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Resigning: How nurses work within constraints

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Abstract

This study explores and explains how nurses care for patients with stroke in the acute care setting and how they process these challenges to enable delivery of care. Using a classic grounded theory methodology, 32 nurses were interviewed who cared for patients with stroke and twenty hours of observations were undertaken. Nurses' main concern is how to work within constraints. In dealing with this challenge, nurses engage in a process conceptualised as resigning and do so through idealistic striving, resourcing and care accommodation. Resigning acts as an energy maintenance and coping strategy, enabling nurses to continue working within constraints. This theory has the potential to enhance nursing care while reducing burnout and making better use of resources, while advocating for stroke care improvements.

Keywords: Care provision, constraints, classic grounded theory, nursing, resigning, stroke

Introduction

Quality and safety of patient care is a continued area of concern in healthcare services where constraints on health expenditure prevail (Aiken et al., 2014; Kirwan et al., 2019). Work environments influence patient outcomes where limited nursing staff and resources have a resultant negative impact on patient care outcomes (Aiken et al., 2014; Griffiths et al., 2021; Jangland et al. 2018; Rochefort & Clarke, 2010; Schubert et al., 2009). Stroke care in designated specialised stroke units is associated with improved patient outcomes (Langhorne et al., 2020) however, despite international consensus on optimum stroke care, wide variations in the delivery of stroke care across Europe persist (Stroke Alliance for Europe, 2020). Such variations in the location of stroke care adversely influence care delivery and patient mortality and morbidity (West et al., 2013; Stroke Alliance for Europe, 2020).

Background

Constraints in the work environment such as reduced staff, lack of time and a lack of resources are reasons for concern regarding their negative impact on patient care delivery (Chan et al. 2013; Winsett et al., 2016; Blackman et al., 2018; Griffiths et al., 2021). Nurses caring for patients with stroke are aware of what optimum stroke care entails however, they often provide a reduced level of care due to the presence of constraints (Clarke & Holt, 2014; Seneviratne et al., 2009). One constraint commonly reported as a barrier to optimal nursing is a lack of time (Blackman et al.,

2018; Chan et al., 2013; Clarke & Holt, 2014) and this includes the area of stroke care (Seneviratne et al., 2009). Reduced nurse staffing levels is another constraint associated with increased levels of mortality (Cho et al., 2015; Department of Health, 2018; Fagerström et al., 2018; Griffiths et al., 2016). Morality also increases with incidence of pressure ulcers and nosocomial infections reported when inadequate nurse staffing levels are present (Cho et al., 2015; He et al., 2016). In addition, increases in nurses' workloads demonstrate statistically significant increase in mortality (Aiken et al., 2014; Fagerström et al., 2018). Limited availability of space, time and interprofessional support in stroke care has a similar effect (Seneviratne et al., 2009). Stroke unit care addresses all elements of the staffing and infrastructure required to create safe specialized care delivery for patients with stroke.

Despite the benefits of stroke unit care, many patients continue to be cared for in the general acute setting. A national audit of stroke services in Ireland found 29% of patients were cared for on wards other than stroke units (National Office of Clinical Audit, 2020), similar to other European countries (Kings College London, 2017). Stroke care provided on non-specialist wards demonstrates poorer patient outcomes such as higher mortality rates and reduced functional ability compared to specialised stroke units (Langhorne et al., 2020; Stroke Unit Trialists, 2013). Few studies have directly explored or examined how nurses care for patients with stroke in the general acute setting (Gibbon, 1991; Gibbon & Little, 1995; Hamrin, 1982; Hamrin & Lindmark, 1990). To our knowledge, no studies have explored this in recent times even though figures continue to demonstrate substantial variations in location of care delivery for patients with stroke across Europe.

Methodology

A classic grounded theory methodology was selected as this area is relatively underexplored with little or no theory to guide practice. As Glaser (2003) suggested, classic grounded theory combines the need for and the promise of relevancy about what is happening within a specific area of research.

Ethical considerations

Ethical approval was granted from two hospital research ethics committees. Anonymity was ensured by using pseudonyms and only the researcher had access to the data consistent with the Nursing and Midwifery Board of Ireland ethical guidelines (2014).

