Thesis Title: Elder care in an emergency department: How does disparity in practice come to be?

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Abstract

Elderly patients in the Emergency Department (ED) receive a different level of care than younger patients. The ED disproportionately deploys resources to serve the needs of the younger patient population, a decision that appears to be mediated by the acuity of the patient’s condition as defined by the institution. This study will seek to examine the institutional work processes by which this disparity in care is created. By looking at the needs of the elderly as ED patients and based on what they identify as important to them, this ethnographic study will examine the work organization of the nurses, physicians, and administrators in the ED. The goal of the research is, through the examination of the organization of work and the texts that mediate it, to explain the ruling relations through which elderly patients are subjugated as patients in the ED.
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The research presented here is an investigation of the question: Elder care in an emergency department: how does disparity in practice come to be? Chapter one outlines the problematic of the research with a sizable emphasis on the questions to be considered for analysis. Chapter two considers two relevant bodies of literature: biomedical and ethnographic. Chapter three outlines the methodology used as well as the methods and procedures to carry out the research. Chapters four and five, the analysis chapters, focus on exactly how the disparity in practice comes to be in the emergency department (ED). Specifically, the focus here is institutional texts, the organization of work, and the relations of ruling that these shape and are shaped by. I close with a section of conclusions and recommendations for change, organizational and governmental, to improve the care of elderly people who access the ED. In an effort to preserve confidentiality, the participants have been assigned pseudonyms and the institution in which the research took place will be hereafter referred to as The Hospital. Throughout the chapters, I will be using terms and concepts specific to institutional ethnography with which my readers may not be familiar. I have for this reason included a glossary of terms at the very end.

The Issue

Working in an ED of a large urban hospital, I came to recognize a disparity in the care. After several years of practicing in an institution unable to properly care for its patients, apparently due to fiscal constraints, what became obvious to me was that resources were distributed in a way that disproportionately served the needs of younger patients, often pushing elderly patients to the margins. The care for which many elderly
patients accessed the ED, they did not receive, or when they did receive care, it was at best marginal. Problems with medical and nursing care for the elderly that are not necessarily problems for younger patients included lack of or less meaningful engagement with the patient, ignoring or neglecting the elderly patient, deferring his or her “basic” needs, such as eating, toileting, and ambulating. There also appeared to be a reluctance by health care workers to provide or assist with other basic activities such as turning and repositioning in bed, sitting up, and daily hygiene activities. These tasks, I found the nursing staff either uninterested in doing or unable to do, due to constraints in time and resources. Perpetually, elderly patients in the ED remained and continue to remain at the margins of medical and nursing care, lacking appropriate attention from nurses, physicians, and administrators, falling short of having their care needs met and being subject to unnecessary harm.

These issues became a problem for me when I could no longer reconcile the practice as it is with what it professionally morally ought to be. I found myself practicing nursing in the same way that made it a problem for me. I as well as other nurses I dialogued with in the department, prioritized the care of the younger patient over that of the elderly, often citing acuity as the deciding factor for this. I would justify deferring elderly patient needs with not having enough time to assist with such often time-consuming needs, and assigning a low value to activities of daily living, such as feeding, toileting, and ambulating. These same issues were present in the physician group as well. When nursing resources are distributed throughout the ED by administration, the decision is often influenced by how acutely ill the patients are and not necessarily according to the length of time it takes to perform the tasks needed. When resources are deployed based
on acuity alone, the majority of elderly patients, who may very well have acute conditions but are overshadowed by having underlying chronic illnesses, become underserved, de-prioritized, and neglected. As I became more aware of the discrepancy between what is happening versus what ought to happen, it became a rather compelling moral problem for me. I felt that this obligated me to re-examine, not only the practice of my colleagues, but also my own practice and my own moral awareness. How is it, I was left wondering, that nurses, physicians, and administrators, whether consciously or unconsciously participate in the creation of this disparity in care?

**Coming to Understand the Significance of the Issue**

Seven years ago, I became a registered nurse and obtained a full-time position in the ED of a mid-sized community hospital. I transferred to The Hospital in search of a more exciting place to work and an employer reputed to provide top-notch care and to value its people – patients, families, and staff. Since early 2004, I have been part of the nursing team there in the capacity of a bedside nurse, team leader, and at one time, the department’s ethics educator.

Several years into my career at The Hospital, working with what I now call “an institutionally politically naïve understanding,” I slowly came to take in the unfortunate reality of patient care, and particularly, the care of elderly people in the ED. The seemingly top-notch health service and the “exciting work environment” slowly transformed into a reality laden with moral and professional problems. I began to notice a particular pattern in the care – there appeared to be a preference to provide care for the young and a distinctly marked indifference to the care of elderly patients. An example from my practice, one of many, I recall, was during a rather busy evening shift. I was the
triage nurse that evening and had been presented with an elderly man brought in by an ambulance from a nearby nursing home, in respiratory distress and in need of immediate medical care. I placed him in an appropriate room and proceeded to report his condition to Claire – his assigned nurse. I recall starting my report with his name and age (in his 80’s) and that he was a nursing home resident, to which I was immediately given an eye-rolling look and a statement along the lines of “…and why is he here? What are we gonna do for him?” The implication is that the nursing home should have kept him and managed his problems, somehow. Of course, this would have been an unrealistic expectation from the nursing home as this man was quite sick - classically, acutely ill. I observed Claire’s reaction in the physicians and in my other nursing colleagues, myself included. The more I became aware of this problem, the more troubled I became, speculating why. How is it, I would often ask, that nurses and physicians, educated and trained to specifically do caring work, come to practice this way? What was it about the patients, staff, or the environment, I wondered, that enabled this disparity in the care?

I continued my questioning of the care and my ponderings, but in the meantime, people were being subject to unnecessary harm, placed at risk for adverse outcomes, and completely deprioritized when pitted against the sexier trauma case or any other acute illness for that matter. The more I came to observe reactions such as that of Claire’s, the more pressing the issue became, as I realized that most elderly people had a serious problem receiving equitable care in the ED, and this only worsened after the Ministry of Health’s introduction of ED benchmark wait times. I have arrived to my shift many a time and taken over the care of elderly patients who have been left soaked in their urine and feces for hours, left suffering from the cold environment in the overly ventilated ED,
and hungry. I recall one evening pulling an elderly woman on a stretcher out of a hallway and into a private curtained area in order to assess her, only to find her linen saturated in cold and foul-smelling urine that had soaked its way up the stretcher and soaked her pillow as well. Needless to say, that when I cleaned her up and gave her warm blankets, her gratitude was immense.
Chapter One: Difficulties at the Point of Care

The Problematic of the Inquiry

Based on two cases as examples of the problems in the everyday/everynight lives of elderly patients admitted to the ED, I will illustrate how some of the disjunctures emerged. As Smith (1987) put it, the problematic “directs attention to a possible set of questions that may not have been posed or a set of puzzles that do not yet exist in the form of puzzles but are ‘latent’ in the actualities of the experienced world” (p. 91). Here, I will first present a field note from my observations during a clinical shift I worked as a demonstration of problematic care for an elderly man in the ED. The second scenario is created from data taken from patient and practitioner interviews, outlining some of the difficulties at the bedside.

Example one: Gordon, the old man who “failed to thrive.” On November 22nd, working an afternoon shift in the ED, I found myself advocating on behalf of an elderly man, only to be met with institutional resistance and power vastly greater than mine that rendered me and my patient at a loss. I was assigned to the area in the ED that houses admitted patients awaiting transfer to their respected wards. This section of the ED is made up of 10 rooms, thus 10 patients who cannot go to the various units within the hospital, as there are no available beds to take them onto the units. This particular zone of the ED consists of a three-nurse assignment, two nurses, each would be responsible for three patients, and the third nurse has the other four patients. I was the nurse responsible for the four-bed assignment, and one of my patients was Gordon – an elderly man, in his 80’s who was admitted to the hospital, awaiting an available ward bed on the general medicine unit. His diagnosis was “failure to thrive.” He was also confused,
a result of his mid-stage Alzheimer’s disease, but was able to recognize me as the nurse, and he was able to recall my name and designation throughout the care period. Gordon had chronic back pain that was poorly controlled at home and had been poorly controlled at The Hospital for the duration of his ED visit, almost two days in length by the time I assumed care for him. As I went in to his room for the first time, I heard him repeatedly yell: “Could you please help me? Help me, please!” I found out that Gordon was having terrible back pain on the stretcher, and after getting assistance from two other nurses to move him on the stretcher and reposition him three times, I was not able to provide him with the comfort he needed to relieve his back pain. In reviewing his chart, I found that he had received Haloperidol twice (a neuroleptic agent) and that the medication had not been effective in “managing his behavior.” The behavior that the previous nurse and physician who gave him the Haloperidol set out to manage was the crying out for help from pain and the confusion from having Alzheimer’s. Gordon also had a urinary catheter inserted by the previous nurse from another area in the ED from which he was transferred. As I learned of this, I asked the previous nurse the purpose of the catheter if Gordon was able to stand and use a urinal. She responded that she “wasn’t sure why she really put it in,” but “it was ordered.” This really troubled me, knowing that certain interventions in the ED on the elderly place them at a high risk for developing delirium (Inouye et al., 2006; Palmisano-Mills, 2007), and the more such interventions are compounded, the risk grows exponentially. The risks for Gordon were: a urinary catheter, having received a neuroleptic agent, a noisy, bright, and crowded environment, and his underlying state of confusion. Having reviewed his chart, I obtained help once again and placed him in a gerichair (a large reclining chair), tilting him back to ease the pressure off
of his back, with good results. Then the nurse in charge came over and asked me to send Gordon to the medical floor on the seven-hour rule. The seven-hour rule – a decision-making tool derived from a set of guidelines given to bedside staff – dictates that from the time of registration, any patient requiring admission be out of the ED within seven hours (The Hospital, ED Immediate Transfer Protocol, 2009). This was put in place to reduce wait times in the ED and to enhance access to the people who need ED services “the most.” Often, with the implementation of this rule, the transferred patient is moved to a ward hallway. The ED patient care manager in a recent staff meeting informed me that there are 20 such hallway “spots” in the institution. There are certain exclusion criteria that if the patient meets, he or she cannot be sent to the hallway, but Gordon met no such criteria, and was to be transferred immediately. Of note is that there were no patients waiting in the waiting room, and there were three vacant ED rooms. I found this experience quite troubling, and one that left me at a moral dis-ease. I was a participant in placing Gordon in a position where he would be at a higher risk for harm, when there appeared to be no immediate need for his bed, as the waiting room was empty.

Recognizing that Gordon was at risk for developing delirium, and especially at a higher risk if transferred to an even noisier environment, laden with overstimulation, bright lights, hyperactivity, and lack of privacy, I spoke to the nurse in charge, Janice, and asked that Gordon remain under my care in the ED until a unit bed was available on the ward with a room. I expressed to Janice my concerns about his risk in developing delirium. She stated that she had consulted the shift manager and that he (the shift manager) had spoken to the ED director of care and that she (the charge nurse) also did not want to have to “answer to the director” and that the patient must go. Disappointed
and overruled, I documented my concern and sent Gordon to the hallway. A short time prior, I had consulted with another shift manager (patient flow administrator), who had agreed with my assessment and clinical judgment against sending Gordon to the hallway, but it appears that this was overruled by the shift manager’s other colleague, reportedly who has more experience, who made the final decision to have Gordon sent to the hall. It is important to note that neither the charge nurse, director of care, nor the shift managers had met Gordon, never mind understood his concerns.

The problems, which I witnessed with respect to Gordon and many other patients alike, arose at several conflicting points throughout my practice. Here, I will illustrate one example of such disjunctures. I recently came upon interesting information on The Hospital’s website. Under its Patient Safety tab, it markets patient care as one that fully involves the patient, promoting this idea as a patient “right.” More specifically, it is declared in the website that patients have “the right to participate with the healthcare team in developing their treatment plans” (The Hospital, Rights & Responsibilities, 2009). A problem emerges at the juncture where the local reality of pushing patients out the door meets the lip service paid by the institution’s website. Gordon, for example, was not given a choice between remaining in his room and being placed in a ward hallway. Gordon could neither have been fully involved in his own care nor participated in the development of his care plan. Other such patient “rights” include: being listened to, having questions answered within a reasonable time frame, and receiving appropriate care that is courteous, considerate, timely, and respectful of the patient’s diverse views, culture, gender, and right to confidentiality. The patient safety standards put in place by the institution, aggressively marketed as patient rights were not honored for Gordon and
for many other elderly patients I came to meet. My observation would tell me that seldom are these institutional ideals carried out in clinical practice, and often it is the younger patient population by whom such “rights” are exercised anyway. Where elderly people with memory and sensory decline are admitted to the ED with no relatives to act as advocates, almost never do they participate with the health care team to make choices about treatment or their care in general. Furthermore, as patient privacy is promptly violated when people are forced to receive their care in a hallway, the “right to confidentiality” piece also falls by the wayside. How can care be confidential when the patient is made to receive it in an open public space? The problem of the lack of fit at the juncture of what the institution markets as the patient’s “rights” and what really goes on in the local happenings raised my concerns as well as the concerns of other practitioners with whom I spoke. The ED physicians also observe problems in the care of elderly patients, as the following comment by a physician suggests:

   You get there on your shift and who’s been waiting the longest? Patients with mental health complaints and older patients, right? And depending on the physician, you sort of get the sense that they’ve been skipped over. (J. Chung, personal communication, February 9, 2009)

After learning that the physicians are also experiencing difficulty in providing adequate elder care, the problem came to be understood as more and more systemic: institutional. The physician quoted above lamented the same problems in the care I observed over the past several years.

   Looking at institutional guidelines (namely e-mail communications and staff meeting proceedings and minutes), I gathered that after a recent “phone call” from the Minister of Health, the institution’s priorities, and certainly those of the ED began to
quickly shift. New documents were produced by management to measure and guide the length of stay of patients and the discharge process, (other departments also became involved in this change). These documents, containing specific guidelines that among other things require patients to be placed in hospital hallways despite the ED having available beds, quickly filtered down to the bedside and are currently being used by nurses, physicians, and patient flow specialists to guide patient movement throughout The Hospital. The goal is to reduce the length of stay of the patient in the ED. This created another problem in that the criteria that determine which patient is taken to the hallways assemble a large number of elderly patients. This, aside from the obvious inequality, places the elderly patient at a high risk for harm. Following is an email communication sent to all charge nurses from the department’s patient care manager, that speaks of such changes:

Please make sure we are sending our seven-hour rule patients up at the correct time. I just had a conversation with [CEO] and we need to meet these guidelines. I understand that in the middle of the night, some staff are reluctant to do this. However, we have been mandated by SLT [senior leadership team] to do this and if the patients fit the criteria, they must go regardless of time. There have been several comments from them [SLT] about patients being held back in the middle of the night in the last two weeks. It does not matter if we are not busy and have extra beds – patients must still be transferred [to ward hallways]. Unfortunately, I understand that this may be hard for some of you, but we need to be compliant. Patients that do not go up are being tracked and patient flow has to fill in forms when this does not happen. (S. Barnaby, personal communication, November 2, 2009)

Following is an e-mail communication sent to all ED staff from the department’s advanced practice nurse. The advanced practice nurse is a nurse administrator responsible for “directing nursing practice” in a specific department; for example, ensuring nurses are
up to date with certifications. The message below was sent in response to some resistance in sending elderly patients to the hallways follows:

Recently, there has been some confusion about the hallway admission of patients on the floor. Please be advised that a patient can go to the hall under the 15-minute rule or seven-hour rule if they are frail elderly (competent). If they are somewhat confused, they may go to the hall with a sitter present. (R. Campiti, personal communication, November 9, 2009)

The 15-minute and seven-hour rules are guidelines that dictate the discharge of patients within either 15 minutes or seven hours, depending on the patient, either home, to another department, or to an admitting ward (often a hallway). These guidelines have certain “triggers” that would indicate the movement of patients out of the department (The Hospital, ED Immediate Transfer Protocol, 2009). The goal is never to have any patient remain in the department greater than eight hours. It is noteworthy that the advanced practice nurse classified staff resistance and reluctance as “confusion.”

I subsequently directed my attention to the Ministry of Health’s wait time initiatives and examined their and the province’s priorities. Interestingly enough, I found that the Ministry has published provincial average benchmarks for ED length of stay, and its goal is to have no patient wait more than eight hours in any ED. The provincial guidelines were set by the Ministry since June of 2009 and were taken up for implementation by The Hospital in October of the same year. The patient care manager communicated this to all ED charge nurses in a staff meeting. Apparently, The Hospital is in the bottom ten worst performing hospitals in Ontario with respect to ED wait times. This is perhaps what warranted the “phone call” from the Minister of Health, then, David Kaplan, to the CEO of The Hospital, which initiated a cascade of changes and new guidelines to “push” patients through to “reduce length of stay.” It is important to note
that it was shortly after the Ministry’s publishing of The Hospital’s wait times, that it began to implement the sweeping changes to “patient flow” processes. This observation focused my attention to the provincial government and its interests in emergency care. The more conversations I had with The Hospital’s staff, the more I came to learn that the province had ruling interests in the reorganization of work in the ED. After a lengthy conversation with the institution’s shift manager (patient flow administrator), he suggested that the Ministry’s priorities lay in the marketing of its government’s image as a strategy to be competitive in the elections. Following is an excerpt from a telephone conversation with him:

What I think, Simon, is that this is an election year and the liberal government wants a push to reduce wait times in the ED so that they can show the public and say “see? We fixed health care” to be competitive in the election. What I suggest to you [after asking him to provide me with documentation outlining this "phone call from the Ministry" or any formal written policy for the seven-hour rule] is to contact a conservative/NDP MPP and ask for such documentation, as they would likely be happy to provide that for you. (H. Small, personal communication, November 7, 2009)

**Example two: Excerpts from patient and practitioner accounts.** My second example I have constructed from various patient and practitioner interviews and conversations with elderly people about their experiences as ED patients. Some of these accounts validated my observations and further raised questions about the disjunctures at the lines of fault experienced at the bedside. Others simply raised my awareness to another set of questions that gained more significance the more I reflected on the local happenings of the ED at The Hospital.

Helga, an elderly woman hospitalized for heart-related concerns articulated some of the difficulties she faced as a patient, maintaining that her experience was “nerve-
wracking, uncomfortable, scary, and rushed.” Having waited several hours to see the physician, Helga spoke at length about the silence of the triage nurses and the registration staff that left her in a state of worry and wondering about her condition and the process of care. She lamented the poor communication she experienced and the staff’s unavailability to assist her with comfort measures and other basic activities of daily living. In speaking with her, I came to see that the long wait to see a physician was not necessarily her biggest problem. Rather the discomfort, the feeling of being “rushed out the door,” and the mystification of the process were her major concerns.

Another account that mirrors Helga’s is Gilles’ wife’s. Gilles is a man with a long history of heart disease, admitted to the ED for chest pain and shortness of breath, accompanied by his wife. Gilles’ wife describes feeling similar anxiety during the wait to see a physician, but not from the wait itself per se, rather the unknown process that was not explained to her and her ill husband, rendering them in a fit of despair and frustration:

We were desperate! Desperate! And you know, the problem…we go to the nurse and we said we’re leaving. She said, no, no no, this is the heart, you have to stay. We have to do some tests, it’s very important. We stayed, but it was very long. Six hours! They took him immediately. They did the electrocardiogram, the blood test and they forgot about him. I think everything was okay, but I don’t know. (B. Beaudoin, personal communication, June 3, 2010)

Concerned about the findings of the electrocardiogram, Gilles and his wife were left to wonder about the state of Gilles’ heart. Although the wait to see a physician was a concern for both Helga and Gilles, the bigger difficulties they voiced had to do with the staff’s “poor communication” and the rushed interventions that were being carried out on them in the waiting room. It was not until Gilles and his wife reached a threshold to want to leave that the triage nurse explained some of the process:
The nurse was very nice. We were very upset and I told her, you know, we are leaving. She said ‘why are you leaving?’ Because we can’t stand it anymore, you know, six hours. There wasn’t any bed available, she told me, no bed and we have to wait, but I guess somebody can come and tell me we are waiting for the bed. We are waiting…waiting, and you know, these people, they come after and they go in, so I think, they forgot you? (B. Beaudoin, personal communication, June 3, 2010)

I came to see from patient interviews that the wait in and of itself was not the central problem for them. Moreover, the family’s anxiety and discontent piqued my interest. I continued to reflect on the disconnect between the institution’s push to reduce wait times, and the priorities of the patient, not necessarily directly concerned with the waiting. I speculated whether this aggressive push to reduce wait times actually exacerbated the rushed type of care that the above two patients spoke of and in fact redirected the staff’s attention to an efficiency type of care delivery, leaving little time to adequately communicate with patients. Here, I found a clear disconnect between the interests of the patient and those of the institution. I came to frequently question the efficiency logic by which the ED functioned that dictates the reduction of wait times amounts to good care.

