkes, de Lange-de Klerk, Pijnenburg, Scheltens, & Uitdehaag, 2009).

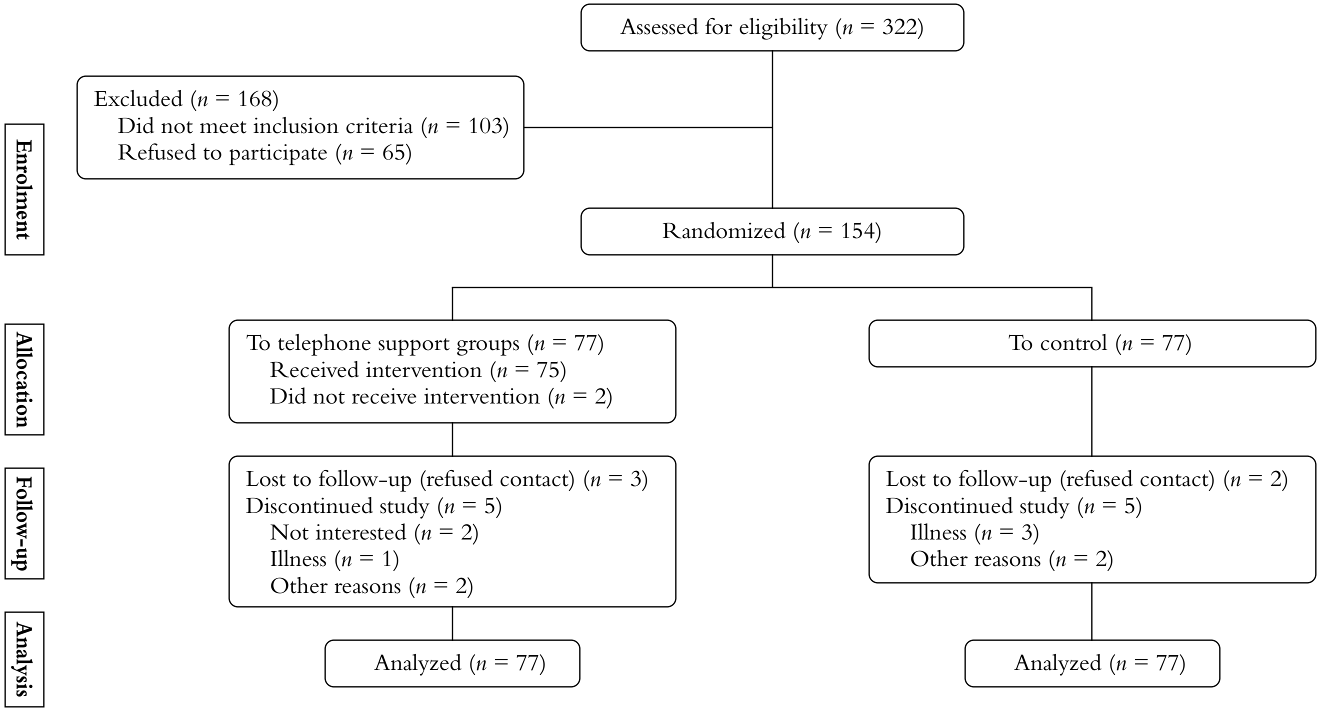
Project Evaluation

After final data collection, participants were asked by telephone about their satisfaction with the groups and components (e.g., format, length, information), any difficulties (e.g., talking to unseen members, distractions), and benefits (e.g., confidence, ability to provide care). Responses were scored from 1 (*not at all*) to 5 (*extremely*).

Data Analysis

The data analysis strategy was intention to treat, with each outcome treated as independent. Baseline data were compared between intervention and control caregivers using chi-squared or independent-sample t tests. Randomized groups were compared using repeated-measures mixed linear models to estimate group by time interaction. Because this model accommodates missing data without subject loss, imputation was not necessary. P values of .05 or less were considered statistically significant, and those between .05 and .10 documented trends that approached statistical significance. The study was designed to provide statistical power of .80 to document a true population difference in intervention effect at least .25 *SD* of a primary outcome variable. For statistically significant comparisons, effect size of at least d 0.2 was considered clinically significant, consistent with the small-to-medium effect sizes for psychosocial interventions (Sorensen, Pinquart, & Duberstein, 2002). Interaction effect sizes were estimated as mean between-group gain score change relative to estimated population standard deviation (Cohen, 1988).

Figure 1 ***Randomization, Follow-up, and Analysis, by Study Arm***



Results

Sample

Of the 322 caregivers screened, 154 were randomized, 77 to each arm (Figure 1). Fifteen caregivers (9.7%) were lost to follow-up or discontinued. Fifteen (9.7%) institutionalized the care recipient, and 18 were bereaved (11.7%), with no significant difference between arms. These caregivers generally remained in the telephone support groups.

There were 24 veteran caregivers. Caregivers were overwhelmingly female spouses approximately 66 years old and care recipients were approximately 16 years older (see Table 1). At baseline, intervention caregivers had a trend towards reporting fewer troubling dementia behaviours (p = .077) and less bother compared to control caregivers (p = .038). At baseline, care recipients were predominantly male and had severe dementia (Table 1). Intervention care recipients, compared to control, had greater use of cognitive enhancers (p = .032).

Process

Of the 77 intervention caregivers, 47 (61%) had at least 75% of the 14 sessions and 59 (76.6%) completed at least half. Six caregivers (7.8%) had fewer than three sessions. On average, for each of the 15 groups, of the eight topics selected by group members, four were behaviour and four were stress and coping. Positive thinking was selected by 73% of groups, activities and holidays each by 60% of groups, and confusion, feelings, and getting help by 53% of groups.

During the year, intervention and control caregivers had contact with study personnel for data collection for approximately 6.75 hours. Data-collection time compared between control (M = 6.4 hours, SD = 1.9) and intervention (M = 5.7 hours, SD = 1.5) caregivers was not significantly different (p = .170).

Outcomes

There were no significant group by time interactions in caregiver outcomes (Table 2). Clinical significance, measured by effect size (d), ranged from .04 to .31. Controlling for baseline values made no substantive change to significant versus not-significant results.

Satisfaction scores for groups and components were all between *very* and *extremely satisfied,* with an overall group satisfaction score of 4.8 and average scores for logistics and components of 4.7 each. Difficulties were minimal. Benefit ratings were between *very much* and *extremely helpful* (M = 4.2). Participants valued the sharing of different perspectives and the support and interaction of others, with two thirds of comments mentioning these areas.

Table 1 ***Baseline Characteristics of Caregivers and Care Recipients (N = 154)***

Variable	**Control (*n* = 77) *M* ± *SD* or %**	**Intervention (*n* = 77) *M* ± *SD* or %**	***p* value[a]**
CAREGIVER			
Demographics			
Age (years)	65.0 ± 12.6	66.2 ± 12.3	.552
Female	85.7	81.8	.512
Race			.510
White/Caucasian	67.5	72.7	
Black/African-American	31.2	27.3	
Filipino/a	1.3	0	
Employed	22.1	27.3	.455
Married	83.1	88.3	.357
Education (years)	12.9 ± 1.9	12.8 ± 2.1	.632
Household income ($)	34,946 ± 22,310	34,041 ± 22,087	.803
Caregiving			
Relationship to care recipient			.764
Spouse	71.4	72.7	
Child	22.1	23.4	
Social support (0–69)	39.5 ± 11.7	39.6 ± 11.4	.944
Length of time caregiving (months)	48.8 ± 35.0	49.1 ± 42.0	.957
Caregiving hours on duty	16.5 ± 8.5	16.4 ± 8.7	.899
Caregiving time (hours)	6.7 ± 4.8	6.3 ± 5.1	.631
Clinical			
General health (1–5)	2.8 ± 1.1	2.9 ± 1.0	.750
Self-care (0–4)	2.9 ± 1.1	2.9 ± 1.0	> .999
Burden (0–48)	17.7 ± 9.1	16.4 ± 8.3	.345
Depression (0–30)	10.4 ± 6.8	10.8 ± 6.2	.709
General well-being (22–110)	67.4 ± 16.3	69.0 ± 16.5	.546
Behaviours (0–72)	24.0 ± 11.2	21.1 ± 9.0	.077
Bother (0–96)	26.4 ± 18.0	21.0 ± 13.7	.038
CARE RECIPIENT			
Demographics			
Age (years)	77.3 ± 7.7	77.5 ± 7.2	.899
Male	88.3	87.0	.806
Education (years)	11.2 ± 3.6	11.2 ± 4.0	.916
Clinical			
MMSE (0–30)	15.6 ± 7.3	15.2 ± 7.7	.785
Use of cognitive enhancers	51.9	68.8	.032
General health (1–5)	2.3 ± 1.2	2.2 ± 0.9	.821
ADL (0–6)	3.1 ± 2.1	2.8 ± 2.1	.401
IADL (0–8)	7.5 ± 0.9	7.5 ± 1.0	.871

[a] *p* value from chi-square tests or *t* tests for independent samples, as appropriate.

Table 2 ***Outcome Data for Intervention Caregivers (n = 77) and Control Caregivers (n = 77)***

Variable	**Baseline** ***M* ± *SD***	**3 Months** ***M* ± *SD***	**6 Months** ***M* ± *SD***	**9 Months** ***M* ± *SD***	**12 Months** ***M* ± *SD***	***p* value**[a]	**Intervention Effect Size**
Bother (0–96)						.875	.07
Control	26.4 ± 18.0	22.4 ± 16.2	22.6 ± 17.2	19.0 ± 13.3	21.7 ± 16.5		
Intervention	21.0 ± 13.7	17.7 ± 12.0	17.0 ± 12.4	15.1 ± 10.7	18.6 ± 14.1		
Burden (0–48)						.708	.07
Control	17.7 ± 9.1	—	15.6 ± 9.3	—	15.3 ± 9.1		
Intervention	16.4 ± 8.3	—	15.6 ± 7.9	—	14.5 ± 6.6		
Depression (0–30)						.802	.04
Control	10.4 ± 6.8	—	10.2 ± 7.1	—	9.4 ± 6.6		
Intervention	10.8 ± 6.2	—	10.0 ± 6.5	—	9.4 ± 5.7		
General well-being (22–110)						.385	.31
Control	67.4 ± 16.3	68.2 ± 16.9	68.9 ± 16.2	70.3 ± 15.3	70.9 ± 16.9		
Intervention	69.0 ± 16.5	67.0 ± 15.7	67.9 ± 15.1	68.4 ± 14.9	67.4 ± 13.3		

Note: Values were not collected at 3 and 9 months for burden and depression.

[a] Group by time *p* values from repeated measures mixed linear model analyses.

Discussion

This study with dementia caregivers found no significant difference in change over time between intervention and control caregivers. There can be multiple reasons for this, including factors related to outcomes, intervention, study design, or participants. There is no obvious reason for the lack of significant difference between the two groups. Because they were providing care for veterans, there was a high proportion of spouses, since more older men are married than older women. In their levels of burden, depression, and general health, our participants were similar to other populations of dementia caregivers (Belle et al., 2006). A qualitative analysis of control participants showed that 82% reported benefits from study participation (Nichols et al., 2012). Judging from the responses of control caregivers, the standardized questions of the assessment battery and the time spent interviewing the caregiver appear to be possible mechanisms of benefit.

CONNECT was based on REACH II (Belle et al., 2003), which has since been successfully translated into the VA (Nichols et al., 2011) and the Scott and White health-care system (Stevens et al., 2012). The CONNECT and REACH interventions both were multi-component with education, skills-building, and support and based on a stress-health process model. Both were risk-based to include safety, caregiver self-care/health and emotional well-being, social support, and patient problem behaviours/caregiver skills, all of which have been shown to be important for caregivers (Belle et al., 2006; Gottman et al., 2011; Schulz et al., 2003). Both were also targeted to the specific needs of the dyads who participated.

However, there were differences. REACH participants had 12 face-to-face or telephone individual sessions plus five telephone support group sessions over 6 months, whereas CONNECT participants had one individual telephone session and 14 telephone support group sessions over 12 months. Although telephone support groups have shown positive results for dementia caregivers (Bank et al., 2006; Martindale-Adams et al., 2002; Salfi et al., 2005), less one-on-one interaction may have decreased caregivers' response to the intervention.

Although the risk appraisal for the two interventions was the same and the intervention was targeted to meet the caregiving of the dyads — and has been shown to be effective (Goy et al., 2010) — there were differences in targeting. REACH was targeted to the concerns of one dyad, whereas CONNECT was targeted to the concerns of the five or six caregivers in a group. With these changes, our intervention may not have been able to elicit the effectiveness of REACH.

Although the cost-effectiveness of the REACH II intervention has been demonstrated (Nichols et al., 2008), in-home and/or individual visits are not feasible for many community agencies (Goy et al., 2010). For the CONNECT study, the telephone groups provided all components of the intervention using a low-cost, low-staffing modality. Each caregiver received 14 hours of intervention over the year in a group setting with four or five other caregivers. The groups had low technological demands, flexible meeting schedules, increased accessibility for those in rural areas and with frail care recipients, and no need for transportation.

One intervention limitation cited by participants was too little time spent in the groups. Some participants providing care for a person in the early stages of disease were frightened by the problems experienced by those caring for individuals with severe disease and felt that the discussions of associated problems were not germane to their situation. They might have benefited more from groups homogeneous as to severity level. Another possible limitation, which is a factor for telephone support groups in general, was lack of face-to-face interaction. One new trend in telephone and online support groups for dementia caregiving is interactive screen telephones or Web cameras so that participants can see each other, although these are not feasible for all agencies or all participants.

Although our study had ambiguous findings, it has clinical and research implications. Comparing CONNECT to REACH II, it appears that interventions targeted to specific needs or held more frequently than once a month may provide better support for caregivers who are caring for someone with a worsening condition. A shorter duration (6 months vs. 1 year) may represent a less daunting time commitment for participants. Based on participant comments, a support group that allows more time for members to discuss their concerns and more homogeneous groups based on severity may lead to better outcomes. In other work, we have focused on specific commitment action plans from each participant in a support group. These commitments may help participants personalize and take ownership of the information presented. In future research and practice, all of these avenues can be explored.

Two reviews have concluded that multicomponent, individualized treatments targeting specific caregiver-identified problems while offering individual and group interaction produce meaningful change in caregiver mood and coping (Brodaty, Green, & Koschera, 2003; Goy et al., 2010). However, while REACH II has been demonstrated to be cost-effective (Nichols et al., 2008), extensive in-home and individualized interventions may be too resource-intensive for organizations (Goy et al., 2010). A short, focused REACH VA intervention, delivered by telephone or in person and maximizing the efficiency of caregiver and interventionist time together, is being implemented in VA. Another face-to-face or telephone model that should be tested is an individualized intervention in a group setting, where caregivers can work on individual concerns but exchange support and problem-solving. These low-cost, low-staffing modalities meet caregiver needs yet feature low technological demands, flexible meeting schedules, increased accessibility for those in rural areas and with frail care recipients, and no need for travel.

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Résumé

Les différences liées à l'âge et au sexe quant à l'insuffisance du soutien social sur le plan émotif et informatif accordé aux aînés, au Canada atlantique

Gloria McInnis-Perry, Lori E. Weeks, Henrik Stryhn

De nombreuses sources démontrent que la pratique infirmière se soucie des besoins des aînés en ce qui a trait au soutien social et de leurs effets sur la santé et le bien-être de cette population. À l'aide des données d'enquête obtenues auprès de l'Atlantic Seniors Housing Alliance, les auteurs explorent les besoins de soutien social sur le plan émotif et informatif des Canadiennes et des Canadiens de 65 ans et plus, résidant dans une communauté et domiciliés dans les provinces atlantiques. Les résultats indiquent que ces besoins ne sont pas pleinement satisfaits et qu'ils augmentent avec l'âge. De plus, les hommes et les femmes rapportent des lacunes différentes quant à des besoins particuliers. Les hommes sont plus nombreux à signaler une absence de soutien sur tous les plans. Le personnel infirmier doit être sensible aux besoins de soutien particuliers des aînés liés à l'âge et au sexe. Il doit également multiplier les évaluations sociales et promouvoir le recours à des réseaux sociaux sains, surtout chez les personnes de 80 ans et plus. Cette question doit faire l'objet de plus amples recherches en sciences infirmières.

Mots clés : aînés, soutien social sur le plan émotif et informatif, réseaux sociaux, différences liées à l'âge et au sexe

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Age and Gender Differences in Emotional and Informational Social Support Insufficiency for Older Adults in Atlantic Canada

Gloria McInnis-Perry, Lori E. Weeks, Henrik Stryhn

It is well documented that nursing is concerned about the social support needs of older adults and the effects of those needs on health and well-being. Using survey data from the Atlantic Seniors Housing Research Alliance, the authors explore the emotional and informational social support needs of community-dwelling Canadians aged 65 and older living in the Atlantic provinces. The results indicate that these needs are not being met fully and that they increase with age. Also, men and women report different insufficiencies for specific needs; more men than women report having no support across all items. Nurses should be sensitive to specific age and gender support needs of older adults. They should also increase their social assessments and promote healthy social networks, especially for those 80 years and older. Further nursing research is recommended.