Before engaging in non-participant observations, staff were informed that patient safety was a priority. Consistent with ethical approval, verbal agreement was sought from nurses and patients before each observation period. Nobody who was approached refused permission. During observation periods, the researcher remained as unobtrusive to staff and patients as possible, where the focus was on viewing nurses delivering care in trying to ensure that nurses and patients were respected and protected during the process. Nurses and ward managers were aware of the researcher's presence and consented to the observation periods. It was agreed with the nurse manager and the participants that if unsafe care was observed, then the researcher would intervene and the episode reported.

Data collection

Glaser (2004) highlighted that any form of data can be used to generate theory, however theoretical sensitivity is required to ensure the concepts are generated from the data. For this study, data were collected using interviews and non-participant observations, which took place at ward level.

Once ethical approval was granted, formal letters of invitation and accompanying information sheets were delivered in person to all relevant medical and surgical wards where clinical nurse managers distributed them to all nursing staff during handover. Nurses who were interested in participating in the study were asked to contact the researcher via the contact details on the information sheet. Unstructured interviews were used to gather data for analysis in keeping with the principle of having no pre-determined questions in classic grounded theory (Glaser, 1978). Following discussion about participation and clarification of any points of concern about the study, dates, times and a location of choice were arranged individually to meet with participants. Again, any further queries participants had were answered in relation to the study prior to the consent form being signed. Encouraging participants to speak freely and listening to what they were saying directed the follow up questions. Time was spent putting the participants at ease so they would feel comfortable to speak truthfully and honestly. Murphy et al. (1998) referred to the importance of a conversational style interview to encourage openness. This was achieved through general introductions, general social conversation and thanking participants for their time. Then the aim of the study was discussed answering any questions the participant may have had on reading the information sheet. Interviews commenced with an open question such as such as "Can you think back to when you last had a patient with stroke on your ward, and can you tell me what that was like?" This is what Glaser (1998) referred to as a grand tour question.

Initially, interviews were digitally recorded and transcribed, varying in length from 30 to 60 minutes. Each interview was analysed prior to the next one, enabling the researcher to generate follow up questions and issues to be explored in what is termed theoretical sampling (Glaser, 1978). This process was further enhanced by making field notes following each interview, including nurses with varying levels of experience and sampling in a number of wards (7 wards).

Sampling continued until data saturation, where no new properties emerged for the core category or sub core categories (Glaser & Strauss 1967; Glaser 1978). A total of 32 nurses; 30 females and 2 males participated ranging in experience from 1 year–40 years, with varying professional positions (staff nurses, ward managers, clinical nurse specialists) and qualifications (BSc Nursing, postgraduate diplomas and masters) working on either general medical or surgical wards caring for patients with stroke (O'Donnell & Andrews, 2020).

As data emerged from interviews, theory generation was further supported by non-participant observations providing a different dimension. Simultaneous to interviews a total of 20 hours of non-participant observations were undertaken in one medical and one surgical ward. Observations are another way of gathering data for analysis when undertaking qualitative studies through observing people, behaviours and/or events (Salmon, 2014; Watson et al., 2010). Observations are a common method of data collection in grounded theory (Pergert, 2009). Non-participant observations were undertaken as they allowed the researcher to observe in real time nurses caring for patients in the general acute care setting and not influence care delivery through involvement (Watson et al., 2010). Much of the literature reviewed on stroke care re-

ferred to how nurses spoke of the care they delivered. Undertaking non-participant observations enabled the researcher to see if this was substantiated in practice and to observe at first-hand how participants deliver care rather than relying on their self-reports. Time sampling was chosen as an appropriate method of observation as the timing of non-participant observations was to cover a full day's nursing shift providing an overview of the care interactions and behaviours delivered during different times as well as providing context. A total of 20 hours of non-participant observations were undertaken. During non-participant observations the researcher took field notes noting date, time, place of observation, details regarding number of nurses on duty and patients on the ward.