A nurse and a physician I interviewed validated these patients’ experiences and commented on this efficiency logic that ED practitioners work by. James, an ED physician asserted, “we do work in an area of time pressure, so you know, get to the facts, get in, get out. There is that culture.” There is the understanding, even among the practitioners, that the care is rushed and that the elderly are not given the time required to complete an adequate assessment. Brenda, a geriatric nurse clinician in the ED echoed James’ remarks about the rush and this “in-and-out” type of approach. After being asked why ED practitioners “do not listen” to the elderly, she offered a similar perspective to that of James’:
Other reasons they may not be listened to… I think time. They’re slower at getting things out and sadly, a lot of them are very tangential and this may be an opportunity for them to socialize and talk and they may be kind of lonely and they’re kind of over-inclusive in their answers, and let’s face it, in the emergency, people just don’t have time for long answers. (B. Kolb, personal communication, June 20, 2010)

Anne, a patient I interviewed, spoke of her “daunting experience” in the ED, and one that left her scared, frustrated, and intimidated. She also placed a greater degree of emphasis on the communication problems and the mystification of the triage process than the length of time it took to see a doctor. “I think it’s because you don’t know what you’re waiting for,” she continued. “They said you’re going to have an electrocardiogram and we’re going to have to do blood work…and then you wait…I had no idea that it would be two or three hours before someone came to say anything to me.” (A. Gross, personal communication, June 22, 2010)

As my observations at the bedside grew more politically astute, coupled with these patient and practitioner accounts of daily/nightly life in the ED, I began to speculate over a different set of questions than those that criticize the practitioner or the patient. From the triage nurse’s perspective, I would find myself scampering to perform tasks and deliver interventions to various patients in the waiting room, quickly and efficiently. Hurriedly, I work with a mental list of what I “need to do” which for most patients often includes reviewing vital signs, drawing blood, and documenting in the patient’s chart. My perspective as the triage nurse is that the care is quick, efficient and thus, good. My focus is to decrease the wait time and length of stay for the patient. The patient has a different story to tell and one that suggests the length of stay or wait time is not a big concern for him or her. One perspective competed with the other.
The more I investigated such disjunctures, the more obvious it became that things happening on the local level were beyond the control of the local actors (nurses, physicians, shift managers, and patients) and serving interests that were not local. In trying to understand the misfit between what is happening (experience) and what is being controlled/subjugated (ruling), I found myself looking into institutional and administrative guidelines and beyond, and into provincial policies and government priorities.

**Arriving at the Problematic**

The questions that formulate the research problematic emerged from three distinct aspects of the institution: the Canadian Triage and Acuity Scale, the Ministry of Health’s guidelines, and the Process changes of The Hospital. Here, I will offer a discussion of these different, yet overlapping institutional domains and the relevant questions they raised for me to launch an institutional ethnography.

**The Canadian Triage and Acuity Scale.** The Canadian Triage and Acuity Scale (CTAS) is a “tool that enables ED’s to prioritize patient care requirements and examine patient care processes, workload, and resource requirements relative to case mix and community needs” (Canadian Association of Emergency Physicians, 2009). The scale became widely used across ED’s in Canada since its publication in 1999 (Bullard, Unger, Spence, & Grafstein, 2008). Administrative groups (hospital and provincial) came to utilize the CTAS aggregate data - originally created as a clinical decision-making tool - to measure workload and subsequently allocate resources, and to create and measure accountability.
I began to see this very important tool as an institutional text and one that is a high-level regulatory text, meaning that other institutional texts can be created and/or altered as a result of its activation by institutional actors. In other words, I came to observe that nursing and medical knowledge is organized in such a way around the CTAS that other forms and guidelines are generated as a result of the nurse’s or physician’s application of the tool for clinical decision-making (processing interchange). The CTAS is an important institutional text because it is the first text that is activated at the first point of contact of the patient with the institution. The trajectory of the patient’s care is determined by how the triage nurse activates this text. I also came to observe that elderly most often were assigned a mid-range acuity level that rendered them waiting long periods to receive care, placed them in a “sub-acute category,” and pitted them against a large number of otherwise “acute” patients, higher on the ED’s priority list. With this observation, I consider the following questions: How does it come to be that a large number of elderly are grouped under this non-acute “residual” category? Is there a flawed understanding of what “acuity” means to the nurse/physician/administrator? Should chronicity be considered as important a factor as acuity when making triage decisions? What other texts are similarly involved in the organization of nurses’ and physicians’ work? How is the CTAS used as a tool to measure workload and create accountability? Is this feasible/reliable? What does this local-translocal relationship look like and what does it mean for my elderly patients?

The Ministry of Health’s guidelines. In another political analytic, I turned to the guidelines of the Ministry of Health. These guidelines, after having been published along with average wait times came to create large-scale departmental and institutional
changes. My focus is on the guidelines themselves that set provincial benchmarks for the average length of stay for ED patients based on CTAS scores, assigned to patients by triage nurses. The focus will be on how these organize the work of the ED staff and as such, function as ruling apparatuses. The questions I began asking became more and more politically charged as I came to question translocal priorities. If patients’ concerns had less to do with waiting and more with the processes of care, then why is the institution pre-occupied solely with reducing wait times? Is there a relationship between the Ministry’s publishing average wait times of hospitals and The Hospital’s initiative to reduce its wait times? What are the relevant texts that came to be produced as a result of the Ministry’s guidelines? Who produces these texts? How do these texts organize the work of the practitioners? What is at stake if these guidelines were not followed, for the practitioner, for the patient, and for the institution?

**Process changes and the P4R program in the ED.** Large and sweeping changes come down onto the ED shortly after the minister of health contacted The Hospital’s CEO to inform him that The Hospital is in the bottom ten worst performing hospitals in the region. The Pay-For-Results (P4R) program was put in place by the Ministry and is a system that certain hospitals participate in by competing for Ministry money through the meeting of certain Ministry targets. By meeting the average benchmarks set by the Ministry, The Hospital would be awarded one billion dollars per year.

The 15-minute rule and the seven-hour rule documents were created as everyday tools for charge nurses to use for patient flow purposes. These documents would determine which admitted patients fit certain criteria, categorizing them as “hallway-appropriate” in order to move them out of the department and into various ward hallways.
This is in an effort to send patients out of the ED within the timeframe set out by the Ministry’s benchmarks. The Ministry requires that no patient is to be in the ED longer than eight hours. The institution set its own benchmark of seven hours to ensure that patients are definitely out by the eighth hour. My focus is the seven-hour rule and the problems it creates at the bedside, both for practitioners and patients. Aside from placing patients in hallways, other process changes took shape in the ED. Some of these process changes include, early patient discharges, fewer geriatric consults for fear of prolonging the patient’s stay, and an environment of hurried care. I began to consider the power of the seven-hour rule to organize and re-organize the work of nurses. ED administrators communicate to the bedside staff that the sweeping move to “push patients out” makes for space for other patients, though many times the rules are implemented routinely, and not based on patient influx. What is the process by which the Ministry’s guidelines translated into this seven-hour rule document? Who was involved in the making of such document? What other changes were taking place in the institution to help it “meet its targets?” Who is really benefitting from these changes?

**Process changes in the institution.** As the changes came to be in the ED, other changes also came into effect. The institution’s wards underwent similar changes, as did the patient flow department. Incidentally, these changes came on the heels of a new patient tracking system for The Hospital that proved to have it’s own technological and logistical nightmares. The wards had to be ready to house patients in their hallways, give nursing care out in the open, and adapt to this rather quickly. Tensions rose between the ED and the receiving wards as the admitted patients often appeared at their doorsteps
with little warning. Patients sent to the wards hurriedly, most of which are, also tended to
be unprepared and in need of multiple interventions shortly after their arrival.

The changes also brought about a re-organization of work to which the patient
flow department needed to adjust. The patient flow department is the entity of the
institution responsible for assigning beds to patients. The seven-hour patient transfers
quickly became a priority for patient flow administrators. A great deal of importance
became placed on the “timely” patient movement out of the ED and into various hospital
wards. The patient flow department created the seven-hour rule criteria by which patients
are screened for “hallway appropriateness.” This along with the ED’s and the wards’
participation in this new form of patient flow management made for this third political
arena to be investigated.

I continued my line of questioning, speculating on how the wards were coping
with the changes and the shifting priorities of patient care. What was the experience of
the receiving wards during such hurried patient transfers? What were the changes to the
patient flow processes (the department responsible for assigning beds to patients in the
hospital)? Where is the patient flow department situated in this new form of ruling that is
being deployed? How is the work organized and re-organized on the wards and in the
patient flow department?

As these questions mounted, I continued analyzing institutional priorities,
processes, and texts. These are preliminary but nonetheless important questions that will
guide my attempts to unravel the institutional layers that have shrouded the true political
nature of the local happenings.
Chapter Two: Review of Literature

Introduction

Two bodies of literature are relevant to this study – ethnographies conducted on health care institutions, and what I came to call biomedical literature. The biomedical literature will be critiqued based on three overarching problems it posed. The significance of the ethnographic literature will be outlined. In closing, I will situate this research within the ethnographic literature reviewed here.

The literature, as I came to interrogate it, became separated into two distinct categories: ethnographies of health care institutions, and biomedical literature. The following diagram, borrowed from the work of McCoy (2005) illustrates a continuum of an area of research in health care at which she looked, not dissimilar to the body of literature reviewed for this project. It depicts a paradigmal separation of the research done on patients’ health care experiences.
Toward the left end of the continuum, McCoy maintains that research done in health care tends to adopt “the standpoint of biomedicine” (p. 792), focusing on the patient’s lived experiences and “the attitudes and behaviors that shape such experiences that are of interest to health care professionals” [italics mine] (p. 792). Towards the right of the continuum lies the body of literature that centers the patient within the inquiry and embarks from that standpoint. Research at this end of the continuum “turns the analytic gaze to the delivery of health services as viewed by the patient” (p. 792) looking at priorities defined by the patient specific to the context of his or her experience. Ethnographic research, for example, falls towards the right side of this continuum.

**Biomedical Literature**

The biomedical literature looks at the individual - the elderly patient - as a system or systems with problems as identified by the institution. I am including the researcher as part of the institution, and *institution* is used here as it is by Smith (2005) (see definition in the *Glossary of Terms* section). The literature also tends to view the patient as a
collection of signs and symptoms of disease, as biomedicine does, and attempts to provide theorized solutions (treatment). An overarching problem with this literature is that it fractures the patient into fragments and provides a picture of the patient as a disembodied collection of organs and systems – institutional categories – dominating and generalizing the patient’s experience. It was under these premises that I came to call this literature biomedical. The three major analytical problems with this literature are: it ignores the local-extralocal interplay, the standpoint from which it proceeds is misplaced, and it holds the practitioner responsible for the problems in the care. It is mainly due to the researcher’s partaking in the ruling relations, knowingly or otherwise, that these three problems in the literature come to be. Following is a discussion of the problems the biomedical literature posed.

**Disregarding the extralocal and the power of texts.** The biggest and most obvious problem, especially when reading through an institutional ethnography lens, is that the investigation is limited to the local setting. That being said, investigating local problems is not problematic in and of itself. However, local problems are seldom created locally. Most of this biomedical literature limits itself to problematizing clinical issues without looking beyond the bedside. Eriksson and Saveman (2002), for example, investigated the problem of the scarcity of time to care for elderly patients who have an “altered level of consciousness.” They attributed the challenge of providing adequate care to a time scarcity. However, if the investigation reached out extralocally, perhaps looking at administration, institutional policy, and government priorities, it may have made visible administration, acting on behalf of the government to reduce human resources to serve fiscal interests. The issue would have less to do with care providers “not having
enough time” and more with adequate human resources provided to do the work. Panno et al. (2000) underwent a similar investigation, identifying strategies to improve elder care, though failing to illuminate the problems of time and other resources direly needed to implement their strategies. This investigation specifically provided recommendations that cannot be implemented due to a resource limitation in the institution – a problem that went socially and politically unexamined. How useful are recommendations if they cannot really be implemented? Many other studies followed suit in this fashion, in that the investigations were limited to the local setting, whether a particular department, a particular section of a department, or a certain group of patients with specific complaints. The literature looked at the patient and the clinical needs as identified by the researcher, the health care worker, or the institution. When the inquiry remains limited to the local setting, ignoring external factors that influence and control the local happenings, the root of the issue under investigation remains or becomes poorly understood. Fulmer et al. (2005); Dyer (2005); and Wilber (2006) identified and investigated issues to a certain extent, limiting their inquiries to the local setting, in fact perpetuating ruling practices over the patient and overlooking the regimes of ruling in the process. A possible contributing problem to this entrapment in the local is the researcher’s use of ideological language (Campbell & Gregor, 2002). A central problem in the work of Baztán et al. (2009) is this loss in ideological language – language of the discourse of biomedicine. This is in part due to the researcher’s institutional capture (Smith, 1987) (see definition in the Glossary of Terms section) as well as the use of “shell words” that carry with them multiple meanings, lacking description in what Smith calls ordinary language (D. S., personal communication, August 26, 2009). Shell words often populate institutional texts,
giving them the ability to rule across various geographic locations. Baztán’s work is immersed in the activation of texts that go unexamined and that are a part of the institution’s ruling regimes. The language used in the research is that from within the many discourses that make up the institution, such as nursing, medicine, administration, reform, et cetera, and that are implicated in the relations of ruling. Terms that carry with them multiple meanings, depending on the speaker and the setting, occupy a sizable portion of institutional texts, a ruling quality inherent in texts. Terms such as deconditioning, frailty, and functional impairment extracted from various texts, such as protocols and best practice guidelines are used and are central concepts to understanding the literature, but lack description in ordinary language.

Another finding that suggests this literature is uncritical of translocal relations is the unexamined activation of texts and the rather considerable dependence on them in the research. The mini mental state exam, for example, a tool used to screen patients for inclusion in research studies, leaves those with low scores; therefore, lower levels of cognition excluded from most of the literature. I would argue that those with a “lower level of cognition” are a group even more marginalized and in need of more attention in health literature. The mini mental state exam is a tool used to screen for dementia and that originated out of the discourse of psychology, later taken up by medicine. It frequents much of the biomedical literature as a ruling text used by the researcher to screen potential participants for inclusion. Depending on the institution in which it is used, the mini mental state exam is strongly linked to institutional policy and nursing and medical standards. It is used to categorize people, mainly the elderly, into different levels of cognitive impairment. The mini mental state exam is not independent of institutional
policy, the Canadian Triage and Acuity Scale, the DSM, and practice standards. The network of intertextuality briefly exemplified here is of social and political importance to any research that considers the institutionalized elderly person. Without an understanding of the history of institutional texts and their intertextual play, their ruling power remains concealed. Other textually mediated practices in the literature include the use of the DSM for definitions of illness, the orientation and memory concentration test, the six-item screener, and the clock-drawing test. The latter three examples are tools used in patient assessments to categorize people into different “levels of awarenesses” (institutional categories out of the discourse of biomedicine). This categorization is another example of the researcher being hooked into the ruling process.

**Who’s standpoint is it anyway?** A second major issue with the literature is the standpoint from which it embarks. Each article I reviewed looked at some aspect of patient care and whether through original research or literature review and synthesis, made suggestions in an attempt to improve care. Two such pieces of literature of approximately 60 made an attempt at understanding the patient’s perspective and to a degree, working from that standpoint. One of the two involved interviews with patients (Kong, Lee, Mackenzie, & Lee, 2002), investigating the psychological consequences for elderly persons who had experienced a fall. The other involved interviews with elderly people and their caregivers (Lindhardt, Bolmsjö, & Hallberg, 2005), revealing differing values of health care staff and the patient’s family. What adds to the problem is, although the tone these two pieces of literature took may suggest that they were conducted from the patient’s standpoint, this is not actually the case. They attempted to address, for example, “identified needs” and “health priorities” for the patient and the family yet it is
unclear how such “needs” and “priorities” were identified to begin with, begging the question: who’s interests does this research really serve? Without the patient’s participation, these “needs” and “priorities” could not be assumed to be those of the patient. The two pieces of literature discussed above came closest to understanding the perspective of those being ruled and thus made an attempt at proceeding from that standpoint. The remainder of the biomedical literature disembodies the patient and to a large degree, disregards experience altogether. I will not cite specific studies, but only point out some themes that emerged. Some studies looked at improving institutional policy, such as falls prevention strategies, antibiotic administration, restraint use, and do not resuscitate guidelines. Others looked at risk assessment and hospitalization-associated risk to the elderly patient. A sizeable body of literature examined attitudes and educational preparedness of the practitioner, namely nurses, pointing out “knowledge gaps” as directly associated with “poor practice.” This is discussed in greater detail below.

**Emphasis on the practitioner.** A third problem the biomedical literature presented is its emphasis on the practitioner. The literature blames, whether the practitioner or groups of professionals for the clinical issues it sets out to investigate. Whether it be nurses’ competence, their “lack of knowledge,” or physicians’ attitudes, the literature shifts blame away from the institution and onto the bedside practitioner. Fulmer et al. (2005) for example, looked at ageism, equating ageist nurses and physicians to their misdiagnosing elder mistreatment and elder abuse. Dyer (2005), Mandiracioglu (2005), and Caterino et al. (2008) looked at practitioner education and preparedness, maintaining that more education amounts to better care. Though to some respect this is true,
institutional structures that likely gave rise to these problems remained unexamined – unchallenged. Simply educating or re-educating the practitioner remedies very little bedside problems that are not created at the bedside. Another example of this sort of practitioner-blaming is seen in the work of Li et al. (2003) and Eriksson and Saveman (2002), in problematizing nurses’ knowledge.

As the biomedical literature partakes in the relations of ruling, it falls under the auspices of Smith’s definition of *institution* (2005) (see definition in the Glossary of Terms section). It further subjugates the patient by disembodying experience and abstracting it into institutional categories. It does so by ignoring the local-extralocal interplay and the power of texts and by failing to represent a standpoint outside the relations of ruling, demonstrating a participation in the extralocally controlled social organization of the very problems it sets out to investigate. The biomedical literature I reviewed shed some light on certain clinical issues that remain to be a challenge in the care of elderly patients in the acute care setting. Even more importantly, what this literature also did is raise questions about its adequacy to radically understand the problems it attempts to expose to address them from the standpoint of the patient.

**Ethnographies**

I reviewed a small body of ethnographic research for two reasons. I was interested in seeing how ethnographic research, especially institutional ethnography, overcame the problems that the biomedical literature posed. I was also looking to see where my research project would fit into the body of institutional ethnographies recently done on health care institutions.
Significance of the ethnographic research. The ethnographies reviewed here warrant a discussion on their helpfulness in demonstrating how taking a standpoint outside the relations of ruling is to be done. All the ethnographic work adopted the standpoint of those being ruled, namely patients and caregivers – it took a standpoint outside the relations of ruling. However, a few ethnographies also demonstrated evidence of being subjugated by the institutional order. For example, Al Omari, Kramer, Hronek, and Rempusheski (2005) attempted to understand the culture of an assisted living centre and its residents’ conceptualization of everyday decisions in this culture, taking up the standpoint of the centre’s residents, but not all residents. What they demonstrate really is the very partaking in the relations of ruling by excluding some residents who were deemed “cognitively impaired,” an institutional category. Obtaining family perspectives of the “cognitively impaired” could have been one way to include their experiences in the research. Another is observation with keen attention to the residents who are not able to verbally express their experiences of the institution. Missing the perspectives of the “cognitively impaired” based on institutional categorization reinforces ruling. The research relates a decreased physical and “cognitive ability” to decreased participation in the institution’s culture. Concepts such as “cognitive impairment” and “cognitive ability” are drawn from institutional texts. The very use of such concepts immediately categorizes and organizes patients in a way that abstracts experience, and for some patients, excludes it altogether. The research likely turned to cognition screening tools (Mini-Mental Screening Exam, for example) or other institutional policies or screening mechanisms to recruit patients, an example of the researcher’s partaking in the ruling process. The researcher became caught in the ruling process in two ways: by the exclusion of some
patients from the research, failing to maintain grounding in the perspectives of those being ruled; and by turning to institutional tools and policies to categorize patients as “cognitively intact” or “cognitively impaired.”

A stronger commitment to the preservation of the perspective of those being ruled was evident in most of the ethnographic literature that was reviewed, and particularly in the work of Bourret, Bernick, Cott, and Kontos, (2001); Kayser-Jones, (2002); McCoy, 2005; Rankin, (2003); Rankin and Campbell, (2009); and Quinlan, (2009). What these studies shared is the common goal of embarking on the inquiries from the standpoint of those being ruled (patients and nurses), and preserved the presence of the subject from whose standpoint the inquiry takes. McCoy (2005), for example, uses concepts such as trust and respect but specifically as they are defined by her patients, the problems such concepts presented her patients with, and how these problems were articulated by them and not by the institution. Where the standpoint of those being ruled is concerned, the ethnographic literature has been helpful in exemplifying how this is done. What it also demonstrated is the ease with which the researcher can be subjugated by institutional practices (activation of texts and categorization), at times, losing sight of those being ruled (Al Omari, Kramer, Hronek, and Rempusheski, 2005).