Keywords: older adult, emotional and informational social support, social network, age and gender differences

Canada's population is aging. Furthermore, Atlantic Canada is experiencing a significant demographic shift, with a higher percentage of persons 65 years or older than other regions of the country (Statistics Canada, 2010). Consequently, this region will see the effects of an aging society and corresponding social changes earlier than the rest of Canada. Moreover, the health-care sector has downsized and home care now targets only the most frail elderly, leaving more care responsibilities to family and friends (Cohen et al., 2006). Conversely, most older adults prefer to "age in place," in the company of their loved ones (Marek et al., 2005), a situation that depends largely on access to home care services (Shiner, 2007). As a result, many older adults are living alone without the social support of their immediate family, friends, and community (Aday, Kehoe, & Farney, 2006).

Atlantic Canada differs from the rest of the country, with less urbanization, lower income levels (at least 20% below national levels), higher unemployment rates, and a higher percentage of seniors (Davenport, Rathwell, & Rosenberg, 2005). Correspondingly, an increased geographical distance between older adults and their children, retirement, divorce, loss of family and friends, minimal income, and transportation issues all increase the older adult's vulnerability to social isolation, loneliness (Pinquart & Sorenson, 2003), and depression (Traynor, 2005). These changes can lead to grave health outcomes, such as addiction, suicide, and increased risk of dementia (Choi & McDougall, 2009).

The support needs of older adults have become a societal priority (Cedergren, King, Wagner, & Wegley, 2007). Seniors' well-being is greatly impacted by the social determinants of health, such as income, social status, social support networks (Dupuis-Blanchard, Neufeld, & Strang, 2009), social environment, physical health and personal health practices, coping skills, and health services. The significance of meaningful relationships for one's health and well-being is well documented (Borrowman & Dempster, 2009; Dupuis-Blanchard et al., 2009).

Approximately one third of persons over the age of 80 report loneliness (Victor, Scambler, Bowling, & Bond, 2005). Additionally, women tend to outlive their male partners and often find themselves alone and lonely in later life (Newall et al., 2009). Reducing loneliness and social isolation and teaching stress-reduction skills are two ways to promote successful aging (Depp, Vahia, & Jeste, 2007). Research on social support specific to seniors in Atlantic Canada is limited and is often subsumed under national research endeavours. We do know that communities across Canada are aging at different rates and that the influences and issues facing these communities vary. Determining the state of emotional and informational social support for seniors in Atlantic Canada would help in assessing the vulnerabilities and strengths of this demographic. In addition, we need nursing research on the social aspects of aging, such as the living arrangements and interpersonal relationships of community-dwelling seniors (Edwards & MacDonald, 2008). Strengthening relationships, addressing social isolation, and providing opportunities for participation in meaningful activities all promote mental health and well-being in later life (Borrowman & Dempster, 2009; Krause, 2010).

The purpose of this study was twofold: to examine the emotional and informational social support needs of seniors living in Atlantic Canada, and to gain insight into how these needs are influenced by age and gender.

Definitions

Understanding the quality and quantity of social support helps determine the extent to which support resources are available. When distinguishing between sufficient and insufficient relationships, one should understand what constitutes a support system and how a support system is measured. Social support plays an important role in human health (Gottlieb &

Bergen, 2010), is viewed as an interactional process (O'Reilly & Thomas, 1989), and is derived from social networks. For the purpose of this research, social support is defined as the "emotional and informational resources that persons perceive to be available or that are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relationships" (Cohen, Gottlieb, & Underwood, 2000, p. 4). Social support is measured using questions that elicit needs with respect to two types of social support: emotional support, such as empathy, listening, understanding, reassurance, friendship, intimacy, and attachment (Finfgeld-Connett, 2007; Stewart, et al., 2006); and informational or affirmational support, such as advice, assistance with problem-solving, and provision of feedback (Stewart et al., 2006).

Age and Gender Differences

Despite the validity concerns of grouping all older adults together based on chronological age, this approach remains the most common means of assessing the elderly and determining their suitability for Canada's wide variety of programs for seniors. Persons are often defined as "old" at age 65. Further differentiation into young-old (65–74), middle-old (75–84), old-old or very old (85+), and frail elderly (Maux, 2006, p. 7) reflects the many changes that can occur over a short span of time (Cicirelli, 2010) and the unique strengths and challenges of each group. We therefore used discrete age demarcations for our study.

The influence of age and gender differences throughout life in terms of social support is beginning to be reflected in the literature (Ajrouch, Blandon, & Antonucci, 2005; Cedergren et al., 2007; Felmlee & Muraco, 2009; Krause, 2010; Sener, Oztop, Dogan, & Guven, 2008; Shaw, Krause, Liang, & Bennett, 2007). Most of the research on social support among community-dwelling seniors does not differentiate between age groups. However, Fiori, Smith, and Antonucci (2007) studied age-group differences and social network types in a sample of 560 adults between the ages of 70 and 103. They identified social network types as "diverse-supportive," "family-focused," "friend-focused-supported," "friend-focused-unsupported," "restricted-non-friends-unsatisfied," and "restricted-non-family-unsupportive." They found that a friend-focused-supportive network was most common among the oldest-old (85+) and diverse-supportive and friend-focused-unsupported among the young-old (70–84). Shaw et al. (2007) investigated age-related changes on 11 dimensions of social networks and support in later life. They found that emotional support was relatively stable with advanced age, whereas other types and/or levels of *received* support (e.g., tangible and informational) increased with age and levels of *provided* support fluctuated. They also found that as older people age, they invest increasingly fewer resources into maintaining intimate social ties. In contrast, Ailshire and Crimmins (2011) compared the old and the oldest-old in terms of the psychosocial factors of social relationships, loneliness, and life satisfaction associated with longevity. They found that the oldest-old had maintained social relationships with family and friends but felt lonelier and had a more negative perception of aging.

Okamato and Tanaka (2004) studied gender differences, social support, and subjective well-being. They found that older men reported less social support and subjective well-being than older women. Cedergren et al. (2007) examined friendship norms and expectations among a cohort of older adults. They found that women rated social support much higher than their male counterparts and that group activities helped them to make new friends. The examination of social norms for affiliative relationships in later life may help to explain the process that leads to friendship conflict and dissolution at this stage of life. Felmlee and Muraco (2009) conducted a similar study of gender and friendship norms and values. They report that women were closer, more cooperative, and more supportive than men. Women tended to have both family and friend networks that focused on positive emotional relationships. Women frequently had higher expectations of friends than men and placed more emphasis on intimacy. The researchers found that gender had a modest influence on seniors' evaluation of friendship norms.

Theoretical Understanding of Social Support

An understanding of how social relationships change over time can be derived from Carstensen's socio-emotional selectivity theory (Carstensen, Isaacowitz, & Charles, 1999). This theory is built on the optimization of social resources in the context of successful aging. Short-term goals are favoured over long-term ones. As adults age, they become increasingly more aware that they have relatively little time left to live and thus engage in an evaluation of their social relationships. A key tenet of Carstensen's theory is that the elderly favour relationships that are emotionally close over more peripheral social ties. They tend to reduce their non-intimate and superficial social ties while maintaining those that are positive and allow for emotional intimacy (Carstensen, 2006; Scheibe & Carstensen, 2010). A primary goal of the older adult is to nurture these relationships as long as possible, as they are a source of emotional meaning and social connectedness (Fung, Stroeber, Yeung, & Lang, 2008).

In summary, research has demonstrated the complexity of the construct of social support and the need to illuminate gender and age differences in the lifespan of the older person.

Method

We used data from the Atlantic Seniors' Housing and Support Services Survey (ASHRA), adapted from a 1998 survey developed by the Canada Mortgage and Housing Corporation (CMHC). With the assistance of stakeholders in each of the four Atlantic provinces, the CMHC survey was adapted to suit ASHRA's determinants-of-health approach; to address Atlantic Canada's unique issues, languages, and cultures; and to fit a mail-out format. Revisions were made following pilot testing with 42 seniors. The final survey contained seven sections related to (1) current housing and living arrangements, (2) feelings about various housing options, (3) transportation needs, (4) difficulties with personal care and activities of daily living, (5) support services, (6) future housing plans and needs, and (7) demographics, including detailed financial information. The support services section included items on whether the respondent was currently receiving or in need of particular services; the types of services listed included physical supports, home maintenance support, support with activities of daily living, and emotional and informational social supports and needs.

Ethical approval was obtained from several universities in Atlantic Canada, including the University of Prince Edward Island.

Sample

The only criterion for participation was community-dwelling adult age 65 or over. "Community-dwelling" was defined as not living in an institution, such as a nursing home, prison, or hospital. We used random procedures for selecting potential participants in each of the four Atlantic provinces. In Prince Edward Island, New Brunswick, and Newfoundland and Labrador, potential participants were randomly selected from the health department's Medicare database. In Nova Scotia, where a random sample from the Medicare database could not be obtained, random digit dialling was used. Potential participants were mailed a letter describing the project and inviting them to take part, along with a reply form and a postage-paid return envelope. Several weeks later, a follow-up letter was sent to those individuals who had not returned the reply form. A survey, covering letter, and postage-paid return envelope were mailed to those who returned the form. Of the 8,880 surveys mailed, 1,670 usable surveys were returned, for a response rate of 19%. The analysis is based on the results of these 1,670 surveys.

Data Analysis

For the purpose of this article, we are reporting only the results of the seniors' current emotional and informational social supports and needs

Table 1 ***Sociodemographic, Health, and Housing Characteristics (N = 1,670)***

	n	%
Gender		
Male	694	41.5
Female	953	57.1
Missing	23	1.4
Marital status		
Married, common law	1,071	64.1
Widowed	425	25.5
Divorced, separated	104	6.2
Never married	50	3.0
Missing	20	1.2
Age		
65–69	555	33.2
70–74	440	26.3
75–79	325	19.5
80–84	175	10.5
85+	120	7.2
Missing	55	3.3
Annual income		
Under $20,000	306	18.3
$20,000–$39,000	706	42.3
$40,000–$59,000	294	17.6
$60,000	182	10.9
Missing	182	10.9
Difficulty completing at least one activity of daily living		
No	1,344	80.5
Yes: fairly serious	211	12.6
Yes: very serious	98	5.9
Missing	17	1.0
Changes in health status in past year		
Yes	327	19.6
No	1,303	78.0
Missing	40	2.4
At least 1 chronic health problem		
Yes	1,195	71.5
No	464	27.8
Missing	11	0.7

(Table 1) that were a component of the support services section of the survey. The results are based on 12 specific social support items designed for the ASHRA survey. Participants were asked to respond on a five-point Likert scale how often they received the different social supports: "none," "a little," "some," "most," or "all" of the time. We considered the scale as an ordinal scale but not as an interval scale because the response categories were not equidistant or otherwise quantitatively related (Norman, 2010). The responses were analyzed with respect to gender and grouped into five age categories: 65–69, 70–74, 75–79, 80–84, and 85+. Descriptive statistics for the sample population were calculated. To meet our research objectives, we stated our null hypotheses: no differences in social support between men and women or between age groups.

Statistical analysis was conducted for each item separately using log-linear models for multinomial data (Long & Freese, 2006). For the proportional odds (or cumulative logit) model, the assumption of proportional odds across all category thresholds of the scale could not be met for both gender and age. Therefore, a multinomial logistic model was used to assess for interaction between age and gender in their effects on responses. In subsequent analyses, a partial proportional odds model (Peterson & Harrell, 1990) with non-proportional odds for gender was shown to provide a reasonable fit to the data, and tests for age and gender effects were based on this model. These effects were represented by percentages of insufficient support (comprising the "none," "a little," and "some" response categories) and for gender by the percentages of no support ("none"). The analyses were conducted using Stata statistical software (StataCorp, 2011). Analysis of the partial proportional odds model was based on the gologit2 add-on package (Williams, 2006). The significance level was set at $p < .05$.

Results

We first present an overall description of the sociodemographic and health characteristics of the respondents (Table 1). We then discuss the support services available to seniors in Atlantic Canada, followed by age and gender differences.

The results indicate that, depending on the support need being investigated, insufficient overall emotional and informational support ranged from 20% to 48% (Table 2). For all items, the multinomial logistic model showed no significant interaction between age and gender effects, despite some fluctuations in the percentages for insufficient support (Table 2). Furthermore, gender effects were clearly inconsistent (i.e., showed non-proportional odds) across the response scale ($p < 0.01$ for all items; data not shown). Age effects were consistent across the response scale, with few exceptions, which are discussed in detail below.

Table 2 ***Insufficient Social Support for Men and Women Across Age Categories***

Item	***n* (%)**	**Women**					**Men**					**Overall**
		65–69	**70–74**	**75–79**	**80–84**	**85+**	**65–69**	**70–74**	**75–79**	**80–84**	**85+**	
Someone you can count on to listen	1,470 (88.0)	42.2	43.5	40.1	43.2	50.7	40.0	47.9	49.6	56.7	60.0	44.5
Someone who shows you love and affection	1,485 (88.9)	17.1	19.8	14.6	22.0	24.6	21.5	20.1	24.6	23.1	25.7	20.0
Someone to have a good time with	1,476 (88.4)	31.1	31.5	37.0	39.3	44.8	25.5	31.1	36.4	40.6	63.6	33.7
Someone to confide in or talk to about yourself or your problems	1,477 (88.4)	33.0	35.9	34.1	45.5	47.8	31.1	37.9	43.4	45.6	48.6	37.1
Someone who hugs you	1,478 (88.5)	31.6	35.0	39.4	42.9	60.3	27.8	37.3	41.0	50.8	54.3	37.3
Someone to get together with for relaxation	1,482 (88.7)	39.4	38.6	41.9	44.4	60.3	28.4	37.8	43.3	51.5	68.6	40.5
Someone whose advice you really want	1,459 (87.4)	44.3	42.7	42.9	55.2	48.4	41.7	46.7	60.0	55.9	62.9	46.9
Someone to do things with to help you get your mind off things	1,483 (88.8)	44.4	44.8	49.1	57.3	59.7	40.9	43.5	55.4	57.6	70.3	48.0

Someone to share your most private worries and fears with	1,466 (87.8)	41.3	41.1	42.7	51.1	53.0	39.0	42.9	54.8	47.0	65.7	44.3
Someone to turn to for suggestions to deal with a personal problem	1,466 (87.8)	39.8	42.8	37.8	50.6	48.5	38.9	42.3	54.6	51.5	58.3	43.4
Someone to give you advice about a crisis	1,466 (87.8)	38.8	41.4	34.9	46.1	43.9	38.5	39.9	54.2	48.5	58.3	41.7
Someone to do something enjoyable with	1,487 (89.0)	29.7	33.9	34.3	39.1	49.3	28.6	34.1	43.7	42.9	54.1	35.0

Table 3 ***Percentages for Insufficient Social Support, by Age Group, With Statistical Test for No Age Differences***

Item	**65–69**	**70–74**	**75–79**	**80–84**	**85+**	p^a
Someone you can count on to listen	41.2	45.4	44.4	48.7	53.3	.231
Someone who shows you love and affection	19.0	19.8	18.6	22.3	24.8	.533
Someone to have a good time with	28.7	31.2	36.5	40.3	50.5	.000
Someone to confide in or talk to about yourself or your problems	32.2	36.8	37.8	45.9	47.6	.016
Someone who hugs you	29.9	35.7	40.1	45.9	57.7	.000
Someone to get together with for relaxation	34.6	38.1	42.4	47.2	63.5	.000
Someone whose advice you really want	43.2	44.2	49.8	55.1	53.0	.030
Someone to do things with to help you get your mind off things	42.9	44.2	51.2	57.7	62.7	.000
Someone to share your most private worries and fears with	40.3	41.6	47.4	49.7	56.9	.007
Someone to turn to for suggestions about how to deal with a personal problem	39.4	42.4	44.6	51.3	51.4	.061
Someone to give you advice about a crisis	38.7	40.4	42.4	47.5	48.5	.087
Someone to do something enjoyable with	29.2	33.7	37.8	41.1	50.5	.002

[a] p value for age difference in support ($df = 4$)

Table 3 compares age groups in terms of percentages of insufficient support, but similar age effects existed for percentages at other scale thresholds. Age effects were statistically significant for all but four items. In general, percentages of insufficient support increased with age. Apart from item 2 ("love and affection"), with generally a high degree of support and no substantial changes across ages, insufficient support ranged from 29% to 43% in the youngest group and from 48% to 63% in the oldest group. High percentages were also found in the 80–85 group, with 58% for "someone to do things with to help you get your mind off things" and 55% for "someone whose advice you really want." Mild inconsistencies across the scale were found for item 3 ("have a good time with"; $p = 0.02$), where the difference between the two youngest groups was more pronounced at thresholds other than insufficient support, and for item 4 ("confide in"; $p = 0.02$), where the oldest group had relatively few responses in the two lowest categories. Item 5 ("hugs you") showed a similar pattern across the scale as item 4, though the inconsistency was statistically stronger ($p = 0.002$).

Gender differences were most marked at the lowest end of the scale, where percentages for "no support" were significantly higher for men on all items (Table 4). Conversely, there were no significant gender differences in percentages for "insufficient support." Many items also showed a significantly larger proportion of "none" or "little" support for men than for women, and a few items (6, 8, 9, and 12) showed a significantly larger proportion of men than women with support "all of the time" (data not shown).

