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Obtaining a Definition of Accountability in Medical-Surgical Nursing Practice

by

Kimberley J. Sommerville

A thesis submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Nursing

FACULTY OF NURSING

CALGARY, ALBERTA

DECEMBER, 2012

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Abstract

Obtaining a Definition of Accountability in Medical-Surgical Nursing Practice

Accountability in nursing practice is not a new concept. Although the term is found extensively in nursing literature and regulatory documents, there has been no agreed upon definition. A review of the literature did not produce any definition from a nursing perspective. The purpose of this qualitative study was to obtain how the cultural group of registered nurses defined accountability. Interviews were conducted with 7 individual medical/surgical nurses and by analyzing their language through the ethnoscience methodology, a taxonomy evolved and a definition of accountability was developed. The three categories of the taxonomy of accountability were intent, process, and outcome. Together they help clarify and promote understanding for accountability in nursing practice.

Acknowledgements

I would like to thank my Supervisor, Dr. S. Hirst for her guidance, understanding, and constructive feedback. I could not have done this without you. I also wish to thank the members of my committee Dr. A. Lane and Dr. S. Raffin Bouchal for your contribution and advice. I would like to acknowledge the different managers I have had at work, who allowed me the time and flexibility to achieve this goal while continuing to work.

To my friends, thank you for your countless texts, phone calls and messages. Your words of encouragement and support helped push me a little farther each time I needed it.

To my family, for their love, support, and encouragement in my educational endeavours. Especially to my parents, your belief in me never waivered even when mine did. You lent me your strength and your support when I needed it the most, and were there for all the ups and downs. Thank you so much for everything, I am blessed, love you.

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CHAPTER ONE

FOCUS OF THE STUDY

Conceptualization of nursing in today's healthcare system offers a diverse and dynamic view of the role of the registered nurse. Nursing has evolved from being described as a calling or vocation to a profession and practice, which is facing many challenges in the current healthcare environment (Liaschenko & Peter, 2004). Nursing has competencies and guidelines for practice in order for its members to remain accountable to the public and the profession as a whole. Accountability in nursing practice is not a new concept. The term is used extensively in the nursing literature and within regulatory documents, such as the Canadian Nurses Association (CNA) Code of Ethics and the College and Association of Registered Nurses of Alberta (CARNA) Standards of Nursing Practice (Gillis, 2003).

Registered Nurses (RNs) are to abide by a Code of Ethics and practice in accordance with the professional scope and standards of nursing set forth by their regulatory bodies. The development of regulatory documents, such as codes of ethics and professional standards are influenced by nursing history, cultural context, and societal changes (Gillis, 2003). Nursing regulatory bodies, such as the College and Association of Registered Nurses of Alberta (CARNA), have a mission to serve the public by regulating registered nurses through the context of these documents, "standards are necessary to demonstrate to the public, government and other stakeholders that a profession is dedicated to maintaining public trust and upholding the criteria of its professional practice" (Canadian Nurses Association, 2008, n.d.). CARNA members are guided by two professional documents, the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (2008) and the CARNA Nursing Practice Standards (2005). In the Code of

Ethics (2008), it is identified that "Nurses are accountable for their actions and answerable for their practice" (p. 18). Within the CARNA Nursing Practice Standards (2005) the first standard of Professional Responsibility reads as, "The registered nurse is personally responsible and accountable for ensuring that her/his nursing practice and conduct meet the standards of the profession and legislative requirements" (p. 1). Additionally, it is stated in the standards that the RN is "accountable at all times for his/her own actions" (p. 1). These documents are to provide guidance and a base for accountability for individual nursing practice but it is not clear in them, how accountability is defined. Although the documents are tools of accountability and are reviewed and revised periodically to better reflect societal and nursing context, they do not ensure accountability in nursing practice (Liaschenko & Peter, 2004). This inability comes from different interpretations of the documents and how they are put into practice can be different from person to person. The basis for accountabilities lies with the RNs' competence to practice and their conduct during practice (Rowe, 2000).

The ability of the nursing profession to regulate itself enables its members to have ownership and accountability for their individual practice (Kramer et al, 2008). In clarifying the difference between autonomy and accountability in nursing services, Lewis and Batey (1982) found no specifics on the critical components of the concept of accountability and no consensus on a definition. George (2003), when considering the use of accountability to improve policy in reproductive healthcare, found few have critically examined how accountability actually operates in health care. Accountability in nursing practice is not a new concept, but a consensus or agreed upon definition in nursing has not been obtained.

This study aimed to explore from the perspective of medical/surgical nurses, their beliefs about, and a statement of accountability that will form the basis of a definition of accountability.

Obtaining a definition from the nurses themselves will provide the opportunity to promote understanding of accountability by nurses practicing in acute care settings. The assumption is made that if this is shared with a group larger then the participants, that this will enhance the evidence informed foundation for quality nursing care. Building an understanding of accountability in practice from the RNs' perspective can have the greatest impact on the quality of nursing care as they have the most interactions with patients in the acute care setting.

Coming to the Question

When I was transitioning from bedside nursing into management, I began questioning what is the definition of accountability used in nursing practice. This questioning started as I felt when I was bedside nursing I was accountable to my patients/families, coworkers, and my employers, and I believe my actions reflected that. When I moved into management I felt I was not only accountable for myself but for all the staff that I managed. I was working from a different perspective and had a variety of staff with different backgrounds and experiences, whose actions were just as varied in practice. As I continue my journey in becoming an advanced practice nurse, I struggle with what seems to me as a lack of understanding and clarity of what accountability means for practicing nurses. I started having discussions with colleagues, staff, and other RNs and soon realized there did not appear to be a generally agreed upon definition of the term accountability. Rather they seemed to use a variety of similar concepts when trying to define accountability, although there was no consensus on those concepts. This ambiguity led me to look for assistance in defining accountability.

Accountability

A basic review of dictionary and thesaurus definitions was conducted to explore the uses of the term “accountability”. The latter source identifies that accountability is derived from late Latin *accomputare* (to account), a prefixed form of *computare* (to calculate), in turn derived from *putare* (to reckon), and is defined as the state of being accountable, liable or answerable (“Accountability,” n.d.). Roget's 21st Century Thesaurus (2008) defined it as responsibility and may be synonymous with answerability, blameworthiness, and liability. The tendency to use responsibility and accountability synonymously or to define each other is often used but they are not interchangeable and have different meanings. While there is a correlation between the terms, there is a difference that is important in helping defining accountability for nursing practice, and this will be discussed later.

Prior to specifically examining the literature on accountability in relation to nursing, it was relevant to explore how accountability was discussed in the literature in general. A search utilizing the University of Calgary On-line Library services, with the keyword accountability was done. From this search and a review of the abstracts, a few areas were prevalent in the literature where the term accountability was used. These areas were business, and government agencies, which include medicine, and education. In these areas, accountability was shown to be important and a few examples to show insight into accountability in these domains are discussed below.

There are varied descriptions and understanding about accountability in business and government agencies. Brandsma and Schillemans (2012) shared that even with the concept of accountability widely used in these domains it does not have an indisputable meaning and seems

to be a constantly developing concept. The variety of contextual usage of the term accountability indicates it has not become more precise. Crofts and Bisman (2010) explained, "accountability is a concept used in a variety of context, particularly in connection with public accountabilities and accountability in the public sector, as well as within social context" (p. 180). Even with the varied context accountability is used, there looks to be two views surfacing related to accountability within this literature of business and government agencies. Willems and Van Dooren (2012) identified that within accountability there seemed to be range from hard external constraints and soft internal norms and values, and in bridging this gap it can be beneficial for understanding accountability as a concept and practice. They also shared, "viewing it as a strategy form managing expectations, accountability is more than the actual fact of being held accountable" (Willems & Van Dooren, 2012, p. 1015). More research and insight needs to be completed on the term accountability to gain greater understanding of what it means.

Accountability has tended to be looked at negatively or pessimistically in the modern administrative areas, with concepts like hierarchy, investigation, rules, and outcome reporting (Willem & Van Dooren, 2012). Galindo (2010), who stated that the lack of accountability is a major problem in business today and can be seen anytime an employee blames someone else, another department, or the system in general, leans towards the negativity of the concept, in focussing on the outcome only. She describes personal accountability as, "unlike responsibility (the before) and self-empowerment (the during), personal accountability is the after...to answer for the outcomes of your choices, actions and behaviors" (Galindo, 2010, p. 19). Messner (2009) discussed, that calls for greater accountability from corporations might not be unambiguously desirable, as there is little understanding of the term but more resources and money are being spent on accountability measures for outcomes. In the financial portion of institutions or business

accountability, reporting on outcomes based on profit and loss statements, and earning announcements are most common. This can become a problem when unethical actions are taken in order to achieve desirable outcomes in business (Messner, 2009).

In the medical area, healthcare systems similar to the United States, have outcomes measures based on unclear, inflexible descriptors that depending on the results can have doctors and hospital organizations being rewarded or penalized (Epstein, 2009). The variability of individual patient needs or services provided by certain organizations are not always taken into account. When looking at accountability measures like length of stay or readmissions, there is vulnerability, if the doctor is more influenced by the desired outcome for a reward versus penalty, then what the patient needs (Epstein, 2009). Chassin, Loeb, Schmaltz and Wachter (2010) discussed that there needs to be caution and clarity when using accountability measurements to improve quality of care because there needs to be distinction between the outcome measures and the process measures.

Accountability in regards to education was focused on how schools have accountability measures for student achievements. Larson (2011) discussed the persistent demand for holding educators accountable for test scores in school, and student achievement was central to government education policy. She explained that these measures of outcomes do not take into account the nuances of individual students, like socio-economic status or English not being a first language, and this can take the flexibility away in meeting that student's need in order to meet the desired outcome (Larson, 2011). The No Child Left Behind legislations in the United States has been controversial, with the test-based results and narrowly defined success measurements, and although there is favour for its purpose there is disagreement with its use of test accountability as the single factor used to declare schools as successful or needing

improvement (Lewis, 2008). With little support and lack of capacity to deal with the accountability of outcomes there is a growing frustration in education.

Trying to manage multiple and sometimes conflicting accountabilities from multiple stakeholders is something that both areas of business and government agencies have to be concerned with. “Accountability as practice means managing many processes of information, discussion and judgement in different forums” (Willems & Van Dooren, 2012, p. 1023). The focus has been on the outcomes and accountability measures associated with these domains. The results were thought to be all that mattered and that negative outcomes/results would improve the actions, decision-making or process based on rewards or penalties. There is development in recognizing the need for process measurements although the focus in these domains remains on being accountable for the outcome. Accountability was further explored in relation to nursing and health literature.

Literature Review of Nursing and Accountability

In this section, a review of the literature found is presented. A review of the nursing and health literature was conducted using the University of Calgary On-line Library services. A systematic review of web based databases; CINAHL, MEDLINE, and Google Scholar were searched using the same search strategies. The search was performed utilizing the keywords of accountability, nursing practice, nursing, and accountable. Settings used in the searches were full text, abstract available, references available, publications between 1980-2012, peer reviewed, and for adult grouping only. The majority of the articles were found in CINAHL and MEDLINE as these two databases were searched first and there were duplications in the findings. The search produced many results where the words accountable or accountability were found within the

literature, yet many of these articles contained the words accountability or accountable related to other topics, such as, competency, scope of practice, duty of care, autonomy, and integrity but did not necessarily provide further definition or insight related to accountability. An initial screening of the abstracts was completed to identify those studies relevant to the review where accountability was the topic of discussion not just used within the article.

Once the searches and screening were complete, it became clear that there is little consensus on a definition of accountability. Griffith and Tengnah (2005) found that despite its common usage in professional practice and its inclusion in nursing texts, organizational policies, and regulatory bodies, the concept of accountability is frequently misunderstood, and often ambiguous. They continued to say, as standards and boundaries of professional practice are imposed on its members, it is essential that accountability be clearly understood by RNs (Griffith & Tengnah, 2005). The literature review did not provide any consensus on a definition of accountability for nursing but rather three broad topics emerged from the literature, these are accountability in healthcare organizations, accountability within the nursing profession, and individual nurse accountability.