Another valuable feature of this literature is its organized and methodical approach to the investigations, eventually leading to the explicating of the regimes of ruling. It takes a radical approach to investigate problems. It problematizes the relevant political structures of the institution and looks at how extralocal superimposition of power is necessarily organizing the work of the local actors. For example, in looking at how nursing work is organized, set against the backdrop of the discourse of health care
reform, Janet Rankin and Marie Campbell (2009) fleshed out the textually-mediated relations of ruling that organize and dominate nursing work. The inquiry took up the standpoint of nurses and proceeded to look at how “nurses play an active part in the subordination of their own professional judgment to the objectified knowledge and knowledge-based practices that externalize decision making” (p. 1). They explicated hospital administration, the Ministry of Health, bed utilization programs, and care pathway documents as covert elements of the ruling process.

A third important feature of this literature is that it offers tangible and concrete avenues for change. Where IE is an empirical method of inquiry, this body of literature is demonstrative of this. It draws direct links between the problem under investigation and the suggested solutions. Elizabeth Quinlan (2009), for example, in her investigation of knowledge work in multi-disciplinary primary health care teams, noted how the creation of new knowledge can “be inhibited by the supremacy of the physician’s position in the team,” (p. 632) drawing from data from field observations of a multi-disciplinary health care team meeting. She suggested directing attention to more dialogue between nurses and physicians to help flatten the power differential and foster a space for collective knowledge construction. She arrived at, among other recommendations, improvement in communication within multi-disciplinary health care teams with attention to power and class. Other recommendations that some of this literature offered included addressing staffing and other resource shortages directly linked to funding and allocation problems, demonstrating that it is not, for example the nurse who lacks the time to give appropriate care, rather the institution’s not hiring enough nurses to do the work (Bourret et al., 2001; Kayser-Jones, 2002; Rankin & Campbell, 2009).
Situating this research within the ethnographic literature. My research contributes to and fills a gap in the ethnographic literature. There has been excellent work done on elder care in a nursing home setting (Diamond, 1992) and in an assisted-living environment (Bourret et al., 2001; Al Omari et al., 2005). I found ethnographic research on nursing knowledge and nursing work, looking at health care reform strategies (Rankin & Campbell, 2009). Though there has been very good work done on certain aspects of elder care, I did not find any ethnographies in the area of acute care, and specifically, none in the acute geriatric care area. My research adds to this body of ethnographies by bringing in the perspectives of the elderly as acute care recipients. It focuses on the difficulties that the emergency elderly patient faces in his or her everyday/everynight life. By explicating what structures in the acute care institution allow for the care disparity to happen, it offers a list of recommendations for better care, arrived at from investigating the very issues experienced by the patient.
Chapter Three: Theoretical Framework and Research Design

Introduction

In this chapter, I will define institutional ethnography (IE) and briefly discuss why it was selected for this project. Smith’s concepts of Problematic (1987), Standpoint (2005), Ruling Relations (2005), Work Organization (2005), and Institutional Texts (2001) will be discussed as the central theoretical underpinnings that guided my inquiry. Lastly, I will provide a section on the procedures I undertook to carry out the research.

Institutional Ethnography: A Historical Glance

Rooted in feminist and Marxist traditions and fueled by the second feminist wave, IE was developed by Dorothy Smith, starting with her inquiry into mothering work in the mid 1980’s. As a single mother, Smith came to see that there was a “peculiar eclipsing” (1987, p. 17) of her and other women’s experiences by the mothering discourse in the academy. In the academic institution in which she taught sociology, Smith found that the mothering discourse was written and predominantly taught by her white middle class male sociologist colleagues in a way that excluded women and women’s experiences. This, Smith asserted, was a symptom of mainstream, or malestream sociology (D. Smith, personal communication, August 14, 2009). The mothering discourse dictated by the institution of the academy, Smith found, did not quite capture her experience and the experience of other women with whom she spoke – it rendered most of their experiences invisible. At this line of fault, she took up the embodied experience of women as a starting point for a new way to do sociological research and to write sociology. She found that the sharing of experiences became a new way of creating knowledge. In The Everyday World as Problematic (1987), Smith carved out this sociology for women,
later, *A Sociology for People* (2005); she set the feminist sociological stage by creating a space for women who have been systematically excluded and whose experiences have been rendered insignificant by mainstream sociology. She created a space where inquiry started from the embodied experiences of these women and maintained full sight of them throughout. Specifically, she developed a method that radically re-envisioned sociology and one that was highly political and considered power and class as social constructs necessarily weaved into its analysis. She came to call this “institutional ethnography.”

**Institutional Ethnography: An Alternate Sociology**

For the most part, Smith (2001) asserts, “sociology formulates the phenomena of organizations and institutions in lexical forms of organization, institution, information, communication and the like, which suppress the presence of subjects and the local practices that produce the extra-local and objective” (p. 159). IE, a method of inquiry that views social life as constructed by the actions of embodied people going about in their everyday/everynight world, looks at how such local actions are necessarily controlled and dominated by extralocal regimes. IE’s underlying assumption is that the local actors are involved in the relations of ruling, with or without their knowledge and participate in the subjugation of their own knowledge to an objectified, institutional form of ruling knowledge (McCoy, 2006). Because IE sets out to empirically investigate institutional processes, directing attention away from the individual and towards how work is institutionally organized, it has the potential to “inform advocacy and organizational change in concrete ways” Smith (as cited in McCoy, 2005, p. 794). In the same way, IE has the potential to guide action. Rankin and Campbell (2009) stress, “it offers nurses [and others subordinated by the ruling process] an intellectually reliable
way to ‘talk back’” (p. 2), to draw back from experiential and professional knowledge and advocate against ruling processes that render nurses, physicians, and more importantly, patients, powerless.

Unlike phenomenological and other biomedical research conducted on patients’ experiences of health care, IE proceeds, from the patient’s standpoint, directing critical analysis toward the institution. IE was selected for this project to generally accomplish two things: to investigate the care disparity that elderly people experience in the ED by tracing clues in the textually-mediated organization of the work of nurses, physicians, and administrators; and to suggest recommendations to help equalize the delivery of care. At the end of this paper, I have included a section titled *Glossary of Terms* specific to IE that may be helpful for reference.

**Problematic of the research.** Methodologically, the research problematic accomplishes two things: it sets the research stage, directing attention to a political examination of institutional structures; and it helps the researcher maintain grounding in the perspectives of those being ruled. My problematic was formulated from a combination of my observations of the local happenings in the ED and from patient and practitioner interviews. The problematic of the research helped identify some issues embedded within the experience of elderly patients. Together, we explored recent experiences they had in the ED, focusing on what they identified as problems or difficulties for them. My observations of the problems at the bedside were validated by the experiences of my participants.

The research problematic allowed me a starting point from which to conduct my research. It also acted as a reminder to remain grounded in the experiences of my
patients. During the interviews with practitioners and throughout my analysis, the problematic was helpful to keep the subject within view. The significance of my questions, analysis, conclusions, and recommendations go back to address the difficulties experienced by my patients, identified in the research problematic.

**Standpoint.** “From different standpoints different aspects of the ruling apparatus and of class come into view” (Smith, 1987, p. 107). From the standpoint of my elderly patient, several such aspects are relevant. The “patient flow” practices that have undergone recent changes, the introduction of new texts and modification of old ones, and the creation of new institutional categories are a few examples. From the patient’s standpoint, these, and other elements of the ruling process become relevant because they are what gave rise to the difficulties they experienced in the ED. It is precisely this standpoint I am preserving in the research when starting from the patient’s experience and in keeping the patient within view. As a “methodological starting point in the local particularities of bodily existence” (Smith, 2005, p. 228), maintaining the standpoint of elderly patients necessitates preserving the embodied experience and the difficulties they faced as patients in the ED.

**Ruling relations.** Analytically, illuminating the ruling relations makes visible the institutional ruling regimes. “Ruling is organized through a construction of knowledge that relies on complex forms of reporting, accounting, noting and recording particular aspects of people’s work and lives. These reporting and accounting activities produce a particular framing of issues and concerns, which then organize, influence and rule what happens” (Smith, 1990b, as cited in Rankin, 2004, p. 78). A central concept to IE; therefore, to this project, the ruling relations in The Hospital will be mapped out. A few
examples of ruling relations may be wait time reduction initiatives, hospital administration, and patient flow activities. It is most helpful to look at the relations of ruling as a network of interconnected relationships across time and space made up of different disciplines in The Hospital and mediated by institutional texts. Exposing the relations of ruling requires making them visible through the examination of relationships, their interconnectedness, and the priorities of the institution. The landscape in which these relations are embedded provides me with a political space for my inquiry. There, I investigate how the ruling relations gave rise to the difficulties my patients experienced in the ED.

**Work organization.** To understand how institutional ruling regimes actually rule, I have used Smith’s (2005) concept of work organization to map out the work of nurses, physicians, administration, and patients. The organization of work is a central concept in IE. It is particularly this work organization that interests the institutional ethnographer when mapping out the relations of ruling, as evidence of the ruling process at play. Local work is organized and reorganized through a ruling process not visible to the local actors. It is this work organization that I will map out which will help me analyze how the priorities of the institution are being served based on how the work of nurses, physicians, administrators, and patients is organized. It is noteworthy that the literature will also be brought into analytical view as a ruling relation. I came to see that the biomedical literature has the ability to organize the work of the practitioner. I refer to such organization not in the direct and strict sense of the organization of the work, rather to the organization of the practitioner’s knowledge that translates into the organization and re-organization of caring work. Being the dominant body of literature in current health care
research, the biomedical literature is situated in a particular position within the institution. It has the power to create knowledge and by the same token, render other knowledge obsolete. The dominant literature, as health care institutions take it up, is funneled into institutional policies, practice standards and guidelines (See for example, International Affairs and Best Practice Guidelines, RNAO, 2010). Best practice guidelines are created from the most current biomedical research, carrying with them the very problems I identified in the biomedical literature review.

**Texts.** Analysis of texts takes the institutional ethnographer through institutional paths that lead to the extralocal to see how the local actions are coordinated extralocally (Smith, 2001). As another central concept in IE, texts come into institutional play as mediators of sequences of action. In this case, texts are seen as mediators of sequences of caring action. They are to be treated as temporal phenomena, having that ability to rule in multiple sites and at various and simultaneous times. Texts are central to my research. In my analysis, I will use them as pivotal points in the processes of care as evidence of how they hook the practitioner into the relations of ruling.

**Methods and Procedures**

**Interviews.**

**Patients.** Recruitment flyers and letters were placed in various locations in The Hospital to draw in patients for interviews. The flyers were posted throughout the Family Practice wing of The Hospital, around the main entrances, as well as in the ED waiting rooms. Inclusion in the research necessitated that the participant be at least 65 years of age and has had a visit as a patient to the ED within six months of the interview. Two months of such recruitment efforts yielded only one respondent. Subsequently,
recruitment letters were sent out to the homes of 30 patients whom had accessed the ED within the previous several weeks. I gained access to the records of these patients’ mailing and demographic information through the departmental database known as EDIS (Emergency Department Information System). Within one week of my second recruitment strategy, I received a generous number of responses from patients, some of whom were interested in enrolling in my study, while others wanted to simply talk to me about their experiences.

I interviewed three patients: one man and two women. Two interviews were conducted in person, one of which required an interpreter. The spouse of the patient being interviewed acted as the interpreter for the Spanish-speaking participant. The third interview was conducted over the telephone. Each interview ran for approximately one hour. The interview topics centered on identifying the elderly’s priorities of care, the difficulties they faced during hospitalization, what could have remedied such difficulties, and what they specifically found helpful during the care. Some examples of interview questions include: I’d like to talk about some of the difficulties you experienced during your stay in the emergency. What were some problems you experienced with which you were not assisted or not assisted to your satisfaction? What was/were the most important thing(s) for you as a patient in the emergency department? How did it make you feel as you were waiting for the nurse [to answer your questions/feed you/take you to the bathroom/help you with bathing, etc..] but you were not getting the help? Did you feel respected?
The interviews were digitally recorded and transcribed in a private meeting space at The Hospital. Pseudonyms were assigned to the patients’ names and their related identifiers, such as their family members’ and family physicians’ names.

**Nurses and physicians.** Nurses and physicians were recruited using two simultaneous methods: by posting flyers in various areas in the ED and through mass inter-departmental emailing. Two nurses and two physicians participated and were interviewed. Each interview lasted approximately one hour. Three of the four practitioners were re-interviewed several months later. The re-interviews ran for approximately half an hour each. The four practitioners were interviewed first for this project, then the three patients, and then once again, three of the four practitioners. I was not able to re-interview the fourth practitioner (a physician), as he did not grant me a second interview due to a time constraint. The re-interviewing facilitated an understanding of how the problems in the care of elderly are organized. Issues that were not examined in the first set of interviews with practitioners that emerged from patient interviews were investigated in the second set of interviews with practitioners. Some sample questions from practitioner interviews are as follows: How do you prioritize the needs of the elderly as emergency department patients? How do you prioritize care when it comes to acuity/complexity of the patient? Give me some examples. What are some problems in the care of elderly in the emergency department? What are some solutions to such problems? Let’s talk about any difficulties you face as a nurse/physician in caring for elderly patients/caring for elderly patients appropriately. Based on one patient I interviewed, she/he stated that she felt that the nurses did not communicate the plan of care to her very well. Can you speak to this experience?
The interviews were digitally recorded and transcribed in a private meeting space at The Hospital. Pseudonyms were assigned to the names of nurses and physicians, as well as their related identifiers, such as the names of their colleagues and the names of other departments or institutions where they work(ed).

**Participant observation.** As a participant observer, I collected journal notes over the period of six months. During my regularly scheduled nursing shifts in The Hospital ED, I created notes in the form of journal entries on significant events that I experienced or observed. I would take notes during my designated breaks on any specific shift, or, if the day were too busy, I would do this at the end of my shift. At the end of the six-month period, I had amassed 20 entries, each with a detailed account of the observation and a corresponding preliminary analysis. An example from my field notes follows; a journal entry only without its corresponding preliminary analysis:

**Entry #20: June 17th, 2010 – Meeting of all ED charge nurses with the manager:** During the meeting, which was predominantly taken over by lectures and discussions about the G20 Summit and the potential for high influx of acutely injured patients, a particular thing stood out for me - something that was said by one of the presenters (a nurse from the critical care unit and one whom has been actively working with the G20 potential “disaster” preparation).

The discussion veered to patient flow, where she suggested that the hospital has been taking measures to operate at 95%, as opposed to the current state of often over 100% capacity, coined the Drive to 95 In this respect, she stated, that the patients awaiting placements into long-term homes and nursing homes, mostly comprising of elderly patients, are being placed in centers that under normal circumstances, would not be. Currently, when a patient is in the hospital and the acute care phase of his or her care is over, but for whatever reason, he or she cannot be sent home any longer (unable to care for self, not enough help at home to support him or her), he or she would be deemed ALC (Alternate Level of Care [see document from the Ministry]). When patients are deemed ALC, they are entered into a list to be placed into long term and/or nursing home centers. To help facilitate the most appropriate place for the patient, he or she is given a list of nursing homes/centers from which to list the top three
choices in which to be placed. This decision is often mediated by the proximity of the nursing home to the patient’s spouse, children, other support systems. To get first, second, or third choice, patients sometimes wait several months for placement.

In preparation for the G20 and the drive to 95, patients are now being asked to list their top five from which to choose. Naturally, the fourth and fifth choices are least desired by the patient and his or her loved ones. This lecturer at the meeting suggested that while patients are being asked to list fourth and fifth choices of nursing homes, more and more are being placed in homes that are fourth or fifth choice, which, she added, is “more or less permanent.” (Field notes, June 17, 2010)

**Analysis of texts.** When examining the relevant institutional texts, I consider the following questions, borrowed for the work of Quinlan (2009): “What is accomplished by the texts that are being used? What are the external causes and effects of people’s activities? What does this tell [me] about how this setting or event happens as it does? What social relations are reflected in the everyday activities? How do these social relations play a part in generalising institutional processes?” (pp. 629-630). Looking at these texts as mediators of local action to achieve extralocal objectives, categorization using institutional texts appears to be a form of control as this new form of ruling in the ED is being deployed. In the following two chapters, I identify the relevant texts and trace how each one hooks the practitioner into the relations of ruling. The path of text analysis for this project proceeds as follows:

1. Identification of an institutional text.
2. Identification of the institutional actors who activate it.
3. Identification of the point(s) during the care period at which it is activated.
4. Looking at what activities the activator engages in as a result of the activation of this text and mapping out the intertextual hierarchy.
5. How the text organizes the practitioner’s work.

6. Examining what other texts come into play as a result of the activation of this particular text.

7. Identification of the next step the text enters (if any), presumably to be re-activated by another institutional actor.

8. Tracing the path of the text and into its institutional purpose, be it recording wait times, or reporting length of stay to the Ministry.

9. Critically examining the institutional use of the information rendered by the text.

10. Going back to the original difficulties at the bedside: looking at to what extent the texts impacted elder care.

**Text one: CTAS guidelines and triage software.** The CTAS, Canadian Triage and Acuity Scale is a “tool that enables ED’s to prioritize patient care requirements and examine patient care processes, workload, and resource requirements relative to case mix and community needs” (Canadian Association of Emergency Physicians, 2009, p. 1). The scale became widely used across ED’s in Canada since its publication in 1999 (Bullard, Unger, Spence, & Grafstein, 2008). Administrative groups (hospital and provincial) quickly came to utilize the CTAS as a data generator - originally created as a clinical decision-making tool - to measure workload and subsequently allocate resources, and to create and measure accountability. I am interested in how exactly the CTAS is used to determine workload and therefore, deployment of resources, namely, human resources. I examine how this particular text mediates the work of the practitioner (here, in the form of a departmental computer software). I am also interested in how CTAS data are collected from patient charts and fed up to administration to help with decision-making.
An assumption here is that *acuity* is used as an institutional (as opposed to clinical) concept to guide administrative decisions about resource allocation. As all other texts analyzed here are dependent on the CTAS, it is considered a boss text, a high level text that establishes the frames and concepts that control and shape lower level texts (see below for the lower level texts) (Smith, 2005).

**Texts two, three, and four: Ministry guidelines.** Ontario’s Emergency Room Wait Time Strategy and Emergency Room Targets are two other documents that come into intertextual play with the CTAS. These two documents set provincial standards based on the CTAS guidelines by using its acuity categories (The CTAS will be discussed in greater detail in the following two chapters). These documents dictate the target length of stay of patients in the ED and make Ontario hospitals accountable to these targets. The relevance of these documents to elder care in the ED is that they privilege “high acuity” (mostly experienced by the younger patient population), as defined by the CTAS, allocating more resources/better care to patients deemed acute, creating a disparity between the acute patient and conversely, the chronic, elderly one. Where these texts become taken up by practitioners who primarily serve acute care needs, they create an environment of a certain level of privilege of acute care over chronic care.

A third analytically important Ministry-produced document is the Alternate Level of Care (ALC) status document. “Beginning July 1st, 2009, all acute and post-acute hospitals in Ontario [became mandated] to designate patients as ALC according to the Provincial ALC Patient Definition. When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided…the patient must be designated ALC” (Ministry of Health and Long-Term Care, Alternative Levels of Care
[ALC] Patient definition, 2009, p. 1). The Ministry maintains that the ALC protocol will help reduce ED wait times, improve patient flow, and inform decision-making. Almost always, when the patient is designated as ALC, a “social admission” to the hospital under the general internal medicine service takes place. The general internal medicine service is the specialty service that looks after almost all admitted elderly patients. However, as illustrated in the following statement by a geriatric specialty nurse, “social admissions” or ALC patients are “not wanted” and are prioritized very low on the care scale:

Nobody wants them; not just the emerg staff. Look at trying to get an older person admitted. I mean this is a teaching hospital. They’re not viewed as interesting teaching cases, so there’s a reluctance to admit to medicine. The general medicine staff physicians are very often cherry picking interesting teaching cases and the elderly generally are not seen as that. It’s really quite appalling. It’s systemic, is what I’m saying. It’s appalling! (B. Kolb, personal communication, February 6, 2009)

**Text five: The immediate transfer protocol.** This document, previously called the 7-hour Rule/15-Minute Rule document is simply an abstraction of the Ministry’s documents discussed above. It is what The Hospital administration calls a “policy in progress.” The document, generated by the vice president of the trauma, emergency, and critical care program and her colleagues accomplishes one methodologically important thing: it organizes the nurses’ thinking and work in a way congruent with administrative priorities. Its goal, verbatim from the document itself is:

It is our intent that placing patients in the hallway will be a short term measure to assist in meeting the acuity need of patients in the ED or assisting the hospital in meeting Ministry of Health length of stay targets. We will begin to actively seek the next available room when patients have been in the hallway for 24 hours. (The Hospital, ED Immediate Transfer Protocol, 2009)
Analysis of this text begins with the unpacking of concepts such as “short term measure,” “acuity,” and “need,” among other institutional categories. The analysis continues to trace clues in the institution of the text’s ruling purpose: its organizing of caring work and subjugating elderly patients to the discourse of patient flow vis-à-vis the Ministry guidelines. In another analytic, I look at what other texts hook up with the immediate transfer protocol in the ruling process. This intertextuality, a tightly knit network of a small number of texts discussed here sets the analytic stage for me to investigate how they organize caring work at The Hospital.