Discussion

The findings of this study demonstrate that the emotional and informational social support needs of older adults in Atlantic Canada are being partially met but moderate gender and age differences are evident. We found it difficult to make clear distinctions among these entities, as the emotional aspect can encompass companionship, esteem, and informational qualities. Nonetheless, the findings indicate that both emotional and informational sources of support are insufficient. Consequently, older adults are at greater risk for social isolation and/or loneliness (Dickens, Richards, Greaves, & Campbell, 2011). Similarly, Fitzpatrick, Gitelson, Andereck, and Mesbur (2005) found that support items such as "someone to do things with," "getting one's mind off of things," "solving personal problems," "providing information," "confiding in or understanding one's problems," and "providing advice about a crisis" were all related to having good mental health and a fulfilling life. Gender roles and social support and their influences on the evolution of social rela-

Table 4 ***Percentages for No Support and Insufficient Support, by Gender, With Statistical Tests for No Gender Differences***

Item	**No Support**			**Insufficient Support**		
	Men	**Women**	p^a	**Men**	**Women**	p^b
Someone you can count on to listen	21.9	12.7	.000	46.5	43.5	.114
Someone who shows you love and affection	7.5	3.4	.000	21.8	18.5	.075
Someone to have a good time with	7.4	4.0	.003	32.5	34.3	.642
Someone to confide in or talk to about yourself or your problems	11.7	5.7	.000	37.8	36.3	.536
Someone who hugs you	10.6	6.8	.004	37.1	37.9	.919
Someone to get together with for relaxation	7.3	4.3	.009	38.6	41.9	.244
Someone whose advice you really want	12.5	7.6	.001	49.5	45.2	.094
Someone to do things with to help you get your mind off things	15.1	7.5	.000	47.9	48.5	.899
Someone to share your most private worries and fears with	17.0	9.2	.000	45.0	43.7	.403
Someone to turn to for suggestions about how to deal with a personal problem	14.5	9.4	.001	44.7	42.2	.196
Someone to give you advice about a crisis	14.4	8.3	.000	43.6	39.8	.105
Someone to do something enjoyable with	5.7	2.9	.003	36.0	34.5	.428

[a] *p* value for age difference in No Support (*df* = 1)
[b] *p* value for age difference in Insufficient Support (*df* = 1)

tionships have been of interest to many researchers (Arjouch et al., 2005; Cornwell, 2011; Felmlee & Muraco, 2009) and are influenced by many factors, such as previous history, interaction with children, marital status, living arrangements, physical health, economics, culture, and the many age-related losses that can come with longevity, especially for men (Antonucci & Akiyama, 1987).

In our study, men had less social support on all of the items with a "none" response. Previous research (Shaw et al., 2007) reports that older men's level of emotional support (affection, interest, concern, help with stress, private feelings) increases with age and that, compared to older women, older men receive and provide less tangible support (with transportation, housework, and shopping) and informational support (how to solve problems, how to cope). Our results are not fully consistent with these findings, as the men in our study reported insufficient needs in all of the "none" categories. However, our results are consistent with the finding by Shaw et al. that women are less satisfied with their support exchange. For example, the women in our study, particularly those in their eighties, had insufficient emotional support ("someone to hug you and relax with"). Men and women have different life influences, such as retirement challenges, as well as gender roles and responsibilities in earlier life that could explain some of the gender differences (Cornwell, 2011). Our results suggest that emotional and informational support needs are diverse and evolve in the later years. However, there appears to be a distinct decline in support for those in their early eighties. This is a concern, as the old-old are at risk for loneliness and feeling socially disconnected (Ailshire & Crimmins, 2011). According to Carstensen's socio-emotional selectivity theory, quality in the relationship is deemed more important than quantity (Carstensen et al., 1999). Moreover, older adults favour relationships that are emotionally close and well established over those that are peripheral in nature. There is allowance for a reduction of certain types of social ties — ones that are non-intimate and superficial — while retaining those that are positive and lead to emotional intimacy (Cornwell, 2011; Scheibe & Carstensen, 2010). For some seniors, there is a desire to substitute peripheral relationships for closer, more intimate ones (Shaw et al., 2007). However, having inadequate emotional and informational supports, with fewer opportunities to replenish the sources of these supports, places older adults at risk for social isolation and negative health consequences. Krause (2010) found that the oldest-old (85+) are at higher risk of having less emotional support. Even within a marriage, seniors can experience emotional and social loneliness (de Jong Geirveld, van Groenou, Hoogendoorn, & Smit, 2009). Men may be more susceptible to unmet social needs because of their reliance on their spouse (Garung, Taylor, & Seeman, 2008). Earlier gender roles have encouraged them to focus more on providing instrumental and informational support, such as helping with travel, giving advice, providing financially, and making home repairs. Nurturing supportive relationships and establishing social networks appear to be less important to men than to women, which corresponds to an emotional deficit in the later years. The literature suggests that the emotional and informational support needs of seniors are not being met at a time of heightened awareness about the importance of emotional social relationships.

Implications for Nursing Practice

Nurses must be skilled in assessing the social support needs, networks, beliefs, and preferences of older adults across their lifespan in order to plan and implement optimal nursing care and promote the health and well-being of this population (Emlet & Moceri, 2012; Finfgeld-Connett, 2007). Moreover, it is crucial that strategies or programs be developed to broaden and strengthen older adults' social support networks. While not all informal and formal supports will be equipped to provide both emotional and informational needs, community health nurses may be in a strategic position to promote integrated age-friendly communities. As seniors age, they may feel that their talents and abilities are no longer useful and choose not to share them. Nurses can encourage the sharing of these talents and skills by establishing formal and informal group activities for seniors, such as working with peers on a community project, helping the vulnerable through volunteerism, and connecting with a senior peer helper. Nurses are often involved in the discharge planning of older adults from hospital to home and it is important that they identify each senior's informal and formal social support needs. Providing professional development will play a key role in maintaining the knowledge and the skills necessary to meet the changing needs of our older population. Borrowman and Demester (2009) cite the importance of promoting mental health and well-being later in life by addressing age discrimination, embracing opportunities for participation in meaningful activities, strengthening relationships in order to eliminate social isolation, and addressing issues of poverty.

Limitations

Our study had several limitations. The Likert scale measurement of social support comprised only 12 items, thus limiting the possible answers and requiring respondents to rate the availability of support rather than how they actually experienced it. Another limitation was the cross-sectional nature of the data, which did not allow for the inference of temporal changes in the relationships examined, whereas a longitudinal study would have captured these differences. Perhaps a time-use method, such as a time diary collection in isolation or in conjunction with a survey method, would be useful in capturing the quality of seniors' relationships, or seniors could be actively engaged in the research on social support relationships through the use of action research methodology. A third limitation is that the study reported only on the emotional and informational aspects of social support. Examination of the effects of all instrumental support needs is recommended.

Conclusions

This study examined the social support needs of community-dwelling older adults in Atlantic Canada. It analyzed one component of the ASHRA survey highlighting social support needs. The findings are consistent with many previous findings on social support, network, and engagement. However, identification of specific needs that gender and age present related to these concepts is unique and points to the importance of the ability of nurses and other health professionals to assess and address the social support needs of older adults, of nurturing healthy support networks among older adults, and of monitoring the social changes that occur as the older adult ages.

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Commentary

Investing in the Nursing Workforce to Improve Quality of Care: The Reinvention Imperative

Lianne Jeffs, Judith Shamian

In a recent issue of the *Harvard Business Review,* Miles D. White posits that leaders keep their organizations relevant and high-performing by heeding the "reinvention imperative" (White, 2013). He delineates two elements of reinvention: separating important and enduring trends from the short-lived and ultimately irrelevant, and deciding to take short-term "hits" (declines) in performance in order to lay the groundwork for long-term gains. White's article has special resonance given the recurring trend in health care to redesign the workforce so as to achieve efficiencies and reduce costs.

In relation to the nursing workforce, cost-cutting has historically involved eliminating nursing positions, leaving vacated nursing positions unfilled, and replacing registered nurses with practical nurses or unregulated health-care providers. Yet more than two decades of research has laid out the relationships between patient outcomes and the nursing workforce (Shekelle, 2013). The findings consistently show a correlation between more RN staff and better work environments (e.g., lower turnover and absenteeism rates) as well as better patient outcomes (e.g., lower mortality and morbidity rates and higher patient satisfaction rates). This downsizing of nursing has sometimes been justified using the allegedly economically based argument that cheaper care is better care. This argument is flawed, however, because it has been established that "quality care" is almost always the most "cost effective" when the fundamental purposes of health-care organizations are taken into account.

The recurring trend to dismantle nursing services and nursing leadership as a cost-reduction strategy is disturbing at a time when the "smart talk" is about evidence-based practice, decisions, and policies. Further, as care becomes more complex it requires an educated RN workforce to meet the many challenges, including a growing elderly population, advances in science and technology, migration of primary care out of hospitals and into community and home settings, and rising public expectations of health care (Bohmer & Imison, 2013).

Workforce redesign based solely on cost (efficiency) needs to encompass quality health care and service improvements (effectiveness). We need to rethink our approach to task assignment and nursing staff mix and to adopt models of care that harness the talents of an educated RN workforce (Wakefield, 2013). How can we heed the reinvention imperative to ensure that our nursing workforce evolves in such a way that it responds to service shifts and improves health care in Canada? We need to move beyond local "natural field experiments" in staffing levels and team composition that emerge from local decisions. We need to base our decisions on ongoing research into trends in nursing workforce characteristics in relation to utilization patterns (e.g., readmission rates, length of stay, cost of care), clinical outcomes (e.g., infection rates, pressure ulcers), and experience with patient care.

Given that we now have the most educated and experienced nursing workforce in history, it is paramount that we invest in the intellectual capital of nurses to optimize their scope of practice and that we adopt innovative approaches to workforce redesign that are scalable and sustainable. This requires building into the funders (e.g., all levels of government, insurance companies) and organizations' accountability models explicit ties to their performance. Promising results have been demonstrated with smaller-scale investments by the Robert Wood Johnson Foundation in preparing nurses to take part in the redesign of health care as members of interprofessional teams (Hassmiller, 2013).

Rather than implementing change for the sake of change or blindly pursuing cost-cutting, the next round of service and workforce redesign needs to reflect on long-term goals and to integrate the lessons of outcomes research and evaluations of innovative service delivery. While it might seem that we are facing "déjà vu all over again" (with apologies to Yogi Berra), nursing health service researchers are in a better position than ever before to help managers and executives make wise choices and progressively improve the cost-quality ratios in their organizations.

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Résumé

Vers une prestation de soins de qualité : l'orientation et le mentorat offerts aux nouvelles infirmières bachelières

Mabel Hunsberger, Andrea Baumann,
Mary Crea-Arsenio

Les nouvelles infirmières bachelières (NIB) peuvent se sentir dépassées par les demandes du travail clinique et vivre beaucoup de stress dans leur premier emploi. Les auteures examinent les effets d'un programme parrainé par le gouvernement offrant une période prolongée d'orientation et de mentorat pour faciliter la transition des NIB à la pratique professionnelle. Une étude longitudinale des tendances a été menée sur trois années du programme (2008, 2009 et 2010). Chaque année, un tiers des NIB interrogées et plus des trois quarts des employeurs interrogés ont répondu aux questions. Les chercheuses ont animé 21 groupes de discussion avec 106 organisations de services de santé, et réalisé 53 entrevues avec des NIB et 15 entrevues avec des infirmières de première ligne agissant comme mentors. Les résultats de l'étude indiquent que le programme joue un rôle clé dans le développement par les NIB de leur capacité à travailler de façon indépendante. Le mentorat a amélioré la confiance des NIB et leur a permis de prendre des décisions cliniques dans un environnement sûr et protégé. Le programme a fourni aux NIB un soutien vital et leur a permis de passer d'étudiantes à infirmières exerçant leur profession.

Mots clés : nouvelles infirmières bachelières, orientation, mentorat, transition

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The Road to Providing Quality Care: Orientation and Mentorship for New Graduate Nurses

Mabel Hunsberger, Andrea Baumann,
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Clinical work demands can overwhelm new graduate nurses (NGNs) and cause significant stress as they begin practice in their first place of employment. The authors examine the impact of a government-supported extended orientation and mentorship program intended to facilitate the transition of NGNs to professional practice. A longitudinal trend study was conducted over 3 years of the program (2008, 2009, and 2010). In each year, 1 third of surveyed NGNs and over 3 quarters of surveyed employers responded. The researchers conducted 21 focus groups with 106 health-care organizations, 53 interviews with NGNs, and 15 interviews with nurse mentors from the frontline staff. The findings indicate that the program is instrumental in developing NGNs' ability to practise independently. Mentorship increased the NGNs' confidence and allowed them to make clinical decisions in a safe, protected environment. The program provided vital support and helped NGNs move from students to practising nurses.

Keywords: new graduate, orientation, mentoring, transition, policy

Introduction

More than three decades ago, Kramer (1974) observed that new graduate nurses (NGNs) experience "reality shock" stemming from the conflict between what they learned in school and what is expected in practice. Boychuk Duchscher (2009) has expanded this concept through extensive research and coined the term "transition shock" to describe a graduate's initial experiences in the workplace. The prevailing gap between the preparation of new graduates and workplace demands results in high levels of psychological stress for NGNs, which increases the likelihood of workplace errors and nurse turnover in the health-care sector (Bowles & Candela, 2005; Chernomas, Care, McKenzie, Guse, & Currie, 2010). Boychuk Duchscher (2012) has developed a model depicting the transition stages of NGNs. The model suggests that graduates need time to adjust as they move into a professional role. It is critical that employers recognize the needs of new graduates and create responsive programs to support their safe transition to practice. This article reports on the evaluation of a unique province-wide government-supported orientation and mentorship program for NGNs in Ontario, Canada.

Background

The Ontario health ministry has introduced an employment policy, the Nursing Graduate Guarantee (NGG), to stabilize the nursing workforce and build capacity within the health-care system (Ministry of Health and Long-Term Care [MOHLTC], 2007). It funds employers to hire NGNs for temporary full-time supernumerary (above staff complement) positions for up to 6 months.

Following general orientation, experienced staff nurses provide daily supervision and guidance in all aspects of direct patient care and role development related to working within the organization. NGNs in supernumerary positions share in the care of patients assigned to the mentors and do not receive a separate patient assignment (Baumann, Hunsberger, & Crea-Arsenio, 2011b).

The government uses the term "extended orientation" to describe the supernumerary positions (MOHLTC, 2011). In this article, "program" refers to an extended orientation, including mentorship. In keeping with NGG policy, "mentor" refers to a nurse who provides clinical instruction and support to an NGN. We report on the impact of extended orientation and mentorship using a triadic approach that includes the perspectives of employers, NGNs, and mentors who participate in the NGG (Jakubik, 2008). Findings are based on a longitudinal trend study conducted over 3 years (2008, 2009, and 2010).

NGN Work Environment

Use of technology and increasing patient acuity challenge the readiness of NGNs for practice. There is a perceived gap "between today's nursing practice and the education for that practice, despite some considerable strengths in nursing education" (Benner, Sutphen, Leonard, & Day, 2010, p. 4). Stress associated with the transition of NGNs to the workplace is well documented (Boychuk Duchscher, 2008, 2009, 2012; Chernomas et al., 2010). Identified sources of anxiety include not knowing what to do in unexpected situations (Craig, Moscato, & Moyce, 2012), interaction with physicians (Casey, Fink, Krugman, & Propst, 2004), and role issues such as ambiguity and work overload (Chang & Hancock, 2003).

Stressors in the workplace can overwhelm NGNs and lead to burnout, a risk that is exacerbated by unsupportive practice environments (Rudman & Gustavsson, 2011). Laschinger, Grau, Finegan, and Wilk (2012) found that job demands and bullying predicted NGN burnout and subsequent mental health problems. NGNs who left their first position have reported patient safety, stress levels, and the work environment as priority concerns (Bowles & Candela, 2005).

NGN Orientation Programs

The difficult shift from education to practice has prompted the creation of employer-based orientation programs and models reflecting the unique developmental process of new graduate transition (Boychuk Duchscher, 2008, 2009; Hoffart, Waddell, & Young, 2011). In the United States, standards have been developed for transition to practice programs and a Transition to Practice™ regulatory model has been designed for use by all health-care settings that hire NGNs (Spector & Echternacht, 2010).

Globally, there is little consistency across programs, which vary in length and teaching strategies. Orientation is described by most authors as 12 weeks in duration, but it may be longer in specialty areas (Baxter, 2010). It usually includes formal classes relevant to the organization and a practice component in the clinical area of employment. Clinical practice components may be called preceptorship, residency, internship, or mentorship. The individual guiding the new graduate is generally called a preceptor or mentor, but these terms are often used interchangeably in the literature (Baxter, 2010).

Mentorship is intended to facilitate professional growth and foster relationships that benefit mentors and mentees by enhancing career satisfaction and reducing attrition (American Nurses Association, 2011). It focuses less on supervision and assessment of performance and more on role modelling and guidance (Canadian Nurses Association, 2004). In an integrative review of new graduate transition programs, Rush, Adamack, Gordon, Lilly, and Janke (2013) found that variability in research design limited the conclusions that could be drawn about best practices. However, a predominant finding in the literature is that transition programs result in increased retention and decreased turnover (Pine & Tart, 2007; Ulrich et al., 2010).