Data analysis

In classic grounded theory data analysis is simultaneous with data collection. It is this constant analysis that supports theoretical sampling in saturating codes and categories to achieve theoretical coverage. Constant comparison occurs within the interview and between interviews, comparing incident to incident establishing uniformity and varying conditions. Following an interview data was coded before the next interview, thereby facilitating theoretical sampling.

The first phase of data analysis is substantive coding which involves open coding. This is where Glaser (1978) spoke of analysing line by line for incidents and concepts. Following each interview data was coded line by line, meaning that each transcript was carefully read and coded. One continuous pattern of behaviour throughout all interviews, referred to by all participants, was nurses speaking of how they washed patients, descriptively coded as washing patients; helped patients to eat, coded as helping patients to eat and/or helped patients to the toilet, coded as helping patients with toileting. Cognisant that codes are independent of people, time and place, which makes them enduring these codes were grouped together as they all referred to the same pattern of behaviour of physically caring for the patient. Collectively these codes then were conceptualised as functional caring. This concept was subsumed under the sub core category of Care Accommodation. Using constant comparison, subsequent interviews were coded similarly, meaning that interviews were coded with previous codes in mind. Once the core category emerged of "working within constraints," theoretical sampling and selective coding began in order to saturate the core category, which was reached following 32 interviews.

Memos were written throughout data collection and analysis. Codes were refined and became more conceptual in what Glaser (1992) termed conceptual refit. Once relevant theoretical codes were identified, the theory met the four classic grounded theory judging criteria of fit, work, relevance and modifiability representing methodological rigour. The theory of resigning explains nurses behaviors when caring within constraints meeting the criteria of work. Vigorous analysis of data from interviews ensured fit, affirmed also during non-participant observations when nurses patterns of behaviors were observed consistent with concepts already generated from data collected during interviews. Relevance is evident as the concepts resonate with nurses in their daily challenges in trying to deliver best patient care and finally modifiability is achieved through the principle of conceptualisation undertaken in classic grounded theory.

What was observed during non-participatory observation periods was as nurses had discussed during interviews; no disparities were evident only further evidence of the busy care environment which nurses deliver care in on a daily basis and their challenge of working within

constraints. Field notes taken during observation periods were analysed and coded similarly to interviews. Coding of observation data were undertaken with constant comparison in mind of the concepts and categories emerging from interviews thus strongly corroborating theory development grounding the emergent theory in the participants' worlds.

The theory of resigning

The theory of resigning explains how nurses work within constraints to deliver best care to patients with stroke in the acute care setting. Once nurses acknowledge the presence of constraints such as reduced staff, lack of resources, and time they engage in resigning. Resigning is a reluctant acceptance to compromise the quality of the care they deliver, in the interests of patient safety and to maintain a basic level of care. Resigning acts as energy maintenance and coping strategy and enacted through idealistic striving, resourcing, and care accommodation.

Idealistic striving

Idealistic striving involves nurses endeavouring to provide the best care possible to their patients. It comprises of professional connecting, knowledge seeking and cluing in. A precondition of idealistic striving is having the commitment to provide the best care possible. To support them in idealistic striving, nurses engage in professional connecting, whereby they initiate and sustain communication with nursing colleagues and other healthcare professionals identified as being able to support optimal care for patients. This is achieved by fostering personal relations and maintaining good working relations with fellow health care professionals by spending time working with others. Time and staff shortages limit the opportunities available to meet and interact with others.

Professional connecting also helps nurses identify the support they need in idealistic striving such as knowledge seeking, where nurses continuously look for opportunities through formal and informal routes to further their knowledge. This may be through structured, evidence based educational programmes and by learning from others such as fellow nurses, physicians, and other health care professionals. Knowledge seeking through informal routes is self-directed and opportunistic and is contingent on being motivated to learn, of which one nurse spoke: "It is really up to yourself, to show that you are interested in this area, showing that you want to learn and seeing available opportunities to learn from" (Participant 8).