**Text six: The patient chart.** The chart, also examined as an institutional text, comes into intertextual play with the above texts. The patient chart, however, is not analyzed here as a stand-alone and specific institutional text as, for example, the CTAS is. Rather, it is seen as a collection of information – data gathered by the practitioner that comes to represent the patient in the paper form. The practitioner, Smith (1987) indicates, experiences a *bifurcated consciousness*, where two ways of knowing the patient come into being. One way is in the actual embodied sense, and the other is in the paper form, the abstracted mode. It would be impossible to analyze the patient chart in the same way the above five texts were because of its inherent intent to be frequently updated, revised, added to, and subtracted from. For this reason, the patient chart is simply seen here as an abstracted representation of the patient as demonstration of how it pulls the practitioner away from embodied knowing – embodied care. The patient chart is also seen as the plexus through which the above texts at some point intersect, a phenomenon coined by (Smith, 2006b) as *processing interchanges*. This is necessary as it is the patient chart, for
example, to which the practitioner resorts come time to implement the immediate transfer protocol.

**Ethics**

Two separate ethical review boards reviewed this project: that of the university and that of The Hospital. Expedited reviews were conducted. I obtained study approval within five weeks of submitting the ethical review packages. Within these five weeks, there were minor changes that needed to be made to the application, which The Hospital requested. Participants were provided with the consent forms and given two weeks to respond. None of the interviewees experienced any discomfort during or after the interviews, though support was readily available had they needed it.
Chapter Four: Institutional Texts and the Social Relations of “Patient Flow”

Introduction

In this chapter, I will provide a brief history of the institutional texts to be analyzed and how they came into existence. I will provide a discussion of their intertextuality, identify the boss text (Smith, 2005) and the lower level texts in the intertextual map, and demonstrate how the lower level texts take up the authority of the boss text as a regulatory mechanism. Texts’ inherent quality of abstracting and generalizing embodied experience will be applied to the ED’s caring work, particularly to the work of the nurse. This, I will illustrate is how texts pull the consciousness of the practitioner away from embodied knowing, bifurcating it into two modes of knowing: the embodied, experiential mode, and the generalized, abstracted mode (Smith, 1987). As a demonstration of how texts rule, I will apply Smith’s (2006a) concept of the Act-Text-Act Sequence to caring work. I will explicate how texts authorize and navigate caring action; with emphasis on the authority texts have over the work of the practitioner. This last analytic will be discussed in greater detail in the next chapter.

Text One: CTAS Guidelines and the Triage Software

I will treat these two texts as one. The triage software is simply an electronic rendering of the CTAS guidelines (a federal document), adapted to fit the patient tracking software of The Hospital’s ED. I will hereafter use the two interchangeably but will be referring to the institutional text of the federal guidelines called “The Canadian Triage and Acuity Scale.” Adapted from the Australian emergency triage system, the CTAS was created to help first responders and bedside practitioners sort through multiple patients and prioritize care based on certain criteria. The ED purchased a computer software titled
the Emergency Department Information System, or EDIS for short, a sophisticated tracking system that contains, among other subsystems, patient list aggregates, demographics, historical information, maps of the department, and a triage subsystem.

The triage function is essentially the first text that is activated by the nurse – the triage nurse – upon patient presentation. It is opened using the click of a mouse. Based on the complaint of the patient, the triage nurse selects a complaint code. This complaint code, also called the “chief complaint,” will come to represent the patient’s emergency throughout his or her ED visit. It was decided by senior ED leadership that this software would facilitate the efficient and accurate triaging of patients. It was introduced in 2002 and has since been the only method to triage patients as they arrive to seek emergency care. The following table, taken from the Ministry of Health’s website outlines the CTAS categories and their corresponding descriptions:
Table 1

*The Canadian Triage and Acuity Scale Categories*

<table>
<thead>
<tr>
<th>CTAS Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Requires resuscitation and includes conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (for example, cardiac arrest, major trauma, or shock states).</td>
</tr>
<tr>
<td>II</td>
<td>Requires emergent care and includes conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts (for example, head injury, chest pain, gastrointestinal bleeding…).</td>
</tr>
<tr>
<td>III</td>
<td>Requires urgent care and includes conditions that could potentially progress to a serious problem requiring emergency intervention, such as mild asthma or dyspnea, moderate trauma, or vomiting and diarrhea in patients younger than 2 years.</td>
</tr>
<tr>
<td>IV</td>
<td>Requires less-urgent care and includes conditions related to patient age, distress, or potential for deterioration or complications that would benefit from intervention or reassurance within one to two hours, such as urinary symptoms, mild abdominal pain, or earache.</td>
</tr>
<tr>
<td>V</td>
<td>Requires non-urgent care and includes conditions in which investigations or interventions could be delayed or referred to other areas of the hospital or health care system, such as sore throat, menses, conditions related to chronic problem, or psychiatric complaints with no suicidal ideation or attempts.</td>
</tr>
</tbody>
</table>


The Hospital has set “door-to-physician” times for each category that dictate the maximum length of time a patient can wait for an emergency physician. A CTAS level I patient’s door-to-physician time is zero minutes, whereas a level II patient can wait up to 10 minutes. A level III patient can wait a maximum of 30 minutes, one hour for the level IV patient, and two hours for the level V patient.
Texts Two, Three, and Four: Ministry Guidelines

I have grouped the following three texts as “Ministry guidelines:” Ontario’s Emergency Room Wait Time Strategy (Appendix A), Emergency Room Targets (Appendix B), and Alternate Levels of Care (ALC) Patient Definition (Appendix C). In May 2008, the provincial government introduced the ER Strategy, a 55 million dollar pay-for-“results” program, or P4R, that gives 46 hospitals across Ontario funding incentives to meet specific targets and reduce the time patients spend in the ED. The Hospital enrolled in this program in 2009. Ontario’s Emergency Room Wait Time Strategy was created in 2008, later modified in 2009, adding initiatives directed at the public that target the reduction of ED use. Such initiatives include educating the public on alternatives to emergency departments, and linking people with family physicians. This document became of particular relevance to The Hospital and specifically, to the senior leadership and patient flow entities of the institution. Suddenly, the amount of time a patient spent in the ED directly impacted the amount of money the institution received from the Ministry. This created competition for Ministry dollars between the 23 enrolled hospitals, and the means by which to “win” the most money is to reduce lengths of stay of emergency patients. To do this, the Ministry outlines in this document that it will “expand alternatives to ED services, increase capacity and improve ER processes, push for faster discharge of ALC patients, and measure and report times spent in the ER” (Ministry of Health and Long-Term Care, Ontario’s Emergency Room Wait Time Strategy, 2009, p. 1).

Around the same time period, the Ministry created the Emergency Room Targets, a document that lists provincial targets “for the optimal length of time within which a
patient should spend in the ER. These targets were developed with the help of clinical experts and serve as a method of accountability and provide a goal for hospitals and ERs to achieve” (Ministry of Health and Long-Term Care, Emergency Room Targets, 2009, p.1). Recall the CTAS table above (Table 1). The Ministry assigned target lengths of stay based on each CTAS category as such: CTAS 1 and 2 patients should not remain in the ED longer than eight hours. Similarly, the CTAS 3 patient’s target is six hours, and that of the CTAS 4 and 5 is four hours. Anytime a patient exceeds the specified lengths of stay, The Hospital is financially penalized. With the development of these targets, the Ministry also began collecting and publishing the CTAS data of all enrolled hospitals. This data includes information on the lengths of stay of patients in the ED with their corresponding CTAS codes. Part of Ontario’s emergency room wait time strategy is to discharge alternate levels of care (ALC) patients faster. Beginning July 1st, 2009, “all acute and post-acute hospitals in Ontario will be expected to designate patients as ALC” (Ministry of Health and Long-Term Care, Alternate Levels of Care Patient Definition, 2009, p. 1). An ALC patient is defined as a patient who “does not require the intensity of resources/services” in the care setting (Ministry of Health and Long-Term Care, Alternate Levels of Care Patient Definition, 2009, p. 1) [italics mine]. Here, I am less interested with the history of this text and more with its aggressive use during the development of the Ministry’s ER Strategy. It is based on this text that the acute care institution, such as The Hospital deems the patient no longer “acute,” can no longer benefit from its services, and a candidate for “timely” discharge. To avoid financial penalty, The Hospital would have to discharge this patient within the set Ministry target times, based on the CTAS score that the triage nurse assigned him or her.
These three texts, although coming into existence during various times, converged in 2008 to set standards and guide hospital administration resulting in a new form of ruling called “the ER Strategy.”

Text Five: The Immediate Transfer Protocol

The Immediate Transfer Protocol (Appendix D), created by the executive vice president came into being at The Hospital in late 2009. This document is simply a distillation of the Ministry guidelines. It is a two-page algorithm that guides the actions of the ED charge nurse on a given shift. In the same way that the Ministry documents outlined above guide hospital administrators’ actions, the Immediate Transfer Protocol mediates the actions of nurses at the bedside when the hospital is at 100% capacity. The tool lists criteria to assemble “hallway-appropriate” patients. Such patients would be sent to the ward hallways when their admitting ward is full. Since its communication to the ED, this document became a main reference tool for the charge nurse on which to rely in order to make decisions about patient movement and discharge. Recently, the document became electronic, available online throughout the ED. Along with this development, the electronic version was interfaced with the live list of all patients in the ED at any given time. This interface allows the charge nurse to select any particular patient deemed a candidate for transfer from a ready list and activate the Immediate Transfer Protocol all at once and rather quickly.

Although the Immediate Transfer Protocol is based on the Ministry Targets, a category only relevant to the hospital emerged as a result, called the “hallway patient.” The hallway patient is any admitted patient who meets certain criteria (See Appendix D).
This is noteworthy because here we can see how institutional categories come to be, and in this case, the “hallway patient” category originated from a Ministry text.

**Text Six: The Patient Chart**

I have deliberately not placed the patient chart into the intertextual map (below) for two reasons: it does not mediate practitioner actions to the extent the first five texts do; and, I will treat it as simply a collection of patient information that is compiled by all practitioners involved in a particular patient’s care. My emphasis is on the first five texts. These five texts, however, do influence modifications, additions to, and subtractions from the chart as they are activated. The patient chart is started with the triage process. After the patient presents to the triage booth, and is interviewed by the triage nurse, whose interview is guided by the triage software, a printout of the interview is generated. This printout acts as a starting document that becomes the nurse’s note and the first piece that begins the patient chart. Other documents that are added to the patient chart shortly after triage are the *Febrile/Respiratory Illness Screen, Emergency Physician Note*, and two pages of labels that contain the patient’s identifying information. The patient chart travels with the patient throughout the ED and other departments; for example, x-ray, CT scan, and MRI, coming to represent the patient during every stop of the emergency care process. The more sophisticated the chart becomes, the more abstract this representation becomes.

**The Intertextual Map**

In this section, I will present the institutional intertextual map as a hierarchy of texts. Using this hierarchical relationship, I will offer an analysis of how the CTAS, as the boss text (Smith, 2005) authorizes and regulates the lower level texts. Next, I will
discuss how these texts, including the patient chart, act as a mechanism to bifurcate the practitioner’s consciousness (Smith, 1987). I will provide an example from my experience to demonstrate how the consciousness of the practitioner in this regard, is torn. I will offer a description of the process by which experiences of care become generalized and abstracted vis-à-vis the recording and reporting process, dubbed by the Ministry “The ER Strategy.” I will provide a discussion on how these texts navigate action, mediating sequences of care, authorizing action – authorizing care. The following map of the first five institutional texts depicts the CTAS presiding over the other texts as their regulatory document. Note the patient chart is absent; though imagine it on the peripheries of the diagram.

**Figure 2. Institutional texts: The intertextual hierarchy**

![Diagram showing the intertextual hierarchy with CTAS at the top, followed by Wait Time Strategy, Wait Time Targets, Immediate Transfer Protocol, and ALC Definition.]
Smith (2005) identifies a boss text as the highest-level institutional text in any given intertextual hierarchy that regulates lower texts. In this hierarchy, I have distinguished the CTAS as the boss text. The CTAS necessarily plays the role of the boss text for two reasons: It is according to its categories (Table 1) that the Ministry sets target times for hospitals to meet; and, in part, it is due to CTAS hospital data that the ER Strategy came to be, and is modified.

The interplay between the CTAS and Ministry targets. According to the Ministry of Health and Long-Term Care, the target times for ED length of stay were set with the consultation of health care experts. The Ministry, however, does not offer any more information on this process, certainly not on the public website. Though I am not privy to the Ministry’s processes of creating guidelines based on CTAS data, I will speak to The Hospital’s role in this reporting regime.

Using the Emergency Department Information System (EDIS), regressive data is aggregated on a monthly basis and emailed to the staff in the form of a weekly report (Appendix D). The report lists the number of patients seen in the ED under each of the five CTAS categories and the percentage of times by which Ministry guidelines were met under each category. This information is emailed to all emergency department staff on a weekly, sometimes, biweekly basis. The chief of staff of emergency physicians is responsible for generating the report, and the ED’s advanced practice nurse disseminates it. The report is generated in a way very similar to that of the Ministry’s, published on the website and available at:

http://edrs.waittimes.net/en/CTAS.aspx?LHIN=7&hospID=4205&period=5 It is with the intent to demonstrate how “efficient” the department is becoming that the report is
regularly communicated to the staff, also called the “Daily ED Flow Report.” Below is an excerpt message taken from a recent one of these reports, sent by the chief of staff of emergency physicians, congratulating the nurses and physicians on their “performance:”

The Hospital presented at the Toronto Central LHIN [Local Health Integrated Network] P4R/ALC meeting this morning and the group was highly appreciative of the organization-wide efforts being made here to impact on patient flow as well as the very positive trends in our indicators throughout the fiscal year. (S. Green, personal communication, February 16, 2010)

It is these reports that are fed up to the Ministry, listing the CTAS categories and their corresponding Ministry targets that were met. Based on this reporting, the Ministry makes the decision to compensate The Hospital. Recently, the ED staff has been receiving reports, titled the “Performance Indicator,” generated by a “Decision Support Program Consultant” disclosing the dollar amount The Hospital is compensated based on the met targets. For the month of April of 2010, for example, the institution was remunerated $30,070, and $47,162 for the month of May. Mapping out this reporting process starting with the patient, it unfolds as follows:

1. A patient presents to the triage booth with an emergency complaint.
2. The triage nurse completes an assessment and assigns a triage code.
3. The data generated by the nurse in the triage software is stored in EDIS, later recalled and aggregated into a report.
4. This report compiles weekly data and is sent to the Ministry.
5. The Ministry reviews this data and allocates money based on met targets.
6. The Hospital receives funding and a consultant of The Hospital generates a report, which is fed back to the bedside staff as the “positive trends” of meeting the targets, reported in dollars.

The Wait Time Strategy is simply a policy the Ministry put forth that takes up the targets created by the process above. It includes other initiatives such as “expanding alternatives to emergency rooms and improving processes within emergency rooms.” As I came to understand this regime, I puzzled over the process by which the Ministry arrived at such target times. How does the Ministry estimate, for example, that a CTAS 2 patient’s care will be complete within eight hours? Similarly, how does the Ministry arrive at categorizing alternate levels of care when the line between acute and chronic is often blurred in the ED? The Ministry has not been forthcoming with the process by which it estimates care times, except that they were formulated with the consultation of “health care experts.” What are the problems created as a result of taking highly abstracted data as a representation of actual local caring work? What is at stake when resource decisions that impact care are made based on such abstractions? I will address these questions in the next chapter, though I wanted to list them here to illustrate that the abstraction of care begins here and leads to a set of problems, some of which were identified by my participants. In the next chapter, I will discuss the consequences of such abstraction and decision-making based on a flawed representation of local caring work.

**The CTAS as an authorizing text.** Above, I have demonstrated the relationship between the CTAS and the Ministry Wait Time Targets as CTAS data is taken away from the bedside and into the arena of the Ministry. The ALC Definition and the Immediate Transfer Protocol are both regulated by the CTAS in a similar fashion.
The ALC definition relies on the patient’s state of acuity, as defined by the CTAS. It uses rather vague concepts such as intensity of resources and reaching potential of care. The Definition emphasizes that the implementation of ALC designation will result in congruency between care delivery and the patient’s clinical “needs.” In the ED, once a patient reaches this “potential,” defined by the targets discussed above, he or she is designated as ALC. Simply by meeting the eight-hour mark for a CTAS 2 patient, for example, the patient apparently reaches a point by which the care is no longer appropriate. The practitioner takes up this definition as dictated by the higher-level Ministry targets. Where the ED is deemed a “high acuity” department, patients are deemed no longer acute once an ALC definition is assigned; this is for every CTAS 2 patient at the eight-hour mark, every CTAS 3 patient at the six-hour mark, and every CTAS 4 and 5 patient at the four-hour mark. The ALC is authorized and regulated by the CTAS in such cases, as it is the CTAS that dictates categories of acuity and their respective definitions. Based on the CTAS categories and their respective target times, the ALC text is activated. Smith (2005) calls this intersection of texts a “processing interchange.”

Thus far, I have discussed the CTAS being a federal document, and three lower level provincial documents: The ED Wait Time Targets, the ED Wait Time Strategy, and the ALC Definition. The Immediate Transfer Protocol is a text generated by The Hospital. It is the lowest level text in the intertextual hierarchy (Figure 2). This is the text that directly interacts with the practitioner, mediating sequences of work in the department. It lists triggers that allow the charge nurse to react in time to move patients to appropriate spots, including expediting their discharge or admission to wards to meet
Ministry targets. The triggers are simply the Ministry target times minus reaction time. Reaction time is the estimated time the charge nurse requires to facilitate patient movement in the department or the institution. For example, recall the CTAS 2 patient’s length of stay is eight hours. The trigger in the Immediate Transfer Protocol for a CTAS 2 patient is seven hours. This allows the charge nurse one hour to either have the patient discharged, admitted, or transferred to another ward in the hospital.

*A note on hospital admission.* A hospital admission is when the status of the patient is changed from ED patient to inpatient. This means that the patient requires overnight care and his or her care period in the ED has ended. Admitted patients receive this status, as it is entered in the EDIS, and often wait until an available ward bed is ready. The wait in the ED for a ward bed ranges between several minutes to several days. There is another level of “patient flow” activities with admitted patient: another Ministry target set by The Hospital. This target dictates that any admitted patient must be moved to his or her respective admitting ward within eight hours of registration. Failure to meet this target results in financial penalties to The Hospital. When Admitting wards are full, the Immediate Transfer Protocol is initiated in order to place patients in ward hallways.

**Two Modes of Knowing**

Dorothy Smith (1987), in her *Everyday World as Problematic* examined her experience as an academic and as a mother. She identified a divide between these two ways of being. She came to see that one way of being was textually organized “to create a world of activity independent of the local and particular,” (p. 6) and the other located her, among other things, as an embodied and experiencing single mother caring for two small children. She called this divide in being and knowing a *bifurcated consciousness.* I
borrowed this concept to demonstrate that a bifurcated consciousness is immanent throughout the hospital, in fact, an institutional prerequisite to “efficient” and “timely” care.

In the local happenings of the ED, there exists a world in which the particularities of patient needs, human interaction, dialogue, and touch are real. Both the practitioner and patient experience each other’s presence as embodied subjects actually located in this world. This is the world of embodied care. In this way of being, care emerges out of patient need and out of the practitioner’s moral commitment to the patient. This world, however, only exists as fleeting moments, as mini experiences within a much larger and concerted setting with its own interests. Through this research, I came to see how overwhelmingly institutionalized care processes have become. Although emergency nursing and medical care have recently shifted to become more in line with the regimes of health care restructuring and re-engineering, having taken on an accounting logic (Rankin & Campbell, 2006), there exist the actual, but brief moments of care as I had imagined them once as a novice practitioner. There is also the other world, and it is in constant opposition to the one described here. This is the abstract world of recording and reporting. This form of existence relies on the paper mode of knowing – the creation of the virtual patient in the form of paper and computer software. Here, the ED is rewritten in the form of reports, policies, guidelines, demographics, diagnoses, life sign values, parameters, abbreviations, and so on. The practitioner is heavily and inescapably immersed in this world.