Accountability in Healthcare Organizations

Within the literature, the implications of accountability to nursing are both broad based for healthcare organizations and individually based to nursing practice. Milton (2008) defined accountability as being understood and referred to from a global health perspective as an "important legal, ethical, and moral term reflecting an attitude of human obligation to other persons, groups, organizations, and societies" (p. 300). Accountability has many facets, such as "ethical, legal, and economic implications as well as implications for patient care" (Sorenson,

Seebeck, Scherb, Specht, & Loes, 2009, p. 874). Milton (2008) explained that definitions of accountability are influenced by societal context and that accountability is "viewed as an essential element in the global, public health arenas" (p. 300). Bergman (1981) identified over thirty years ago that accountability stems from two sources; society, where there are increasing costs of healthcare, more knowledgeable public, and greater demands on outcomes; and the profession, where increasing scopes of practice, increased education of nurses and a shift to patient as partner, have added pressures to nurses to be increasingly accountable for the care they provide.

RNs usually practice within healthcare organizations that have rules and policies that guide the care provided to ensure accountability. Lewis and Batey (1982) shared, "as a formal obligation, accountability is an institutional requirement expected of one participating in an organization" (p.10). Lachman (2008) referred to accountability as being an organizational responsibility, through clear communication to its employees, to set out equal expectations of rules and standards. Through these clear expectations it is possible for accountability to be achieved. Hochwarter, Perrewe, Hall, and Ferris (2005) stated, "holding individuals answerable for their decisions and actions at work is a process that must be managed carefully" (p. 517). Infrastructures and frameworks are needed by organizations to make the values and principles of standards important to all those professions working within the healthcare organization and by doing so there is a promotion of accountability as a valued component of practice (Lachman, 2008). Hochwater et al. (2005) explained, "a traditional assumption was that the implementation of such formal mechanisms would be perceived as such by all and, therefore, that accountability would be ensured" (p. 518). However, as organizations are made up of individuals with different backgrounds, values, and beliefs this does not prove to be the case to ensure accountability.

Laschinger and Wong (1999) shared, in an empirical study of nurses' perceived empowerment and collective accountability, that the profession of nursing has long been advocating for work environments that can foster true professional practice of nurses within organizations and by providing access to structures to support that, nurses perceived more empowerment which led them to assume greater accountability.

Accountability includes responsibility for the provision of quality care and promotes collaboration amongst other disciplines (Hockenberry-Eaton & Kennedy, 1996). Building accountability mechanisms in health care need to aim to support collaborative solutions to care of patients, where all disciplines involved in the care have joint ownership of the actions provided and outcomes achieved. This can be difficult in a hierarchal environment as, "good collaboration usually takes place between partners who are interdependent and who have joint ownership over decisions" (p. 162). Unfortunately, these types of ideal partnerships are rare in healthcare. Hochwater and colleagues (2005) agreed that accountability is a fundamental component for professional practice within organizations but further stated that little is understood what the terms perceived consequences are on work attitudes and behaviours.

Accountability within the Nursing Profession

Taking accountability for decisions and actions, implies disclosure to self, to the client, employer, and the profession, this leads to personal efficacy, trust, and strengthens the profession of nursing and job satisfaction (Wade, 1999). Laschinger and Wong (1999) discovered in their study that the ability to provide nursing care according to those standards and values promoted by the profession, increased the commitment to both the organization and the profession. The public funds the health care system and receives nursing care within that system, and licensure

ensures that registered nurses (RNs) have met minimal standards of competence to practice; this is one way of demonstrating accountability to society. In healthcare environments, Milton (2008) noted that accountability in practice as being "in accordance with international, national, and specialty nursing organizations' codes of ethics, and in professional scope and standards of nursing practice statements found within the discipline of nursing" (p. 300). Gillis (2003) discussed that accountability is a concept which implies that nurses are answerable to the public for the standards and ethics set out by the profession and that accountability does not just involve management holding nurses responsible but nurses need to hold themselves and each other accountable for actions and practice. Laschinger and Wong (1999) stated innovations in the shared governance style "create conditions within the work place which facilitate professional nursing practice and require nurses, not their managers, to be responsible and accountable for all aspects of the care they provide" (p. 308). Whatever the position of the RNs in an organization, they cannot abdicate their responsibility for how they deliver care, regardless of the demands imposed by their work environment, management, or anyone else (Allen & Dennis, 2010). Kurtzman et al. (2008) referred to performance measurement and public reporting as being key vehicles to motivating accountability in healthcare and achieving improvements in health outcome and patient safety. With healthcare professionals having an obligation to answer to a regulatory body for their actions, whether generally to ensure competencies or specifically due to problematic actions, there is a requirement to give an account (Cornock, 2011). If a member is unable to provide adequate account based on professional standards, there is the possibility of a sanction against that member.

RNs are accountable and answerable for their actions they choose to take and those they choose to omit. Rowe (2000) stated,

> professional accountability is fundamentally concerned with weighing up the interests of patients and clients in complex situations, using professional knowledge, judgment and skills to make a decision, and enabling the practitioner to account for the decision made. Thus, professional accountability means being responsible for one's standard of practice. (p. 549)

Accountability in nursing is an integral part of professional practice. The RN has to make judgments in a variety of elements affecting patient care and be answerable for those judgments. Cornock (2011) stated, "in accepting accountability, the healthcare professional accepts they may be required to justify their actions – to explain the rationale that prompted the actions and the consequences of their actions" (p. 25). Constantino (2007) suggested that for nurses to obtain personal accountability and competence, they must practice and be consciously aware of the impact of actions, words, and decisions.

Individual Nurse Accountability

Constantino (2007) shared that society holds each RN accountable for the actions and the execution of assigned tasks and duties. The intentional actions and moral responsibility of accountability, when based on values, judgments, and decisions can be motivational depending on the harmful or beneficial results (Hindriks, 2008). Scrivener, Hand, and Hooper (2011) cited a positive view of accountability that was offered originally by Caulfield (2005), "a wider view of accountability is that it is an inherent confidence as a professional that allows a nurse to take pride in being transparent about the way she or he has carried out their practice" (p. 36).

According to Cornock (2011) accountability is a 'higher level' activity than responsibility, as taking responsibility is fulfilled by undertaking the action and not necessarily

means being called into account. The focus of responsibility is on the tasks, accountability goes beyond the task because it implies that there was assessment and planning by the individual nurses before the action and evaluation occurred after the action (Cornock, 2011). As Marks-Maran (1993) stated as noted by Cornock (2011):

> an accountable person does not undertake an action merely because someone in authority says to do so. Instead, the accountable person examines a situation, explores the various options available, demonstrates a knowledgeable understanding of the possible consequences of options and makes a decision for action which can be justified from a knowledge base. (p. 26)

RNs, as professionals, assess the course of care and interventions they provide and evaluate their effectiveness, but doing so blindly or just because someone told them to, does not release them of accountability.

Other authors have presented their views on the concept of accountability as it relates to individual nursing practice. According to Kramer et al. (2008), accountability is about self governance based on ownership, partnership, and equity principles. Milton (2008) discussed the individual nurse's answerability to self and others for personal actions:

> Individual nurses are accountable for judgements made and actions taken in the course of provision of nursing services. Clearly, national, state or provincial regulatory agencies assign responsibility and accountability for professional nursing practice through regulations that include broad, yet legally binding statements for the scope and standards of responsibility and action for individual professional nursing practice. (p. 301)

The accountability of a RN's individual practice has been discussed by Sorenson et al (2009) as the answerability of the nurse to patients, peers, and the organization for outcomes of one's actions, but also includes being "accountable for ensuring that the practice of his or her colleagues meets the standard of care" (p. 875). By performing a role the RNs are in effect stating they are competent to perform that role and they are held accountable for those actions, independent of outcomes (Rowe, 2000). "By accepting the responsibility to perform a task the practitioner must ensure the task is performed competently at least to the standard of the ordinarily competent practitioner in that type of task" (Scrivener et al., 2011, p. 35). The public is becoming increasingly more knowledgeable and is demanding expert care, thus more than ever before nurses are being held accountable by patients and families to deliver safe, effective, and appropriate care. Snowdown and Rajacick (1993) discussed that for nurses' accountability to move toward a heightened level of professionalism, it is imperative for nurses to work together and be a supportive network for practicing nurses who are faced with ever changing roles. As there is a lack of literature on how nurses view accountability or a consensus of a definition for nursing practice, it makes it difficult to build these professional supportive networks to provide assistance to move toward a more accountable level of professionalism.

Scott Tilley (2008) stated that a model should be developed to help show how accountability would provide for safe patient care and incorporates the choices made by RNs to demonstrate their practice role. As the nurse carries personal responsibility and accountability for nursing practice and maintaining competence, the nurse must be clear and well advised of what accountability means. Gillis (2003) stated "Canada's healthcare environment calls for professional nurses who can work from a principle-centred paradigm of leadership, based on broad principles such as accountability and ownership" (p. 3). Nurses will continue to be

accountable for the care they provide and the decisions that are made; therefore having a clear understanding of the concept of accountability is imperative for their individual practice.

What is Missing in the Literature?

Within the comprehensive literature reviewed, there were no articles or research found that provided a definition of accountability for nursing specifically nor any that explained the concept of accountability from registered nurses' perspective. In fact, no articles were found that discussed what registered nurses think about accountability in their practice, how they defined it, and how it fits with their professional standards or personal perspectives. How do we know what is meant by accountability for RNs when there is no literature or research that looks at that topic from the professional perspective of RNs? What is the direct impact this can have on the quality of nursing care? This lack of insight and understanding into nursing and accountability is further explored.

One may question, so what? Why does it matter if we look at nurses and how they define and perceive accountability in their practice? As shared above in the literature review, often healthcare professionals are grouped together when looking at accountability from a healthcare organizations perspective. RNs are not discussed separately from the larger group of healthcare professionals that could include physiotherapist, respiratory therapists, licensed practical nurses, social workers, and physicians. The problem in not taking a more defined closer look at RNs is that acute care RNs make up the majority of the healthcare team, they spend the most time, and have the most direct contact with the patients during the hospital stay.

The care that RNs provide in the acute care setting is intimately involved in the day-to-day functions and progress of health status during a patients stay. RNs are with patients on in-

patient units twenty-four hours a day, seven days a week. RNs assess and notify other health professional team members in changes occurring in a patient's health status and through their assessments of the patient's ongoing needs, help direct the care needed throughout the hospital stay. Considering that the RNs provide the most direct interventions and care, their actions can greater affect outcomes of patients, depending on the care they provide. Having a definition of accountability for nursing provides understanding of their accountability to the patient, team, profession, and organizations, and with clear understanding and expectations this will directly influence the quality of nursing care.

Without a consensus on a definition or agreed upon understanding from a common perspective RNs are left to define it individually for their practice. With many RNs coming from different backgrounds and value systems, how accountability is perceived or defined can be very different based on their history, education, and experiences. Through common educational standards and competencies there are similarities in the professional values of nurses. Without providing a consensus for those practicing there can be different or ambiguous interpretations. Can nursing as a profession rely only on the educational formation of standards, professional values, and competencies to provide guidance for accountability? Are there not some obligations for nurses and the profession of nursing to define terms used in regulatory documents used to ensure consistency in holding RNs accountable? Without this clarity a problem can arise when a RN is being held to account about care provided, as without understanding of expectations for the definition of accountability, it is left to those individuals and their perceptions at that time.

Purpose of Study

To ensure that RNs are able to demonstrate competencies, standards and code of ethics, they need to understand the terms and concepts within those documents. When accountability is used within the documents it is important that RNs know and understand what that means for them and their practice. As RNs work with colleagues and other disciplines, they must understand their role and their accountability within the healthcare team. The literature provided no clear consensus of accountability and no views from a nursing perspective to practice, so my question evolved, How do acute care registered nurses define accountability? The purpose of the study was to determine how they define accountability and to build a definition based on their responses.

CHAPTER TWO

APPROACH TO THE STUDY

A qualitative approach was chosen for this study. Qualitative research is useful where human subjectivity and interpretation are involved, and to better explore the lived experiences and understanding of a particular population. There are a variety of qualitative research methods, each with a different perspective and focus of method. Choosing the specific method depends on clearly identifying the focus of the inquiry and what approach will most effectively answer the question under study (Streubert Speziale & Rinaldi Carpenter, 2007). One way of approaching the selection of a specific qualitative method is through exploring some of the fundamental premises of the researcher. For this researcher, culture was an important consideration for reasons that will be explained.