NGG Program

The NGG is a joint effort of employers, nursing leaders, researchers, and the government. According to government guidelines, organizations are expected to provide NGNs with at least 12 weeks of orientation, including 3 to 6 days of general orientation; clearly define the roles of NGNs, mentors, and orientation leaders; and ensure the use of a learning plan by NGNs and mentors (MOHLTC, 2011).

The NGG is designed to provide a comprehensive orientation, including elements of preceptorship and mentorship. The 3-to-6-month supernumerary positions allow for in-depth clinical instruction (similar to preceptorship) and the opportunity for NGNs to receive professional guidance from the same expert nurse over time (similar to mentorship). Supervision is generally one-to-one. In some cases, however, the NGN rotates to a different unit for increased clinical exposure, and thus is supervised by more than one mentor.

Methodology

Research Design

A trend study design was used to examine the impact of extended orientation and mentorship on the transition of NGNs to professional practice over a 3-year period (2008, 2009, and 2010). Trend studies draw from the same population repeatedly over time but different people are sampled each year (Cohen, Manion, & Morrison, 2000). A mixed-method approach was used for data collection. Quantitative methods included online surveys of NGNs and employers who participated in the NGG. Participating employers were defined as organizations that received government funding to hire new graduates for NGG positions (Baumann, Hunsberger, & Crea-Arsenio, 2012). Qualitative methods included semi-structured individual interviews with NGNs and mentors and focus groups made up of employers.

This study was part of a policy evaluation of the NGG conducted annually from 2007 to 2010. Results of the overall evaluation have been published elsewhere (Baumann et al., 2012; Baumann, Hunsberger, & Crea-Arsenio, 2010, 2011a; Baumann, Hunsberger, Idriss-Wheeler, & Crea-Arsenio, 2009). All participants provided informed consent prior to data collection and approval was obtained from a research ethics board.

Surveys

Surveys were developed using SurveyMonkey.© The NGN survey was pilot-tested for face and content validity using a convenience sample of 77 new graduates. It included questions about demographics, employment, and mentorship. New graduates were asked to rate their mentorship experience on a five-point Likert scale (1 = poor; 5 = excellent) and whether it had been helpful in their transition to practice (1 = strongly disagree; 5 = strongly agree).

The employer survey was pilot-tested with five employers for face and content validity. It included questions about demographics, satisfaction with the NGG, implementation experiences (including mentorship), and perceptions about the effectiveness of the program. Employers were asked to rate the mentorship provided by their organization using a five-point Likert scale (1 = poor; 5 = excellent).

To participate in the NGG, employers and NGNs had to register on a Web-based employment portal created by HealthForceOntario. Upon registration, NGNs were asked for their consent to be contacted for research purposes related to evaluation of the NGG. HealthForceOntario services were used to e-mail all newly graduated registered nurses (RNs) and registered practical nurses (RPNs) in each year studied: 3,550 in 2008, 4,630 in 2009, and 4,817 in 2010.

At the time of survey distribution, 1,198 employers (155 hospitals, 613 long-term-care facilities, and 430 community organizations) were eligible to participate in the NGG (MOHLTC, 2012). The MOHLTC provided the researchers with the names and contact information of the employers who participated in the NGG in each year of the study. The survey was e-mailed to 301 employers in 2008, 197 in 2009, and 211 in 2010.

Interviews

Focus groups were held with employers and individual interviews were conducted with NGNs and mentors. Semi-structured interview guides were developed separately for each group (see Appendix 1).

Employer focus groups were arranged according to size of organization (large teaching hospitals, mid-sized community hospitals, small community hospitals); geographic region (urban/rural); and employment sector (hospital, long-term care, community, public health). Employers were contacted by e-mail and invited to take part in a focus group.

The sample of NGNs was obtained by asking survey respondents to provide contact information if they were willing to be interviewed. A convenience sample of NGNs was chosen from among the resultant e-mails by selecting across geographic locations and sectors (hospital, long-term care, community, public health). A convenience sample of mentors was also selected across sectors; the sample was obtained by asking employers at participating organizations to identify frontline nurses who mentored NGNs and who agreed to be contacted.

Data Analysis

Survey data were entered into PASW version 18.0 (SPSS Inc.). Responses to each item were summarized using descriptive statistics and compared across the 3 years. Frequency distributions were calculated on demographic data and satisfaction ratings obtained from the NGN and employer survey data collected each year. The focus groups and individual interviews were conducted by phone, recorded, and transcribed verbatim. The research team followed a sequence: interview, transcription, analysis, reflection, and modification of the interview questions.

Interviews were coded using QSR NVivo version 7.0 (QSR International). Texts were then interpreted using thematic analysis methods (Boyatzis, 1998). Preliminary coding was carried out by three members of the research team, who coded several texts independently. Team members then collaborated to develop a refined scheme for coding the texts. Additional codes were assigned as new themes emerged. Major themes were highlighted and key findings were categorized appropriately under each thematic heading. The texts were coded by year and compared over time so the team could explore common themes across the years.

Results

Surveys

In each year studied, one third of NGNs and over three quarters of employers responded (see Table 1).

As shown in Table 2, most of the employer respondents were from acute-care hospitals and long-term-care facilities.

Across the 3 years of the study, the majority of NGN respondents were RNs (63%–72%), female (90.5%–91.2%), and under the age of 30 (68%–71%). Respondents were asked whether they believed the NGG facilitated their transition to nursing. An average of 90% agreed or completely agreed with this statement; a small percentage (< 1.0% over the 3 years) completely disagreed.

Across the 3 years, an average of 93% of employers rated the mentoring they provided as excellent, very good, or good. An average of 82% of NGNs rated the mentorship they received as excellent, very good, or good.

Interviews

Across the 3 years, 21 employer focus groups (7 groups per year) were conducted with 106 health-care organizations (34 in 2008, 36 in 2009, and 36 in 2010); 53 interviews were conducted with NGNs (16 in 2008, 18 in 2009, and 19 in 2010); and 15 interviews were conducted with mentors (4 in 2008, 4 in 2009, and 7 in 2010). Employers, NGNs, and mentors reported their perspectives on the NGNs' transitioning experiences. The findings, which were compared across the groups over the 3-year study period, indicate that working with a mentor helped NGNs transition to professional practice. The perceived value of the mentorship and its impact are described below, as are common themes.

Theme 1: Stress Associated With Transition to Clinical Practice

Transition to clinical practice is stressful for NGNs. Employers described NGNs as "very, very nervous" upon entering the workplace. There was a

Table 1 ***NGG Survey Response Rates: 2008, 2009, 2010***

Year	**Survey**	**Sent**	**Received**	**Response Rate (%)**
2008	NGN	3,550	998	28
	Employer	301	254	84
2009	NGN	4,630	1,358	29
	Employer	197	162	82
2010	NGN	4,817	1,457	30
	Employer	211	163	77

Table 2 ***Employer Survey Respondents, by Sector: 2008, 2009, 2010***

	2008 ***n* (%)**	**2009** ***n* (%)**	**2010** ***n* (%)**
Acute-care hospital	103 (40.6)	67 (43.2)	68 (44.7)
Long-term-care facility	91 (35.8)	48 (31.0)	50 (32.9)
Public health	14 (5.5)	11 (7.1)	2 (1.3)
Community[a]	12 (4.7)	10 (6.5)	7 (4.6)
Other hospitals[b]	11 (4.3)	9 (5.8)	14 (9.2)
Other[c]	23 (9.1)	10 (6.5)	11 (7.2)
Total[d]	**254 (100.0)**	**155 (100.0)**	**152 (100.0)**

[a] Community health centres, Community Care Access Centres, mental health facilities, physicians' offices, nursing agencies, and hospices.
[b] Includes continuing complex care/rehabilitation and addictions/mental health.
[c] Family health teams, combined acute and long-term care, colleges, and universities.
[d] Missing data: 2009 (*n* = 7), 2010 (*n* = 11).

sense that not all new graduates were prepared for the realities of their professional role. One manager from a mental health hospital said, "They're not getting as much clinical as they need . . . they absolutely need that extra time . . . in the workforce on a full-time basis to cement the skills."

NGNs indicated that upon graduation they lacked confidence and were concerned about their ability to navigate the work environment. One commented, "There's nothing coming out of school that can . . . prepare you for the actual workplace." They also reported not feeling job-ready. Mentors likewise indicated that NGNs lacked confidence and that many were "afraid to hurt somebody" while on the job. One mentor explained that they were "not familiar with the environment" and consequently could become overwhelmed.

Theme 2: The Value of Mentored Time

A unique feature of the NGG is the length of time NGNs are able to work with mentors. One employer noted, "The big difference . . . [is that] 2 years ago we had 10 days for integration [and] now [we have] 6 months." An employer described how NGNs were able to "get a lot of learning out of the way in protected [i.e., mentored] time." As a result, NGNs more quickly acquired the confidence, competence, and experience needed to work with acute patients. Working with mentors also enabled NGNs to establish relationships with staff nurses. Employers believed "the mentor/mentee relationship [within the NGG] is stronger than in the old way, where you would come in and . . . be buddied in orientation with . . . whoever was on that day."

The support of a mentor increased the NGNs' comfort level as practising nurses. They liked "having someone there" to answer questions and did not "feel judged." Some NGNs felt reassured by their mentors: "It's okay for us to make the decision because . . . we're registered staff now. . . . So it's good just to have somebody to say, 'Yes, you're right in this decision'."

Nurse mentors from frontline staff reported that there was plenty for NGNs to learn during the supernumerary period: "There's an awful lot for them to absorb, and I think being on the unit for a fair amount of time [is] beneficial . . . and not just a few shifts." Extended orientation allowed mentors to increase the responsibilities of NGNs gradually. Initially, the NGNs shadowed their mentors. The mentors then gradually let them assume patient-care responsibilities.

Theme 3: Towards Better Clinical Decisions and Safer Patient Care

Extended orientation and mentorship helped NGNs manage the demands of clinical practice. Employer focus group interviewees agreed that NGNs who participated in the NGG were better prepared than those who received only the usual orientation. One nurse educator described the difference between the two groups:

> *From our perspective, hiring new graduates [through the NGG] versus new graduates [not through the NGG] and evaluating them after 3 to 6 months, there's a huge difference in their ability to think critically, to respond to patient needs in a timely manner, and to understand the safety issues of patients and other factors that really impact on patient care.*

The NGNs indicated that mentorship helped them become more confident about documentation and in administering medication according to patients' preferences. One new graduate said, "Whenever you're doing something, you're so cautious." However, having a mentor helped "take the fear away" and facilitated "safer practice." As a result, NGNs were more self-assured and felt better prepared to work alone.

The mentors highlighted the importance of helping NGNs develop their assessment and decision-making skills in the clinical practice setting: "It definitely helps take the skills that they learn in the classroom to a whole new level . . . it's the hands-on that makes all the difference in the world." The mentors allowed the NGNs to make decisions and assisted them throughout the process:

> *[The NGN] could do her medications and deal with incidences, [but] if it was a particular incident — say, a heart attack or something like that — then, I would usually be there . . . but I would let her take the lead role . . . and see what kind of decision she would make.*

Theme 4: Greater Productivity

Employers noticed that NGNs who participated in the NGG had increased productivity. They attributed this to the NGNs having learned effective time management during mentorship. Some employers also indicated that mentorship helped NGNs function more effectively in their nursing role: "They [were] not afraid when they actually hit the ground on their own . . . [their] confidence ha[d] already been gathered and they [were] able to be very productive."

New graduates indicated that mentorship helped them develop organizational skills and control work demands. Moreover, it made them "feel capable of doing the job." Over the course of the 6-month mentorship, NGNs went from being overwhelmed by the requirements of practice to knowing how to prioritize their workloads:

> *In the first 3 weeks there, I hardly took a lunch break [and] didn't take a morning break. Now I take a quick, 10-minute, break in the morning, I take my full lunch, and I take another quick break in the afternoon. I've been able to manage my time to get to that point.*

Mentors viewed their role as instrumental in teaching NGNs how to organize their tasks. They reported that NGNs wanted advice on how to be productive and function optimally within the organization. One mentor said, "A lot of them want to do the calling, they want to do the reporting, [and learn] what things doctors are going to ask for when they call so that they're organized and they look professional."

Theme 5: Integration Into the Workplace

The results of our 3-year trend study suggest that employers, NGNs, and mentors believe the NGG helps NGNs transition to practice and facilitates their integration into the workplace. Employers indicated that after NGNs have gone through the NGG, "they are very confident," "know who to go to," and have established social relationships. In addition, they reported that the NGG provides NGNs with "a really robust opportunity to integrate into the culture of the unit," which results in NGNs being more satisfied with their positions.

New graduates indicated that mentorship made them feel part of the team. They reported that staff nurses, nurse managers, and other allied health professionals responded positively to mentorship and created a supportive environment that helped them integrate. One NGN felt she was "respected for [her] experience . . . people say, 'You were on the Surgical floor for 7 months — you must know your stuff'." How others responded to NGNs affected their confidence: "If I . . . [had] any questions, I could ask anyone on my team or anyone from anywhere. I felt very comfortable."

Over the course of mentorship, the NGNs were transformed, as perceived by their mentors, from students and learners to colleagues and peers. Many mentors described how successfully the NGNs functioned upon completing their mentorship. One mentor described her mentee as "unbelievable and knowing [how] to take initiative. She never was afraid to ask questions. She feels right at home with all of the nurses." Another said of her mentee, "I worked with her the other day, just as a peer now, and she had her first code and she did so well. I was so proud." Clearly, mentorship was viewed positively by employers, NGNs, and mentors.

Discussion

The issue of new graduates transitioning to the workplace is not new, but the problem of an education–practice gap has yet to be resolved. Without an effective approach to the transition, employers could lose investments made in recruiting and orienting new hires and quality patient care could be jeopardized. Our study provides vital information pertaining to best practices in new graduate transition programs and presents longitudinal, quantitative, and qualitative data and responses across various groups, sectors, and regions.

The positive responses from employers, NGNs, and mentors in the focus groups and interviews were consistent across the three groups. Employer and NGN survey data confirmed the interview data with respect to satisfaction with the program. Although implementation of the program was viewed slightly more positively by the employers than by the new graduates, an average of over 90% of NGNs gave the program a very high rating for facilitating their transition to nursing practice.

Interview findings indicate that NGNs enter the workforce feeling unprepared and anxious. The supernumerary role and mentorship for an extended period were critical features of the program. The supernumerary position allowed the NGNs to work for a period of time without having to carry a full workload. Employers referred to this period as "protected time." New graduates who participated in the NGG gained confidence and refined their clinical skills. They were not expected to provide total patient care immediately upon entering the work environment. Instead, they were able to accept responsibility gradually. They progressed from job shadowing to playing a dependent role, which led to greater independence. This progression and gradual development of skills and confidence is consistent with the findings of Boychuk Duchscher (2012).

Working with a mentor on a shared assignment had a significant impact on the NGNs because of the reduced pressure. According to Laschinger et al. (2012), the "job demands of new graduate nurses may be reduced by ensuring that workloads are manageable" (p. 83) and "adequate staffing levels and reasonable nurse:patient ratios reduce the possibility of exhaustion and subsequent stages of burnout" (p. 183). The NGNs took comfort in knowing that "someone was there" when they were making decisions that could affect patient care. The mentor represented a safety net for NGNs testing their assessment and clinical judgement skills.

Mentorship provided the NGNs with consistent clinical practice supervision and facilitated a learning partnership between mentors and mentees. According to Chernomas et al. (2010), supernumerary positions "allow for the time, guidance and support that new nurses need to develop clinical judgment and complex patient management skills in a less stressful environment but are rarely available to every new graduate" (p. 81). In our study, the supernumerary position created a supportive environment for the gradual development of the skills required for safe patient care. As the NGNs became increasingly productive and better able to manage their work schedules, they felt more like valued members of the team and the organization. Extended orientation and mentorship helped them integrate and transition to professional practice.

Nurse turnover is costly for an organization and can affect the quality of patient care (Bland Jones & Gates, 2007). Orienting and mentoring an NGN for 3 to 6 months may be less costly for an organization than losing that nurse within the first or second year of practice. Moreover, it may contribute to the provision of quality care, which continues to be a concern, particularly given changing practice variables (e.g., aging populations and increasing patient acuity). Researchers recommend that educators, employers, and regulatory bodies work together to develop transition programs, which should be evaluated for cost efficiency and applicability (Hoffart et al., 2011; Wolff, Pesut, Regan, & Black, 2010).

Implications

The NGG is available to all employers in Ontario who are willing to support the initiative and all NGNs who are successful in matching with a participating employer. It is important that researchers continue studying the impact of transition programs and identify best practices to help employers respond to the needs of NGNs. Further research is needed to develop a database around the impact of transition programs in relation to the changing health-care population and changing workplace demands.

Conclusion

There is an identified need to integrate NGNs into the workforce efficiently and effectively. However, changes in the work environment have resulted in increasingly more complex practice settings that challenge NGNs. As a result, it is vital to continue developing a database of NGN needs and clarifying the key features of the most successful transition programs. Changes in the variables that affect the transition of NGNs to practice need ongoing research to determine the effectiveness of transition programs from the perspectives of employers, NGNs, and mentors. Our study examined a unique province-wide employment policy intended to bridge the education–practice gap. Future research could examine the impact of the NGG on employment status, job turnover, and the professional practice of NGNs in Ontario.