Knowledge seeking also promotes focused care through being aware of the specifics and complexities of stroke care such as impaired swallowing, lack of mobility and speech impairment. Through knowledge seeking, nurses learn what to observe in stroke care, essential for cluing in where they are constantly alert and responsive to changes in the patient's condition. Nurses pre-empt physiological and/or psychological changes in the patient's condition and respond appropriately. Cluing in facilitates idealistic striving with its focus on pre-empting changes through monitoring a patient's condition to detect changes from normal or sourcing equipment to support care. One nurse stated:

> Once we get a patient with a stroke on the ward we start ringing around to the other medical wards looking for equipment usually mattresses for the patient as we wouldn't have them or they may all be in use at that time. (Participant 9)

Idealistic striving enables nurses to coordinate, direct and prioritise care, in an attempt to reduce potential complications.

Resourcing

When resourcing, nurses actively resist the effects of constraints, seeking to overcome constraints through time borrowing and badgering in trying to maintain idealistic striving. When working within constraints, resourcing is always required to ensure a safe level of care. The greater the degree of resourcing the higher the expenditure of energy for nurses. Continuous resourcing may result in burnout; therefore, engaging in resourcing is only an interim position for nurses trying to continue delivering best care.

Resourcing aims to improve care delivery while also protecting nurses from professional recrimination by senior staff and patients' family. It acts as a preserving and coping mechanism enabling nurses to work successfully within constraints. The greater the degree of constraints the greater the resourcing. Continuous resourcing with no change in circumstances may lead to exhaustion and burn out. When nurses become too tired to resource continuously, patient care may be compromised however, they must still engage in a level of resourcing to support patient safety.

Time borrowing facilitates resourcing to ensure a certain level of care is delivered. It involves taking time from one area of work to gain more time in another, aiming to optimise and prioritise care. It is a short-term coping mechanism and demonstrates nurses' determination to optimise care. Time borrowing happens when nurses' reduce their breaks or skip them, commencing work earlier or finishing later or taking time from one activity of care to give time to another which, may compromise the activities of daily living, as one nurse mentioned: "Sometimes it's just faster to wheel the patient to the bathroom then assisting them to walk out to the toilet as we just wouldn't have the time you know. It's my way of making up on time" (Participant 2).

Nurses' commitment to giving the best care influences time borrowing. The greater the degree of commitment to idealistic striving the greater the degree of time borrowing and when successful, care delivery is improved.

Resourcing is further increased by badgering, which explains continuous verbal and written reporting nurses engage in with senior management when highlighting their concerns at having to compromise care delivery. Through badgering, nurses try to prevent the impact of compromised care. Knowledge seeking strengthens the need for badgering since nurses know the care patients require and understand that compromising care is potentially risky. Badgering is used to protect nurses from recrimination from patient's family and other healthcare professionals by providing documentation supporting their concerns to management in trying to improve patient care delivery. The aim is to have their concerns acknowledged and appropriately acted on so that they can engage in idealistic striving. If successful, badgering reduces constraints, enabling optimal care, which is more likely to succeed when nurses identify to management, that patients are at risk and have documented evidence to support this such as clinical risk forms. However, if unsuccessful and nurses engage in continuous badgering, this may lead to possible burnout.

Badgering through written reporting is time consuming, compromising time with patients, therefore badgering is often opportunistic, in the form of verbalising concerns to ward managers and unit managers. However, if nurses want a visible record of badgering then they make a written submission, since they perceive this as providing some legal protection from accusations in the event of an untoward event. Through badgering, nurses are trying to preserve their integrity and show their commitment to delivering optimal care, while mitigating against adverse events.

A level of resourcing is essential when working within constraints in providing optimal care. In the theory of resigning, resourcing coexists with idealistic striving, which supports care accommodation.

Care accommodation

Care accommodation provides a typology of caring as a means of dealing with constraints until they are resolved or reduced, comprising of functional caring, assisted self-caring and ideal caring. The aim is to provide the best level of care feasible at a given moment. The degree of engagement in idealistic striving and the success of resourcing determines the type of care accommodation provided. For example, a reduced level of care may result when the degree of constraint is high and there is a reduced level of commitment to idealistic striving. One nurse voiced: "I am happy to be able to just give basic nursing care as the norm to all patients given the circumstances I find myself in when we are down in staff" (Participant 23).