When undertaking a qualitative study it is also important for the researcher to provide insight into their assumptions and biases on the topic for discussion. Qualitative research is influenced by the researcher's analysis of the data or stories collected (Streubert Speziale & Rinaldi Carpenter, 2007). The assumptions for this researcher on accountability follow.

As a RN, I believe that accountability is an integral part of nursing practice as it directly influences quality of care provided to patients. I trust that RNs can articulate their actions and decisions while they practice and I assume that understanding accountability can inform and assist both RNs and administrators to dialogue about it, creating a culture of accountability. I am also of the opinion that reflective practice, knowledge, and understanding can change behaviours of nurses in their practice. With this understanding of assumptions and my view of nursing as a

culture, a description of the approach and influencing terms is provided in the overview of the method section.

Overview of the Method

Culture

Culture is a group-shared knowledge and the reality for a cultural group is developed and constructed over a lifetime of receiving, processing, and interpreting information and passing this on through interactions with each other and sharing through language (Evaneshko & Kay, 1982). In most theories related to culture, language plays an important part in the study of that culture. Language in culture is crucial because it provides the most complex systems of classifications of experiences and shows patterns of behaviours by language used (Duranti, 1997). Culture may also be described as practices and participation based on communications that are inherently social, collective and participatory in quality which is learned from other members of a certain culture and other various forms, such as books, education, and television programs (Duranti, 1997).

Holland (1993) identified, "a cultural group's existence is dependent on ensuring that the knowledge gained by its members is transferred" (p.1462). This begins within nursing education programs, where the professional values, skills, and theory are initiated to help bridge differences among nurses of varied backgrounds, to identify with common nursing professional standards, and ideology (Shaw & Degazon, (2008). Understanding cultural norms continues into the work place environment that new nurse chooses to work in. "Culture finds expression in learned, shared and inherited values, in the beliefs, norms and life practices of a certain group, guiding

their processes of thinking, decision-making and action" (Suominen, Kovasin & Ketola, 1997, p 186).

The cultural group chosen by the researcher was the medical/surgical acute care RNs. As shared by Suominen, Kovasin and Ketola, "the cultural system of nursing or nursing culture has its own distinctive characteristics: a common language, common rules and rituals, a common dress" (p.187). Nursing knowledge is enhanced by the stories shared between nurses in the working environment to increase understanding of cultural norms, derived from experiences with and in memories of different events (Robinson Wolf, 2008). This knowledge shared through stories among nurses working on similar units or working environments imparts beliefs, values, skills and the norms of the culture. It is through these shared stories of experiences in the working environment that cultural knowledge is increased. Robinson Wolf (2008) indicated, "the anecdotes of frontline caregivers validate who nurses are, express how nurses acquire practice knowledge, and relate how nurses get in touch with what is good in practice" (p. 326).

The RN population chosen within acute care was the medical/surgical RNs. These cultural members form the majority of all nurses in the acute care setting and are the largest single group of nursing professionals in healthcare (Canadian Association of Medical and Surgical Nurses, n.d). In their work environments medical/surgical RNs utilize diverse clinical knowledge and skills to provide nursing care to multiple acutely ill adults and their families, when these patients are experiencing complex variations in health. These cultural members in acute care hospital environments work with multidisciplinary groups to provide the best outcomes for the patients.

The study of culture from a qualitative research perspective is ethnography. Holland (1993) utilized an ethnographic study of nursing culture and shared that ethnography is "the descriptive study of culture where the ethnographer gains understanding of a cultural behaviour within a specific setting" (p. 1461). In this instance accountability within the acute care nursing cultural group will be explored.

Ethnography

Ethnography is one of many approaches that can be found in social research today. Ethnography is a form of qualitative research that permits the researcher to obtain insights into how events, things, and interactions are understood by the participants of a culture (Evaneshko & Kay, 1982). Atkinson and Hammersley (2007) stated "the origins of the term lie in nineteenth-century Western anthropology, where an ethnography was a descriptive account of a community or culture, usually one located outside of the West" (p. 1). The development and utilization of ethnographic approaches for the study of health care and the cultures within it, have the researchers drawing upon the practice of anthropologists, as they describe specific cultures under study. While the roots of ethnoscience are found in anthropology, philosophically it is derived from symbolic interactionism (Hirst, 2002). The history of symbolic interactionism, "redefined human behaviour as a response to individual interpretations of the world rather than to the world itself" (Oliver, 2012, p. 410). Symbolic interactionists believe "the best way to understand social reality is to study people as they routinely act and interpret events of significance to them" (Gallant & Kleinman, 1983, p. 10). So ethnography is a means to gain access to a culture, and view the phenomena in the context of the beliefs and practices of the cultural group in which they occur. The ethnographic researcher becomes immersed with the people and their ways, in order to understand the meanings that cultural participants attach to behaviours, knowledge,

traditions, and experiences (Hirst, 2002). The ethnographic approach can provide the cultural context through observation, interview, and description rather than statistics and experimentation.

Evaneshko and Kay (1982) stated "The method is also useful in studying aspects of the nursing profession itself since the knowledge associated with the profession is cultural in nature and based on underlying organizing principles of cultural data" (p. 62). This cultural knowledge associated with the profession of nursing is what interested this researcher in discovering how the cultural members would define accountability.

In order to best describe the culture of nursing and how that culture defines accountability, ethnography is useful. Ethnography utilizes the emic approach where the purpose is to study and understand the behaviour in the cultural setting in which it occurs (Hirst, 2002). Ethnography usually involves many different forms of data collection and can range from the researcher participating in the daily routines and lives of the cultural members for an extended period of time, observations, informal and formal interviews, collecting documents, and what ever may provide insight (Atkinson & Hammersley, 2007). Generally ethnographers draw on a range of data although they sometimes rely primarily on one method. There are different methods within ethnography depending on what the researcher seeks to understand from the cultural group's perspective. As language is viewed as a cultural activity, it is utilized as both a resource for and a product of cultural interactions. A form of ethnography is ethnoscience, also called ethnolinguistics or linguistic anthropology to emphasize the focus on language (Leininger, 1985).

Ethnoscience

Ethnoscience is a linguistic and anthropological method with the goal of obtaining culturally based knowledge derived from the participants' language (Leininger, 1985). Ethnoscience is the study of the language used by a culture to study "the systems of knowledge and classification of material objects and concepts" ("ethnoscience," n.d.). Ethnoscience differs from ethnography in that it focuses on the language of the cultural members and has a systematic way of analyzing the data or language used; and it is more rigorous, formal, and systematized way of documenting, and analysing data through the language of cultural members (Hirst, 2002). "Ethnoscience is based on the well-established principle that language is the primary symbol system through which meaning is conveyed" (Porr, Olson, & Hegadoren, 2010, p. 1317). Early ethnoscience researchers relied on principles of structural linguistics which implied that the data contained an intrinsic order, but subsequent development of ethnoscience reveals the researcher must develop that ordering, using knowledge of the total cultural system, and verified with the informants (Evaneshko & Kay, 1982). The aim of ethnoscience is to classify information gained from the cultural members, so that it accurately portrays and provides scientific integrity about the cultural group's views. A basic assumption of ethnoscience is that the cultural group either knows or unconsciously structures their experiences. This structure is evident by what language the individuals choose to use to explain those experiences. Yet since the subjectivity of individuals creates their knowledge, the cultural members may use different words with similar meanings to express the experience. The researcher then must order and analyze that language to discover the structure of the cultural groups' views. Leininger (1985) stated that the premises for the ethnoscience method includes, "the researcher works for an understanding of the words, perceptions, cognition and interpretations of the meaning of whatever is presented or observed in

the context of the informant" (p. 240). This is to ensure the cultural members 'point of view' is understood, not that of the researcher's. Another premise shared by Leininger (1985) is the participants statements are analyzed individually and collectively in order to ascertain similarities or variations in the context of the larger cultural group. This helps to promote rigor and a greater understanding of the members of the cultural group as a whole.

One of the first steps in conducting ethnoscience research is to learn to ask questions that are culturally relevant and meaningful to the cultural members. When the investigator knows little about the culture she can utilize a contact within the cultural group who is willing to provide information to establish some of these questions to ask. In this particular study the researcher is a RN who was previously employed on medical/surgical units and therefore was embedded in the culture. It is from this knowledge of the culture, this researcher developed culturally relevant questions to guide the interviews with participants (see Appendix F).

The answers provided by the participants are then analyzed and constructed into a taxonomy, in other words, the researcher arranges the data received from the participants in an inclusive hierarchy, leading to the last steps of a componential analysis to discover the similarities and contrasts between the language used and presenting the participants with the specific terms they have produced (Bush, Ullom & Osborne, 1975). Language used by cultural members both as individuals and as a collective, provides a mechanism for understanding the cultural knowledge of a specific group. Nursing, like other cultures, generally has knowledge that is obtained through language, as large parts of every culture are transmitted through language. This provides insight into the decision-making processes of medical/surgical nurses and their practice.

Ethnoscience provides strategies for analyzing and identifying understanding embedded in language. Through the analysis the researcher identifies words and phrases used by each participant to describe the experience of inquiry. There is limited research on this method specifically since its inception, but a growing number of researchers are using this approach to learn more about the beliefs and behaviours of culture from the language the cultural members use to describe those beliefs and behaviours. More recently Bernhardson, Olson, Baracos, and Wismer (2012) used ethnoscience to understand the beliefs of patients with cancer about eating while experiencing chemosensory alterations. Graffigna, Vegni, Barello, Olson, and Bosio (2011) used ethnoscience to explore how beliefs, and values shape symptoms, and the behavioural demonstration of cancer related fatigue. Ethnoscience utilized by Porr, Olson, and Hegadoren (2010), to explore the influences of tiredness, fatigue, and exhaustion, on illness experiences in individuals with major depressive disorder. This study on how nurses define accountability, will also contribute to the collective research using the ethnoscience method.

Through the study of the cultural members' language, researchers can discover how culture shapes their experiences and interact with each other. It is the researcher's belief that nursing as a profession has its own cultural system and within it there are subcultures, for example the acute care nursing group that is a subculture based on the type of nursing unit or type of nursing care provided. Using ethnoscience to research how the medical/surgical nurses within that culture defined accountability allowed the researcher to generate a definition of accountability that is significantly relevant to the specific nursing culture. This research went to the culture group of RNs to analyze what language they used to describe and define accountability in nursing. As all RNs are held accountable to the regulatory bodies of their province, they had a vested interest in helping to define what accountability means to them.

Participant Recruitment and Selection

Site Selection

Three adult acute care hospitals in Alberta were selected as the sites for participant recruitment. I chose these sites based on convenience for the researcher and their similar health services provided to patients at the sites. As partial completion of the ethics approval process for the Conjoint Health Research Ethics Board (CHREB), the researcher obtained signatures for support from medical/surgical Program Executive Directors of the adult hospitals listed above. I then sent in emails to the managers of those units, when ethics approval was received.

Participants

Adult acute care medical/surgical RNs were chosen for recruitment as this cultural group of RNs largely work within the hierarchy of physician led care and account for the highest number of RNs employed within the healthcare system in Alberta (CARNA, 2008). The inclusion criteria for participants:

- registered nurse
- who has been nursing a minimum 2 years FTE hours (4044hrs)
- is currently working at least a FTE of 0.50 and
- working on a medical or surgical unit

Demographic information was collected (e.g. age, level of education, total years in nursing practice) (see Table 1.0). The exclusion criteria included anyone that worked as a staff nurse under the researcher's authority as a patient care manger or who did not meet the inclusion criteria.

Recruitment

Once approval was received from CHREB, emails were sent to the managers and unit managers of the medical/surgical units of the three acute care centres listed above. The emails included a brief description of the research study and asked permission to come and speak at a staff meeting or to drop off copies of the recruitment brochures to recruit RNs (see Appendix A). The researcher deliberately excluded units where previously she was in a management role to avoid any concerns about coercion or influence. The researcher's personal email address was used to contact managers and any potential participants who inquired to ensure they did not feel influenced to participate and could differentiate between the researcher's role as a graduate student from her role as an Alberta Health Services (AHS) employee.