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Appendix 1 ***Interview Questions***

Employers

1. Can you describe how the mentoring process works within your organization with respect to working above staff complement?
2. How does the NGG orientation differ from your usual orientation?
3. What do you think is an ideal orientation and why?

NGNs

1. Can you describe the kind of mentorship provided during the temporary full-time supernumerary position?
2. Do you feel that the mentoring/supervision met your needs during this temporary full-time supernumerary position?
3. What do you think is an ideal orientation?
4. Tell us what you liked and did not like about the NGG mentorship?
5. Do you think the NGG helped you to feel prepared to transition into your job?
6. How job-ready did you feel upon graduation? How about now?
7. What is your perception of how you have been able to integrate into the workplace as a result of the NGG?

Mentors

1. Can you describe the mentorship model that was used?
2. How did you establish the roles of mentor and new graduate in patient care for the new graduate to achieve autonomy?
3. From your experience, how did the orientation/mentorship facilitate transition of new nursing graduates into the workforce?
4. Were there any negative aspects?
5. How does the NGG compare to the standard orientation program for new nurses in your organization?
6. If you had new graduates through the NGG last year, how do you think they are functioning now with respect to usual expectations in your organization?

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Résumé

Les compétences culturelles du personnel infirmier formé à l'étranger : étude des problèmes et recherche de solutions

Elena Neiterman, Ivy Lynn Bourgeault

Les compétences nécessaires pour exercer la profession infirmière sont généralement évaluées par des organismes de réglementation professionnels, lesquels évaluent les normes d'éducation, les titres de compétences et l'expérience. Toutefois, la compatibilité *bureaucratique* fondée sur la vérification de documents et l'identification de l'expérience *clinique* ne coïncident pas toujours avec la compatibilité *culturelle* et la capacité d'agir en tant que professionnel de la santé selon les normes en vigueur dans un pays. Les auteures examinent les défis que peut entraîner l'absence de compatibilité culturelle dans l'intégration d'un personnel infirmier formé à l'étranger (internationally educated nurses [IEN]) et en transition vers un nouveau système de santé. Des entrevues semi-structurées menées auprès de 71 IEN et 70 interlocuteurs clés au Canada ont révélé que la question de la compatibilité culturelle du personnel infirmier immigrant comporte des défis particuliers pour les organismes de règlementation, le personnel infirmier immigrant et les employeurs. Des constats indiquent que les programmes de transition visant à accroître les compétences des IEN offrent une voie pour préparer ceux-ci à travailler dans un contexte culturel canadien.

Mots clés : personnel infirmier formé à l'étranger, compétences culturelles, compatibilité culturelle, expérience clinique, intégration du personnel infirmier

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Cultural Competence of Internationally Educated Nurses: Assessing Problems and Finding Solutions

Elena Neiterman, Ivy Lynn Bourgeault

Competency to practise nursing is typically assessed by professional regulators who examine educational standards, credentials, and experience. But *bureaucratic* fit based on verification of documents and determination of *clinical* competence does not always coincide with *cultural* fit and ability to fulfil the role of health professional according to a country's standards. The authors examine the challenges that lack of cultural fit can pose to the integration of internationally educated nurses (IENs) transitioning to a new health-care system. Semi-structured interviews with 71 IENs and 70 key stakeholders in Canada revealed that the cultural fitness of immigrant nurses presents a unique set of challenges for regulatory bodies, immigrant nurses, and employers. Bridging programs for IENs to upgrade their skills were found to be a means of preparing IENs to practise in the Canadian cultural context.

Keywords: internationally educated nurses, professional integration, cultural competency, Canada

> *What some people have said to me is that there's this kind of international . . . "a nurse is a nurse is a nurse" thing. Kind of an . . . imagined community of nurses . . . "We are nurses!" Almost like the international boy scout movement. [laughing]* (from interview with a key informant)

Examining the cross-cultural transition of health professionals who migrate reveals an interesting paradox: Whereas the clinical management of health problems is considered universal, the skills and qualifications of the health professionals responsible for delivering health services are not. The assumption that the processes of diagnosis, treatment, and management of illness across different countries are similar is evident in the development of international practice guidelines. Yet the growing movement of health-care workers across the globe illustrates the diversity of the cultural and educational backgrounds of internationally educated health-care providers (IEHPs).

The assumption that "a nurse is a nurse is a nurse" has received its share of criticisms from scholars and nursing professionals (Acord, 2000;

Carpenito, 1995; Wieck, Dols, & Landrum, 2010). When health-service delivery rests on the belief that any nurse can be substituted for another, without regard for the utilization of their unique skills or the impact of substitution on health outcomes, the practice of nursing is devalued and specialty-specific nursing qualifications are disregarded. We argue that this assumption, which is embedded in the practice of recruiting internationally educated nurses (IENs), has come to be seen as problematic by both professional regulators and practising nurses. The profession of nursing is not situated in a social vacuum, and cultural differences often become manifest in the way that nursing is practised.

Competency to practise nursing or another health profession is typically assessed by professional regulators on the basis of educational standards, credentials, and experience. But *bureaucratic* fit based on verification of documents and determination of *clinical* competence does not always coincide with *cultural* fit and the ability to fill the role of health professional according to the standards and expectations of every country. In this article we examine the challenges that lack of cultural fit may pose to the integration of IENs into a new health-care system. Specifically, we explore (1) the ways in which international models of nursing differ from Canadian ones and the challenges that arise from cultural differences, and (2) policy solutions aimed at preparing IENs to work in Canada. We begin with a review of the literature on the migration and professional integration of nurses. After briefly describing our methodological framework, we present our findings. Summarizing the data from interviews with IENs and a range of policy stakeholders, we demonstrate that the issue of cultural fit among IENs presents a unique set of challenges for professional regulators, immigrant nurses, and employers. In conclusion, we reflect on the role of cultural competence in the integration of IENs and propose some practices for facilitating the successful adaptation of IENs to Canadian health care.

Literature Review

The increased mobility of nurses has received growing attention in both the academic and the policy literature. One research topic is the reasons for and motives behind nurses' migration. Much of this research explores the relationship between "push and pull" factors — the various difficulties experienced in the country of origin (e.g., poor working conditions, political or economic instability) and the attractive features of the destination country (e.g., higher living standards, higher salaries, political or economic stability) (Buchan, 2006; Khaliq, Broyles, & Mwachofi, 2008; Klein, Hofmeister, Lockyear, Crutcher, & Fidler, 2009; Rasool, Botha, & Bisschoff, 2012). Although this approach is often described in the migration literature, the relationship between push and pull factors and the dominance of some factors over others remain relatively unexplored. It has been noted, for instance, that pull factors alone do not account for the mass exodus of nurses from low-resource countries and that push factors are often the reason why nurses migrate (Kingma, 2006). Therefore, a country concerned about nurses migrating might do best to focus on improving working conditions for nurses, including remuneration and the safety and security of their work environment.

The impact of nurses' migration on a country's economy and overall development is often discussed in the context of the ethical aspects of migration or the "brain drain" from low-resource countries and the "brain gain" to high-income countries (Ahmad, Amuah, Mehta, Nkala, & Singh, 2003; Likupe, 2013; Ogilvie, Mill, Astle, Fanning, & Opare, 2007). Researchers and political activists raise ethical questions related to recruitment of nurses from the developing world, which already faces significant shortages of nurses and physicians (Hawkes, Kolenko, Shockness, & Diwaker, 2009; Mackey & Liang, 2012). Low-income countries cannot compete with rich states in terms of the conditions offered to nurses. Researchers have documented the mass emigration of nurses from developing countries through the recruitment practices of high-income countries (Ahmad et al., 2003), while others have traced this movement to the culture of migration fostered through colonization by the imperial West (Hagopian et al., 2005). Finally, while some states look for ways to retain their nursing and medical workforce, others promote emigration since migrant workers often contribute considerably to private households in their country of origin through remittances. According to the International Council of Nurses, IENs regularly send remittances to their home country, which helps to explain why the Philippines, India, and China produce nurses for international export (International Centre on Nurse Migration, 2007).

Along with research on the reasons for and patterns of nurse migration, there is growing interest in the experiences of IENs in the destination country. IENs can face racial discrimination in the host country (Alexis, 2012; Dicicco-Bloom, 2004; Higginbottom, 2011; Newton, Pillay, & Higginbottom, 2012). For example, Dicicco-Bloom (2004) explores the racialization and discrimination experienced by Indian nurses in health-care facilities in the United States. IENs of colour in the United Kingdom also report discrimination (Allan, Larsen, Bryan, & Smith, 2004). In Canada, nurses from African countries working in the provinces of Quebec and Ontario have similarly been subjected to racism and discrimination (Calliste, 1996).

Although the research cited above touches upon issues related to nurse migration, it deals mainly with nurses who are planning to emigrate or are already integrated into the health sector of the host country. The role played by culture in hindering or facilitating integration of IENs into the health-care workforce remains relatively unexplored, although a few studies have concluded that culture can be a challenge to integration (Baumann, Blythe, Rheaume, & McIntosh, 2006; Kingma, 2006). Baumann et al. (2006) explored the experiences of IENs in Ontario. They report that failure to pass Canadian regulatory nursing examinations, a necessary step in obtaining a licence, can result from IENs' lack of familiarity with Canadian nursing culture.

Although the literature does acknowledge that culture may become a barrier to successful integration (Baumann et al., 2006; Kingma, 2006), the issue of cultural "fit" has not been sufficiently problematized. Cultural differences between IENs and domestically trained nurses can stem from a number of factors. First, IENs, like other immigrants to Canada, come from a diverse array of countries. While some of these countries adhere to Western ideals, others have different sets of beliefs and ideologies. For instance, not all countries promote gender or ethnic equality, gay rights, or religious freedom. Such personal beliefs and attitudes have been found to impact nursing practice (Harling & Turner, 2012) and thus can become a challenge for the professional integration of IENs whose cultural ideologies vary from those of the host country.

In addition to the cultural influences of IENs' country of origin, there are cultural differences in the models of nursing education and practice. Depending on the jurisdiction, nursing credentials can take the form of either a diploma or a degree, and even within these categories there is considerable variability in nursing qualifications across the world (Kingma, 2006). In some countries the role that nurses play within the health-care system is very different from the role they play in Canada. Adapting to not only the culture but also the model of nursing practice in Canada is therefore a challenge for some IENs.

Even those IENs whose cultural values are similar to those of Canadian nurses and whose education and training are consistent with Canadian nursing standards may experience challenges during professional integration. Nursing practices can differ from one workplace to another and especially from one country to another (Bourgeault, Neiterman, LeBrun, Viers, & Winkup, 2010). For instance, IENs from the United States may share cultural values and nursing practice models with nurses in Canada yet still need time to adjust due to differences in the health-care system, which is publicly funded in Canada and predominately privately run in the United States.

Exposure to different cultural ideologies, variability in nursing education and training, and diversity in nursing practice styles can affect the integration process. The purpose of this study was to examine the role of cultural fit during the process of professional integration. The concept of "cultural competence" is gaining ground in nursing education, reflecting the importance of showing cultural sensitivity and respect when providing nursing care to diverse communities of patients (Betancourt, 2007; Boyle, 2007). The discussion on cultural competence, or "the ability to provide effective care for clients who come from different cultures" (Anderson, 2001, p. 1), is usually concerned with the relationship between nurses and their patients (Betancourt, 2007). Nurses are encouraged to acknowledge the cultural diversity of their patients and to be sensitive to different customs and traditions. Cultural education is often seen as inseparable from nursing curricula (Harrowing, Gregory, O'Sullivan, Lee, & Doolittle, 2012). In applying the concept of cultural competence to the analysis of professional integration of IENs, we ask how and why cultural competence of internationally trained nurses becomes a challenge in their professional integration.

Methodology

Semi-structured, qualitative interviews centred on the experiences of professional integration in Canada were conducted in 2007–08 with 71 IENs residing in British Columbia, Manitoba, Ontario, and Quebec. The IENs were recruited through professional associations, immigration communities, advertisements in professional publications, and snowball sampling. Approximately two thirds were practising at the time of the interview and the remainder were in the process of obtaining a professional licence. The majority of the IENs had arrived in Canada between 2000 and 2005 (n = 60), while 11 had arrived between 1992 and 1999. They were born and trained in 29 different countries, including Australia, New Zealand, the United States, and countries in Africa, Asia, the Caribbean, Eastern and Western Europe, the former Soviet Bloc, and the Middle East. The three most common regions of birth and training were the United Kingdom and other countries in Western Europe (Belgium, Finland, France, Switzerland) and Eastern Europe (Bosnia, Moldova, Poland, Romania, Russia, Ukraine). Twelve IENs either were not trained in their country of birth or practised nursing in more than one country prior to arriving in Canada. The majority of IENs entered Canada as skilled workers or with a partner, and only a few had refugee status. Some were recruited abroad to work in Canada and some arrived through an independent immigration process. Approximately one third (n = 23) began to work as an IEN within 2 years after arriving. Roughly one third self-identified as a member of a visible minority. The vast majority were between the ages 30 and 49 and most (n = 59) were women. The interview included a set of demographic questions about age, sex, country of origin, country of training, year of entry to Canada and immigration category, type of licence obtained (if any), family status, and, where relevant, ages of children. The remainder of the questions were open-ended and focused on the participants' experiences of immigration and integration, from the decision to leave their country of origin to their arrival in Canada and the licensing process. The interviews, which lasted from 60 to 90 minutes, were conducted in person or by phone and were recorded and transcribed verbatim.

The protocol for the study was approved by a research ethics board. The participants were informed that the information was being collected for academic research purposes, that all records would be kept confidential, and that participation in the study would have no implications for the interviewee's licensing or practice. Although participants were very forthcoming during the interviews, it is possible that some did not fully share their negative experiences in Canada for fear of endangering their professional integration.

In addition, 70 short, semi-structured interviews were conducted with federal and provincial stakeholders purposively sampled to include members of professional associations, provincial regulators, government officials from immigration and health offices, and other key figures involved in the process of IEHP integration. These participants were recruited from federal organizations (e.g., Citizenship and Immigration Canada, Human Resources and Skills Development Canada) and provincial regulatory bodies, professional associations, and educational institutions where IENs were updating their training. The provincial key informants were recruited from British Columbia, Manitoba, Ontario, and Quebec. These interviews were conducted exclusively by phone. They lasted from 30 to 60 minutes and were recorded and transcribed verbatim.

The two data sets were analyzed separately using NUD*IST 6, a computer program for managing qualitative data. The analysis of interviews with key informants was based on unstructured, "free" coding, which was later modified into structured coding and reflected the relationship between different thematic categories. The theme of cultural competence as a challenge to professional integration emerged from the analysis in this fashion — that is, it was not an a priori code.

The interviews with IENs were analyzed using NUD*IST 6 as well and the data were approached as a new data set. The interviews were read and coded using unstructured, free coding and later reorganized into structured coding reflecting the relationship between analytical categories. The two data sets differed in content, reflecting the differences between the interviews describing the personal experiences of IEHPs and the more structured interviews with key informants describing the roles of their organizations in the integration process. We compared the accounts of IENs and those of stakeholders related to the issue of cultural competence and found that both groups perceived it to be a crucial factor for successful professional integration. We identified two interrelated themes: (1) cultural differences as a challenge to professional integration, and (2) policy solutions to address the challenges posed by cultural differences in nursing. In the following two sections we describe the findings as they relate to these two overarching themes.

Cultural Differences as a Challenge to Professional Integration

Lack of Fit

The first step in becoming a practising nurse in Canada is passing the credential assessment by provincial regulatory bodies. The registration process in the different provinces/territories is generally similar: Every nurse wishing to practise in Canada must provide nursing credentials, be qualified to practise nursing in her country of origin, have practical experience and language proficiency, and pass the Canadian Registered Nurse Examination (CRNE) (College of Nurses of Ontario, 2012) or, in Quebec, l'Examen professionnel de l'Ordre des infirmières et infirmiers du Québec.[1] When applying for registration, often nurses must have their level of nursing qualification determined before submitting the application to the regulatory body. The different educational models used in different systems and the different nursing qualifications pose the first barrier for IENs wishing to work in Canada. They make it difficult for nurses and professional regulators to determine the skills and qualifications of IENs:

> *[The College of Nurses said,] "We're not going to accept your education. You have an associate degree in nursing and that's not equivalent to anything here" . . . So I said, "Well, I have 15 years of nursing practice . . ." I had the associate degree in nursing . . . and it didn't fit the normal mould . . . they just didn't know how to assess my education. They didn't know what to make of me.* (IEN practising in Ontario)

The nurse quoted above, who was an immigrant from the United States and knew the regulatory system well enough to navigate it, managed to have her credentials approved. However, many IENs, especially those who had been recruited abroad and were not familiar with the local educational requirements, did not realize that the licence

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[1] While some nurses may be required to pass the Canadian Practice Nurse Registration Examination, none of the nurses among our respondents were writing this exam.

assigned to them by the regulatory bodies was below their qualifications until they began to practise in Canada.