With every workday, upon entering the organization, the practitioner immediately and unconsciously takes part in this world’s social relations – relations that take the
particularities of patient care and represent them in the ways I listed above. The practitioner comes to know the patient in an overwhelmingly abstract way, at the cost of the humanistic, embodied interaction. The relationship is, for the most part, based on this abstract way of knowing the patient, through various institutional texts, categories, and concepts. The nurses and physicians of the ED spend the majority of their work time recording assessment findings and interventions, as well as interfacing with various computer programs. This is necessarily so, as for the patient to receive any care, in a few moments, at least two texts are activated, several institutional categories are named, and policies (knowingly or not) are implemented. Below is an example, taken from my field notes, documented September 13th, 2009. In bold are the various institutional texts, categories, and concepts that navigated my experience:

I was the nurse assigned to the EMS Hallway (the area to which the ambulances offload patients for emergency care). My four patients were distributed throughout a narrow hallway on stretchers. Two of them were adjacent to each other, along a wall, separated by a curtain for privacy. Another, I will call Keith, was also on a stretcher alongside a wall that was further down, to the right of the first two patients. The fourth patient lay across from Keith, also on a stretcher, who had just been brought in by an ambulance, dizzy and vomiting. This entry is concerned with Keith and an incident related to him, involving Donna, the physician on duty that evening. I had noticed that upon my initial assessment of Keith, his level of consciousness was decreased, in that he was slow to respond to my questions, he often slurred his speech, and preferred to lay back with his eyes closed. I also noted that he was severely jaundiced and his legs and abdomen were extremely swollen. I asked if he was in pain to which he responded: “a little bit here” pointing to his abdomen, “and my back hurts from laying on this stretcher.” His mother and another man were present at Keith’s bedside. Keith’s mother, unprompted, proceeded to tell me about Keith’s medical history, explaining to me that he has colon cancer and that the cancer had spread to his liver and his liver is causing these complications. I explained to her that I needed to go and speak to the physician to explain Keith’s condition and perhaps expedite his care. My intention was really to speak to Donna to request of her to speak to Keith and his family regarding end of life care and what his wishes were, as I believed that Keith was dying. In cases where dying patients near the end
of their lives, it is very important to establish what we call **advanced directives** regarding end of life care for the patient. Either the patient requests a **DNR** status (Do not resuscitate) and this involves different levels of resuscitation, or chooses to be deemed a **full code**, meaning that all life-saving/life-preserving measures would be taken should he experience a cardiopulmonary arrest. I left Keith’s bedside in the EMS Hall and proceeded to find Donna, seated in the **Green Zone** physician room, and presented a quick verbal **report** to her about Keith as follows: S: Donna! I have a gentleman with colon cancer with metastases to the liver. He looks like he’s **end-stage**. I’m just wondering if you can glance at him; perhaps speak to him regarding a DNR. He’s in the EMS Hall though, perhaps when he moves into a room…shortly. I’m not sure what room we have available…

Donna: Sorry, what’s his **primary**?

Simon: Colon

Donna: And metastases to the liver?

Simon: Yes.

Donna: How old is he?

Simon: He was born in…[looking at Keith’s **chart**] ‘61

Donna: **1961**?

Simon: Yes

Donna: Whoa! He’s young.

Simon: Yes. He’s quite young. (Field notes, June 13th, 2010)

By accessing Keith’s chart and completing a short, 45-second assessment on him, I activated five different institutional texts and participated in placing him into at least seven different institutional categories. To Donna and me, Keith was the colon cancer patient with metastases to the liver, who had been delivered by an ambulance for complaints of abdominal and back pain, likely in end-stage cancer, in need of pain control and a resuscitation status. His being categorized as an ambulance patient navigated his care trajectory in a specific direction. Similarly, his diagnosis and the advancement of his disease also placed him in a particular location within the institution. By my activation of one institutional text after another, I quickly shifted from one mode of knowing Keith, to the other. I moved from the embodied world and into the abstract, and this would be the world in which I would operate for the duration of the care period for Keith. In the 45
seconds that I completed an assessment, I was able to touch him: rest the palm of my hand on his shoulder and feel his damp clothing from the perspiration resulting from pain and shortness of breath. I was able to see his yellowed skin and sclerae and observe the facial grimaces with every move he made in an attempt at comfort. I felt his bounding pulse and palpated his distended abdomen, often resting another hand on his shoulder. This mode of knowing quickly met its end upon my leaving Keith’s bedside to never be experienced again. I remove myself and enter the abstract and generalized mode of knowing Keith. I communicate my findings with the physician and document in the chart. I move Keith into another area and adjust the department map in the EDIS to reflect this move, dispense medications, obtain a reading of his vital signs and quickly medicate him for pain. After obtaining a second vital signs reading after the pain medication takes effect, I document in the chart once again, place Keith on a cardiac monitor, and move on to my next patient. The world of high touch quickly transforms into a world of high tech in which Keith and his caregivers are suspended.

When Smith experienced a bifurcation in her consciousness, the proportions of each mode of knowing were nearly the same. She observed that she spent one part of her life in the embodied world, and another being ruled by the abstract one. Practitioners in the ED spend most of their time in the abstract and generalized world, being navigated by texts and categories. This is the dominant world in which the practitioner and the patient exist, so much so that the embodied mode of knowing is fractionally insignificant. All of the actions of the practitioner are embedded in this abstract mode of knowing, even the activities that unfold in the embodied interaction. These too are required to be documented and reported. They are timed, audited, and measured. All the actions of the
practitioner are authorized, prompted, and evaluated by the abstract world. The practitioner comes to know the patient care world in the ED, the only world, as the abstract and generalized, concerted via a network of texts, concepts, categories, and so on. Whereas Smith vacillated between two worlds – two modes of consciousness – the ED practitioner almost always operates within the abstract and generalized, seldom within the particular.

**Authorizing Care: Texts as Mediators of Sequences of Care**

I will draw from my experience with Keith to illustrate exactly how my consciousness was pulled out of the embodied world and into the abstract one. Using Smith’s (2006a) Act-Text-Act Sequence, I will illustrate how the activation of institutional texts methodically navigated my actions. Let us take, as an example, the advanced directives text, also known as the Do Not Resuscitate Confirmation Form, introduced by the Ministry in February 2008. The instant I learned about how advanced Keith’s disease was, I immediately considered this specific text. I activated the text in my mind in a way that allowed me to plan his care. I had no other way to think but to invoke this document, imagine its categories, and apply them to Keith. I would not have known how to navigate his care otherwise. Thus, the reaction was immediate and necessary to maintain the “flow” of care. Similarly, the CTAS navigated my thinking, certainly when deciding Keith’s acuity and subsequently, my response to his needs. Before meeting Keith, I am presented with his chart, on which the CTAS code is located as a large bold-faced font. The instant I see Keith’s assigned CTAS 3 code, my thinking takes on a certain trajectory. The CTAS navigates my thinking in a particular way: I understand that his condition, based on the code is “urgent” but not “emergent” or “resuscitative.” Keith
is quickly deprioritized in my head until I approach him and complete my assessment on him. The triage process follows suit in the same fashion, in that the consciousness of the triage nurse is organized around the categories of the CTAS, more so at triage than at Keith’s beside. As I illustrated above, to the practitioner, Keith quickly becomes the colon cancer patient with metastases to the liver, and so on. This is also the story conveyed by the paramedic to the triage nurse, who assigns him the code CTAS 3 that would represent his emergency for the duration of his visit. The following illustration, depicting how texts mediate action is taken from Smith’s (2006a) Act-Text-Act Sequence, where act represents local work processes. Note the time’s arrow at the bottom indicating that textual mediation is not an atemporal process:

Figure 3. Smith’s (2006) Act-Text-Act Sequence

How exactly does the navigation of thinking, thus action, take place when mediated by institutional texts? To answer this question, I will list the sequences of thought and action of the practitioner as institutional texts are activated. I will base this list on Keith’s example:

1. Thought: Keith is a CTAS 3 patient; therefore, “urgent” care is required.
2. Thought: Keith can wait while the other CTAS 2 patient is attended to.
3. Action: I attend to the care of my more “acute” patient.
4. Action: I finish my “acute” interventions and read Keith’s chart, accessing the Triage note.

5. Thought: I verify that Keith belongs to CTAS 3 category and read the triage narrative generated by the triage nurse.

6. Thought: I place Keith in the categories of “colon cancer, end stage cancer, abdominal pain, decreased level of consciousness, and potential DNR.”

7. Thought: I review the Do Not Resuscitate Confirmation Form and consider asking Donna to speak to Keith about his status.

8. Thought: I consider the likely possibility that Keith is palliative, requires pain control, and will appear to have yellowed skin and a large abdomen.


10. Thought: Keith is a colon cancer patient.

11. Thought: Keith is “end-stage.”

12. Thought: Keith requires a DNR status.

13. Thought: Keith is in pain and requires pain management.


This list represents two or three minutes of my work, during which I was controlled by several factors (texts and categories) that lay beyond my consciousness. It is important to note that the activation and reactivation of these texts and others, continues as Keith’s “condition” changes medically and institutionally. This is where Smith’s (2006a) act-text-act sequence continues as a temporal phenomenon: constantly navigating thought and action, thereby authorizing specific events of care.
For a moment, I want to draw attention away from the actual interventions that take place during Keith’s experience. My analytic intent is not to focus on the actual actions, interventions, or clinical outcomes. Keith definitely needed a private space to receive care, pain control, and needed to be made comfortable. He would not dispute these sequences of care either. My interest here lies in the power of the texts and categories to navigate my thoughts and actions. The outcome for Keith was desirable in that he obtained rather quick pain control, was moved to a private room, and was assessed by the physician relatively quickly. What happens, however, when this navigation of the practitioner’s thoughts and actions results in an “undesirable” outcome, or “desirable by some and not others”?

**Authorizing Care: Categories as Mediators of Sequences of Care**

I will demonstrate how institutional categories as navigators of sequences of caring action lead to difficulties at the point of care. In a similar way that texts mediate and navigate sequences of care, institutional categories do the same. I have borrowed from Smith’s idea (Figure 3) to create Figure four, below, to illustrate that institutional categories navigate caring action in a very similar way texts do.
Figure 4. The Act-Category-Act Sequence


Let us go back to Gordon’s experience from chapter one. Recall Gordon: an elderly man, in his 80’s who was admitted to the hospital, awaiting an available ward bed on the general medicine unit. His diagnosis was “failure to thrive.” He was also confused.

Here, my analytic gaze turns to the charge nurse’s decision-making process. This process, I will demonstrate, was influenced by Gordon’s “failure to thrive” and confusion. The charge nurse’s actions constructed an institutional understanding of Gordon’s “failure to thrive,” a “condition” that otherwise means the patient has lost all community supports and requires a hospital admission in the time it takes to set them up for him. These two institutional categories as well as the “hallway patient” category are my analytic focus. At face value, for the practitioner, these categories are a diagnosis, an assessment finding, and a patient “disposition.” The term “disposition” refers to the patient’s destination, i.e. ward, home, et cetera. However, enter institutional “patient flow” priorities, and suddenly the picture becomes highly political, in fact, more political than clinical.

Carrie, the charge nurse, suspended in the abstract and generalized world, must complete certain tasks to facilitate “patient flow” in line with Ministry guidelines. Based
on her application of the Immediate Transfer Protocol (Appendix D), Carrie had deemed Gordon “hallway-able” that evening. This means that Gordon was to be admitted to the hospital and sent to a ward hallway to spend the night. As I identified in chapter one, this placed Gordon at a high risk for developing delirium that can lead to various other dangers. Carrie’s focus was to remove Gordon from the ED within Ministry target times, and ensure that he fit the “hallway patient” criteria. Having a diagnosis of “failure to thrive” immediately placed Gordon in a particular place within the institution. As far as Carrie was concerned, Gordon was a “social admission,” a CTAS 3, non-acute patient, requiring a general medicine ward admission. Carrie operated within the abstract world to “place” Gordon. Initially, she activated the Immediate Transfer Protocol as Gordon’s care time approached the Ministry length of stay limit. Gordon’s “failure to thrive” came to dominate Carrie’s thinking in that the “placing” of Gordon was based on this diagnosis. To “place” him, Carrie would ensure he had reached the maximum amount of time in the ED allowed by the Ministry, that he was a “hallway candidate,” and that he was informed about the move. Carrie’s course of action was mediated by Gordon’s diagnosis as to make him “hallway appropriate” in combination with meeting the hallway criteria (Appendix D).

As an elderly man with a non-acute condition (confusion) Gordon quickly became deprioritized, slotted into the hallway category, and moved out of the ED in a “timely” manner. Recall from chapter one that I, his primary nurse, was attempting to keep him in the ED in an effort to advocate for him. I had come to know Gordon as a human being, and given the time constraint; I had come to know him very closely. Gordon and I created an embodied relationship not based in the abstract or general. On the other hand, Carrie,
and the shift managers were also operating in the mode of the abstract knowing. Their courses of action, mediated by texts and institutional categories subjugated my advocacy efforts and Gordon’s experience. They implemented their patient flow regime based on the policies and guidelines at hand as well as the categories that had been preset for Gordon: Failure to thrive, confused, and ALC. Carrie and the shift managers based their decision-making in a political-institutional regime and not a humanistic, even clinical one. As I demonstrated in chapter one, clinically, it is unadvised to have Gordon sent to the hallway given the risks to him. Institutionally, however, Carrie had an agenda to carry out that competed with, and won against her better humanistic judgment.

Conclusion

The practitioner operates within two modes of knowing: the abstract and fleetingly, the embodied. Here, I have presented the texts that play an important role in the creation of this abstract way of how nurses and physicians come to know their patients. Texts and institutional categories not only bifurcate the practitioner’s consciousness, trapping it within the abstract and generalized, but also navigate action. Here, the regime of “patient flow” comes to light in demonstrating how its texts mediate, navigate and authorize the actions of nurses and physicians at the bedside.
Chapter Five: Institutional Structures and the (Re) Organization of Caring Work

Introduction

Having focused in the last chapter on the key documents, in this chapter, I will look at how the work of the practitioner is organized by a system of ruling to serve extralocal interests. Smith’s idea of work organization (2005) will be critiqued based on its being static and not representative of the changes to the organization of work in contemporary hospitals. I will discuss the various ED “initiatives” that impacted the organization of the work of bedside workers. I have identified six such structures of ruling that came to organize and reorganize the work of nurses, physicians, and other bedside workers. These institutional structures are: The zoning of the ED, the nursing model of care, the Bed Management System, the Kaizen Lean events, The P4R mode, and the Drive to 95 Initiative.

The (Re) Organization of Work

Dorothy Smith looks at work organization as a symptom of ruling (Smith, 2005; D. Smith, personal communication, August 15, 2009). She maintains that control over the organization of the work of those being ruled is necessary for ruling to exist. Recall from chapter four Smith’s (2006a) Act-Text-Act Sequence (Figure 3). She depicts textual ruling as a temporal process, in that institutional texts mediate the actions of the practitioner across time and in multiple geographic locations. I have come to see that certain institutional structures rule in a very similar way. The concept of work organization took on a temporal quality when I looked at how the institutional structures I listed above actually ruled. Contemporary hospitals are plagued with continuous change. Process changes at The Hospital occur as frequently as every day, lasting several days to
several weeks. With the introduction of various managerial “initiatives” to increase efficiency and measure accountability, the work of nurses and physicians is organized and reorganized as frequently as management sees “fit.” Looking at how work is organized, as Smith explains it, can demonstrate how the local actors are hooked into institutional social relations that serve interests elsewhere and elsewhen. I would like to, however, look at the concept as a temporal phenomenon. I will analyze the organization of the work of the practitioner and its local happenings to explicate how these structures rule.

Following is a continuum of the ruling structures to be discussed here. These institutional structures are listed on the continuum in chronological order, based on their time of introduction into the ED. Notice they are placed on a continuum, suggestive that others have come and gone and others will be introduced in the future. With the introduction of each ruling “initiative” work is organized in a specific way, then reorganized time and again with every evaluation of each particular initiative.

**Figure 5. Continuum of institutional ruling structures**

<table>
<thead>
<tr>
<th>ED Zoning</th>
<th>Nursing Model of Care</th>
<th>Bed Management System</th>
<th>Kaizen Lean Events</th>
<th>Pay For Results</th>
<th>Drive to 95 Initiative</th>
</tr>
</thead>
</table>

These ruling structures came into place over the course of several years. Some were implemented in the call for measuring accountability, while others came to be strictly for patient flow and funding purposes. The first two (ED zoning and nursing model of care) were introduced in order to control nursing assignments, workload, and
measure accountability. The latter four came into place around the same time as the Ministry ED Strategy was disseminated. It is noteworthy to see the institution’s priorities shifting along this continuum; moving away from nursing accountability and into a patient flow and fiscal direction. Below, I will provide an outline of each institutional structure and its role in creating the disparity in practice.

**ED Zoning**

The zoning of the ED came along with the opening of the new department. In January of 2008, the ED was replaced by another larger, newer, “state-of-the-art” building. With this new department, many changes to the work flow and the work organization came along, and one such change was the zoning of the ED. Zoning simply means that the ED is divided into multiple zones. There are six such zones, and they are: the orange zone, blue zone, purple zone, green zone, the triage desk, and the trauma room. The idea behind zoning the ED in this fashion was to group certain types of patients together for organization, workload, and flow purposes. Recall Gordon from the orange zone. Frequently, admitted patients are kept in the orange zone, who often are elderly and complex. The blue zone houses “sub-acute” patients, such as patients with abdominal pain and non-cardiac chest pain. Patients with the most minor of all complaints are sent to the purple zone. These patients typically seek care for small lacerations, uncomplicated fractures, and prescription refills. The green zone is where “acute” patients are streamed. Typically, these are patients with emergencies such as myocardial infarctions, strokes, and cancer-related complications, to name a few. Patients who present with major traumas such as those from serious auto collisions or life-threatening violent events are streamed into the trauma room. I will only look at the
orange zone, as it is of most relevance to answering some of the questions raised by the problems in the care of the elderly.

**The orange zone.** The orange zone was initially created to consolidate “sub-acute” patients. When the idea was re-evaluated and found to be “inefficient,” the decision was to make the orange zone the area in which to store admitted patients. Most patients who end up in this zone tend to be elderly people with complex medical conditions. They are consolidated here for at least two reasons: For management to gain control over the admissions when it comes to patient movement and dispositions; and for management to gain control over nursing assignments. Since its recreation as the admission zone, I have heard it being dubbed “the nursing home, the geriatrics ward,” and “diaper land.”

Here is where care is simply fractured into institutional tasks. This is necessary for the “bare bones” of care to be delivered. Nurses are often assigned four patients in the orange zone. Given the patients’ complexity, nurses tend to be in a constant scurry to make care ends meet. This is where the practitioner is almost always suspended in the abstract, and necessarily so. It is this abstract world that puts forth a list of institutional tasks that must be completed for each patient. Some such institutional tasks include: entering patient admissions, completing patient swabbing for hospital-acquired infections, and reporting off on the patient to the receiving wards.

Consolidating these patients creates a particular problem that has not yet won managerial sympathy. To start, most of these patients are considered non-acute, especially when admitted with social concerns, such as Gordon was. This categorization immediately places them at a deprioritized state. Along the line of thinking that non-acute
patients require fewer resources, they are streamed to an area with less human and support resources: the orange zone. As the ALC definition has it, these patients apparently “no longer require the intensity of resources/services provided in this care setting” (Ministry of Health and Long-Term Care, Alternate Levels of Care Patient Definition, 2009, p. 1); therefore, they are moved here. Ideally, soon after moving to the orange zone, a ward bed would become available and the patient would be transferred. Unfortunately, the ideal situation has seldom presented itself in the past several years. Many patients remain for several days before an available ward is able to take them. I recall an elderly woman remaining in the orange zone for six days!

Time and time again, I, as well as my nursing and medical colleagues have cared for apparently “alternate levels of care” patients whom have required the same intensity of resources and services as those deemed “acute.” As the geriatric nurse clinician put it: “It just occurred to me how much more time the elderly take and I think that’s what’s resented about them” (B. Kolb, personal communication, February 6, 2009). What she implies by “resented” is that that basic care (feeding, toileting, and so on) and the care that takes “longer than expected” is either deferred or neglected altogether. This “resentment” is a symptom of a much larger issue. The push to consolidate patients, redesign care as a list of tasks, and process them in a speedy manner to meet Ministry guidelines creates this “resentment.” This is simply the practitioner working against the grain of falling into the embodied world. The practitioner cannot enter the embodied world. He or she is overwhelmed by institutional tasks that must be completed by a set time frame. This is done at the expense of actual patient needs and the embodied interaction. Operating in this mode, under these managerial pressures necessitates that Helga’s and Gilles’
questions about their care be deferred and Gordon be placed in a hallway despite the
dangers involved in doing this.