Many managers who responded indicated that staff meetings were often poorly attended and to forward an electronic copy of my recruitment brochure and they would forward it on to their staff (see Appendix B). This was how all the brochures reached the staff of those managers that responded. I did not attend any staff meetings or physically drop off the recruitment brochures at any of the sites. No follow up emails were sent to other managers, as there were sufficient replies from potential participants the first time around.

Potential participants contacted the researcher either by email or telephone and during initial contact the researcher confirmed that they fit the inclusion criteria. Based on the participant's preference for communication, arrangements were made for an initial interview at a convenient time and location. Those that did not meet the inclusion criteria were thanked for their interest in the research.

There were 7 participants that were interviewed for this study. The participants were given random participant numbers in order to provide confidentiality and anonymity when sharing their stories and examples. The demographic data collected are included in Table 1 below. The mean age of the participants was 40.6 years and the mean of years of experience was 15.8 years.

Table 1 Demographics Participants	Age	Years of Experience	Level of Education
1	25	3	Undergraduate nursing degree, specialty certificate, some graduate studies
2	61	39	Nursing Diploma
3	60	36	Nursing Diploma, specialty certificate
4	28	4	Undergraduate Nursing degree
5	26	2.5	Undergraduate Nursing degree
6	31	5	Undergraduate Science and Nursing degrees
7	53	21	Undergraduate nursing degree, non-nursing masters degree

Table 1

Data Collection and Analysis

Ethnographic interviews often incorporate a particular style of using a free-flowing approach allowing the participants to use the language and terms they choose (Leininger, 1985). Atkinson and Hammersley (2007) shared that in ethnographic studies most data collection does not follow a specified procedure and the categories used for interpreting what people say are not built into the data collection process. The categories are developed throughout the process of

data analysis; data is collected in various ways, including semi-structured interviews, use of field notes written in descriptive terms and through audio or video recordings. Through the data collection and analysis, this researcher utilized field notes throughout the research process and audio recorded each interview. Each interview audio recording was then transcribed for analysis.

Semi-structured interviews

All interviews were conducted by the researcher in a location and at a time individually negotiated with the participants. Interviews lasted approximately 30-60 minutes and were audio taped/digitally recorded. Field notes were maintained throughout the research process and will be discussed further under the Personal Documentation section. An open and relaxed atmosphere was maintained by the researcher in order to promote and encourage the participants to speak about their experiences and ideas about accountability. All the RNs who participated were interviewed at their site of work, for convenience of the participant. The participants were given a copy of the consent form (see Appendix C) and provided time to review the document and ask any questions they had before signing the form. All participants signed the form and the interview proceeded.

The interviews began with a "grand tour" question, which is a descriptive type of question that is usually open ended and designed to give a general, initial view of the participant's perspective (Sorrell & Redmond, 1995). The grand tour question for this research was: How do you define accountability in nursing? Follow up questions were based on responses received or taken from prepared questions (see Appendix F) to elicit more specific cultural information related to defining accountability, such as "what words or actions do you use to demonstrate accountability?" Contrast questions were also incorporated to help determine how

the participants saw particular similarities and differences between words and to help differentiate between concepts and words used, as an example "do you define responsibility and accountability differently?" The hidden or unconscious structuring of experiences was evident in the cultural group members' language. The task of the researcher was to uncover this structuring. This uncovering procedure was done through analysis of the answers provided by the participants to the series of questions asked (Hirst, 2002). After each interview, the audiotape was transcribed and listened to by the researcher to denote tones and expressions. These answers were then analyzed. When this analysis was grouped together from all the interviews the researcher looked for categories, subcategories, and characteristic cluster labels that emerged from the analysis of the data. Data obtained from the participants was then constructed into a taxonomy.

Boyle (1994) described taxonomies as created from the information provided by the participants to gain the range of variation and consistency about a particular focus or subject, such as accountability. The development of a taxonomy classifies the relationships among the words used by participants and enables the researcher to create a visual representation of how categories and sub-categories of cultural knowledge are interrelated (Hirst, 2002). This also provides rigor to the research as it demonstrates a large portion of how the data was analysed and categorized for further understanding, and can allow another researcher to follow the processes and decision trail of data analysis (Sandelowski, 1986). This development of the taxonomy contributed to the articulation of a definition of accountability based on the words and perceptions of the RNs, as cultural participants. As the data collection and analysis occurred concurrently and with follow up conversations with participants through the analysis, it enabled

the researcher to verify understanding of the cultural definition of accountability provided with participants throughout the entire research process.

Personal Documentation

Data collection was enhanced through personal documentation with the use of field notes. Field notes can help in the descriptive data collection of the research that cannot be heard on audio recordings and to collect visual observations of the participants throughout the interviews. These field notes were maintained throughout the study. During the interviews these notes related to a number of different components. For instance notations and interpretations on comments from participants that stood out to the researcher included such things as “kept repeating work environment hardships” and “focused a lot on personal growth”. Another area recorded in the field notes were non-verbal behaviour such as “rolling eyes when commenting on generational differences” or “little eye contact and fidgeting at the beginning of the interview, this did not continue throughout”. Any interruptions to the flow of the interview from a friend stopping by, to the overhead paging system were noted as well. During the interview I noted tones or emphasis on words used by participants, such as “very quiet in response to responsibility and accountability definitions” and “spoke clearly and confidently about definition”. Field notes were also utilized for personal notes of the researcher for overall impressions and any other questions for follow up, such as “interview took awhile to find a flow” and “follow up on what morals mean to her”.

Following each interview, the field notes were reviewed and additional notes and observations were added related to the same areas discussed above. These notes were also

utilized and reviewed when play back of the audio recordings were listened to and transcripts were analyzed.

Ethical Considerations

Ethical approval for this research study was obtained from the Conjoint Health Research Ethics Board (CHREB) (http://fp.ucalgary.ca/medbioethics/chreb/index.html). To ensure that the participants voluntarily agreed and that there was no question of influence, the researcher did not recruit or accept any participants that worked under her previous role as a nurse manager.

Participants were advised prior to the start of the interview that if a situation was described that clearly contradicted the legislation regarding professional nursing practice, the researcher would be required to report it. No incidents of this type occurred during the course of the study. Participants were asked to sign a consent form prior to the start of the interview. Time was provided in this initial stage to ask any questions regarding the consent form. All participants included in this study signed the consent form (see Appendix C). They were informed that they had the right to withdraw from the study at any point. Confidentiality and anonymity was also enhanced through the assignment of numbers in order to provide examples from the transcripts.

While a transcriptionist was used, she signed a confidentiality agreement (see Appendix D) and all drafts created of the transcripts were provided back to the researcher for destruction. All recordings are stored in a secure location on a memory stick that is both password protected and stored in a locked drawer for the required period of time.

Rigor in Qualitative Research

In qualitative research it is important to balance the story or experience of the participants with the relevance or validity of the research (Sandelowski, 1989; Thomas & Magilvy, 2011). Rigor is important to qualitative research as it provides consistency of the study method and accurate representation of the population studied. Thomas and Magilvy (2011) spoke to qualitative rigor where credibility, transferability, dependability, and confirmability are to qualitative research, as internal and external validity, reliability and objectivity are to quantitative research. Rigor can be obtained in qualitative research through comparisons with literature, sharing a clear decision trail from how the researcher became interested in the subject matter, the process followed and purpose of the study, providing information on how the data was collected and analyzed, sharing examples from the participants and obtaining validation from the participants themselves (Sandelowski, 1989; Thomas & Magilvy, 2011). It is important for the qualitative researcher to be clear in the processes followed in order to establish the rigor of the research.

In this study the researcher outlined the clear decision trail from interest in the topic of accountability, the literature review and comparative literature, the process of data collection and analysis. The findings of the research in Chapter Three provide clear examples from the participants supporting the analysis of the data and validation of the taxonomy and the definition of accountability was verified with participants. It was through this clarity of process that rigor was established.

Summary

Ethnography and ethnoscience are discussed as the method to explore how the cultural group of acute care RNs from the population of medical/surgical nurses defined accountability in nursing. Data was obtained by participant interviews and follow up conversations. Audio recordings of the interviews were used for data analysis and field notes were utilized throughout the study from interviews to data analysis.

CHAPTER THREE

FINDINGS

The purpose of this chapter is to present the results of the data analysis obtained through the method described in the previous chapter. A brief overview of the findings are presented to answer the research question, *how do acute care medical/surgical registered nurses define accountability?* Individual interviews with the medical/surgical RN participants revealed many shared beliefs, values, and perspectives. From the language the participants used, an analysis was completed to break down the language into categories, subcategories, and characteristic cluster labels, then into the development of a taxonomy and a definition of accountability based on the language from the participants. The following sections of this chapter will focus on the categories that emerged through the analysis of the participants' language and the development of the taxonomy and definition.

Overview of Findings

Although participants had their own unique way of talking about experiences and how they practiced related to accountability, as the interviews progressed it became evident that the participants had a vested interest in this concept, as they all were eager to share their ideas and definitions. As interviews progressed, the participants began to relax and were better able to reflect on their own experiences related to accountability. Verbal and non-verbal expressions such as voice tone and facial expressions lent insight into the emotion or passion that was tied to some of the examples and stories used when explaining what accountability meant to them.

All participants clearly stated that there was a personal and professional aspect to their understanding of accountability and identified nursing as being accountable to patients/families,

coworkers, employer, and licensing body, and in one case the union was listed. There were emerging themes and categories that began to take shape through the analysis, and the identification of the categorization process led to the taxonomy, as presented in Figure 1.

The Participants

The RN participants in this study shared their individual perspectives and insights into accountability and what it means to them in their practice. Through their stories and experiences related to accountability, they were provided an opportunity to express and further explore what accountability means to them as an individual nurse, as a team member, and as a caregiver, on a more conscious level.

Ethnoscience: Taxonomy

The research was directed toward developing a qualitatively derived taxonomy of accountability based upon language similarities and differences as reported by the participants. How decisions were made regarding the categorization and sub-categorization process is explained further. All words included within the taxonomy are the exact words used by the participants in the interviews.

The building of the taxonomy began with the analysis of the data collection from the interviews. The researcher reviewed her field notes for each participant while analyzing each transcript and recording. During this process, the researcher highlighted the words used by the participants to define accountability and how they spoke about those words. From each interview the researcher collected a list of the words used by the participants. Once this analysis for each participant was complete, the researcher utilized colour coding and marked those words used

repeatedly and in related context. The word lists were further analyzed according to similar topics or context and these similarities were grouped together on new single page lists.

Figure 1

Taxonomy of Registered Nurses' Definition of Accountability

Accountability

Intent	Process		Outcome
	Knowledge	Actions	
• Ethics • Beliefs • Values • Respect • Responsibility • Ownership • Integrity • Morals • Honesty/trust • Work ethic • Patient Safety • Commitment • Obligation • Awareness • Working environment • Transparency • Expectations	• Scope of Practice • Standards of Nursing Practice • Code of Ethics • Experience • Policy/procedures/ guidelines • Continuous learning • Critical thinking • Professionalism • Education • Competencies	• Providing care • Decision making • Nursing Process (assessment/ action/evaluation) • Addressing each other, speaking up or reporting of inappropriate action for self and others • Correcting errors/ admitting mistakes • Teamwork • Giving of time • Coaching others • Contribute • Advocate • Self evaluation • Question	• Rationale • Justify • Liability • Culture of accountability • Owned • Compromise

Figure 1

These word lists were referred back to the original participant transcripts to ensure appropriate placement within that similar context. Once this was complete the emergence of the categories became clear. The labels of the categories came from the terms and context provided by the participants. For example, all participants shared their 'intent' was to provide the best care for the best possible outcome for their patient, and then shared what personally influenced that

intent, hence the creation of the category listed as intent. This similar process was followed for the process and outcome categories. Based on the word types used under the process category it was further broken down into two subcategories to better reflect the aspects of process, these were knowledge and action. Participants felt there was an interdependent influence from one category to the other (as presented in Figure 1). Each category of intent, process, and outcome is discussed further.