Language Proficiency

Another key barrier to the integration of IENs is the language proficiency requirement. Fluency in English or French is a crucial factor for successful professional integration. There are a number of language proficiency tests approved by provincial nursing regulatory bodies. Some of our key informants, however, pointed out that the majority of these do not assess for ability to work in health care:

> *English-language deficit is a primary problem for people [seeking] licensure. So a number of our applicants had their credentials assessed, but what they lacked was the ability to pass English-language assessments . . . And [often even if] they have passed their English assessment they are not seen as meeting the . . . level of functioning that the employer wants. And there's a differential between what an academic test tells you about competency and what the employer demand is.* (stakeholder from provincial regulatory body)

Thus a general knowledge of English or French does not necessarily mean that an IEN is familiar with nursing terminology, which can include acronyms and culturally specific terms. This concern was often reflected in IENs' own assessment of their language competency. As pointed out by a nurse from the United Kingdom, even native English speakers can be confused by Canadian nursing language:

> *We [in the United Kingdom] don't abbreviate stuff. So . . . you'll hear a lot of people in the workforce talking about certain abbreviations and you're kind of, like, well, what does that mean? . . . Different names for the same drugs . . . or the same thing but completely different words.* (IEN practising in Manitoba)

Because general language tests do not assess the individual's knowledge of nursing language, many IENs are forced to learn nursing language "on the go," which can pose problems not only for professional integration but also for clinical care.

Nursing Licensure Examinations

A major hurdle for IENs on the way to professional integration is passing the licensure exam. The pass rates for IENs are considerably lower than those for Canadian-trained nurses (Baumann et al., 2006). Some scholars argue that IENs have lower pass rates because they are at a disadvantage due to language deficits, unfamiliarity with the nursing culture and terminology, and unfamiliarity with the multiple-choice exam format (Baumann et al., 2006; Bourgealt et al., 2010).

The interviews with IENs revealed that indeed language posed a challenge when it came time to write the exam. Because of one's reading speed in English and wording nuances, clues to the correct response (e.g., the nurse *advises* the physician or *informs* the physician) could be missed in the stressful exam environment. However, most of the difficulties reported by our interviewees had to do with the culturally specific questions on the exam. For many IENs who expected to be tested on their knowledge of practical skills and medical knowledge, the cultural questions were a stumbling block:

> *It's very hard to choose the right answer because they're all right and you have to choose the* most *right answer, and it's, like, oh, my god! . . . I had a question on exam, they're saying that your patient passed away and [the relative is] crying . . . she's looking down and crying and you come to her and what is your response? The first option is to put your hand on her shoulder, another is to hold her hand, and another one I can't remember. But it all sounds, like, right . . . it all sounds logical . . . I expected . . . too many questions about some pharmacology and about the calculations and about . . . some diseases, but it wasn't that hard. The big part is the cultural.* (IEN practising in Manitoba)

Our respondents found the cultural component of the exam to be more challenging than the clinical aspects. They felt sufficiently prepared for questions related to pharmacology or anatomy but not for questions about nurses' interactions with other health professionals or with patients. This may have stemmed from their unfamiliarity with the culture. For instance, one IEN recalled a question about the most appropriate toy for an autistic child and not knowing how to respond because she did not know what a Jack-in-the-Box was.

Local Model of Nursing Practice

The cultural model of nursing practice was identified by both IENs and key informants as posing a challenge to integration:

> *What people perceive as a nurse in some countries is not what a nurse is in Canada . . . [We have] different roles that people play in nursing, different roles in terms of advocacy, specifically. Other countries don't play an advocacy role on behalf of their patients and that's an expectation here . . . Maybe in their country nursing is, dare I say, a little bit of a subservient role, and it's much more autonomous here and there's some struggle in that.* (stakeholder from regulatory body)

Nurses' degree of autonomy varies widely from one health-care jurisdiction to another. While in some health-care systems nurses are not free to question a physician's authority, the orientation of Canadian nursing is to strongly advocate for autonomy:

> *[In Canada] nurses have authority and scope to function at an independent level on a collaborative team, and the individuals that come to us from other countries for the most part do not do that. They're not an equal player on the health-care team. And so . . . they don't necessarily have the skills to . . . challenge a physician if they know something is wrong.* (stakeholder from provincial educational body)

> *Some of those things . . . from my home nursing . . . were, like, off-limits . . . In Nigeria you don't advise the physician. You just inform . . . You inform the physician of patients' results. You inform and not advise. Advise is like you being the authority.* (IEN practising in Manitoba)

Coming from a variety of nursing cultures, the IENs often found that procedures, the use of technology, and communication between nurses, other health professionals, and patients did not reflect their own experience:

> *In the Philippines you have more power [over] the patients . . . you can tell what is the best for them. But here the patient is the one who is going to decide what is the best . . . you are here only . . . to explain what is available that you can offer, and then if they don't agree you cannot force no matter what, because it is their own life.* (IEN practising in Manitoba)

The main differences, as identified by our respondents, between the Canadian model of nursing practice and the models imported by the IENs revolved around nurses' communication with physicians and patients. Whereas for some IENs the role of patient advocate was familiar, for others it was a new role they had to learn upon entering practice. This was a challenge for IENs who had been trained in a health-care system with different relationship structures with regard to physicians, nurses, and patients.

We have demonstrated that many of our key informants and IENs viewed the model of nursing practice, familiarity with the Canadian nursing landscape, and language skills as playing a large part in professional integration. Next we describe a number of policy initiatives that address the issue of cultural competency of IENs and these challenges.

Policy Solutions: Facilitating Integration of IENs

In recent years health and immigration policy-makers and the Canadian public have become increasingly concerned about the issue of "brain waste," which reflects the lack of professional integration of internationally educated health professionals (IEHPs) (Bourgeault, Neiterman, & LeBrun, 2011). Federal and provincial ministries, regulatory bodies, and professional associations have invested in developing strategies to better accommodate IEHPs in Canada. In 2005–06, for example, Health Canada established the Internationally Educated Health Professionals Initiative to facilitate the process of integrating IEHPs through collaboration with provincial bodies and professional associations (Health Canada, 2010). The Foreign Credentials Recognition program, an initiative of several federal departments, helped streamline the process of credentials verification. Finally, the Canadian Nurses Association's LeaRN program offers preparation and a study guide for the licensing exam, the CRNE Readiness Test, and links to Web-based courses on language and nursing practice (Barry, Sweatman, Little, & Davies, 2003).

Not all policy solutions that have sprung up in the past decade address the issue of cultural integration of IENs, but some do provide useful tools. For instance, by collecting as much information as possible about the registration process in Canada via the Web sites of professional associations and regulatory bodies, IENs can become informed about cultural aspects of Canadian nursing practice. Some of our respondents revealed that they studied diligently for the registration exam while still in their country of origin. Our respondents found that language courses specifically designed for IENs and offered in some provinces were a useful tool for upgrading their language skills.

Our interviewees found that the best way to learn about Canadian culture was to enrol in a bridging program. Bridging programs address the gaps in the skills of IENs and prepare them for practice in Canada. They include language and cultural training, exam-preparation courses, and measures to fill gaps in clinical and academic knowledge (see Table 1). We will now describe the specific role of cultural education in some of the bridging programs developed for IENs.

Cultural Competence

Knowledge about Canadian nursing practice is what our key informants referred to as "cultural competence." Our findings indicate that lack of cultural competence is increasingly being viewed by Canadian stakeholders as a challenge to the integration of IENs and that bridging programs have become a key tool for addressing not only clinical gaps but also cultural gaps among IENs.

Table 1 ***Bridging Programs, by Province/Territory***

	Services Offered				
Province / Territory	**Language Courses**	**Academic Courses**	**Clinical Experience**	**Exam Preparation**	**Counselling**
British Columbia					
International School of Nursing and Health Studies	✓	✓	✓	✓	✓
Kwantlen University	✓		✓	✓	✓
Vancouver Community College	✓	✓	✓	✓	✓
Open University	✓		✓	✓	✓
Omni College	✓			✓	
Alberta					
International School of Nursing and Health Studies (Psychiatric Nursing)		✓	✓	✓	✓
Norquest College (in development)					
Grant McEwan College	✓	✓	✓	✓	✓
Mount Royal University (research project)	✓	✓	✓	✓	✓
Saskatchewan					
No programs identified					
Manitoba					
Canadian Nursing Tutorial Services	✓			✓	
Red River College	✓				

Ontario					
Care for Nurses	✓	✓	✓	✓	✓
Algonquin College	✓	✓	✓	✓	✓
Quebec					
No programs identified					
New Brunswick					
6 to 8 weeks' supervised clinical experience required			✓	✓	
Nova Scotia					
CRNNS program in development					
Prince Edward Island					
No programs identified					
Newfoundland and Labrador					
No programs identified					
Northwest Territories					
No initial licensure					
Yukon					
No initial licensure					
National					
LeaRN CRNE Readiness Test				✓	
Canadian Practical Nurse Registration Examination Predictor Test				✓	

Source: Association Strategy Group (2005).

The inclusion of cultural education in the curriculum of bridging programs was supported by all of our participants. Many of these IENs were grateful to have had an opportunity to enrol in bridging programs and were confident that these helped them to obtain their licence:

> *There's just so much information . . . I'm glad I did it [enrol in the bridging program] because if I [hadn't I wouldn't have been able to] pass the [licensing] exam for sure. In my opinion everybody should take these courses.* (IEN seeking professional integration in Ontario)

Upon completion of nursing bridging programs, which can range from several weeks to 6 to 12 months in length, IENs are generally prepared for the licensing exam. While in some situations bridging programs are compulsory (when assessment reveals lack of a specific set of competencies), in other cases nurses take the courses voluntarily. The nurse quoted above, for instance, decided to remain in the program, even after she passed the licensing exam, in order to learn more about Canadian nursing culture prior to applying for a position. However, bridging programs operate on limited funding, which often is renegotiated yearly with local governments and funding agencies. Therefore, prioritizing the focus of bridging programs is unavoidable. Not surprisingly, cultural education is not always given priority and made accessible to IENs:

> *We're finding that even individuals that do get licensed . . . tend to have some stumbling blocks when it comes to integrating well into the workplace . . . Even after internationally trained nurses graduate [from] the programs and become registered with the College . . . they still have a difficult time in the workplace . . . I've heard this from a number of bridging programs — they're focused on the exams . . . that's their primary focus. And the other issue is . . . well, you have to understand the [cultural] difference . . . I'm being broad here, but those types of issue are really sort of secondary.* (stakeholder from provincial government)

As Table 1 suggests, there is no common curriculum among the different bridging programs. While some programs emphasize cultural competence, most concentrate on clinical skills or language proficiency. Also, regional differences in program availability and accessibility make it hard for IENs to attend and inconsistency in funding makes it difficult to recruit and retain educators and participants.

Recently the Canadian Nurses Association announced that the Canadian Association of Schools of Nursing (CASN) would create a Pan-Canadian Framework of Guiding Principles and Essential Components for IEN Bridging Programs ("Bridging the gaps," 2012). This project is intended to streamline bridging education, and currently a number of bridging programs are testing an assessment tool developed by CASN to streamline the bridging curriculum. If implemented within the next 2 years, as planned, this could become a useful tool for developing bridging education that addresses the cultural needs of IENs and that provides some consistency in bridging programs offered to IENs.

Finally, a considerable number of IENs are recruited abroad to work in Canadian hospitals. Having signed a contract with the hospital, these nurses are generally expected to begin work within weeks or even days of their arrival. They usually receive orientation in the hospital that employs them. The length and content of the orientation vary from one health-care setting to another.

In summary, evidently many IENs receive cultural orientation in the Canadian health-care system before they begin their professional practice, but the content and structure differ widely among provinces/territories, bridging programs, and local hospital settings.

Discussion and Conclusion

Our study of how the cultural differences in nursing practice impact the process of professional integration for IENs in Canada reveals that many nurses have difficulty adjusting to the Canadian practice model. When navigating the registration process, some IENs find it difficult to understand the different levels of nursing in Canada, which often delays the integration process. Language proficiency remains a central challenge for many IENs, including nurses who are native speakers of one of Canada's official languages (English and French) but are unfamiliar with Canadian nursing terminology. Finally, one of the biggest impediments to IENs passing their exams and becoming successfully integrated into the Canadian health-care system is the differences in the model of Canadian nursing practice compared to models prevalent abroad.

Bridging programs are an important means of introducing nurses to the Canadian health-care system and helping IENs to overcome the challenges they face in the process of professional integration. Due to financial constraints, however, these programs are not always available and accessible to IENs wishing to upgrade their skills. Moreover, duration and content differ greatly from one program to another, and therefore quality and comprehensiveness — particularly vis-à-vis cultural context — are not guaranteed. It is possible that CASN's new initiative to streamline bridging education will mitigate this challenge, but there is still considerable variability in the curricula of bridging programs.

Bridging programs are not mandatory for IENs entering practice in Canada. Some nurses, including those recruited abroad, receive orientation (of varying duration) in the workplace before commencing work. These nurses are essentially left to learn Canadian nursing practice on the job, which can prove difficult. Due to the nature of our sample, we were unable to explore the different ways in which cultural fit acts as a barrier for IENs who were recruited abroad and those who arrived in Canada without pre-arranged employment. Future research could address this question.

Policy Recommendations

Our findings suggest a number of policy recommendations for addressing cultural gaps and better preparing IENs for Canadian practice.

First, accessibility needs to be increased and more opportunities need to be provided for IENs to enrol in a bridging program. Also, the content of bridging programs should be augmented to meet both clinical and cultural competency needs. As noted above, the CASN initiative is promising in this regard. Given that the need to develop bridging education for IENs is not unique to Canada, it would be beneficial to learn from integrative initiatives in other countries. In the United Kingdom, for instance, IENs must complete a 20-day Overseas Nursing Program and can also, occasionally, be required to undergo a period of supervised practice that can last anywhere from 3 to 12 months.[2] In the United States, the Transitioning Internationally Educated Nurses for Success program developed at the University of Pennsylvania has been suggested as a model for national bridging programs (Adeniran et al., 2008).

National bridging programs may not be feasible or practical in Canada, where health-care delivery and professional regulation fall under provincial jurisdiction. Nevertheless, a pan-Canadian collaborative effort to streamline bridging education could benefit all parties, especially in smaller provinces with more limited resources and a smaller pool of IENs.

While streamlining of bridging programs seems to be on the policy agenda, the orientation provided by employers also needs streamlining. Although orientation is usually offered in the workplace, creating dialogue between employers and learning lessons from each other could be fruitful ways to begin developing an orientation process that better prepares IENs for practice.

We do believe that collaboration between all parties involved can facilitate the integration process for IENs. Admittedly, the assumption that "a nurse is a nurse is a nurse" can simplify and speed up the process of integrating IENs into the health-care system. But this assumption is also known to cause problems: Unfamiliar with local practice culture, IENs

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[2] Due to standardization of nursing education in European Union countries, nurses from EU and EEA countries are exempt from this requirement.

often find it difficult to navigate the system, which can create problems at the managerial level, complicate inter- and intra-professional interaction, pose challenges to communication with patients, and raise numerous safety issues.

Finally, the cultural diversity of IENs should not be seen only as a disadvantage:

> *Right now, the emphasis is on how the internationally educated professional must change. And it disturbs me no end that we are not looking at that as a partnership with [immigrants]. Transition and integration is only going to happen effectively if it is seen as a sharing and a gaining and an expanding of the system's capability, not just [as] how can we make these people turn into our cookie-cutter nurses?* (stakeholder from nursing regulatory body)

Once the concept of cultural competence is applied to the assessment of IENs' readiness to practise, it can be used in two ways. The first is to define what is lacking in the education, qualifications, and experience of IENs. Bridging programs and other policy initiatives could target these gaps when developing curricula. The second is to ask what is lacking in *our own* education, qualifications, and experience. We rarely ask this question, and the answers might help us to not only integrate IENs more successfully but also improve our health-care systems.

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Résumé

Le leadership résonnant, le pouvoir d'agir dans le milieu de travail et « l'esprit au travail » : leur effet sur la satisfaction au travail et le degré d'attachement à l'organisation des infirmières

Joan I.J. Wagner, Sharon Warren, Greta Cummings,
Donna L. Smith, Joanne K. Olson

Des chercheuses canadiennes ont élaboré un outil appelé « l'esprit au travail » (*Spirit at Work* (SAW)) dans le but de recenser les expériences des personnes pour qui le travail est une passion et une source d'énergie. Le présent article décrit a) ce que les infirmières perçoivent comme contribuant à leur esprit au travail personnel et b) les liens existant entre les concepts de leadership résonnant, de pouvoir d'agir structurel et de pouvoir d'agir psychologique; d'esprit au travail; de satisfaction au travail; d'attachement à l'organisation; et les variables démographiques de l'expérience, de la formation et du rang dans le milieu de travail des infirmières. Le modèle théorique a été testé au moyen de LISREL 8.80 et des données d'enquête de 147 infirmières sélectionnées au hasard. Selon les résultats, un travail agréable représentait 63 % de la variance expliquée dans les variables endogènes du modèle. Le lien spirituel avait un effet causal sur l'attachement à l'organisation tandis que le leadership résonnant et le pouvoir d'agir individuel avaient un effet causal sur l'esprit au travail, la satisfaction au travail et l'attachement à l'organisation. Ces résultats appuient ceux d'études antérieures établissant les structures, les procédés et les contributions dans le milieu du travail menant à des environnements de soins supérieurs. D'autres études devront être menées pour préciser le rôle de l'esprit au travail dans le milieu de travail.