Functional caring is attending to basic but essential components of care such as hygiene, dressing, assisting a person to eat and toileting as well as monitoring patients' physical condition (vital signs). Functional caring involves nurses actively carrying out care tasks for patients. Functional caring ensures patients' comfort, wellbeing and safety. It occurs as a result of prioritising care and can be delivered individually or with colleagues.

Functional caring is more likely when there is less capacity to provide care as it ensures the immediate care needs of patients are met. The greater the capacity the greater the opportunity to provide more than functional care. Functional caring demonstrates what nursing is for some people. Nurses are aware that more types of caring exist and view functional caring as only one type of nursing care.

Functional caring is acknowledged by nurses to be a basic level of patient care because it ensures that minimum needs are met. As constraints increase, functional caring may become the best level of care nurses can provide, until such time as they can provide more care.

Assisted self-caring involves giving time to patients: encouraging and assisting them to self-care in a rehabilitative way. It involves two aspects of care, the nurse providing some element of care such as assisting with hygiene and the patient also taking an active part in care. However, it depends on the degree of constraint and the nurse's self-responsibility to providing the best care possible, but when time constraints predominate; nurses frequently revert to functional caring. Patients view assisted-self caring, as part of other healthcare professional's occupation such as physiotherapists.

Ideal caring incorporates functional caring and assisted self-caring but additionally in-

volves assessment and planning of individualised quality care. Successful resourcing makes ideal caring more likely, but when unsuccessful, nurses revert to functional or assisted self-caring, depending on the degree of constraint present. Nurses' commitment to providing the best care enhances ideal caring as nurses take pride in their care delivery. In the presence of constraints, care accommodation ensures that at least basic care needs are met.

Conclusion

The theory of resigning processes the main concern of how nurses work within constraints when caring for patients with stroke in the general acute care setting. In this context, resigning is a new concept in healthcare and the theory of resigning has the potential to provide new insights for nurses in care provision of patients with stroke while working within constraints.

There is a dearth of literature in healthcare on the concept of resigning. The understanding of resigning in the literature is context dependent and generally has negative connotations such as, relinquishing and giving up on beliefs and values. Resigning generally refers to a kind of submission, a reluctant acceptance or a surrender to some condition (Lundh et al., 2011; O'Reilly et al., 2009; Räty & Wilde Larsson, 2011) or situation (Josephson et al., 2008; Lundh et al., 2011; Sandgren et al., 2007) or in the context of leaving a position (Bragg & Bonner, 2014; Josephson et al., 2008; Ohue 2014; Webster et al., 2009).

The theory of resigning explains how nurses work within constraints offering an alternative way of coping with the circumstances. This is comparable to Takase's (2010) study where nurses did not always physically leave their jobs but instead withdrew psychologically, disengaging in trying to provide care in their attempt to continue working with opposing attitudes and beliefs. The theory of resigning suggests how nurses can remain committed to ideal care when delivering the care that constraints permit, rather than leaving their position. Continuous working within constraints is tiring; the theory of resigning as an energy maintenance strategy suggests another way of doing so successfully.

Bragg and Bonner (2014), using a classic grounded theory methodology, generated the theory of the degree of value alignment which explains why nurses resign from their hospital jobs. These nurses did so when their personal values conflicted with those of the hospital organisation. The theory of resigning supports and corroborates Bragg's and Bonner's (2014) theory of the degree of value alignment as both theories are similar where nurses suffer from conflicting personal and professional values. Both theories hold the ideal of providing a high level of patient care as a priority while suffering from conflicting personal and professional values and both theories use to the concept of resigning. However, they differ in the understanding of resigning; the nurses in Bragg and Bonner (2014) conceded their values whereas in the theory of resigning nurses do not concede their values but actively try and deal with constraints to maintain their values through resourcing and care accommodation. This current theory expands on Bragg's and Bonner's (2014) theory of the degree of value alignment as it explains where nurses' personal values can be accommodated through care accommodation and resourcing where nurses learn how to work within constraints. This theory explains resigning as a more positive way of dealing with constraints rather than getting to the stage of conflicting values where nurses leave their position, feeling relieved but also frustrated and angry.