Intent

Intent was identified as a category of accountability through the analysis of the words used by the participants (see Table 2). The words categorized under intent influence and happen before the action or process for which the RN may be called into account but reflects a basis for accountability. All participants stated that a guiding concept for them in accountability was the purpose, aim or intent of providing the safest, best outcome possible for their patients. One participant stated, "(accountability) would be first to my patients and the safety and care of my patient...be accountable to RNs and our guidelines and my values" (Participant #3). Many participants identified that their personal beliefs, values, ethics, and morals helped shape their approach to practice and how they take responsibility and ownership of the care they provide. Participant #1 shared, " to start off with my personal (accountability) definition, (it) involves a lot of what integrity is for me, which includes respect...and taking ownership for the actions I do...and professional accountability incorporates my own personal integrity and respect". Participants agreed that without an understanding or awareness of personal values it would be hard to conceive personal impact on others. "Probably the most important, is just being aware of how your actions impact others, and understanding, and knowing that what you do is going to make a difference, understanding your actions and how you do it matter" (Participant #5).

Table 2 **Taxonomy: Intent** (words categorized under intent)	
Ethics	Work ethic
Beliefs	Patient safety
Values	Commitment
Respect	Obligation
Responsibility	Awareness
Ownership	Honesty/truth
Integrity	Transparency
Morals	Expectations
Working environment	

Table 2

As accountability is a term based in ethics, many of the characteristics that the participants identified under the category of intent (Table 2) are related to personal values, such as, honesty, integrity, respect, and work ethic. Other words categorized under intent not related to personal values, such as working environment, expectations and patient safety were categorized under intent based on the fact these words had a context of influencing how the RN would make a decision or carry out an action or simply effect the intent of the RN.

Participants viewed the intent of providing care for the best possible outcomes for the patient as being inherent to nursing as a profession and independent of positive or negative outcomes within the process. All participants shared that if through the process of caring for a patient, mistakes occurred, that by being transparent and owning up to them a nurse was remaining accountable to her patient. As Participant #4 shared, “accountability for me is being responsible for your own actions, so if you make a mistake, to do the right thing...report it and follow through with it”. All participants identified the importance of owning your mistakes and learning from them. This is discussed further in the actions section.

A few participants also mentioned the generational influence on personal values. As Participant #2 said, “I get disappointed sometimes in our newer younger nurses, don’t get me wrong there are lots of good ones, but ... we learn our values, we learn our morals, we learn our codes from each other at coffee breaks, at lunch breaks –I go for lunch with five new nurses... they’re just sitting around the table texting. It is truly a different world, I know I’m old...however, I think some of that old stuff is not such a bad thing”. Participant #1 also shared that the younger generation nurse like herself “more readily questions why things are done and look for more evidenced based information on their own, seem less task based, and don’t just follow direction with no explanation even though something may have been done like that forever”. Participants agreed there is much information and knowledge passed from the experienced nurse to the newer nurse. Participant #7 stated, “as a junior nurse you know most of the basics but you work with a team...and you learn more. Now as a senior nurse when you work on a team...I show the junior nurses what they (need to) do. We’re all accountable on what they are doing”. Participant #3 shared the experienced nurse “is in a mentorship role...they will say you have full accountability but be there when you need them”. Acknowledgement of the generational differences can support how this knowledge is passed.

As discussed, above terms such as patient safety and working environment fell under the category of intent based on how they were used by the participant. The contexts of the words were used as influencing the intent of actions or decision making of the RN when providing nursing services. With the added pressures of high hospital occupancy and staffing shortages, many nurses felt those added pressures might affect quality safe care. Participant #2 shared, “with getting patients discharged and then bringing people in, you get these tremendous pressures from above, site managers, we’re over complement and we have all these people

(patients)...and we just need to provide safe patient care no matter what". Participant #3 shared her concerns regarding the occupancy pressures and hallway patients, "I'm very unhappy about it...I consider it a safety issue but I've been told by (the organization) that its safer there then in a busy emergency room. I haven't seen theses guidelines but I guess...it makes us all accountable to the patient. I have no problem speaking to our manager or a manager on a different unit about my concerns, so I am accountable to my patients". Due to these added tensions of caring for patients in less than ideal places with fewer staff, participants all expressed that to provide the best care possible within the standards and guidelines always remains their intent, which they believe keeps them accountable within their practice.

It was acknowledged by the participants that RNs may describe their personal values and intentions differently or use different words but they felt that the qualities they shared were inherent in the majority of nurses practicing within their area of medical/surgical nursing. It was felt by participants that while others may explain the intent of accountability using different words the context of the words included in the taxonomy would be expressed and shared by them in any acute care area of nursing.

Process

Through data collection and analysis, the concept of process developed. The participants shared that the knowing and doing of providing care is what they are most held accountable. RNs are answerable to the public for the standards and ethics set out by the profession and RNs need to hold each other accountable for the care that is provided. Participants agreed that the nursing education received and the standards set out for practice, and the policies/procedures set in the work environments guide the RNs' actions while caring for patients.

When the data was analyzed, two sub-categories emerged under process based on the terms that the participants had shared (see Table 3). These two sub-categories were knowledge and actions, and the majority of the words participants used to define accountability fell within these sub-categories.

Table 3
Taxonomy: Process

(words categorized under process from defining accountability)

Knowledge	Actions
• Scope of Practice • Standards of Nursing Practice • Code of Ethics • Experience • Policy/procedures/ guidelines • Continuous learning • Critical thinking • Professionalism • Education • Competencies	• Providing care • Decision making • Nursing Process (assessment/ action/evaluation) • Addressing each other, speaking up or reporting of inappropriate action for self and others • Correcting errors/ admitting mistakes • Teamwork • Giving of time • Coaching others • Contribute • Advocate • Self evaluation • Question

Table 3

Knowledge

The characteristics that were grouped under knowledge were centred on experience, education, standards, code of ethics, competencies and scope of practice. As displayed in Table 1 in Chapter Two there was a mean of 15.8 years nursing experience among the participants with the range of years between 2.5-39 years. There was also a full range in the levels of education, from diploma, undergraduate, graduate, and specialty certifications. Participant #1 said, “ I

believe very strongly in the modern scholarly nurse...we see BSc or BN and see the difference between diploma nurse and a LPN, and all of those, from what they were 10 years ago to now...accountabilities that we expect of all of those have excelled". Participants #2 and #3 both spoke of the importance of ongoing education and certifications to keep up to date with modern technology and processes. Participant #3 stated, "I went and got my certificate in gerontology...its important to keep up with your education...for patient care and your competencies". All participants spoke about the significance of education and gained experience.

The CARNA Nursing Practice Standards (2005) and the CNA Code of Ethics (2008) are the guiding documents in Alberta for registered nurses. "I'm looking at it (accountability) as, an obligation, a commitment for the nurse to be competent and to be able to provide, quality nursing care to the patient, as required by the nursing standards and scope" (Participant #7). When the participants were asked if they had read these two documents recently all replied they had not, and many said they had not read them since they were in training or in their undergrad program. "I read them a very long time ago...I know they're there if I need them...but I think a lot of it is embedded in us from our education and we just know it's what should or shouldn't be done and in situations" (Participant # 4). Participant #6 said she had not read them since school but "you do things (provide care) and you follow it (standards), even if you're not thinking about it because they're quite general". Participants said that the standards are mostly thought of through the competencies for yearly renewal of their registration for the licensure to practice. "I know they're there if I need them, when there's an issue that comes up, I have my binder with CARNA information in it that I use to hold my competency info for my registration" (Participant #3). The competencies are based on the standards of practice and are required for yearly registration with CARNA in Alberta.

Staying current of new procedures, policies, and scope of practice to ensure the best care possible in the performance of skills and tasks were considered very important in being accountable. “I would look at accountability in terms of always furthering my education, keeping up with what’s going on today, especially in my area” (Participant #2). This was common among all participants, they shared that nursing practice in their areas are always changing and they constantly have to learn more and integrate changes into their unit practice guidelines. Participant #6 said, “you follow your nursing policies and procedures, or certain practice, you always check, review them before you do something. Always ask if you’re not sure. We ask each other all the time”. Participant #3 shared “I follow our standards for safe care. Our guidelines are there and there (is room) for discussion of details if you need to”. Participants felt that one way they could ensure accountability of practice is by following the practice protocols, procedures and guidelines.

Actions

The actions of accountability are the doing and the being accountable, in all the nurse chooses to do or not do within the profession. Actions carried out by the nurse are ideally based on the knowledge she has and the decisions made and carried out based on that knowledge. Participants identified that their actions are often based on the nursing process of assessment, intervention and re-assessment or evaluation. Participants agreed that the nursing process is embedded in their practice as part of their knowledge base. This was explained by Participant #5, “It is the basics of assessment, treatment, diagnosis, all of that, which I think is ingrained in nursing practice. Like, that’s how you’re taught in school, to assess the situation (of the patient), see what you would do for the patient, and implement a plan of action and do it”. It is this process that contributes to the level of accountability that rests with RNs in practice. Participant

#1 stated, “it started when I was in nursing school it (nursing process) was how we learned and I still think that way...nursing assessment, nursing intervention, outcome and evaluation”. Although RNs carry out tasks that may be ordered by other health care professionals, they have the responsibility and freedom of whether they do or do not undertake a task or action. Participant #3 indicated, “I feel more comfortable questioning orders and doctors (based on scope and assessment)...I have the knowledge and comfort in saying no I can’t or won’t do that”. This decision-making, about knowing when or when not to do something is a key point in RNs being personally accountable within their practice.

The individual nurse must exercise judgment in accepting responsibilities, seeking consultation, and assigning activities to others who implement nursing services. With stressful work environments, different levels of experience and education and ever changing processes and guidelines, mistakes while providing care do occur. Participants agreed that when these mistakes occur, it is how the RN handles the mistake that will demonstrate how the nurse takes on accountability in practice. “As a new nurse...if you don’t know the signs and symptoms (of a specific problem), you have to learn from your mistakes, so instead of shrugging it off (you own up to it)...later I went to the educator and I started doing sessions with the educator, I helped myself. Now I know better when to get help, so it was a bad experience but I learned from it and I didn’t blame it on others” (Participant #4). The participants identified that when they saw or learned of other nurses making mistakes it was often related to their lack of knowledge or experience. In cases where they were aware of these mistakes or knowledge deficits they felt they had a shared accountability and needed to intervene in some way, whether stepping in immediately with the individual nurse, addressing it later with them or following up with the management. The example given by Participant #6 was, “I don’t know if they don’t know (that

they made a mistake), but I would let them know if I noticed. I would make sure that they are aware, this is wrong (the action) and follow the necessary steps...like if it was a medication error or something...you let the doctor know, let the patient know, you document and then fill out a learning report (incident report)". Participant #3 spoke about how the new electronic way of reporting incidents allowed for more reporting on mistakes because "you don't feel like you will be punished". Both the CNA Code of Ethics (2008) and the CARNA Standards of Nursing Practice (2005) have language in the standards and listed ethical responsibilities that ensure there is a shared accountability within the profession. When choosing to become a RN in Alberta, one assumes the responsibilities to practice within the standards, competencies and the code of ethics and with that comes the professional commitment of shared accountability among all RNs in how they provide care or services to the public.

Outcomes

Although RNs are accountable for their nursing practice in most instances the concept of accountability usually is highlighted when that nursing practice is being questioned or reviewed, whether the outcomes are positive or negative. As the participants stated, the goal of the care they provide to patients is to have the best possible outcome of health. When positive health outcomes for the patient are not achieved, RNs look at their actions that contributed to that outcome or when others, such as when management or physicians, ask the RNs to justify their actions.

Words the participants used that fell under the category of outcomes were related to the answerability of the actions or decisions made during the process (see Table 4). Participant #7 shared, "when you are able to account, on what you do or what your decision making (was), the

care you provided to the patient, it's your responsibility and also in terms of the liability as well". All participants indicated that although having to provide a rationale or justifying their actions called them into account, at no time did the outcome of care change the fact they are always accountable. Participants felt that outcomes may be the prevalent trigger to being called into account, but it played the smallest role in accountability for the nurses and their practice.

Table 4 **Taxonomy: Outcome**
• Rationale • Justify • Liability • Culture of accountability • Owned • Compromise

Table 4

Additional Finding

During the course of this study, two additional finding were revealed. First was the common expression that the level of experience that RNs have directly affected how a RN would or should be held accountable. The participants agreed that no matter the level of experience, a RN is accountable for her practice but the participants shared that the expectation of accountability increases with the years of experience in nursing. A couple examples of discussion from the participants were "a newer nurse...needs to ask questions...coming to an experienced nurse, (to say) this is what I have thought about, what I'd like to do, what do you think?" (Participant #2) and "the new grad, they expect you do...the basic requirements...but senior you're required to do more, they expect it. You take a mentor role, the expectation is getting bigger and so is your accountability" (Participant #7). Although this finding does not

affect the accountability of the RN in practice, it was of interest to share the expectations that increase with the experience gained.