**Go sit over there!** Anne, an interviewee, reports her “daunting experience” in the
ED triage area, being faced with the potential of a heart attack. Her story follows, and I
have included a sizeable piece from her narrative to illustrate the level of anxiety she
experienced when her requests for assistance and reassurance were met with institutional
directions: “Go sit over there!”

I arrived at 12:00 noon with quite severe chest pain. Understandably, I was
very worried. I walked in and I could not see where I was supposed to go. I
see Triage, and I know what triage means, but I didn’t know I was
supposed to go and sit there, especially with chest pains. So I went up to
the… I don’t even know how I got up to the little office where I met you.
At that point, it was another nurse, and I said I’m having chest pain and
she said go and sit over there. I said over at triage? “Yes!” And I thought
that was a really funny to say to someone who is having chest pain because
I understand if you have chest pain, you’re looked at. They look at
you certainly right away, and, you know, I mean if you are in serious trouble or
if you in fact can wait. But nobody did that and I went to sit. I sat down
and I waited for a few minutes, and I saw all these emergency guys
walking around, you know, in the navy shirts, and so I stood up and I said
to one of them, what are you supposed to do when you have chest pain?
And he said, well, you’re supposed to wait over in triage, and I said well,
I’m doing that but no one is paying any attention to me, and I said if I fall
on the floor, does someone come and help me? And he just sort of looked
at me. So, then I sat down again, then I got up a few minutes later and I
went over to that same office and I said I don’t know if you understand,
but you know, I am having chest pain and I’m really very worried, and
that’s when she, I think she told me to sit down again, and in about a few
seconds they called me into that room. (A. Gross, personal
communication, June 22, 2010)

Anne’s experience was not independent of “workload” issues related to resource
allocation. Hers is an example of deferred needs that were deemed institutionally trivial,
thus overlooked. Clearly, to her, the need to be seen immediately directly related to her
level of anxiety, and the longer she waited to be greeted by the nurse, the more her
anxiety escalated. She described her ED experience as “daunting and intimidating.”

Albeit, Anne was never an “orange zone patient,” I wanted to include her experience as an example of how actual patient needs are deferred when deemed institutionally insignificant. Anne wanted to be seen immediately, but was overruled by the institutional process of having to read the signs, sit in the front row, and wait to be called.

How does management come to the decision to consolidate patients and assign nursing and medical staff accordingly? We have seen in the previous chapter how local caring work can be abstracted and brought into the Ministry sphere to calculate average wait times. In a similar process, to make decisions about patient consolidation, hospital management enlists the help of the EDIS (patient tracking software), and specifically, vis-à-vis the institutional category of “admitted patient.” Once the patient is admitted, unless he or she is in critical, therefore, “acute” condition, the patient is moved to the orange zone. Basing decisions of resource allocation on a flawed, abstracted view of the work results in an array of problems, for the patient and the practitioner.

Patient care at the bedside is very different than that in administrative spaces. Much, if not most of the local patient care is rendered invisible by the recording and reporting regime. Nursing and medical “interventions” are delivered one way and documented in a very different way. Following is a typical example of a nurse completing a nasopharyngeal swab on a patient suspected to have an upper respiratory tract infection. I will list the sequence of actions of the nurse in completing this seemingly ordinary task:

1. The nurse reads the Febrile Illness/Respiratory Screen document.
2. The nurse realizes that her patient screens positive and requires a swab.
3. The nurse enters this order in the computer to generate a label for the specimen, which takes five minutes or less.

4. The nurse gathers the necessary equipment with the exception of the swab itself as the orange zone is out of stock.

5. She either tours the ED to find one in the other zones or calls a Patient Service Provider to obtain one from other units in the hospital – this takes approximately five to 10 minutes.

6. The nurse obtains the swab and proceeds to the patient’s bedside.

7. As the patient is suspected to have a communicable illness, the nurse must wash her hands and don her personal protective equipment: her mask, gown, gloves, and goggles as dictated by the institution’s infection control policies.

8. She enters the room and explains the procedure to the patient, which may take up to five minutes.

9. Then nurse obtains the swab and labels it, which takes only several seconds.

10. She then removes part of her personal protective equipment in the room, washes her hands, exits the room, removes the rest of the equipment outside, and washes her hands a second time, as dictated by the institution’s infection control policies.

11. She places the specimen in the pneumatic tube system that automatically delivers it to the lab.

12. She washes her hands a third time and documents in the Febrile Illness/Respiratory Screen document a check mark that the nasopharyngeal swab has been completed.
The documentation reflects that a nurse completed a nasopharyngeal swab. Simply reading this out of this document does not nearly represent the tasks involved and the coordination needed to execute this seemingly simple nursing “intervention.” It conveys to the reader, through the simplicity of the check mark that the task is simple and should not require more than a few minutes to complete. What I have listed above is simply a straightforward, typical, and uncomplicated nasopharyngeal swab task. Add patient anxiety that requires alleviation, contaminated equipment that needs replacing, and other unplanned interruptions, and the work of this seemingly short task triples.

The swab was one example of how complicated a particular task can be, though represented in institutional texts as rather simple and quick. Feeding elderly patients who have swallowing difficulties and helping them to the bathroom are two other nursing tasks that demand a considerable amount of time from the practitioner, though represented in the documentation simply as: “Patient fed” or “patient up to the bathroom.” This method of categorization/representation strips context and deletes the particularities that Smith (1987) also found to be subjugated by her academic institution. When a manager activates the text, reading “patient fed” and “patient up to the bathroom” it causes an immediate misrepresentation of this feeding and toileting. The reader does not imagine an elderly person with a history of stroke and one-sided leg and arm weakness and who is possibly confused, being fed and helped to the bathroom. The text does not allow for this to be documented. Much of the care in the orange zone entails tasks that take much longer than those, for example, in the blue or green zone, simply because the patients here are often elderly with complex histories, compounded by an illness that often debilitates their functionality.
As dictated by the recording and reporting regime, the nurse and physician document all processes of care in this fashion. Highly coordinated, complex, and time-consuming tasks become represented as single or two-word categories and are pulled out and into managerial contexts to come to represent local caring work. Resources are allocated based on this abstract representation of the happenings of ED nursing and medical care. It is no wonder Helga and Gilles were never updated about the status of their wait and blood results, and Anne never got the immediate reassurance she was looking for. These are not tick boxes or any other institutional categories that can be found. It is these particularities of embodied patient care that fall by the wayside when pitted against institutional structures that dictate specific tasks.

**The Nursing Model of Care**

With the move to the new ED building, management implemented a “trial” team-nursing model of care. A team-nursing model of care is a particular way of distributing patients between nurses, as opposed to the original primary-nursing model. Team nursing involves two nurses looking after seven or eight patients, whereas primary nursing is one nurse to three or four patients. This “trial” was in place for one year, until management re-evaluated it and reverted it to primary nursing.

My interest here lies in the reasons behind the creation of the team-nursing model and the reversion to primary nursing. It is of analytic importance because the interests of management behind this reorganization of nursing work is in line with the recording and reporting regime, renamed “accountability.” This specific structure is one demonstration of management’s reliance on institutional texts as the primary source of data that represent the local happenings of the department. Team nursing was implemented in the
call to “foster better team work.” With the opening of the newly expanded ED, the department underwent a mass hiring of nurses (60 or more), most of whom were recent graduates. The team-nursing model of care is apparently beneficial to the new nurses as it allows for them to work with experienced nurses as teammates. The team-nursing model of care presented management with a problem that lead to reverting it back to primary nursing. Management had difficulties “following up” on clinical problems and issues of nursing practice when patient charts were audited. Specifically, the advanced practice nurse (a nurse administrator) informed the department that nurses “were not being accountable” and team nursing made it difficult for management to identify which of the two nurses was responsible for reported clinical problems. With team nursing in place, when both nurses were interviewed regarding a given “error,” for example, both rejected responsibility for it (R. Campiti, personal communication, 2010). For this reason, the team-nursing model was dismantled, reverting to the primary nursing model of care, as it was before the move to the new building.

Management’s inability to identify the culprit in patient care “adverse outcomes” resulted from a “problem in the documentation.” Apparently, nurses failed to complete certain tasks; therefore, did not document them. When the charts were audited, this missing information could not have been linked to a specific nurse for purposes of reprimand in the team model and both nurses could not have been punished for a missed task that originally would have been the responsibility of one nurse. Here is another structure that demonstrates how management is dependent on the recording and reporting regime to do its day-to-day work. The patient chart is no longer a clinical advisor or a collection of information on the patient for purposes of health care professionals to
communicate with one another. It has become an institutional tool from which to derive data to judge the work of the practitioner. Now, with the primary nursing model, when charts are audited and problems are found, the primary nurse – the only nurse – is held responsible.

Noticeably, the implementation of the team-nursing model of care and the reversal to the primary nursing model organized and reorganized the work environment for nurses. Here is a clear example of the extralocal coordinating and controlling local caring work to mainly serve extralocal interests. Though for the most part, reverting to the primary nursing model serves extralocal interests, some local interests are also being served. For example, with the primary nursing model, when “regressions in practice” are made, the “erring” is easily identified and the team is not blamed in its entirety for one nurse’s mistake. It is of importance to note that since the team-nursing model of care was reversed to the primary nursing model in 2009, the work organization of nurses entered a state of flux. Some nurses remain practicing the team model, but have modified their documentation to fit the needs of management (i.e. more “thorough” documentation), while others reverted back to primary nursing. Still others practice both models of care, depending on the specific shift. The very fact that nurses did not completely revert to the original primary nursing model is a demonstration that work organization is not static. Work does not simply change and remain frozen in time. The work of the ED nurses has been and will continue reorganizing itself based on the model of care changes since the middle of 2009.
The Bed Management System

The Bed Management System, or BMS, is a hospital-wide patient tracking system. Purchased in 2009, it was implemented hospital wide in October of 2009, linking all hospital departments together. With the functions of the BMS, any department is able to view other departments’ patient loads at any given time. Apparently, the BMS was to bring along efficiency and order to “patient flow.” Having gone past the unplanned and rather disordered “roll-out” of this system, the untrained staff rather quickly picked up on this efficiency idea. The system certainly did bring an efficiency logic that further abstracted the already disembodied care in the ED.

Fracturing care. As another form of control over local work, the BMS, a part of the patient flow regime organizes the care of nurses in a particular way. Especially after The Hospital’s enrolment in the Pay for Results Program, the BMS came to be a key institutional relation that navigated, authorized, and reorganized caring work. The patient, vis-à-vis the BMS, simply became a collection of institutional categories, to be processed by the patient flow regime. The system further stratifies the patient than the Emergency Department Information System (EDIS) does by creating higher levels of abstraction. Among other new categories, the following were introduced by the BMS: Vital signs on admission, past medical history, code status (referring to resuscitation), and isolation status (referring to communicable diseases). This higher level of specificity of categories is to assist the nurse to more quickly and “efficiently” complete patient admissions and transfers and “improve interdepartmental communication.” The BMS is interfaced with another, older hospital-wide system called the Admission, Discharge, and Transfer (ADT) system. This interface allows it to draw other patient information, such as gender,
insurance details, and diagnosis for a more accurate “placement.” Clearly, a complex computer system that proved to be more demanding of the practitioner’s time than the previous admission process. Here, I saw a shift in the work of nurses from a clinical focus to an administrative one. In fact, administrative time encroached on clinical time.

This high stratification of patient “placement” by the BMS further abstracts care. To begin, administrative tasks that took priority over actual care have been inserted into the work of the practitioner. These administrative tasks, having been downloaded onto the bedside practitioner not only dangerously add to the workload, but also further abstract care. Here is an example of how the institution, by the means of the BMS, pulls the consciousness of the practitioner into the abstract and generalized world. Not only this bifurcating consciousness, but also reinforcing that the patient is in fact a collection of institutional categories: code status, isolation status, and so on.

With the combination of further abstracting care and adding administrative tasks to the work of the practitioner, patient care suffers. Nurses are seen tending to the administrative tasks as dictated to them by the patient flow regime and to the “acute” care needs of the patient, at the expense of “basic” daily living needs. As a major ruling relation, the BMS, through the dictation of tasks that must occur, authorizes certain care actions while prohibiting others.

The Kaizen Lean Events

The Kaizen Lean events were a series of one to two-week long “process improvement” events for selected departments. Apparently, certain departments’ wasteful practices contributed to The Hospital’s fiscal deficit as well as the increased wait times and the unnecessarily prolonged patient lengths of stay. The Kaizen Lean consultant
group began its “process improvements” around the same time as the ER Strategy was disseminated. As part of the Ministry’s ER Strategy, the following was put forth:

To help hospitals reduce the time patients spend in the ER and improve their admission and core operating processes, the Ministry of Health and Long-Term Care is:

- Providing dedicated funding to hospitals which demonstrate measurable quantifiable reductions in the time patients spend in the ER
- Activities to increase health human resource capacity
- Focusing on improving various hospital processes (Ministry of Health and Long-Term Care, Ontario’s Emergency Room Wait Time Strategy, 2009, p. 2)

The Hospital, taking up the Ministry’s recommendations, selected certain departments believed to be the most wasteful and enrolled them in the Kaizen Lean program. Each department’s manager recruited workers from multiple disciplines with the exception of physicians. The recruited individuals convened every day for one or two weeks and formulated a plan to improve their apparently troubled current situation. I attended several of these events. They particularly focused on hospital porters and improving transport times, improving nursing communication between departments, and streamlining the medical supplies in the ED. This last strategy apparently should have resulted in nurses taking fewer steps in search of misplaced medical supplies, thus eliminating waste.

The Kaizen Lean events micromanaged in this manner. The events looked at small process difficulties that were simply symptoms of a much larger resource problem that went unacknowledged. The $907,000 Kaizen program delivered its events over the course of nine months and reported quantifiable results to the Ministry. I attended a one-week event called the “Transport Kaizen.” This event looked at the “waste” of the patient
transport department and culminated in strategies that made the process more “efficient” and reduced “wasted porter hours.” At the end of the weeklong event, having identified multiple strategies to eliminate “waste,” the Kaizen consultant calculated that the institution would be availing at least 12 full-time employees. This is the quantitative information the Ministry is interested in and is precisely the information that the recording and reporting regime delivers to it.

**The danger in quantifying care.** I have illustrated how the abstracting of care leads to a flawed representation of the actual care. I have also discussed that basing resource distribution on such a distorted understanding of the care creates problems at the bedside. Designing a program, such as Kaizen to specifically look at local caring work and deliberately abstract it, exponentially augments these problems. Here, we have a corporate consulting group, who’s self-declared most successful project was the Starbucks® project, looking to improve a hospital. Apparently, the basic principles are the same, certainly when compared by the efficiency regime.

The quantification of care processes not only abstracts care and reinforces this abstraction, but also dangerously objectifies the patient. As does the Pay for Results program, the Kaizen events place monetary value on faster, more “efficient,” and mechanical care. To quote a colleague: “Think of every so many patients who meet the target [Ministry wait times] as one nursing position being funded” (personal communication, August, 2009). The representation of care processes in dollar amounts creates a sense of competition to “expedite” care, especially when “waste” is translated into hospital fiscal deficits, lost tax dollars, compromised access to health care, and so on.
For most ED patients, who tend to be categorized as “acute,” care is often quick; therefore, “efficient.” Simply by tending to the clinical needs of patients with life-threatening or potentially life-threatening conditions helps the practitioner apply the Kaizen recommendations. When such needs, however, are of a chronic, albeit urgent nature, addressing them is seen as wasteful and not in line with the efficiency regime. To make such non-acute care processes more efficient, they are either outsourced or assigned to non-nursing workers. Given the Kaizen Lean philosophy, which is to “eliminate waste and simplify the system,” outsourcing more workers would not be an option. For the past several years, the ED has been plagued with service workers’ role confusion (Adam, 2009) and reluctance to assist with geriatric daily needs, thus, they are neglected. With Kaizen prohibiting the hiring of more service workers, coupled with the staff’s role confusion, “chronic” geriatric care becomes neglected.

**The Pay for Results Program**

This ruling structure resulted in several process changes, and one of which directly impacted the ED’s resources. After The Hospital’s enrolment in the Pay for Results (P4R) program, high emphasis was placed on the meeting of Ministry target times. As a result, the department’s management created the role of the Clinical Care Leader (CCL), or charge nurse. This role, to be filled by the existing charge nurse, deals strictly with managing patient flow. The CCL, formerly a bedside nurse in part, took on the role of tracking patient registration, admission, and discharge times. The CCL is to perform no clinical tasks whatsoever and focus on Ministry targets.

The P4R Program resulted in an overhaul of the work of nurses. First, with the creation of the CCL position, bedside time was reduced. The CCL is to appear for his or
her shift in “business casual” attire, and tend to the computer software provided to him or her. Among other software, the CCL mainly interacts with the EDIS, the BMS, and the ED Dashboard (a summary of patients and their wait times, triggers, and so on). Despite the inaccuracy of the title, the CCL became non-clinical in focus – the “patient flow” go-to person in the department. Next came the change in focus for the bedside nurses. The preoccupation with meeting Ministry targets bled into the consciousness of the bedside practitioner swell. Nurses are often heard reporting to the CCL their patients’ target times, asking about “hallway criteria” for their admitted patients, and length of stay times. With this change in thinking and the growing emphasis on “pushing patients through,” bedside nurses began to work with the idea that their patients are, despite their emergency needs, approaching target times. The already fast paced care sped up even more, though in the call to meet Ministry targets and prevent “missing the boat on patients” (personal communication, December, 2009).

A quick overhaul and reorganization of the work of nurses happened. The introduction of the P4R regime resulted in two changes to the work of nurses: The number of bedside nurses was reduced to create the CCL and nurses took on the extra tasks of recording and reporting their patients as Ministry targets. Again, here we have another example of an institutional ruling structure that reinforces care as an abstract and monetary phenomenon.

The Drive to 95 Initiative

An emerging ruling structure, the Drive to 95 is the latest regime resulting from the Ministry’s ER Strategy. Following is an excerpt taken from The Hospital’s website,
outlining the need for the 95 percent occupancy and the potential successes of this “initiative:”

Progress was also made in the implementation of The Hospital’s strategic plan and the development of strategies to maintain the organization’s leadership role in patient safety and to improve the accessibility of The Hospital for senior citizens. The groundwork was also laid in 2009/10 for plans to reduce in-patient occupancy to 95 percent and to create a Multi-Year Operating Plan. The ‘Drive to 95’ and the Multi-Year Plan will be examples of industry best practices that will reduce some of the stress and strain on teams across The Hospital and provide a financial road-map that will attempt to create more stability in the organization’s operational planning (The Hospital, Management Commentary & Analysis, 2010).

The Drive to 95 refers to having The Hospital always operate at no more than 95% capacity. This refers to patients who are admitted into ward beds. Taking up the Ministry’s ER Strategy, The Hospital is looking to implement more “timely patient discharges,” and streamlined “discharge planning.” We have seen how some of the other institutional structures abstract care, reinforce this abstraction, deliberately quantify care, and objectify the patient. Dubbed as a leading innovative initiative, this Drive to 95 also subjugates the patient and practitioner from another angle.

The implementation of the Drive to 95 is imminent, in fact has been demonstrated in the recent past. During the G20 Summit, The Hospital underwent “preparations” as it was named a “G20 facility,” to treat mass patients related to the G20 Summit activities. In “preparation,” several activities came into existence. During a staff meeting shortly before the G20 Summit, I came to see The Hospital’s demonstration of “the industry’s best practices:”

During the meeting, which was predominantly taken over by lectures and
discussions about the G20 Summit and the potential for high influx of acutely injured patients, a particular thing puzzled me. Jill, one of the presenters and a critical care nurse, had been actively working with the G20 “potential disaster preparation.” She spoke in some detail about this “preparation.” She suggested that The Hospital has been taking measures to operate at 95%, as opposed to the current state of often over 100% capacity. In this respect, she stated that patients awaiting placements into long-term homes and nursing homes, mostly comprising of elderly patients, are being placed in centers that under normal circumstances, they would not be. Currently, when a patient is in the hospital and the acute care phase of his or her care is over, but for whatever reason, he or she cannot be sent home any longer, he or she would be deemed ALC. When patients are deemed ALC and unable to go home, they are entered into a list to be placed into long-term and/or nursing home centers. To help facilitate the most appropriate place for the patient, he or she is given a list of long-term and/or nursing homes from which to select the top three choices. This decision is often mediated by the proximity of the nursing home to the patient’s spouse, children, other support systems, and so on. To get first, second, or third choice, patients sometimes wait several months for placement. In preparations for G20 and the Drive to 95, patients are now being asked to list their top five from which to choose. Expectedly, the fourth and fifth choices are least desired by the patient. Jill confirmed that while patients are being asked to list 4th and 5th choices, more and more are being placed in homes that are the 4th or 5th “choice.”