Mots clés : esprit au travail, lien spirituel, milieu de travail, pouvoir d'agir, leadership, satisfaction au travail, attachement à l'organisation

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Resonant Leadership, Workplace Empowerment, and "Spirit At Work": Impact on RN Job Satisfaction and Organizational Commitment

Joan I. J. Wagner, Sharon Warren, Greta Cummings, Donna L. Smith, Joanne K. Olson

Canadian researchers have developed the Spirit At Work (SAW) tool for identifying the experiences of individuals who are passionate about and energized by their work. This article describes (a) what registered nurses perceive as contributing to their personal SAW; and (b) the relationships among resonant leadership, structural empowerment concepts, psychological empowerment concepts, SAW concepts, job satisfaction, organizational commitment, and the demographic variables of experience, education, and rank in the RN workplace. The theoretical model was tested using LISREL 8.80 and survey data from 147 randomly selected RNs. Engaging work was found to account for 63% of the explained variance in the model's endogenous variables. Spiritual connection had a causal effect on organizational commitment, while resonant leadership and individual empowerment had significant causal influence on SAW, job satisfaction, and organizational commitment. These results strengthen those of previous studies reporting workplace structures/processes/contributions leading to superior care environments. Future studies will clarify the role of SAW in the workplace.

Keywords: Spirit At Work, spirituality, workplace, empowerment, leadership, job satisfaction, organizational commitment

Registered nurses are working in increasingly stressful environments associated with severe shortages of experienced nurses, an aging workforce, professional autonomy issues, imposed organizational change, occupational health and safety issues, and continual restructuring (Jackson, Firtko, & Edenborough, 2007). Discussions with RNs in the Canadian province of Alberta indicate that "resource allocation and difficulties in professional and inter-professional relationships" (Webber, 2009, p. 1) cause moral distress or a sense of powerlessness to take ethically correct action. RNs throughout Canada, the United States, and elsewhere describe burnout and job dissatisfaction as reasons for quitting their jobs (Leiter & Maslach, 2009; Wang, Tao, Ellenbecker, & Liu, 2011). An aging client/patient population, increasingly complex treatments, and a demand for nursing specializations pose further challenges to health-care providers

(Health Canada, 2007). Researchers, nursing leaders, and policy-makers are actively searching for solutions (Cummings et al., 2010). The fostering of spirituality in the workplace has been proposed as one means of moderating the damaging influences on job satisfaction (Altaf & Awan, 2011; Kinjerski & Skrypnek, 2008).

This study singles out Spirit At Work (SAW) (Kinjerski & Skrypnek, 2004) as a distinct and significant facet of the work setting that has not been examined within RN workplace empowerment research (Laschinger & Havens, 1997). It sheds light on the effects of leadership on SAW, structural empowerment, psychological empowerment, job satisfaction, and organizational commitment. This original research contributes to the knowledge that leaders require in order to create an empowered environment featuring increased commitment and job satisfaction among RNs and improved patient outcomes (Aiken, Clarke, & Sloane, 2008).

Literature Review

Resonant Leadership

A systematic review of the literature on nursing leadership (Cummings et al., 2010) indicates that resonant leadership occurs when "there is investment of relational energy . . . to build relationships with RNs and manage emotion in the workplace" (Cummings, 2004, p. 76). The review describes leadership practices that tend to have positive outcomes, such as increased job satisfaction and organizational commitment, increased recruitment and retention rates, improved staff health (decreased anxiety, emotional exhaustion, and stress), and increased productivity. Leadership also plays an important part in increasing SAW in the workplace (Kinjerski & Skrypnek, 2006a). Since leaders play a significant role in the implementation of workplace empowerment actions and the SAW of RNs, resonant leadership must be investigated further to examine its relationship to a positive RN work environment.

Empowerment

Laschinger and Havens (1997) report that employees need control over their circumstances, or structural empowerment, in order to achieve optimal performance, including job satisfaction and organizational commitment. Research on structural empowerment indicates that it has positive relationships with behaviours/attitudes and workplace outcomes similar to those revealed in SAW research (Armellino, Quinn Griffin, & Fitzpatrick, 2010; Purdy, Spence Laschinger, Finegan, Kerr, & Olivera, 2010). A systematic literature review (Wagner et al., 2010) found that employees display increased job satisfaction and are less likely to quit when the workplace manifests the following job-related empowerment structures:

> [support] feedback and guidance . . . from superiors, peers and subordinates . . . [information] the data, technical knowledge and expertise required to function effectively in one's position . . . [resources] the time, materials, money, supplies and equipment necessary to accomplish organizational goals . . . [opportunity] autonomy, growth, a sense of challenge and the chance to learn and grow. (Laschinger & Havens, 1997, p. 16)

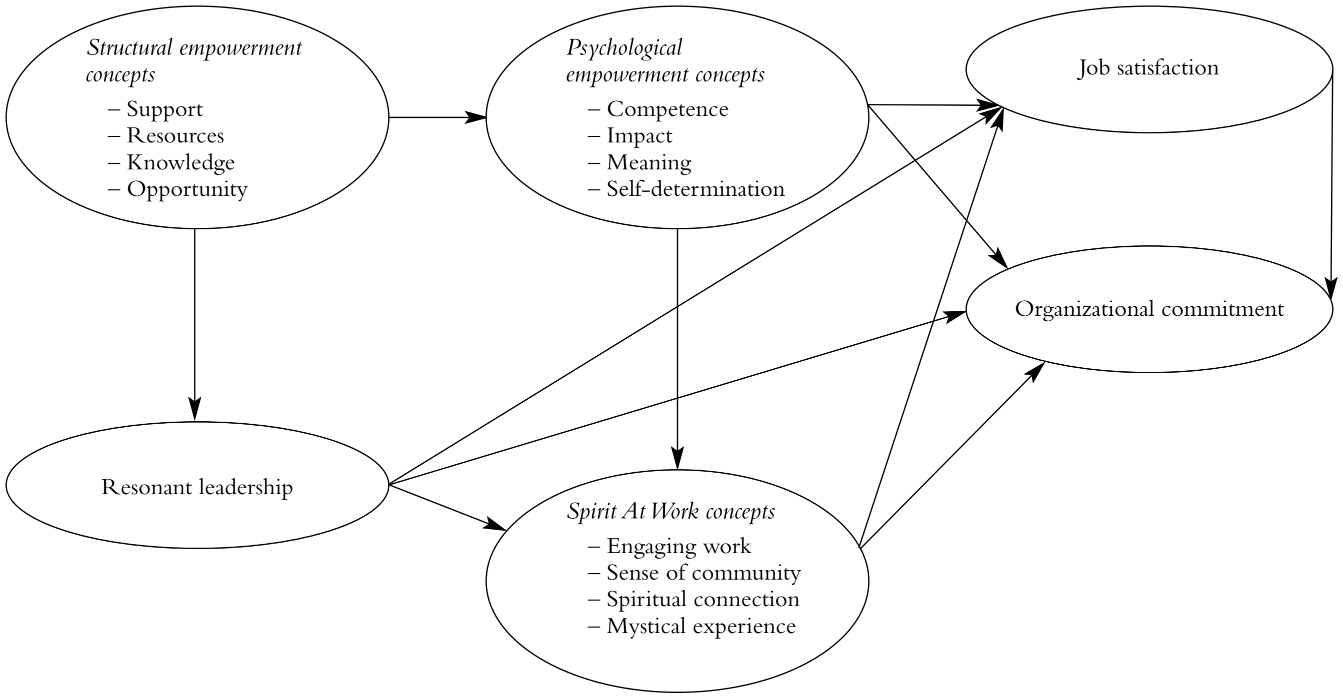
Research shows that these job-related empowerment structures, or concepts, lead to a work orientation that reflects the individual's desire and ability to influence or fashion the workplace labour, otherwise known as psychological empowerment (Spreitzer, 1995). Research also demonstrates that psychological empowerment plays a mediating role between structural empowerment and increased job satisfaction and organizational commitment (Laschinger, Finegan, Shamian, & Wilk, 2001). The construct of psychological empowerment comprises four concepts: meaning (fit between job requirements and beliefs), competence (confidence in ability to perform activities proficiently), self-determination (sense of control over work), and impact (sense of being able to influence outcomes) (Spreitzer, 1995). The literature review by Wagner et al. (2010) reveals the important roles that both constructs play in a healthy workplace.

Spirituality, the Workplace, and SAW

The business literature describes how spirituality in the workplace leads to such outcomes as increased job satisfaction and organizational commitment (Altaf & Awan, 2011; Kinjerski & Skrypnek, 2008; Mitroff & Denton, 1999). However, research studies focused on spirituality in the RN workplace are noticeably absent from the literature. Although RNs do not often use the word "spirit" when referring to their workplace, spirit may be a noteworthy consequence of day-to-day work for both RN staff and RN managers.

Kinjerski's research on SAW acknowledges the contributions of spirituality to successful workplace outcomes. Kinjerski (2004) approached her study of SAW from a human ecological stance and used grounded theory to identify the experiences of employees who were passionate about and energized by their work (Kinjerski & Skrypnek, 2004). Additional studies (Kinjerski & Skrypnek, 2006a, 2006b, 2008) indicate that the SAW construct comprises four concepts: engaging work; sense of community, expressed as trust and connectedness to co-workers; mystical experience, an uplifting state associated with energy and vitality; and spiritual connection, or a belief that one is contributing to something larger than oneself (Kinjerski & Skrypnek, 2008).

Figure 1 ***Theoretical Model Depicting Relationships***



Job Satisfaction and Organizational Commitment

In this study, job satisfaction was defined as the difference "between how much an employee wants or expects from the job and how much the person actually gets" (Laschinger, Shamian, & Thomson, 2001, p. 212) and organizational commitment as "the employee's relationship with the organization and . . . implications for the decision to continue or discontinue membership in the organization" (Meyer, Allen, & Smith, 1993, p. 539). Job satisfaction was used to measure positive workplace outcomes, since organizations employing strategies to create empowered workplaces have had positive outcomes, such as increased nurse and patient satisfaction and reduced patient falls (Aiken et al., 2008; Armellino et al., 2010; Purdy et al., 2010). In addition, both job satisfaction and organizational commitment are strongly related to RN retention (Ellenbecker & Cushman, 2012) and are considered to be a direct result of RN workplace empowerment (Hauck, Quinn Griffin, & Fitzpatrick, 2011).

Demographic Variables: Experience, Education, and Rank

Koberg, Boss, Senem, and Goodman (1999) report that individuals with more tenure, who have learned through experience that continued effort leads to a sense of competence, display greater feelings of empowerment. Organizational rank is also associated with increased empowerment, as it indicates "sociopolitical support and perceived access to information, resources, and influential persons" (Koberg et al., 1999, p. 76). In addition, Spreitzer, Kizilos, and Nason (1997) and Kuokkanen, Leino-Kilpi, and Katajisto (2003) report that individuals with a higher level of education feel more empowered.

Nursing research has identified specific managerial behaviours needed to improve job satisfaction among clinical RNs (Ellenbacker & Cushman, 2012; Furtado, Batista, & Silva, 2011). Not surprisingly, emerging research indicates that nurse managers also experience workplace stress. Four workplace attributes moderate negative outcomes with respect to the aging RN workforce and the loss of knowledgeable and experienced RN managers: autonomy/shared decision-making, support, good relationship with supervisor, and core self-evaluation (Ellenbacker & Cushman, 2012; Kath, Stichler, & Ehrhart, 2012; Laschinger, Purdy, & Almost, 2007).

Purpose and Research Question

The purpose of this study was to explore the relationships between resonant leadership, structural empowerment, psychological empowerment, SAW, job satisfaction, and organizational commitment among RNs in Alberta. An initial healthy workplace model (Figure 1) was developed based on a review of the literature. The research question was as follows: *Do resonant leadership, experience, education, rank, and structural empowerment concepts predict psychological empowerment concepts, SAW concepts, and, in turn, the outcome variables of job satisfaction and organizational commitment among RNs in Alberta?*

Method

Sample

A sample size of 5 to 10 participants per variable in the model was established for this exploratory descriptive cross-sectional study (Norman & Streiner, 2008). RNs were eligible to take part if they were registered with their professional association with an up-to-date postal address. The provincial RN licensing association distributed a Web-based survey and follow-up postal survey to 467 randomly selected RNs across Alberta. In order to elicit the voices of RNs throughout the province, the researchers stratified RNs according to area of residence — urban or rural.

The study was approved by the Health Research Ethics Board of the University of Alberta, Alberta Health Services, and Catholic Health of Alberta.

Survey

The study consisted of six questionnaires tested for reliability and validity (Table 1), as follows: a 12-item modified Condition for Work Effectiveness Questionnaire II (Laschinger, Finegan, et al., 2001) measuring RN perceptions of opportunity, information, support, and resources; a 12-item psychological empowerment scale (Spreitzer, 1995); an 18-item SAW questionnaire (Kinjerski & Skrypnek, 2006b); a 10-item resonant leadership scale (Estabrooks, Squires, Cummings, Birdsell, & Norton, 2009); a four-item scale measuring the outcome variable of overall job satisfaction (Quinn & Shepard, 1974); and a six-item scale measuring organizational commitment (Meyer et al., 1993). On the last page of the survey, respondents were asked to state their organizational rank (staff or management), years of professional experience, and highest level of education achieved. The survey ended with an open-ended question simply labelled "Comments."

Statistical Analyses

Chi-square testing ascertained whether the sample was representative of the population. Since no variables with 15% or more missing data were identified (Polit & Beck, 2008), pairwise deletion of the missing variables provided appropriate representation of the results. Assessment of the fit between the proposed model using LISREL 8.80 (Jöreskog & Sörbom,

1996) and the survey data indicated significant causal relationships based on theory.

Structural equation model (SEM) and theory development. The initial theoretical model of relationships shown in Figure 1 was tested. Since the sample was small, a single indicator that displayed clarity and closely matched the sample's conceptual definition (Hayduk, 1987; Hayduk et al., 2007; Hayduk & Littvay, 2012) represented each of the 18 variables in the model.[1] Careful review of theory describing relationships among the latent variables led to sequential inclusion of additional relationships and increased model fit.

The negative relationship between rank and job satisfaction was not supported in the management literature, since it indicated that managers have less job satisfaction than staff RNs. A further exhaustive search revealed staffing shortages and rapid and overwhelming change leading to reduced job satisfaction among Ontario RN managers during the SARS crisis (Laschinger et al., 2007). Nursing shortages in Alberta had a similar impact on job satisfaction among RN managers during the 2008 data collection; therefore, this negative or inverse relationship between rank and job satisfaction was retained.

Results

Survey Data

The RNs returned 148 useable surveys, for a return rate of 31%. Pearson's chi-square analysis revealed a significantly larger number of RNs in management and RNs with master's or doctoral preparation in the survey data than in provincial demographic data. Cronbach's alphas for the research constructs were similar to those reported in the literature (Table 2). Range and mean scores for all variables are shown in Table 2.

Model Fit

The fit indices of the final model fit the observed data ($\chi^2 = 56.222$, $df = 56$, $p = 0.466$; NFI = 0.96; GFI = 0.958; RMSEA = 0.0) according to the chi-square test, a useful test of significance for sample sizes ranging from 50 to 500 (Hayduk, 1987). The independent variables in the final model explain 12% to 63% of the variability (R^2) in each dependent variable. This healthy workplace model indicates multiple significant relationships between concepts.

Seventy-seven, or 53%, of respondents wrote comments in answer to the open-ended question. These were analyzed using the same coding

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[1] The covariance and correlational matrix and the measurement error specification for the latent variable in SEM can be obtained from the author (Joan.Wagner@uregina.ca).