The second finding from the participants was the consensus of the concept of accountability was not shown on the forefront of the participants' minds when providing care but more embedded in their practice. Participant #4 stated, "for myself, its not a conscious thing...I don't always think about accountability...it's just part of my practice. I guess it's embedded in me". Another participant shared, "you follow your nursing policies and procedures...you review guidelines and care practices...but you're not thinking about it (accountability) when your providing the care, it's just part of what we do" (Participant #6). The theoretical concept of accountability is therefore directly tied to practice by being embedded in what the medical/surgical RNs do when providing care.

Definition

The definition of accountability for nursing developed through the collection and analysis of the language used by the acute care participants is as follows. *Accountability is a term based in ethics, which includes values (such as integrity, respect, and morals), and professional knowledge that provides the rationale of; and the taking ownership of, all the actions and decisions made during professional practice.*

Summary

The concept of accountability was not shown to be on the forefront of the participants' minds when providing care but more embedded in their practice. Accountability becomes a focus when the nursing care is being reviewed or the RN is required to justify actions based on her knowledge and the reason for that action. The development of the taxonomy (see Figure 1)

organizes the data to show that when moving through the categories of accountability the intention of the best possible outcome leads the nurse to have or find the knowledge/skill necessary to make a decision and carry out that action, which in turn leads to an outcome. When accountability is being called into question, looking at that same process in reverse shows the action, knowledge and intent of the outcome. By being able to articulate what accountability means to the acute care medical/surgical RN and being able to provide a definition for registered nurses to utilize, derived from their own language, will help in the understanding of accountability.

CHAPTER FOUR

DISCUSSIONS OF FINDINGS

The intent in this chapter is to present a discussion regarding accountability that have emerged from the findings of the previous chapter. A review of the research and literature established that there is no consensus on a definition and a lack of research of accountability from the RN perspective to practice. The majority of the literature focused on organizational or professional accountability or personal accountability of the nurse from an organizational, professional or legal perspective. None of the literature focused on how the nurse perceives or defines accountability within personal practice, as a member of an organization, or professional body. The following discussions include how the created taxonomy and definition of accountability reflect and relate to nursing practice, regulatory documents and within the context of related knowledge.

The focus of this study was to have the cultural group members, the medical/surgical RNs of acute care, define accountability for themselves. The goal was to understand the perspective of how they define and comprehend accountability as a cultural group based on the analysis of the language they chose to use, and from this create a definition for practice.

Many of the words used by the participants to define accountability (see Figure 1) are similar to the concepts and terms found within the existing literature. In this research the participants were clear on whom they identified as being accountable to. For all participants the first identified were patients and families, the remainder listed came in no particular order and included co-workers, employer, licensing body and union. This research was completed in order to ascertain that medical-surgical registered nurses, as a culture, can have a shared understanding

of accountability and to provide a framework and definition for accountability in practice, as accountability is directly tied to practice. From this small group of participants, generalizations can not be made to the larger group of RNs as a whole, but questions can be asked, if this was repeated within other groups of RNs, would similar results be obtained.

Discussion of the Taxonomy

As a theoretical concept accountability does not stand alone, as intent, process, and outcomes are tied to practice. The practice implications from this research and comparison to the content of the regulatory documents are discussed according to the categories of the taxonomy for further understanding.

Intent

As discussed in the previous chapter much of the language under the category of intent was focused on personal values. Values directly influence every decision or action that a person makes and behaviour displayed (Rassin, 2008). Edgar and Pattison (2011) surmised that through socialization a person forms personal values. This was further discussed by Rassin (2008) as, "values are a learned criteria that predispose us to act as we do. They emerge from the cultural environment, social groups, education (knowledge system), and past experience" (p. 615). This acknowledgement lends itself to a generalization that a cultural group, like the medical/surgical RNs from acute care, would in fact share similar personal values based on their choosing the nursing profession, and based upon the education involved to provide the care set out in the standards and codes of practice. Questions of values and value priorities are closely related with questions of responsibility and accountability in the discipline of nursing (Milton, 2008). The intentional actions and moral responsibility of accountability, when based on values, judgments

and decisions can be motivational depending on the harmful or beneficial results of how outcomes are dealt with (Hindriks, 2008).

As shared in Leduc and Kotzer (2009), the code of ethics "serves as an expression of the rules, goals, and non-negotiable ethical standards. Moreover, the code of ethics is an expression of nursing's understanding of its commitment to society" (p. 279). The CNA Code of Ethics (2008) is at times revised to reflect societal changes and values and should be reflective of what society expects of its RNs. As technology and evidenced based practice are more prevalent in healthcare, guidelines and procedures are increasing to guide the care of patients and there is less focus on nursing values such as integrity (Tyreman, 2011). Rassin (2008) echoed those sentiments and stated, "rapid advances in technological knowledge have led to drastic changes in the health professions. Today, more then ever, there is a conflict between personal, professional, institutional, and social values" (p. 614). It is imperative that nursing holds on to the values of the profession, and they be brought forward to organizational decision making and provide a framework which standards and expectations can be developed (Weis & Schank, 2009). As the words used to describe accountability in nursing practice by the participants included the personal values they shared as part of their intent of providing nursing care, it appears that those values still have a place in nurses' current practice.

As previously shared from Edgar and Pattison (2011), socialization leads to the building of ones' values in culture. One of the concepts that effect values that was voiced by a few participants was generational influence. Leduc and Kotzer (2009) conducted research on the professional nursing values of students, new graduates, and seasoned professionals; they determined that through educational expectations and employee practice standards those multigenerational employees have a congruence of their value systems. Although the makeup of

the nursing workforce is changing the biggest difference is not in what values are important to nurses, but how generations are approached in unit involvement, organizational decision-making, and communication (Stanley, 2010). With there being similarity in the professional nursing values across generations there is further support that the culture of nursing is strong and should continue to directly influence the development of values through the education of nurses and through the guidelines of practice set out by CARNA Nursing Practice Standards (2005) and the CNA Code of Ethics (2008).

A pressure on the personal values of the RNs when providing care is the working environment. Leduc and Kotzer (2011) concluded that the state of the healthcare system raises serious concern about organizations' commitment to values. The participants shared there are many stressors and tensions in Alberta's healthcare environment with nursing shortages, high acuity and occupancy, and limited resources throughout the continuum of care. The participants felt that the environment effects the actions that they carry out, providing care in less then ideal locations, such as over capacity hallway patients, discharging patients while unsure of supports at home, and having higher acuity with a larger patient to nurse ratio. Tyreman (2011) noted that these stressors are difficult for RNs as the respect and integrity they have is challenged while attempting to provide the highest quality care. Edgar and Pattison (2011) shared, "professional integrity, personal integrity, and professional and personal integrity combined, seem to be regarded by many as indispensable in the workplace" (p. 95). The CARNA Nursing Practice Standards (2005) has Ethical Practice listed as its third standard (indicator 3.5) and it states, "the registered nurse advocates for practice environments that have the organizational and human support systems, and the resource allocations necessary for safe, competent and ethical nursing care" (p. 3). Participants felt they provided safe, competent, and ethical nursing care and did

advocate for better work environments by having conversations with management regarding the stressors to providing quality nursing care. Many participants said their hands were tied in regards to decisions to actually change work environments. Participants did feel their manager listened to them and would work with them on case-by-case bases, and a few participants said they knew the organization was trying to work on these issues. It may be questioned if the RN experienced a moral dilemma or practice conflict in these situations. The findings did not show there to be. Participants agreed these pressures, although not ideal, are a reality of the current healthcare environment and did not distract them from providing care or impact their accountability in practice. Edgar and Pattison (20110 identified that integrity:

> can most usefully be seen as a competence or capacity for reflection and discernment in the midst of the conflicting demands between professional and personal values, roles, and ethical systems. It is required because there are stresses and conflicts between these things in the context of actual or potential action, and therefore it is a situationally related competence. (p. 95)

The CNA Code of Ethics (2008) Part II, discusses the ethical endeavours for RNs, associated with health that relate to broad aspects of social justice. These address the need in systems to address the full continuum of accessible healthcare services to ensure right time, right place, and to address all system factors that relate to health and well being (CNA, Code of Ethics, 2008). Participants agree this would be ideal but say they feel they have little control over the larger system decisions and felt larger groups such as CARNA and the union have more influence then they do as individuals.

The intent or purpose of the RN, as shared by the participants, is to provide the best possible outcomes for their patients through quality nursing care. With outside pressures that are present in today's healthcare environment it can be understood the dilemmas or tensions RNs feel when their personal values are being tested. Through their strong cultural values, guiding standards, and ethics of the profession, the intention will remain the same.

Process

The second category from participants, when defining accountability showed the context of process as being important. They expressed the effect of knowledge, such as the standards, codes, and education, influencing their intent based on expectations. It is this knowledge and experience that influence and lead to the decisions and actions the RNs choose to make and carry out when providing care. For further discussion under process it will be broken down in the subcategories like in the taxonomy (see Figure 1).

Knowledge

Education is a major influence on the culture of medical/surgical nursing. The starting point of gaining the skills and critical thinking needed in nursing is through the education that RNs receive. With the progression of the nursing profession there has been an change in entry level to practice for nursing education, moving from a diploma training program to university baccalaureate nursing degree, and currently, more nurses continuing on to graduate nursing degrees (Raines & Taglaireni, 2008). The participants involved in this research had a range of educational backgrounds from diploma trained to a master's degree (see Table 1). Pardue (1987) shared that because of the continuing complex, innovative changes in the healthcare environment, new pathways and changes in nursing education have emerged. The change from

the apprenticeship diploma model for direct patient care to the baccalaureate programs, with additional education such as nursing research, public and community health, and nursing management, prepare new nursing graduates to practice in a variety of settings and roles (Raines & Taglaireni, 2008).

A key element of nursing practice is the ability of the RN to process information and to make a decision. This entails critical thinking and knowledge to make these decisions. The discussion of the professional practice of nursing has been evolving for many years. Valiga (1983) stated:

> nurses who engage in professional practice must expand their cognitive or intellectual repertoire from one of following orders of others to one of making independent nursing decisions. They must think broadly and be able to make sound judgments and decisions in practice (p. 116).

This statement supports nurses making decisions on whether to follow through with interventions or not, based on their own assessments, and knowledge, thus taking accountability for their practice. Pardue (1987) studied the decision-making skills and critical thinking ability among nurses who were educated at associate degree, diploma, baccalaureate, and masters prepared nurses. The findings of her study showed the baccalaureate and masters prepared nurses had the highest mean scores for critical thinking ability but showed no significant differences among educational levels for making difficult decisions, or for factors that would influence a nurse's decisions (Pardue, 1987). The ability for decision-making revealed congruence between different educational backgrounds and was attributed to the diploma-trained nurse's experience and gained knowledge from practice (Pardue, 1987). This correlates to the findings of this

accountability research as all participants identified experience, education and continued education as contributing to their knowledge and ability to make decisions. Staying current on policies, procedures, and skills within scope of practice is a large contributing factor to medical/surgical RNs remaining accountable. Tingle (2010) shared that patient safety protocols and clinical guidelines are important tools that need to be routinely reviewed so that nurses know that contemporary, evidenced based clinical practice is guiding clinical judgment, which in turn supports the accountability of practice by providing the knowledge needed to provide the best care possible. As shared in the findings the participants believed that by following the guidelines of their workplace they were practicing accountability. All participants identified that following the most recent procedures and guidelines is a significant part of their practice.

The standards and codes of practice that the regulatory bodies hold RNs accountable to were identified under the knowledge subcategory. Both the CNA Code of Ethics (2008) and the CARNA Nursing Practice Standards (2005) contain language stating the RN is accountable for her practice. As all RNs practicing in Alberta are held accountable to the contents of the regulatory documents and to adhere to the competencies laid out by CARNA, it was not surprising these documents were included in the knowledge needed. Many of the words and their context used by the participants to describe accountability mirror that in the CARNA Nursing Practice Standards (2005). Although the documents are tools of accountability and are reviewed and revised to better reflect societal and nursing context, these documents do not ensure accountability (Liaschenko & Peter, 2004). All participants stated during the interviews that they had not read the documents recently but felt that from their base of education, on going competencies required in their practice settings and for registration to practice, that most minimum indicators of standards included in the documents were far exceeded in their practice.