(Field notes, June 17, 2010)

I puzzled over the institution’s conflicting messages. I could not reconcile how to “improve the accessibility of The Hospital for senior citizens” and the fast discharges of elderly patients, even if they resulted in transfers to distant nursing homes that are inaccessible by the patient’s family.

The lip service paid by the Drive to 95 administrators to improve senior citizen access to The Hospital translates, in fact, to the very opposite. The ED has taken up the processes put in place by this regime, evident in the difficulties created for Helga. Not only discharges are expected to happen much faster from the hospital wards, but there also came a push to send patients home immediately after the care period has ended,
without exception. This explains Helga’s 3:00 AM discharge on an icy winter night, having been expected to go home without assistance or any community support.

**Synergistic Ruling**

Currently, the ED is being subjected to at least the six ruling structures discussed here. They are in constant and overlapping existence. Their simultaneous existence is evident in management’s conversations and actions. Each ruling structure has brought along a particular reorganization of the work of the practitioner. The ED zoning and the nursing model of care changes contributed to workload problems and reinforced the abstraction of care. The Bed Management System facilitated an administrative and categorical understanding of the patient – more abstraction of care. The Kaizen Lean structure blamed the “wasteful” practitioner and created an objectified understanding of the patient. The Pay for Results program also objectified care by quantifying it and directly equating it to monetary “wins.” Lastly, the Drive to 95, the most recent ruling structure, made arbitrary the notion of patienthood, in that whenever “deemed necessary,” patients are with no exception, transferred out of the institution, or discharged altogether.

What happens to an already underserviced system that becomes enclosed within such ruling structures that are unified and with interests competing with those of the local actors? Below, Figure six illustrates a map of the ruling structures as an encircling force around the local actors. The patient, located in the center of the diagram represents the highest level of subjugation. Notice I have included the CCL (Clinical Care Leader) as a subjugated institutional actor. It is due to strict and specific managerial direction that the CCL acts when putting the patient flow regime into effect. The CCL is thus held
accountable to implementing the processes by which the institution meets the Ministry targets.

In the diagram, we can see a representation of the ruling structures as clamping down on local caring work. Together, these ruling structures have greater authority and control over local work than the sum of their separate effects. This, I came to call synergistic ruling. One structure bifurcates the consciousness of the practitioner, another abstracts and quantifies care, and another reinforces such objectification. We can see how extralocal interests colonize the practitioner’s consciousness using a multivector assault approach. The practitioner becomes well trained in abstract care and can only think and act in one way. These different ruling structures, introduced along a continuum of several years ensure that the practitioner seldom deviate from the abstract mode of knowing. When one ruling structure ceases to exist, another more “efficient” one and more in line with institutional interests at the time replaces it.
Figure 6. The circle of ruling: Institutional structures as a constricting power
Conclusion

Through the organization and reorganization of caring work, some of these ruling structures superimposed a new consciousness onto the practitioner while others reinforced an already-existing institutional order. Belonging to the patient flow, efficiency, and recording and reporting regimes, together, these structures perpetuated some problems while creating new ones, both for the patient and the practitioner. As a combined mega-structure, they establish an effect of synergistic ruling from which local caring work seldom escapes the grip of the abstract, quantified, and objectifying world they create.
Chapter Six: Conclusions, Recommendations, and Implications for Research

Introduction

In the first section of this chapter, I will return to the difficulties experienced by my patients and other such problems I identified in this ethnography. In a list, I will summarize the institutional processes that gave rise to these problems and provide recommendations to help redress the care disparity. To attend to the problems identified in my research problematic and in my analysis, I will provide a list of specific and concrete recommendations at various institutional levels. I will provide recommendations for the Ministry of Health and Long-Term Care, addressing its recording and reporting process. For The Hospital, at the managerial level, practice and policy change recommendations will be provided. At the departmental level, I will make procedural and practice-based recommendations for nurses and physicians. While these recommendations are aimed for The Hospital, they are applicable to other Ontario hospitals, as they share very similar problems. As I do make reference to The Hospital in my recommendations, I also propose their relevance to other Ontario acute care institutions. In the second section, I will make recommendations for future research. I will offer a short discussion of research possibilities in the area of geriatric care in Ontario hospitals.

The Difficulties at the Point of Care and their Origin

Let us return to the experiences of Helga, Gilles, and Anne. Recall Helga’s troubling 3:00 AM discharge, Anne’s “daunting and intimidating” experience, and Gilles’ and his wife’s despair over the uncertainty of Gilles’ heart condition.
What exactly was happening that Helga “had to be” sent home at 3:00 AM? What was it that created the “daunting and intimidating” experience for Anne? Why is it that the anxiety associated with uncertainly was never addressed for Gilles? What about Gordon’s hallway fate? What are the processes by which these things come to be?

Following is a concise list of extralocal and local happenings that created these problems:

1. Ministry obtaining an abstracted (false) view of actual caring work in The Hospital.
2. Ministry creating benchmarks, targets, and lengths of stay based on this false view.
3. Ministry compensating and/or penalizing The Hospital for meeting/not meeting the set benchmarks.
4. Management obtaining an abstracted (false) view of actual caring work in the ED.
5. Management basing resource allocation decisions on this false view.
6. Management implementing and enforcing the efficiency, patient flow, and recording and reporting regimes, causing care to suffer.
7. Practitioners suspended in the abstract world.
8. Practitioners under/uneducated about the unique needs of the elderly.
10. Practitioners enacting the efficiency, patient flow, and recording and reporting regimes at the cost of embodied care.
11. Practitioners prioritizing “acute” over “chronic.”
12. Practitioners overwhelmed with institutional tasks, thus “unavailable” to address certain patient needs.

It is these 12 institutional processes that mainly create the poor care experiences for my patients, my colleagues, and me. I will offer a discussion to address these problems through various recommendations. My recommendations are grouped into three categories: Recommendations for the federal and provincial governments, recommendations for ED management, and recommendations for the bedside practitioner.

**Recommendations for the Federal and Provincial Governments**

**Accurate representation of caring work from practitioners.** Seeing as the abstraction of caring work created by the Ministry is a large problem, my first recommendation is for the Ministry to re-examine the measuring of caring work. Currently, care is measured using clinical decision-making tools, quantitatively aggregated and removed from the clinical sphere to come to represent the practitioner’s work. This transportation of data involves computer software and people far removed from local caring work. Hospital management and computer software technicians, with the aid of multiple patient tracking databases report this to the Ministry. The practitioner’s subjective contribution is not a part of this reporting process. The practitioner’s opinions and expertise into caring work measurement is disregarded. For a much more accurate representation of caring work, the practitioner doing this work must be consulted. I recommend the Ministry seek out nurses and physicians to obtain their perspectives on caring work. As much of local work is rendered invisible by the recording and reporting regime, seeking the actual work knowledges (see definition in
the Glossary of Terms section) of bedside practitioners will bring to sight these lost particularities of caring work. Through the specific sampling of ED practitioners for surveying or interviewing, or by conducting practitioner focus group consultations, the Ministry can obtain this perspective. This should be “protected” time for the practitioner. In other words, the practitioner should be paid for his or her time to participate.

To be clear, my intention is not to further empower the regime of recording and reporting by involving the practitioner. Nor am I suggesting that the practitioner become in any way positioned as a ruling institutional actor. In fact, my intent is to move towards the opposite direction. By tapping into the expert knowledge of the practitioner and genuinely valuing it, perhaps even the practitioner-regime power imbalance begins to flatten. Valuable knowledge on the actualities of caring work can inform the recording and reporting process and help provide a more accurate way of local caring work. With this idea, the Ministry can have a more representative view of the actualities of caring work.

Accurate representation of caring work from patients. As another way to more accurately measure caring work, patients must be involved. Involving patients not only helps construct a more accurate picture of care but also makes for a participatory experience in the navigation of care. Here, I would also recommend obtaining the perspectives of patients’ family, friends, and loved ones to make for a more holistic representation. I do not want to convey the idea that involving the patient flattens the Ministry-patient power structure. The Ministry will always remain a ruling body and the patient will always remain subjugated by its regimes. My intention is, to a certain degree,
to soften this subjugation by illuminating patient’s experiences to the Ministry and by allowing patients to voice their particularities.

There are several ways in which the Ministry can solicit the patient and family experience. Through connecting with recent ED patients by mail, telephone or email, the Ministry can conduct surveys, interviews, or simply open dialogue for them to convey their experience. On the Ministry’s website, there can also be a space where the members of the public provide their feedback on their ED experiences. The public can also be given access to mail written feedback to the Ministry. Holding various town hall meetings is another way that the Ministry can bring in patient and family perspectives. A Ministry committee can focus on recruiting patients and family members to conduct interviews and focus groups to obtain their feedback on the care. Marketing patient recruitment can take the form of flyers in the mail, telephone recruitment strategies, literature in municipal and hospital newspapers, and television and radio advertisements. Inpatients can also be given information brochures, inviting them to provide feedback.

Currently, as part of its Ontario Emergency Room Wait Time Strategy (Appendix A), the Ministry promises to “expand alternatives to ER [ED] services” by “increasing public awareness that the ER is not the only option for people who need immediate, unscheduled care.” To facilitate this “public awareness” the Ministry has recently put forward multiple television advertisements in an effort to steer people away from ED’s and towards other “options” such as urgent care centers, walk-in clinics, and Telehealth services. The Ministry has demonstrated thorough this “public awareness” strategy that it is able to reach the public (though in this effort, to serve it’s own interests).
My recommendation is that all these methods be used. In an effort to reach as many people and as diverse as possible, I suggest the Ministry employ all the feedback-soliciting methods I discussed above. It is my hope the once patient perspectives are incorporated, along with those of the practitioner, a more accurate and representative view of the local happenings of ED care emerges.

**Changes to texts and policy.** Thousands of patients filter through Ontario ED’s each month. For the Ministry to obtain approximate wait times to set benchmarks, it requires a system of aggregating information and doing this on a mass level. To be realistic, I will not propose that an enterprise on this level completely do away with its current measurement strategies, despite the problems it is creating. Since the problem originates in the CTAS text, this needs to be changed. I propose to the CTAS document reviewers the following changes (refer to Table one for the CTAS categories): Recall the CTAS I level: “Requires resuscitation and includes conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (for example, cardiac arrest, major trauma, or shock states).” To this, I recommend adding the clause: “Or complex or geriatric patients who require a relatively longer amount of time for care or that equivalent to the CTAS I acuity.” Recall the CTAS II level: “Requires emergent care and includes conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts (for example, head injury, chest pain, gastrointestinal bleeding...).” Here, I would also recommend adding “Or complex or geriatric patients who require a relatively longer amount of time for care or that equivalent to the CTAS II acuity.” Similarly, the other three categories would be modified in the same fashion. This way, the CTAS is modified for the triage practitioner
to better allocate bedside resources, as well as for the Ministry to gain a better understanding of local caring work and more accurately set benchmarks.

To Ontario’s Emergency Room Wait Time Strategy (Appendix A), I recommend several changes. Instead of the punitive approach the Ministry is currently employing, “dedicated funding” can be proactively given to hospitals to begin with. Hospitals are then given the Ministry’s aggregated lengths of stay based on the modified recording structure I outlined above. In this way, the Ministry-hospital relations can be built on positive reinforcement rather than the current punitive, reactionary approach. With a more representative recording structure and a positive relationship between hospitals and the Ministry, it is my hope that wait times decrease and patients access quality timely care. Currently, the Ontario Emergency Room Wait Time Strategy proposes the following: “Providing dedicated funding to hospitals which demonstrate measureable quantifiable reductions in the time patients spend in the ER.” I recommend changes as follows: “Providing dedicated funding to hospitals with particularly long wait times.” Then, given that this policy is to do with wait times to access care, I suggest a departure from “reductions in the time patients spend in the ER,” restating it as such: “Giving hospitals feedback on their performance with their wait times.”

In its strategy to “increase capacity and improve ER processes,” the ministry proposes “activities to increase health human resource capacity” and “focusing on improving various hospital processes.” We saw how this simply translated into the nearly one million-dollar Kaizen project that in turn created some of the problems here. Recall that physicians were not a part of this “process improvement” effort and that it isolated nurses and service workers as the wasteful practitioners. To these two clauses, I suggest
adding a third: “By involving all members of the health care team (nurses, physicians, service workers, clerical workers, students, and volunteers), hospitals can investigate wasteful areas through a consultative approach.” Specifying the Ministry’s strategy to “improve hospital processes” in this way moves us away from blaming a particular group of workers and towards a more collective and participatory solution. I also recommend deleting the term “quantifiable” as we saw how damaging the quantification of care is. What I suggest putting in place of “measureable quantifiable reductions in the times patients spend in the ER” is simply “positive patient, family, and practitioner feedback.” This moves us away from the objectification of care and towards a more humanistic “measurement” of it.

Seeing as “the faster discharging of ALC patients” is resulting in unsafe patient discharges and transfers, I recommend changing the idea of “faster” to “appropriate,” and specifying it further. In addition to the four strategies provided under this section of the policy, I would add: “Increased intrahospital support to care for ALC patients.” Moreover, given that strategies in this section are a lengthy process, for example, “increased home care and community supports, development of long-term care and transitional beds, and outreach services,” I suggest putting a timeline here. As the Ministry is suggesting it will do all these things, I recommend a time by which these support systems are to be expected. That way, Ontario hospitals have a goal to work towards when starting to look at discharging their ALC patients “faster” once these support systems are in place.

The Ministry has set two targets within which care is to be delivered in the ED: “High acuity” and “low acuity.” Under the high acuity target, the Ministry suggests that
the patient does not spend more than eight hours in the ED. Similarly, the low acuity patient is expected to be discharged within four hours. This is specified in the Ministry’s Emergency Room Targets document (Appendix B). When making decisions about distribution of human resources, the institution often resorts to the “acuity” of the patient. The problem the concept of “acuity” poses is twofold. For one, it often acts as a shell word; a term that is vague and that can have multiple meanings in different contexts (D. Smith, personal communication, August 26, 2009). Due to its subjective nature, the term “acuity,” when taken out of clinical context may easily come to mean anything the reader chooses. As in Smith’s (2006) text-reader conversation, based on the context in which the reader is activating the text (or category), it can come to represent whatever the institution wants it to represent at that time and in that location. For these reasons, I propose the insertion of the term “chronicity” to help ameliorate the polarity between them when it comes to decisions about resources and lengths of stay. I recommend that the categories of the Ministry’s Emergency Room Targets be rewritten as “high acuity/high chronicity” and “low acuity/low chronicity.” This way, it introduces to the practitioner and to the recording and reporting structure “chronicity” as a factor in determining resources. We can move towards seeing chronicity as just as important as acuity when determining distribution and allocation of resources and “lengths of stay.”

To the Alternate Levels of Care (ALC) Patient Definition (Appendix C), I propose two changes: the addition of the patient as a key decision maker in the processes of care, and the addition of an accountability clause. In the introduction section, the policy states: “The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient’s health status, treatment
plan and goal.” My recommendation is to rewrite it as follows: “The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient and the health care team.” Once again, collective decision-making can be achieved through the inclusion of the patient in his or her health care plan. The current ALC definition only becomes a problem when it is incorrectly applied or applied for purposes of “meeting targets.” I suggest the Ministry insert an accountability note that stipulates hospitals are held accountable to all their ALC discharges. My intention here is not to penalize hospitals, but rather to ensure that when patients, especially elderly patients, are discharged, they are linked up with the appropriate community supports. That said, I wish to see the following inserted at the end of the policy: “Hospitals are responsible for ensuring the safe discharges of all their patients. This includes ensuring that every patient scheduled for discharge under this definition be linked with community resources such as Homecare or Home At Last as required by the patient. Additionally, elderly patients are to have geriatric and social assessments prior to their discharge to ensure that the appropriate resources have been identified. Their status as ALC is to be communicated to them, their family members, or legal representative immediately and this document is to be provided to all patients as they are deemed ALC.”

**Recommendations for ED Management**

The hospital management is in a pivotal position to make changes to improve the care for elderly people in the ED. Following is a list of specific recommendations for The Hospital’s ED management team.
**Changes to texts and policy.** For The Immediate Transfer Protocol (Appendix D), I will not make recommendations that address the links between it and the Ministry policies. These sections in the protocol become problematic only because they are authorized by the higher-level ministry texts. It is my hope that if the Ministry integrates my recommendations, The Hospital’s Immediate Transfer Protocol will follow suit, as it takes up the authority of Ministry texts. I will, however, address the criteria by which the “hallway admission” (criteria for placing patients in hallways) is carried out in the Immediate Transfer Protocol. Currently, the policy lists the following criteria:

1. No isolation
2. No telemetry
3. No suction
4. Alert and cooperative
5. No O2>4l/min NP
6. No immediate needs for additional comfort or compassion
7. No need for frequent toileting or perineal care
8. No need for special devices or equipment ie CPAP, dialysis, hoyer anticipated prior to room placement
9. No invasive procedures ordered to be completed on ward prior to anticipated room placement
10. Skill set necessary is appropriate to ward
11. No more than 2 hallway patients/ward

Adding the next five criteria not only identifies elderly patients who might be at risk for harm if placed in the hallway, but also brings in the missing element of consent:

12. Negative delirium screen
13. Negative for wandering or falling risk
14. Unable to give consent to be placed in a hallway
15. Does not consent to being placed in a hallway
16. Elderly with no family present
**Resource distribution.** As far as the hospital management is involved in the direct creation of problems at the bedside, it is mainly to do with the incorrect distribution of resources. As discussed in the *orange zone* analytic, the workload there far outweighs the number of nurses allocated to do it. Similarly, when distributing human resources throughout the other zones of the department, elderly patients, deemed “chronic” tended to be grouped together and allocated inadequate resources. My first recommendation is to the clinical care leader (CCL). He or she is positioned to make decisions to deploy nurses and consolidate assignments. When consolidating assignments (moving patients for flow and grouping purposes), I would suggest creating a “variety in the level of need.” What I mean by this is that when there are multiple patient admissions, they are not to be immediately moved to the orange zone simply by the virtue of their “admitted” status. Instead, some can be moved, while others can remain in the green zone or the blue zone, for example, to ensure fair distribution of workload. This is currently practiced with “acute” patients, such as those requiring critical care services, life support, and so on.

There has been, for several months, some talk about what is called the “one bed one head” idea. The “one bed one head” idea simply means “dezoning” the ED, in that, the orange zone, for example, would no longer be the place where admitted patients are consolidated. This also means that whichever zone any given patient is in, once he or she is admitted, that patient remains there until a bed is available on the ward. Due to physicians’ resistance, The ED has not yet moved to the “one bed one head” system despite nurses strongly advocating for it. The reason for their resistance, as communicated by the chief of staff of physicians, is to do with the “safety” of the patient.
Apparently, consolidating patients in various zones based on their “acuity” and others based on their “admitted” status is safer for care delivery. As a second recommendation, I would strongly advocate for the “one bed one head” strategy. This is a simple solution to a resource distribution problem. It can alleviate nurses’ workload by distributing “heavier,” more time-consuming patients more evenly.

As does the Ministry, the ED management, though to a lesser degree, takes up abstracted representations of caring work as actual and real. As I recommended the ministry do to obtain a more accurate view of local caring work, I suggest ED management do the same. By involving nurses and physicians, and I would add service staff here, management can have a more accurate picture of bedside care. The department management is better positioned to gain the insight of practitioners. Based on managers’ proximity to the practitioner, they have better access to recruiting them for interviewing, focus group consultations, and so on. The more accurate the representation of caring work, the less troubles come to be at the bedside. With a better understanding of the particularities of work and less reliance on the recording and reporting regime, the more inclined management will be in changing practices. Though a promising recommendation, let me be clear that obtaining management buy-in to involve practitioners in resource-allocation decisions is extremely difficult.

Lastly in dealing with resource distribution remedies, I recommend reversing the clinical care leader (CCL) role. With the redefinition of this role, the nursing team lost what once was a nurse who performed bedside care during his or her shift, including assisting with break coverage, and so on. Now, the CCL is strictly a “patient flow” manager in the department. He or she performs no clinical tasks, but rather focuses on
administrative ones. The current CCL role addresses only patient lengths of stay and achievement of Ministry targets. I would strongly recommend reverting to the original *Facilitator* role. This would reintroduce additional nursing resources and de-emphasize the accounting logic pressing down on the consciousness of the nurses.

**Acuity versus chronicity.** Although I recommend that we continue to use the term “acute” more so for its clinical than its institutional value, we also need to look at the concept of “chronicity.” The flip side to the negligence of elder needs is that they often stem from chronic conditions, for which the ED is “not equipped to handle.” It is my hope that if managers took up the perspectives of the bedside practitioners, they will be better informed of the intricacy and effort needed to give geriatric care. As the “acutely” ill patient requires a considerable portion of the practitioner’s time, so does the chronic one, with needs such as feeding, toileting, ambulating, and so on. My intent here is for managers to move away from the thinking that “acute” requires immediate (more) care, whereas “chronic” can wait (less). I suggest that the concept of “acuity” and chronicity” be given equal weighting when deciding to allocate and distribute resources.