Table 1 ***Psychometric Properties of Survey Tools***

Tool	**Measurement**	**Scoring**	**Reliability**	**Validity**
CWEQ–II (Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012)	19 items composing 6 subscales (opportunity, information, support, resources, formal power, and informal power)	Scores summed to create total structural empowerment score Likert scale (1–5) for each item; items summed and averaged to provide a score for each subscale ranging from 1 to 5	α = 0.78–0.81 Subscales α = 0.71–0.95	One factor CFA fits the data well. Time 1: "χ^2/df = 0.20; CFI = 1.00; TLI = 1.00; RMSEA = .00 (90% CI: 0.00, 0.05). All factor loadings were statistically significant (p < .01), ranging from 0.22 to 0.63" Time 2: "χ^2/df = 1.39; CFI = 0.99; TLI = 0.98; RMSEA = .02 (90% CI: 0.00, 0.08). All factor loadings were statistically significant (p < .01), ranging from 0.34 to 0.75 . . . Factor loadings were consistent with theory" (p. 319)
Psychological empowerment (Spreitzer, 1995)	12 items composing four subscales of meaning, competence, self-determination, and impact	Scores of subscales summed to create total score; higher scores represent higher empowerment Likert scale (1–7) for each item; items summed and averaged for each subscale	Total psychological empowerment α = 0.62–0.72 Test-retest among subscales α = 0.79–0.85 (*p* < .05) with tests 5 months apart	Factor analysis (convergent and divergent validity) AGFI = 0.93–0.87, RMSR = 0.04–0.07, NCNFI = 0.97–0.98

SAW (Kinjerski & Skrypnek, 2006)	18 items composing four subscales of *engaging work, sense of community, mystical experience,* and *spiritual connection*	Scores of 4 subscales summed to create *SAW* score; higher scores represent higher perceptions of *SAW* Likert scale (1–6) for each item	Total *SAW* α = 0.93 Four subscales α = 0.86–0.9	Cross-validation comparison of two samples Factor loadings 0.56–0.99 Subscales and total scale significantly correlated Face/content validity
Resonant leadership (Estabrooks et al., 2009)	10 items measuring components of resonant leadership	Likert scale (1–6) for each item Means of those who answered (1)–(5) used as resonant leadership score	High internal consistency for total scale α = 0.95	Face/content validity Correlations between variables above 0.5, most above 0.6
Job satisfaction (Quinn & Shepard, 1974)	Four items from job satisfaction index	Likert scale (1–7)	Internal consistency of items α = 0.72	
Organizational commitment (Meyer et al., 1993)	Six-item modified affective organizational commitment scale	Likert scale (1–7)	Six-item scale α = 0.74–0.85	Face and content validity

Table 2 ***RN Mean, Standard Deviation, and Reliability of Variables and Components***

Scales/ Subscales	**Minimum– Maximum**	***Mean (SD)***	**Cronbach's α (Survey)**	**Cronbach's α (Literature)**
Structural empowerment	**22.00–57.00**	**37.49 (7.69)**	**0.86**	**0.78–0.93** (Laschinger et al., 2012)
Opportunity	4.00–15.00	11.85 (2.30)	0.78	
Information	3.00–15.00	8.56 (3.06)	0.87	
Support	3.00–15.00	8.66 (2.77)	0.83	
Resources	3.00–15.00	8.47 (2.23)	0.73	
Psychological empowerment	**30.00–82.00**	**61.41 (9.64)**	**0.88**	**0.62–0.72** (Spreitzer, 1995)
Competence	3.00–21.00	16.84 (2.87)	0.81	
Meaning	3.00–21.00	17.36 (3.27)	0.91	
Self-determination	3.00–21.00	14.70 (3.55)	0.74	
Impact	3.00–21.00	12.23 (3.74)	0.90	
SAW	**20.00–108.00**	**75.94 (15.14)**	**0.93**	**0.93** (Kinjerski & Skrypnek, 2006b)
Engaging work	8.00–42.00	31.68 (6.22)	0.87	
Sense of community	4.00–18.00	13.32 (2.61)	0.79	
Mystical experience	5.00–30.00	18.41 (5.12)	0.79	
Spiritual connection	3.00–18.00	12.41 (4.05)	0.88	
Organizational commitment	**6.00–42.00**	**22.98 (3.18)**	**0.86**	**0.74–0.85** (Meyer et al., 1993
Job satisfaction	**4.00–28.00**	**20.18 (5.14)**	**0.93**	**0.72** (Quinn & Shepard, 1974)
Resonant leadership	**10.00–59.00**	**37.67 (11.55)**	**0.96**	**0.95** (Estabrooks et al., 2009)

system developed for the other questions, to permit comparison. This manifest content analysis provided additional insight into the causal effects between model variables, or concepts. The unstandardized causal estimates of the significant parameters and the associated survey comments follow.

Resonant leadership led to greater perceptions of resources ($\beta = 0.51$, $p < 0.05$), support ($\beta = 0.28$, $p < 0.05$), self-determination ($\beta = 0.43$, $p < 0.05$), engaging work ($\beta = 0.16$, $p < 0.05$), and spiritual connection ($\beta = 0.26$, $p < 0.05$).

Respondents made 17 separate comments on leadership. Eleven expressed concern: "Leaders are 100% accountable for the teams they create." Six commented that the work environment was positive despite worries about management. Two respondents expressed concern about the presence of acting managers: "We haven't had a formal leader (permanent) in place for over a year now."

Structural empowerment. The concepts of information ($\beta = 0.27$, $p < 0.05$) and opportunity ($\beta = 0.31$, $p < 0.05$) led to an increased perception of self-determination, while opportunity led to a greater perception of impact ($\beta = 0.29$, $p < 0.05$). Support led to greater perceptions of opportunity ($\beta = 0.29$, $p < 0.05$) and information ($\beta = 0.45$, $p < 0.05$), while resources led to an increased perception of opportunity ($\beta = 0.22$, $p < 0.05$).

Twenty-two respondents commented on structural empowerment and six described an absence of support in their workplace, with comments such as "every day I am faced with an environment that is high-paced and critical with little reward." One described a supportive work environment: "The sky is the limit as to what creative programs and super patient care people in helping professions can come up with when they feel valued and empowered." Seven described the impact on their work environment of the lack of resources such as adequate staffing, time for patient care, staff-wellness resources, and overall budget. Three of the seven expressed the view that "time constraints are huge barriers to 'being there' for clients when they need you."

Psychological empowerment. The concept of meaning led to greater perceptions of engaging work ($\beta = 0.28$, $p < 0.05$) and spiritual connection ($\beta = 0.43$, $p < 0.05$), while impact led to an increased perception of sense of community ($\beta = 0.19$, $p < 0.05$). Competence led to a greater perception of meaning ($\beta = 0.42$, $p < 0.05$). Self-determination led to greater perceptions of impact ($\beta = 0.43$, $p < 0.05$) and competence ($\beta = 0.42$, $p < 0.05$).

Nine respondents referred to psychological empowerment: "I believe strongly in empowering people, and emanating a passion to work in such a challenging department." Two questioned the meaning of the organization for them: "I feel less satisfied with the entire organization and at times question the values that are acted upon (not the ones in writing)." Three wondered if they had any impact within the organization: "I worked with my manager for over a year before she learned my name."

SAW. Spiritual connection led to greater perceived sense of community ($\beta = 0.15, p < 0.05$) and mystical experience ($\beta = 0.43, p < 0.05$). Sense of community ($\beta = 0.32, p < 0.05$) and mystical experience ($\beta = .29, p < 0.05$) led to a greater perception of engaging work. Engaging work was an important outcome variable, since it received significant effects from meaning, sense of community, and mystical experience, accounting for a total of 64% of explained variance (R^2).

Respondents wrote 34 comments about SAW. Eight discussed the influence of each team member on team dynamics: "I work in a very small teaching unit of 10 RNs. We are close and work together in harmony, but also efficiently." Five commented on the benefits to the client of a positive and "upbeat" atmosphere: "I strongly believe that this can be a healing atmosphere when the client senses that the staff get along with each other." Six said that the loss of sense of community culminated in loss of staff: ". . . some of the really good staff are starting to feel undervalued and are seeking and gaining employment elsewhere. This is a sad loss to the clients as well as to peers."

Seven RNs commented on engaging work. Five described having difficulty providing proper care: "I am feeling very frustrated as I love my job and what I do for my patients."

Seven expressed a failure to feel a connection to their work or the absence of a mystical experience. One voiced unhappiness with her work: "I work in this job because I have a mortgage and I like to eat. I would quit in a heartbeat if I had enough money." Two cited a spiritual connection and stated that openness to spiritual beliefs was important for client care and the workplace.

Job satisfaction. Impact ($\beta = 0.32, p < 0.05$) and resonant leadership ($\beta = 0.26, p < 0.05$) led to a greater perception of job satisfaction but rank led to a reduced perception of job satisfaction ($\beta = -1.22, p < 0.05$). It is important to note this inverse relationship between rank and job satisfaction, which indicates that RNs in management positions have less job satisfaction than those in staff positions. Job satisfaction accounted for 56% of the explained variance in the model (R^2).

Four RNs mentioned job satisfaction. Three of these expressed satisfaction: "I am very content in my position as an RN, and satisfied in my career choice!" The fourth stated that her satisfaction levels were constantly changing due to the changing nature of her profession.

Organizational commitment. Impact ($\beta = 0.34, p < 0.05$), spiritual connection ($\beta = 0.32, p < 0.05$), and resonant leadership ($\beta = 0.43, p <$

0.05) led to an increased perception of organizational commitment. Organizational commitment accounted for 50% of explained variance (R^2).

Eight respondents described a lack of organizational commitment, with seven seriously thinking about quitting: "I think . . . that nursing has burned me out. My spirit for nursing and its work is gone — too many years of abuse from the system — overwork — underappreciated and tired of trying. Now it is just a job and pays the bills — maybe it is time to leave nursing."

Rank, experience, and education. Rank led to greater perceptions of information ($\beta = 1.55, p < 0.05$) and support ($\beta = 0.60, p < 0.05$). Experience led to greater perceptions of impact ($\beta = 0.40, p < 0.05$) and competence ($\beta = 0.19, p < 0.05$). Education did not have a perceived effect on any of the variables constituting this model.

Discussion

SAW

The results illustrate the powerful effect of spirit on individuals and their workplaces, with engaging work accounting for more of the explained variance in the model than either job satisfaction or organizational commitment. Individuals with high SAW are valuable employees who combine good relationships with their co-workers with exceptional "customer service." This SAW combination of engaging work, sense of community, spiritual connection, and mystical experience receives direct and indirect effects from resonant leadership, structural empowerment, and psychological empowerment, culminating in increased workplace productivity and commitment (Kinjerski & Skrypnek, 2008). SEM analysis indicates that the perception of resonant leadership, the demographic variable of experience, and the perceptions of individual concepts within structural empowerment and psychological empowerment all have significant causal effects, leading to the perception of SAW.

However, SAW concepts do not have a significant effect on job satisfaction, and only one concept has an effect on organizational commitment, which runs counter to the theoretical model (Figure 1). To explain this incongruity, we turned to the environmental context of our survey. Alberta experienced massive cutbacks to health care throughout the previous decade and, as a direct result, many RNs lost their jobs or were "bumped" from their area of clinical expertise and moved into alternative work. More than 58% of the sample were over the age of 44 and thus had been working in health care during the cutbacks. For the study, job satisfaction was defined as the difference "between how much an employee wants or expects from the job and how much the person actually gets" (Laschinger, Shamian, et al., 2001, p. 212). RNs who were working during the health-care restructuring experienced bumping and as a direct consequence did not have the same expectations of their job. These RNs perceived SAW, with its holistic emphasis, as a workplace outcome separate from job satisfaction. This singular causal effect of SAW on organizational commitment further suggests that, for this group of RNs, SAW concepts represent outcomes separate from both job satisfaction and organizational commitment.

Structural and Psychological Empowerment

Laschinger, Shamian, et al. (2001) identify important relationships among structural empowerment, psychological empowerment, job satisfaction, and organizational commitment. The use of a single indicator representing each latent concept rather than an average of several indicator scores (Hayduk et al., 2007) supports this finding. The many statistically significant relationships displayed by the single indicators demonstrate the strength of these concept measures.

Separate measures of the individual concepts making up each construct further explain the interactions between concepts within a specific construct while also indicating relationships between constructs. For example, the structural empowerment concepts of support, information, and opportunity had a direct effect on psychological empowerment concepts. However, resources did not have a direct effect on psychological empowerment concepts — rather, resources had a direct predictive effect on information, and therefore an indirect effect on psychological empowerment. All the concepts in this model had a direct or indirect effect on job satisfaction or organizational commitment. Therefore, the model, with its emphasis on individual concepts, described the predictive power of RN perceptions of the health-care workplace.

Resonant Leadership

The perceived effect of resonant leadership on individual concepts within structural empowerment, psychological empowerment, and SAW was evident throughout data analysis. Resonant leadership also had perceived significant effects on job satisfaction and organizational commitment. Educating and supporting health-care leaders to provide resonant leadership is conducive to a healthy work environment, leading to increased organizational commitment and workplace longevity among talented leaders (Lee & Cummings, 2008).

Rank

Although the majority of research literature indicated that nurse managers have greater job satisfaction than bedside nurses, further investigation revealed that job satisfaction may be dependent on environmental context (Laschinger, Finegan, Shamian, & Wilk, 2004). The nursing short-age at the time of the survey created a stressful environment for managers, similar to that experienced by RNs in Ontario during the SARS epidemic. This environmental stress on managers in Alberta most likely led to the negative effect of rank on job satisfaction in the model.

Education

The absence of an effect between education and other variables in the model should be noted. Slightly more than 50% of the RNs in the sample were diploma-prepared. Neither diploma-prepared nor baccalaureate-prepared nurses perceived a difference in their empowerment, SAW, job satisfaction, or organizational commitment based on their educational preparation. This implies that individual nurses do not experience different treatment by patients, colleagues, or workplace leaders based on educational preparation.

Recommendations for Decision-Makers

Policy-makers, leaders, and educators must develop an awareness and understanding of the components of a healthy workplace. Resonant leadership, the demographic variables of experience and rank, and the concepts that form structural and psychological empowerment all have significant direct or indirect predictive relationships with job satisfaction, organizational commitment, and SAW. SAW also has a moderate effect on RNs' perception of organizational commitment. RNs' perceptions of SAW in their individual workplaces will help leaders and policy-makers to adapt RNs' workplaces to the specific environment or work context. Management awareness of the importance of SAW and the workplace relationships between structures/processes and SAW as an outcome can facilitate health-promoting changes for both RN staff (Stewart, McNulty, Quinn Griffin, & Fitzpatrick, 2010) and patients (Aiken et al., 2008; Middleton, Griffiths, Fernandez, & Smith, 2008).

Leaders must strive to provide resonant leadership, opportunity, and information to their RN staff. Education of staff in healthy workplace concepts and development of formal and informal leadership roles will lead to positive role models for staff, resulting in increased SAW. The model shows that select leadership actions foster perceptions of self-determination, which in turn increase RNs' perceptions of job satisfaction and organizational commitment (DeCicco, Laschinger, & Kerr, 2006; Laschinger et al., 2007). Leaders are encouraged to adopt a resonant style of leadership by actively listening to, acknowledging, and acting on staff feedback (Laschinger, 2004). This may include additional resonant behaviours, such as focusing on successes and potential, supporting and mentoring teams and individuals to achieve goals and outcomes, engaging staff in striving towards a shared vision, and promoting RN autonomy in decision-making (Estabrooks et al., 2009).

Our findings indicate that frontline managers have lower perceptions of job satisfaction than staff. Both our findings and those reported in the literature (Laschinger et al., 2007; Lee & Cummings, 2008) suggest that when the managerial workplace features structural empowerment concepts such as organizational and social support, educational opportunities, information, and adequate resources, RN managers' perception of job satisfaction increases.

Recommendations for Further Research

The results of this exploratory study can serve to guide ongoing inquiry into workplace theory. Both these results and those found in the recent literature (Lee & Cummings, 2008; Leggat, Bartram, Casimir, & Stanton, 2010) indicate that job satisfaction will increase when health-care policy-makers and senior executives ensure that structural empowerment components, such as organizational and social support, decentralized decision-making, educational opportunities, information, and adequate resources, are present in the workplace for both RN staff and RN managers. Further research will deepen our understanding of the relationships between the individual concepts forming the constructs of structural empowerment, psychological empowerment, and SAW. The absence of a causal relationship between education and job satisfaction contradicts the research literature and requires further investigation. Further research may also serve to clarify the role of SAW in the workplace as both a mediating and an outcome variable. In addition, we need to investigate the relationship between RNs' perception of SAW and positive outcomes such as reduced absenteeism and increased retention. Combining RN outcomes research with research on the relationship between SAW and objective patient outcome data such as reduction in patient falls, pressure ulcers, and medication errors will provide valuable information for decision-makers.

Limitations

The survey return rate of 31% may have introduced bias into the study despite random selection of participants. The relatively small sample size and the complexity of the model necessitated the use of a single indicator for each measured concept. The single indicator was chosen as the best representative of the concept according to theory, whereas the common practice of using two or three indicators might have improved statistical control of potential confounders (Hayduk & Littvay, 2012).

The sample had a slightly higher representation of RNs in management and RNs with a higher level of education; consequently the results may be weighted towards the perspectives these two groups. However, the failure of education to have a significant effect on the model may discount the limitation imposed by the excessive representation of RNs with degrees. Since all of the model concepts represent the perceptions of the individual and can be measured only through self-report, none of the data were observational. However, as Laschinger, Finegan, et al. (2001) hypothesize, "given the demonstrated reliability and validity of the measures used . . . common method variance problems should be somewhat attenuated" (p. 265).

Conclusion

The findings contribute to health-care workplace theory and research that guide the creation of a healthier environment for staff and patients alike. Exploration of the relationships between SAW concepts and individual theoretical empowerment concepts further develop workplace theory and strengthen and complement previous results (Kinjerski & Skrypnek, 2008; Laschinger & Havens, 1997). This research situates SAW within the realm of evidence-based management as both a mediator and an important outcome of the RN workplace. In addition, the role of resonant leadership, with its multiple effects on other constructs within workplace theory, is shown to be an essential component of a workplace where professionals function as employees (Cummings, 2004). This research provides RNs and health-care leaders with a rich body of information upon which to base decisions concerning the evaluation of existing workplaces and the design of future healthy ones. The findings make a valuable contribution to the substantive body of nursing knowledge, introducing SAW as a workplace outcome that provides a holistic measure of the nurse's voice within the health-care workplace. Decision-makers in the areas of policy, leadership, and organizational structure will benefit from listening to the voice of this professional caregiver situated at the patient's side.

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