This reflection on their practice happens formally each year in Alberta when RNs must re-register with CARNA in order to continue to work as a RN. This CARNA registration integrates three elements: practice reflection, continuing practice development, and competence assessment (CARNA website, n.d.). The participants identified this process of registration as the way they are accountable to the profession, as through the self-assessment and setting goals for the following year they have to establish they are competent for practice. Bryne, Delarose, King, Leske, Sapnas and Schroeter (2007) shared, "continued competency has been defined as the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public health and safety" (p. 24). Specifics from standards and codes are discussed further within each section they pertain to.

The knowledge subcategory encompasses the education that RNs receive which has an impact on the values and basic understanding of nursing, as they complete the education to be a RN. Once working as a RN in Alberta, regardless of the practice setting or role, RNs are held accountable to the same standards of practice, code of ethics, and competencies for licensure. Through the expectations of the practice setting and the need to register for licensure each year, RNs engage in continuing education, critical thinking, and gain experience, which enriches their knowledge in caring for patients.

Actions

The actions of accountability are primarily what RNs are answerable for in their daily work. As shared in the previous chapter the participants identified their actions and decisions were primarily made through the nursing process of assessment, intervention and evaluation. According to Warren (1983) the nursing process "defines and communicates to others the

specific problems a patient is experiencing which require nursing care" (p. 34). Pardue (1987) stated, "in the nursing process, which is a problem-solving process, the nurse collects data utilizing both inductive and deductive reasoning, makes hypothesis (or inferential nursing diagnosis), and plans, implements, and evaluates patient care" (p. 355). This statement also is reflected within the CARNA Nursing Practice Standards (2005). Under the second standard of Knowledge-Based Practice, the indicator 2.3 reads, "the registered nurse demonstrates critical thinking in collection and interpreting data, planning, implementing and evaluating all aspects of nursing care" (p. 3). "Accountability moves beyond responsibility because it implies there is an element of planning before the action and that evaluation also occurs after the action" (Cornock, 2011, p. 26). As professionals who are required to follow these processes, it makes them not only responsible for the care they provide but accountable for the care and how they determined what care was appropriate.

In both the standards and codes of ethics for practice, there are guidelines that state a nurse is accountable for all that she does or does not do. This would determine that at anytime a RN is within her work setting there is not a moment she is not accountable for her patients and her practice. The participants of this research expressed these similar sentiments, saying they could not give accountability away during this time but felt there was a shared accountability with other team members for the care of the patient. Tyreman (2011) stated, "it is rarely one individual who has sole responsibility for a patient; practice nurses, pharmacists, physiotherapists and so on, work with doctors in a team to provide effective care" (p. 108). This teamwork approach is included in the CARNA Nursing Practice Standards (2005) as the fourth standard of Provision of Service to the Public includes two indicators that speak to fostering teamwork and collaborating with other members of the healthcare team, and also includes this

collaboration with the patient and significant others. While participants were obvious about the need for teamwork in their practice settings, a few expressed that the stressors of the work environment did not always allow for proper communication among team members of other disciplines, so they relied on their communication to the charge nurse on duty to close that loop for them.

Even in the best organizations with the best of intentions, assessment, and planning, mistakes can occur. Mistakes can occur when actions proceed as planned but the plan does not achieve the intended outcome. Participants articulated mistakes can and do happen even when processes are followed. Errors are inevitable in healthcare as humans provide the care and humans are fallible (Reason, 2000). According to Mattox (2012) there are two types of mistakes: rule-based, when "a nurse recognizes the situation as familiar and easily managed through the application of rules" (p. 55) but does not have all the information needed to manage the situation; and knowledge-based, where problem solving is needed as "understanding (or mental model) of any given situation is inherently incomplete and flawed" (p. 55). When this occurs the RN must take appropriate steps to reduce the impact of the error to the patient at the time of the error. Following up by reporting the error through incident reporting systems allows a review of the situations surrounding the event to enhance the system from similar errors occurring in the future (Mattox, 2012). This system thinking takes the blame behaviour out of the environment and looks at errors as consequences of system problems rather then the cause. "Organizational decision makers and care providers need to understand that the risk introduced by system factors is much greater then any risk presented by a single individual" (Mayer & Cronin, 2008, p. 427).

The participants all included how the RN deals with mistakes she makes, demonstrates how the individual enacts accountability in practice. Participants also shared that when they had

been involved in an error, depending on what the error was, they would report it to the charge nurse, physician and/or management, but would not always report it in the incident reporting system utilized by the organization. Most shared that due diligence was already covered by following up with the healthcare team and ensuring the patient was taken care of. The incident report may not have been filled out due to fear of further repercussions. Mayer and Cronin (2008) shared that the shift to system thinking is an important one, as by focusing solely on the individual involved in the adverse event the opportunity for understanding why the event occurred is lost. Further, the opportunity to determine if there are ways to prevent it from happening again to a similar patient is lost.

In the CNA Code of Ethics (2008) under the value of Providing Safe, Compassionate, Competent and Ethical Care the fifth ethical responsibility listed reads, "Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harm" (p. 9). The participants believed there was shared accountability among team members and this also was true for them in regards to holding other nurses accountable to the mistakes made or nursing conduct that may cause a mistake or cause harm to the patient. This is supported in the CNA Code of Ethics (2008) under the value of Being Accountable, the fifth point that reads, "Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care" (p. 18). The other value of Preserving Dignity, listed as the fourth ethical responsibility, reads, "Nurses intervene, and report when necessary, when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behaviour" (CNA Code of Ethics, 2008, p. 13).

The subcategory of actions is the actual doing of the RNs' practice and often what RNs must give account for. Action includes the gathering of all data needed to make the best decisions for the care of the patient and implementing those decisions. Actioning is more then a task but rather being a key member of the team where that task was contemplated, planned and evaluated. By providing RNs with a definition of accountability, specifically the one created in this research, it can help guide the RN to be accountable. The definition of accountability illuminates for the RNs that it is the intent, process, and outcome together that define accountability. The definition is not about faultfinding or just about the outcome of care; rather it explains that RNs are accountable for all decisions and actions in their professional practice. When mistakes are made, taking ownership and learning from them or identifying concerns in others as a professional, are key for accountability in practice.

Outcomes

The category of outcomes captures those words used by the participants that related to the context of taking ownership, providing rationale, justifying, and having liability. All participants identified that the outcome of their decisions or actions, whether positive or negative for the patient, did not change their accountability in any way. Neither the CARNA Nursing Practice Standards (2005) or the CNA Code of Ethics (2008) have any language that speaks specifically to patient outcomes but rather the language is general to nurses being accountable for all that is done or not done for the patient to maintain health and well-being.

Reasons why a RN may need to give account could be as part of a monitoring system, or a need to share learnings for the benefit and education of others, or when harm has come to a patient and review of care is completed (Cornock, 2011). Participants shared that they are usually

questioned or asked to provide rationale for their decisions and actions more often when a mistake has occurred or when a patient has had a negative outcome. When care is called into question is traditionally when the caregiver was the only component examined, to find individual blame (Reason, 2000). Participants with more years of experience did say that in the past it seemed errors were kept quieter, from fear of discipline or liability. They went on to share that over the last few years or so, errors were looked at within context and not just the individual, which allowed for broader learning from everyone as discussed by Participant #3.

As shared by Reason (2000), there are two approaches to errors. One approach is to blame the individual person only, which can be satisfying for employers because the belief is if you remove the individual you have fixed the problem. The second is to look at the system conditions under which that person works and to share learnings from the error and build defenses to avoid more errors or to lessen their effect. The system approach shifts the errors to being thought of as the consequences instead of the causes. As implied by the participants it would appear their working environments are shifting from one of blame to more of the system approach, this strengthens the knowledge, experience and accountability of the team, which can lead to more positive outcomes for patients.

Discussion of Definition

One of the goals of this research was to create a definition of accountability derived from the language used by the cultural group of medical/surgical acute care RNs. The existing healthcare literature has no consensus of a definition of the term accountability and although the concepts of accountability are discussed often in the literature, many do not include an explicit definition of accountability, either for general terms or specifically for practicing nurses. This

definition of accountability is derived from the language of the RNs interviewed, the definition is for all acute care RNs to better understand what accountability means in their practice and to have a meaning that directly reflects what they do and to clarify their accountability to the regulatory documents.

In creating this definition a few aspects were highlighted by the participants to be clarified and included within the definition. First, the participants suggested that the definition stay away from using terms that traditionally are thought of as synonyms, such as responsibility and answerability. The participants understood how they differ and wanted to avoid confusion of the terms being included in the definition. The second was the importance to highlight that accountability is not just about outcomes in healthcare, but rather the whole process, therefore the definition does not include statements such as provide rationale or ownership for the outcomes.

Summary

The taxonomy and definition created are the expressed content of how the medical/surgical RN participants define accountability. The taxonomy and definition shows that many words and concepts expressed by the participants are similar in nature and can be supported when compared to the regulatory documents and the literature. When these concepts are put together a working framework and definition for accountability for practice is developed, which will help clarify and promote understanding for accountability in nursing practice. By building consensus for this created definition there can be clear expectations between RNs and their employers, and professional licensing body, which in turn will affect nursing practice.

CHAPTER FIVE

CONCLUSION

In this chapter I will discuss the limitations, strengths, and the research implications of this ethnoscience study. The purpose of this discussion is to highlight the ethnoscience approach to inquiry, and the strategies and interventions used in this study, which were beneficial to capturing the experiences of the nurses related to accountability. The implications for nursing practice and ideas identified by the nurse participants, as well as recommendations for future nursing research in accountability and for nursing practice will be discussed.

By engaging with participants using the ethnoscience method, there was an opportunity for them to share and reflect on their experiences and validate their thoughts, views, and perspectives on behalf of their cultural group. As the researcher, I learned about the participants, their experiences and felt the value of the research, from the passion expressed by participants as they were defining accountability in their practice. Ethnoscience methodology involves an obligation on the part of the researcher to build understanding of the cultural members and have due diligence in ensuring the analysis of the language is reflective of their cultural understanding. The participants were all given the taxonomy and definition in order to provide feedback on its relevance to their practice and accurate portrayal of their cultural group. The feedback received was of general consensus and many felt the categories were consistent with their understanding of accountability and felt each descriptor was appropriate as a reflection of their understanding of accountability.

Rigor of the research was established through the clear outlining of the study, explaining and having examples of actual statements from the interviews, which showed the decision trail of

analysis to the development of the taxonomy and definition. This was further supported through validation of participants in follow up discussions and comparative evaluation of the literature and regulatory documents.

Strengths and Limitations of the Study

A number of strengths from completing this research were identified. There was common consensus on a definition of accountability; the participants expressed the value of having a definition they could use, to provide greater understanding for themselves and other team members. They also identified having one definition could influence education, practice and competencies. The validation that RNs interviewed have a passion for what they do and the commitment to their patients' well-being is unwavering no matter what the working environment or stressors. The creation of the definition for RNs also provided them with the voice to link the term accountability to their practice in a meaningful way to them. Participants also expressed they were happy to participate in research about nurses for nurses. Through greater understanding of ourselves (RNs), we can better articulate our roles and responsibilities in an ever changing healthcare system.

There was not anything shared by the participants that was contradictory from the regulatory documents but were similar and consistent in their concepts of accountability. In Alberta, the language of the regulatory documents are intended to guide practice of RNs in a variety of settings and roles, therefore they are not prescriptive documents. This allows for different interpretations of indicators and listed ethical responsibilities, but the general context is to provide quality nursing care, to be responsible and accountable in all that RNs do.

There are limitations to a study of this type. The taxonomic analyses are meaningful only if the words and categories are those used and identified by the cultural members themselves. Hirst (2002) discussed "the taxonomic structure never completely reflects the knowledge patterns of the culture under study; such analysis only approximates how participants actually organize and gain meaning from their cultural knowledge" (p. 280). The small sample size of the participant group is a limitation to the study, however recruitment of participants continued until data saturation was achieved. By increasing to a larger number of participants across different locations, the findings would provide more breadth to the qualitative research. Another study limitation could be that the RNs who volunteered to be participants in a study about accountability may already have a clearer understanding of accountability or a higher feeling of responsibility in the profession. Another identified limitation is that it is possible the nurses gave answers that they thought were the acceptable answers to give based on the implications to their practice. In other words, they may have shared their own experiences in a positive manner as opposed to providing experiences where they may not have acted accountable.