Cook and Hayes (2008) discussed the automatic acceptance of a situation, not attempting to change the situation or protest against it. For Cook and Hayes (2008), acceptance is associated with better outcomes than resignation. The theory of resigning supports this position as it offers a new positive perspective of resigning enabling nurses to remain working in the challenging environment of working within constraints. This is supported also by Yao et al. (2013) who discussed psychological acceptance in their group of nursing participants and infer that active acceptance of negatives experiences may produce positive effects. Psychological acceptance is viewed as a major individual factor in determining the behavioural effects on nurses. In common with the findings of Yao et al. (2013), the current theory suggests that a positive attitude maintained through idealistic striving has a positive effect on care if nurses engage in resourcing rather than passively accepting the presence of constraints and their consequences.

The theory of resigning enables nurses to cope within the circumstances often presented in the general acute setting such as a lack of staff, equipment and finances. When working within constraints care can be reduced or is often of a poorer quality (Papastavrou, 2012; Rochefort & Clarke, 2010; Schubert et al., 2007). The presence of constraints in the workplace influences nurses' provision of care (Papastavrou, 2012; Rochefort & Clarke, 2010; Schubert et al., 2007). The theory of resigning resonates with this, as a care environment under constraints has difficulty in delivering quality patient care. The theory of resigning identified issues such as lack of time, staff and resources with regards constraints as similarly identified by Haigh and Ormandy (2011). Collectively, these factors were found to impact negatively on patient care delivery resulting in a compromised level of care and poor patient outcomes. In the theory of resigning working within constraints was found to influence stroke care provision in the general acute setting where care provision was found to be reduced to functional caring in the presence of constraints concurring with findings of Haigh and Ormandy (2011).

Patient safety is of utmost importance in healthcare delivery and movement towards ensuring avoidance of low quality healthcare delivery is a priority (Kalisch et al., 2014). Ensuring patient safety is cited as a factor in nurses prioritising care for their patients. Nurses' in the theory of resigning aim to deliver the best care possible within the circumstances always ensuring that patients' safety is adhered to. The theory of resigning is the first time a study has explained how nurses' work within constraints as literature to date identifies constraints in the care environment and how this influences care delivery but does not explain how nurses continue to provide care in this environment.

Given the current high demand of modern healthcare nurses need to understand and be able to work within constraints. Tensions for nurses between wanting to provide quality patient care and the reality of working in care environments constrained by a lack of time, lack of equipment and reduced staff levels can result in a reduced level of care provision. The theory of resigning suggests another way of explaining and understanding how nurses deliver care in a resource scare environment.

Nurses always need to work within constraints. This theory of resigning explains how they can provide optimal care through identifying and explaining the process of resigning. By identifying the process of resigning nurses can recognise their behaviours, making necessary changes to ensure optimal care of patients with stroke. Resigning is an energy maintenance and coping

process, which supports nurses in such situations. The theory has the potential to enhance nursing care and make better use of resources while advocating for improvement.

Implications for Practice

The theory of resigning offers a unique contribution capturing and explaining what is currently happening in practice for nurses caring for patients with stroke in the acute general care setting. Knowledge of this theory can assist nurses caring for patients with stroke on how to work through and deal with constraints and how to deliver care within these circumstances. The theory of resigning explains nurses' patterns of behavior, illuminating three levels of care that nurses can provide, dependent on the care environment they work within. This has not been previously explored therefore, generating a new theory adding to the body of knowledge on stroke care provision. The theory of resigning provides a strategy for nurses when working within constraints in supporting them in daily delivery of care. As Glaser and Strauss (1967) stated, grounded theory offers a "broader guide to what they already tend to do, and perhaps help them to be more effective in doing it" (p. 248), therefore it is envisioned that the theory of resigning will help nurses recognise the situation of working within limited resources earlier. This could potentially help nurses to maintain best care delivery for their patients while working in resource scare environments.

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