Contributions to Nursing Practice

Accountability is a part of nursing practice and the healthcare system as a whole. With the provincial reorganization of Alberta's healthcare system, the addition of the term accountability was added to the values of the organization, to highlight the accountabilities for the provincial health services. With the opportunity for greater understanding of accountability from the RNs perspective, and a common definition of accountability it may be possible to impact practice by supporting a consistent foundation for quality nursing care.

This study contributes to nursing practice by providing a definition and a breakdown of the concepts related to accountability as given by RNs. Although the number of participants was small there was saturation of data and with the developed taxonomy and definition, these can be taken forward to other nurses in practice and provide them with understanding or clarity for their practice. The contribution of RNs to health services through their practice is ongoing but this research provides a clearer understanding of expectations of accountability for all RNs in practice and can lend to a clarification of roles and responsibilities within the greater healthcare team.

One may question, so what? Why is it important there is a consensus of a definition of accountability from a RNs perspective? As participants shared during the study, they learned about accountability, nursing values, and ethics through their nursing education. It is also when many of them claimed they had last read the Code of Ethics and Nursing Practice Standards in entirety. Having common language and congruence between education, regulatory documents, competencies, and nursing practice will strengthen the profession as a whole.

This research provides a common definition of accountability and with this, there is an opportunity to dialogue between administration, management and RNs providing care, to discuss expectations of practice and the health services provided to the public. By having these conversations about accountability there is an opportunity to create a positive culture of accountability with shared learnings from errors, different disciplines and roles among nurses. The definition of accountability from this research clearly included intent, process, and outcome of the RNs' accountability. The definition is not about blaming or finding fault with nurses but rather openly taking ownership of all that RNs do within their professional practice. As RNs

have the greatest interaction with patients receiving health services, to have an understanding regarding their accountability in practice may reveal the quality of care provided.

Recommendations

As discussed, the word accountability is used often within healthcare and nursing practice. The literature does little to provide further insight on what accountability means to the RN in practice and the mere fact that there is so little research on how nurses define accountability, underlines the need for further research. The insights gained through this study highlights the need for future efforts in accountability within nursing practice, in order to come to a better understanding of the nursing culture as a whole. The findings of this study, however, are specific to this group. It is noted there is a clear need to study accountability in nursing, in particular to determine if all RNs would define accountability similarly.

A few recommendations came from completing this research, which are listed below.

Recommendation 1: Duplicate this research with a larger number of participants to broaden the recruitment of medical/surgical RNs to other locations within Alberta, Canada or further locations. This would provide more breadth to the findings of medical/surgical nurses and their understanding of accountability, and as the largest group of RNs working there is an opportunity for greater impact to practice.

Recommendation 2: Utilize a combination of qualitative and quantitative methods to further explore accountability. A qualitative method would capture the experiences of the RNs and their understanding of their environment and the quantitative method would gather empirical data utilizing tools, scales and measurements for questions, such as, if RNs agree or disagree with

specific statements. By combining the methods a deeper picture and understanding of nurses' views of accountability could be achieved.

Recommendation 3: CARNA should include the definition of accountability in a glossary of the nursing practice standards, and the CNA should incorporate the definition in the glossary of the Code of Ethics. This would provide clarity and understanding to all licenced RNs, employers, and the public what definition of accountability RNs are being held to.

Summary

Accountability will continue to be a term used often in nursing practice and the healthcare literature. As there is still very little research on how accountability is defined, this researcher's findings support a possibility to find consensus on a definition of accountability when using the words and context of the cultural members themselves. From the discussions of the findings were recommendations for future research and the profession of nursing as a larger cultural group. As RNs practice in a variety of settings and roles within healthcare their impact on the health system is remarkable and with continued research a greater understanding of RN work can be achieved.

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Appendix A

Sample Email to Managers for Permission to Present for Participants

(Letter of Invitation)

Dear (Manager),

I am a MN student at the University of Calgary who is completing my final thesis. My focus of study is the medical surgical nurse as a culture and how they define accountability in nursing practice.

Background

Accountability in nursing practice is not a new concept. The term is used extensively in the nursing literature and within regulatory documents but there are no specifics on the critical components of the concept of accountability and no consensus on a definition. With many RNs coming from different backgrounds and experiences, and with no clear agreed upon definition of accountability, there is a gap in understanding what accountability means to those practicing.

Purpose of Study

I am looking for volunteer participants for my research which include interviews with medical surgical nurses. The purpose of this study is to develop a definition of accountability to help promote the integrity of the nursing profession and the ability of individual nurses to work within the guidelines of the Code of Ethics.

I am requesting the opportunity to attend your next staff meeting or arrange an opportunity to drop off recruitment brochures, in order to solicit volunteers for this research.

If you could please respond to this email so I may make arrangements to attend or forward you more information if you require.

Thank you for your time.

Kimberley Sommerville RN BScN

Obtaining a Definition of Accountability in Medical-Surgical Nursing Practice

Dr. S Hirst

Version 1.0: September 21, 2011 Ethics ID# 24231

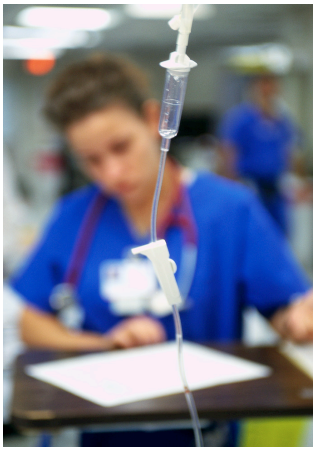
Appendix B

Information Brochure for RNs

UNIVERSITY OF CALGARY

Accountability in Med/Surg Nursing

Are you interested in contributing to nursing research by sharing your knowledge and understanding of how you define accountability in nursing?



Background

Accountability in nursing practice is not a new concept. The term is used extensively in the nursing literature and within regulatory documents but there are no specifics on the critical components of the concept of accountability and no consensus on a definition. With many RNs coming from different backgrounds and experiences, and with no clear agreed upon definition of accountability, there is a gap in understanding what accountability means to those practicing.

Purpose of Study

I am looking for volunteer participants for my research which include interviews with medical surgical nurses. The purpose of this study is to develop a definition of accountability to help promote the integrity of the nursing profession and the ability of individual nurses to work within the guidelines of the Code of Ethics.

Inclusion Criteria

- Registered Nurse,
- who has been nursing a minimum 2 years FTE hours (4044hrs)
- and is currently working at least a FTE of 0.50.

There will be demographic information collected (e.g. age, sex, level of education, total years in nursing practice). Exclusion criteria: anyone that worked as a staff nurse under the researcher's authority as a patient care manger or who does not meet the inclusion criteria.

For more information or to participate in the study contact:

Kimberley Sommerville RN BScN

MN Candidate, University of Calgary, Faculty of Nursing

Phone: (403) 969-5644

kjsommer@ucalgary.ca

Advisor: Dr Sandra Hirst

Phone: (403) 220-6270 shirst@ucalgary.ca

This study has been approved by the Conjoint Health Research Ethics Board

Title: Obtaining a Definition of Accountability in Medical-Surgical Nursing Practice

Version 1.0: September 21, 2011 Ethics ID 24231

UNIVERSITY OF CALGARY

FACULY OF NURSING

CONSENT FORM

Accountability in Nursing

TITLE: **Obtaining a Definition of Accountability in Medical – Surgical Nursing Practice**

SPONSOR: **N/A**

INVESTIGATORS: PI: Dr Sandra Hirst,
Co-investigator: Kimberley Sommerville (Student)

Contact info: Kimberley Sommerville 403-969-5644

kjsommer@ucalgary.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

Please note that this research is being conducted by the co-investigator, as part of the requirements of a Masters in Nursing (MN) degree.

BACKGROUND

Accountability in nursing practice is not a new concept. The term is used extensively in the nursing literature and within regulatory documents but there are no specifics on the critical components of the concept of accountability and no consensus on a definition.
Culture is a group-shared knowledge and the reality for a cultural group is developed and constructed over a lifetime of receiving, processing, and interpreting information and passing this on through interactions with each other and sharing through language.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to develop a definition of accountability to help promote the integrity of the nursing profession and the ability of individual nurses to work within the guidelines of the Code of Ethics.

WHAT WOULD I HAVE TO DO?

As a participant, your involvement will be to be available for an initial interview of approximately 30-60 minutes. Once initial interviews have been analyzed, a follow up interview will be arranged to confirm the analysis and keywords identified. This second interview should take no more then 30minutes. Although unusual, in some cases a third interview, often by telephone, made be requested to ensure the researcher is clear about your views. All interviews will be audiotaped.

WHAT ARE THE RISKS?

As a participant a potential risk of the study to you, could be the possibility of sharing examples in the course of the interview that may require the researcher to report to CARNA or other government agencies based on legislative requirements for unprofessional conduct. If such a situation emerges, this will be discussed with you. Another risk that may arise is you become distraught while sharing experiences where practice observed of others or yourself were less then accountable but not reportable. If you require someone to talk to or need further assistance dealing with situations, please contact your employee assistance program.

WILL I BENEFIT IF I TAKE PART?

The benefit of participating in this study is the contribution you will have to the profession and affecting practice by defining accountability to your professional group.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary and you may withdraw from the study at anytime. Please understand that due to the methodology used that analysis of the data gathered begins during the first interview, therefore data gathered prior to leaving the study will still be utilized, as it will have already influenced the study.

To withdraw from the study the participant needs to speak with the researcher and follow up in writing, expressing their desire to withdraw from the study.

If new information becomes available that might affect the participants willingness to participate in the study, they will be informed as soon as possible.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

N/A

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

Participants will not be paid to participate in the study. As interviews can take place at any agreed upon area or time there should be no costs to reimburse the participants for.

WILL MY RECORDS BE KEPT PRIVATE?

Data collected on field notes will be collected by the co-investigator and may be shared with the Principle Investigator and MN committee members. Audio tapes will be utilized during the interviews and will be transcribed by a third party who will be required to sign a confidentiality agreement. Recordings will be stored on a USB drive and along with the field notes and transcriptions, will be kept in a file locked in a file cabinet. During the analysis and reporting of the data, names of the participants will be changed in order to provide confidentiality.

The University of Calgary Conjoint Health Research Ethics Board will also have access to the records as requested

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

N/A

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Sandra Hirst (403) 220-6270

Or

Kimberley Sommerville (403) 969-5644

If you have any questions concerning your rights as a possible participant in this research, please contact The Director,Office of Medical Bioethics, University of Calgary, at 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

UNIVERSITY OF CALGARY

MO·SHOILE·TOGAM·SUAS

FACULY OF NURSING

CONFIDENTIALITY AGREEMENT

This agreement is between you and Kimberley Sommerville, MN student researcher, for the purposes of transcription services for research conducted with the University of Calgary.

By signing this agreement you agree to the following terms and conditions:

1. all health information, personal information (as defined in the FOIP, HIA or any other privacy legislation in effect), that I collect, use, retain, and disclose is private and confidential,

2. I will ensure the information collected for services will only be shared with the researchers,

3. At the completion of services I will obtain no records of the research (electronic, taped, documents).

By signing below I accept the terms and conditions of this agreement and intend to be bound by them.

_____ _____

Name Witness Signature

_____

Signature

_____

Date

Appendix F

Question Guide

Grand Tour Question

How do you define accountability in nursing?

Guiding Questions

Do you define responsibility & accountability differently?

What words do you think RNs(other nurses) would use that would define accountable/accountability?

What words or actions do you use/see when you are working to demonstrate accountability? Can you tell if the nurses around you are being accountable or not?

Can you provide an example?

Spectrum of accountability

Outcome vs process of accountability

What do you do to ensure your practicing accountability?

Define accountability as a nurse as if I knew nothing or not in health care. How would they be able to recognize if a nurse was being accountability?

Have you read the documents (AB Nursing Practice standards & Code of Ethics)? How do you follow them in your daily practice?

Is accountability transferrable?

Is there anything else you would like to add?