**Elder care-trained champions.** As there exists only one full-time geriatric nurse clinician, I recommend augmenting this very important resource in two ways. One way to expand on this is to train already-existing ED physicians, nurses, and service workers. This is another “easy fix.” These individuals have untapped resources in whom some educational and monetary investment can equate to a vast gain in terms of care improvement. Several physicians, nurses, and service workers can be put through a geriatric educational program with paid time. Currently, The Hospital owns several on-line learning modules geared towards geriatric care, and specifically, delirium,
depression, and dementia. These, and other already-existing modules can be a starting point for a curriculum to train the champions. The geriatric nurse clinician, who would require paid time to deliver the education, can deliver other, perhaps more interactive aspects to the curriculum, as they are developed. She has, in fact voiced a desire to deliver educational workshops for the ED staff though has no time to do so due to her patient load. Surely, my recommendation here is also to avail her for a part of the time she is in the ED to deliver these educational workshops. This means providing geriatric nurse clinician coverage in her absence while she teaches.

The idea behind having elder care-trained personnel is twofold. One is to ensure that at any given time, there is one or more specially trained elder care practitioner in the ED at all times, as opposed to the current state of one clinician, less than half the time. Furthermore, it is my hope that a ripple effect in the champions occurs. In other words, specially trained champions take on the task of training or educating others in the ED.

**ED elder care team.** In addition to creating departmental champions, I recommend augmenting the geriatric nurse clinician resource. This, of course, requires investing money and will be another difficult buy-in from managers. However, I maintain that it is one of the most important and most direct ways by which elder care in the ED can improve. Other hospitals have created elder care teams in their ED’s. These teams consist of a geriatric nurse clinician, a nurse practitioner, a social worker, an occupational therapist, and a geriatrician. I suggest adding to the current nurse clinician another nurse practitioner to work together as the geriatric emergency team, and then perhaps adding specially trained champions to this team in the future.
Recommendations for the bedside practitioner

I have very few recommendations for the practitioner, as we have seen that the practitioner has little to do with the problems experienced at the bedside. The first thing the practitioner can do is to self-educate on geriatric care and on the political happenings of the institution. The practitioner can also lobby the hospital management team for better geriatric support, including the funding of personnel and educational programs.

Until the geriatric curriculum is funded, in that people are paid to attend, my recommendation is that the practitioner take the initiative and self-educate in geriatric emergency care. Nurses and physicians can do this by accessing The Hospital’s available e-learning module materials as well as coordinating with the geriatric emergency medicine nurse in the ED for workshop possibilities. Let me reiterate that the problems I discussed in this ethnography are for the most part given rise to by institutional ruling structures that subjugate the patient and practitioner together. My intent is not to blame an “uneducated” or “unprepared” practitioner. There is, however, an element of this local problem, though once again, not created locally, and beyond the scope of this project to analyze. I want to stress the importance of self-directed learning here. Most institutional change takes a long time, and given the urgency here, I urge the practitioner to take this small step to help improve the care for elderly people in the ED.

Another recommendation I have for the practitioner is to become more politically aware. There are several ways in which to do this. By attending the weekly staff meetings, nurses would be able to listen to the current issues in the ED as well as voice their concerns. I understand that oftentimes, nursing issues in meetings are not heard, though I do recommend this strategy as a first step. Next, there is the involvement in the
department’s “leadership” team. This requires the nurse to “advance” to the position of a “facilitator” (charge nurse) and advocate on behalf of the elderly. Management is more inclined to listen to someone “deemed a leader” (as qualified by hospital management). Therefore, using one’s position as a “facilitator” to advocate for better geriatric care is another step in improving it. Thirdly, nurses and physicians together can directly approach management (patient care managers, chiefs of staff, directors of care, and the CEO) to express their concerns. Advocacy gains much more strength in numbers.

Lastly, through research and through the delivery of educational workshops and “professional development” sessions, nurses and physicians can work towards lobbying for change. A possibility for change lies in the demonstration of the need for better geriatric care through an academic and research focus. Practitioners can conduct research, publish, and market their findings to help sway management towards better support in geriatric care.

**Implications for Research**

In doing this research, I identified several problems in the care of elderly patients and how these problems come to be. With that, several areas for further research also became relevant. Here, I will outline possibilities for further research into the problems of elder care in acute care areas.

A similar but larger study than this one can help do two things: validate that the problems here are in fact not isolated to one hospital, and by that token, make a stronger case for change. A multi-site institutional ethnography can be conducted. With a study that large, hospital administration and governments are more likely to be swayed in the direction for change to improve care. Another possibility for research here can be a
qualitative project to measure care. Starting from the grassroots level, patients, practitioners, and service workers can be interviewed and their knowledge into patient care work solicited. This can have promising possibilities. Qualitative representation of actual caring work can be presented to hospital administration and to the Ministry to give a better understanding of caring work. It would be interesting see the possibility of integrating qualitative care measurement with that of the current quantitative one. Lastly, a historical policy analysis can be done on the Ministry documents that create these problems for elderly patients across Ontario and the rest of Canada. Through its privileging of acute care over chronic care, the Canada Health Act can be historically investigated first to see how the privileging of “acute” over “chronic” historically comes to be. With this radical understanding of the problem, specific problems in the Act can be explicated and recommendations for change can be made. Documents that take elements of the Act such as the CTAS can also be looked at as other texts in intertextual play with the Canada Health Act. Another policy analysis possibility can be an investigation of how the Local Health Integrated Networks (LHINS) distribute their resources. Perhaps another large institutional ethnography is appropriate to answer this question. LHINS include regional hospitals, long-term centers, rehab centers, nursing homes, and community care centers. In doing this, research can explicate resource distribution and allocation practices at a higher level (Ministry to regional units).

**Visions for the Future**

What does a world of all-embodied care look like? How do the experiences of Helga, Gilles and his wife, and Anne unfold in this world? What if we embarked on the journey to care for people starting from and ending with the particular and the embodied?
Here, I propose a counter-picture to the abstract way of being, one that envisions no difficulties at the point of care. I create this world of embodied care hoping that in the near future, it becomes realized in Ontario hospitals.

**Helga.** Helga’s experience takes on a different form, when she is given the attention and support she needs. After having visited her family physician, located at The Hospital, Helga was required to visit the ED immediately for further testing. Here, Helga’s anticipated arrival to the ED is communicated to the triage nurses and Helga is reassured that this is happening. Her anxiety from the uncertainly of the care plan, to a certain degree, is alleviated. She arrives to the triage desk in the ED and is immediately greeted by the triage nurse, who has been expecting her arrival and has been informed of her condition. The triage nurse interviews Helga and the care plan is explained to her. She is reassured that she will not be “forgotten” despite the long wait in the waiting room. She is urged to approach the triage nurses with any questions that may surface during her wait. The nurses are readily available to answer her questions and alleviate any anxiety related to her visit.

Inside the ED, Helga’s embodied care experience continues. The care process here unfolds just as the triage nurse explained it. The physician greets Helga, examines her, reiterates her plan of care, explains the procedures and their rationale to her, and offers to be available to answer any of her questions. The nurses obtain Helga’s blood twice in eight-hour intervals, having been available to explain all care processes and alleviate any new anxiety. During this time, the physician or nurse returns periodically to update Helga about her care and the blood results and suggests to her that a cardiologist will see her to complete a more thorough cardiac assessment. As did the ED physician,
the cardiologist explains the plan of care to Helga, completes an assessment, and communicates the findings to her. Helga is told that her chest pain is not related to her heart and that it is likely muscle-type pain that can be alleviated with anti-inflammatories. She is given a prescription for the medication and is told that her care period in the ED is over. Helga is asked if she has any questions that the physician and the nurse are readily available to answer. She is given a quiet and private place to sleep during the night. Helga’s daughter arrives in the morning to take her home.

Gilles and his wife. Having come to the ED with a possibility of a heart attack, Gilles’ anxiety is quickly addressed. Upon his arrival, he is immediately greeted by the triage nurse and taken in for an interview in the presence of his wife. The triage nurse notes Gilles’ and his wife’s anxiety and begins explaining the care plan to them. The nurse outlines the triage and registration processes, projects an estimated waiting time and possible interventions to be done, including blood work and other tests. Then, the triage nurse instructs Gilles and his wife to wait and informs them that she is available to answer any questions that may surface during their wait. At this point, their anxiety has considerably diminished.

While inside the ED and during the physician assessment, Gilles’ wife asks the physician about Gilles’ multiple medications. She expresses a sense of worry about the number of medications and asks that the doses be reassessed. The ED physician and the ED pharmacist review all of Gilles’ medications and reassure Gilles and his wife that the medications are the right doses. The pharmacist speaks to Gilles and his wife at length about the medications, possible unwanted effects of the medications and other daily considerations to take into account while taking these medications. After a short wait,
Gilles is seen by a cardiologist, who completes an exam and recommends an echocardiogram to have a closer look at the walls of the heart. Shortly thereafter, a technician is contacted and a bedside echocardiogram is completed on Gilles’ heart. The process is ongoingly explained to Gilles and his wife and the findings of the test are immediately communicated to them. Gilles is told that he had not had a heart attack, although the walls of the heart have been damaged from a previous one, which may be causing the problems he is experiencing now. Gilles and his wife are asked if they have any questions. The cardiologist addresses all their concerns and books a follow-up appointment with Gilles in one week. Gilles is discharged home with care instructions that same evening.

Anne. Let me take away Anne’s “daunting, intimidating, and apprehensive” feelings and provide her with a different experience. Here, she walks into the triage area in the ED and is immediately recognized by the triage nurse as needing assistance, as she is clenching her chest. Anne is taken into the triage booth and assessed by the nurse. The anxiety associated with her chest pain somewhat eases, as does some of her pain. Her breathing slows down to a normal rate and she is able to explain how she feels. Anne asks: “Am I having a heart attack?” To which the nurse replies: “I don’t know, but I will find out in a couple of minutes one I do an electrocardiogram on your heart.” The nurse directs Anne into a private space (the triage assessment booth) and completes an electrocardiogram. The findings of the electrocardiogram are negative for a heart attack and this is verified by a physician and communicated to Anne. Her anxiety almost dissipates at this point. The triage nurse explains that although the electrocardiogram reads negative for a heart attack, there may be a very small chance that she could still be
having one and this could only be confirmed or disconfirmed with blood work. Anne agrees to have her blood taken. The nurse draws her blood and sends it to the lab. Anne is reassured that the electrocardiogram is almost one hundred percent accurate and blood work is almost always confirmatory. The triage nurse explains that in six hours, Anne is required to give blood once again for a final confirmation to rule out a heart attack, and remains available to answer any of Anne’s questions.

While inside the ED, the care plan unfolds just as the triage nurse explained it. Anne gives the second, six-hour blood sample and receives the results that a heart attack has been ruled out. At this point, Anne’s pain and anxiety have completely dissipated and she is discharged home.
References


Campbell, M., & Gregor, F. *Mapping Social Relations: A Primer in doing Institutional Ethnography.* Aurora, Ontario, Canada: Garamond Press.


Appendix A:

Ontario’s Emergency Room Wait Time Strategy

Ontario’s Emergency Room Wait Time Strategy

Reducing the time people spend in the ER is a complex health system issue. It cannot be solved by focusing on the hospital ER alone. Prompt emergency care requires making improvements across the entire system – from providing patients with information on alternative options where they can receive immediate, unscheduled health care to supporting timely discharge from the ER to a hospital bed, to home or to other appropriate care settings.

Ontario has a strategy to achieve this goal by:

- Expanding alternatives to ER services
- Increasing capacity and improving processes within ERs
- Faster discharging for Alternative Levels of Care (ALC) patients
- Increasing community and home-based care supports
- Measuring and reporting on patient time spent in ERs

Expanding Alternatives to ER Services

To help patients make appropriate health care choices and to ease pressures across the system, the Ministry of Health and Long-Term Care is:

- Supporting patients with chronic conditions
- Creating more urgent care centres
- Increasing public awareness that the ER is not the only option for
people who need immediate, unscheduled care.

**Increasing Capacity and Improving ER Processes**

To help hospitals reduce the time patients spend in the ER and improve their admission and core operating processes, the Ministry of Health and Long-Term Care is:

- Providing dedicated funding to hospitals which demonstrate measurable quantifiable reductions in the time patients spend in the ER.
- Activities to increase health human resource capacity.
- Focusing on improving various hospital processes.

**Faster Discharging for ALC Patients**

The Ministry of Health and Long-Term Care is supporting earlier discharges for ALC patients by:

- Increased home care and community supports.
- Increased capacity through the development of long-term care and transitional beds.
- Community programs and outreach services.

**Measuring and Reporting Patient Time Spent in ERs**

Reporting time spent in ER information on this public website means that health care providers can track and assess:

- The time patients spend in the ER at the local level.
• Their progress to reducing this time and improving ER performance.

**Recent Initiatives**
In addition to the initiatives announced through the Ontario government’s ER Strategy in May 2008, the government recently launched two more initiatives to improve ER performance and reduce the time patients spend in the ER:

• **Your Health Care Options**  

• **Health Care Connect**  

**Performance Management Approach**
The Ministry of Health and Long-Term Care is using a Performance Management Framework to help ensure that the goals of the ER Wait Time Strategy are achieved. The framework is supported by:

• Quarterly ER/ALC Stocktake Reports - The term “stocktake” literally means to take stock of LHIN and provincial performance related to ER/ALC. The reports have information on Ontario’s progress towards achieving the goals of the ER / ALC Strategy at the provincial and LHIN levels.

• Performance management discussions take place between the Assistant Deputy Minister, Health System Accountability and Performance at the Ministry of Health and Long-Term Care and the LHINs at quarterly results meetings.
The first round of **Quarterly Stocktake Reporting**

**For More Information**
Call ServiceOntario, INFOline at 1-888-779-7767 (Toll-free in Ontario only)

E-mail: transforminghealth@moh.gov.on.ca
<mailto:transforminghealth@moh.gov.on.ca>

TTY 1-800-387-5559. In Toronto, TTY 416-327-4282
Hours of operation: 8:30am - 5:00p
Appendix B:

Emergency Room Targets

Ontario Wait Times

Emergency Room Wait Times - Emergency Room Targets

Ontario has set two provincial targets for the most favorable length of time within which a patient should spend in the ER. Clinical experts helped to develop these targets. The targets are a way for the Ontario government and ERs to be accountable to Ontarians for achieving results in reducing the total time spent in ERs. They are goals for hospitals and their ERs.

**Total Time Spent in the ER:** Time spent in the emergency room starts when a patient registers or is triaged (whichever comes first) until the patient is discharged or is admitted to a hospital bed. During that time, emergency room doctors and nurses may be diagnosing or treating a patient’s condition, ordering tests and waiting for results in order to determine the best course of treatment. Sometimes treatment for a condition requires admission to a hospital bed. This may mean that a patient spends time being cared for in the ER before a bed becomes available.

<table>
<thead>
<tr>
<th>High Acuity Target</th>
<th>Low Acuity Target</th>
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<tbody>
<tr>
<td>9 out of 10 patients with complex conditions/requiring more time for diagnosis, treatment or hospital bed admission</td>
<td>9 out of 10 patients with minor or uncomplicated conditions/requiring less time for diagnosis, treatment or observation</td>
</tr>
</tbody>
</table>
**Target**: no more than 8 hours in the ER from the time they arrive and register or are triaged to the time their visit is complete and they are discharged or admitted to hospital.

**Target**: no more than 4 hours in the ER from the time they arrive and register or are triaged to the time their visit is complete and they are discharged or admitted to hospital.

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Hours of operation: 8:30am - 5:00p
Appendix C:

Alternate Levels of Care Patient Definition

Ontario Wait Times

Alternate Levels of Care (ALC) Patient Definition

To support reductions in ER wait times, improve patient flow and inform decision making, better information on patients waiting in hospitals for alternate levels of care is required. As a first step, a comprehensive, standard, provincial definition of an ALC patient will be implemented across the province.

Beginning July 1st, 2009, all acute and post-acute hospitals in Ontario will be expected to designate patients as ALC according to the Provincial ALC Patient Definition.

The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient’s health status, treatment plan and goals.

The definition applies to all patient populations waiting in all patient care beds in an acute or post acute care hospital in Ontario.

Definition

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (acute, complex continuing care, mental health or rehabilitation), the patient must be designated ALC1 at that time by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination2 (or when the patient’s needs or condition changes and the designation of ALC no longer applies).

Note 1
The patient's care goals have been met or:

- progress has reached a plateau or
- the patient has reached her/his potential in that program/level of care or
- an admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission").

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

**Note 2**

Discharge/transfer destinations may include, but are not limited to:

- home (with/without services/programs),
- rehabilitation (facility/bed, internal or external),
- complex continuing care (facility/bed, internal or external),
- transitional care bed (internal or external),
- long term care home,
- group home,
- convalescent care beds,
- palliative care beds,
- retirement home,
- shelter,
- supportive housing.

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

**Final Note**

The definition does not apply to patients:

- waiting at home,
- waiting in an acute care bed/service for another acute care bed/service (e.g., surgical bed to a medical bed),
· waiting in a tertiary acute care hospital bed for transfer to a non-tertiary acute care hospital bed (e.g., repatriation to community hospital).

If you have any questions regarding the Provincial ALC Definition or this initiative, please visit CCO - Alternate Level of Care <http://www.cancercare.on.ca/ocs/alc/> or email: ALCdefinition@cancercare.on.ca <mailto:ALCdefinition@cancercare.on.ca>.

For More Information

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Appendix D:

Immediate Transfer Protocol

Immediate Hallway Transfer Protocol

Goal:
It is our intent that placing patients in the hallway will be a short term measure to assist in meeting the acuity needs of patients in the ED or assisting the hospital in meeting Ministry of Health length of stay targets. We will begin to actively seek the next available room when patients have been in the hallway for 24 hours.

Triggers:
For Acuity:
1. CTAS 2 or 3 in waiting room >30 mins and 1 hour respectively with no stretchers available
2. Either Resuscitation room filled with no stretcher for patient to move to
3. Trauma patient in trauma room with no stretcher for patient to move to
4. Patient in EMS offload> 1 hour with no stretchers available

For Length of Stay:
1. Admitted patient in the ED <= 8 hours ** must be able to leave ED by 8 hours from time of triage **

Criteria for Placement in Hallway:
17. No isolation
18. No telemetry
19. No suction
20. Alert and cooperative
21. No O2>4l/min NP
22. No immediate needs for additional comfort or compassion
23. No need for frequent toileting or perineal care
24. No need for special devices or equipment ie CPAP, dialysis, hoyer anticipated prior to room placement
25. No invasive procedures ordered to be completed on ward prior to anticipated room placement
26. Skill set necessary is appropriate to ward
27. No more than 2 hallway patients/ward

ED signoff:
The ED CCL will complete the criteria checklist (attached document) and sign off that the patient is appropriate for the hallway. This checklist will be faxed to Patient Flow and/or paged to Shift Manager at which time the algorithm below will be followed to find the most appropriate hallway.

**Ward Algorithm (rotate initially 1/ward except as noted below **):**
1. On service, on program with discharges anticipated
2. Off service, on program with discharges except GIM where preferred is 2/ward initially to main on service designation **
3. On service, on program with no discharges anticipated
4. Off service, on program with no discharges anticipated
5. Off service, off program with no discharges anticipated

**Ward Notification:**
Patient Flow will contact the most appropriate ward and notify them that they will be receiving a hallway patient with reason as to acuity or length of stay.

**ED Notification:**
Patient flow will indicate in EDIS that the ward is ready to accept the hallway patient. The ED will place a transfer request in BMS.

**Patient Notification:**
The patient and/or family will be informed that they are being transferred to ward. Initially the care will be provided in the hallway but they will be placed in an appropriate room as soon as possible.

**Hospital Notification:**
An e-mail alert will be sent by Patient Flow to staff and physicians in the hospital to indicate that a patient has been placed in a hallway. This e-mail will indicate that this was done either for acuity or length of stay reasons.

**Appeal Mechanism:**
If a ward receives a hallway patient that they believe does not meet criteria they will immediately contact Patient Flow or the Shift Manager. If it is clear that an error has been made either Patient Flow or the Shift Manager will attempt to find an appropriate bed as soon as possible. If there is no such bed that can be found in a timely fashion the patient will be returned to the ED. Clear errors will be forwarded to the Manager of the Emergency Department for follow up.
If it is not clear to Patient Flow or the Shift Manager that an error in criteria has been made then this will be escalated to the Manager of Patient Flow during business hours and may be escalated to Administrator on call during off hours.

December 10, 2009
Glossary of Terms

Coordinate/Coordination

“Rather than treat the social as existing over and above individuals and determining their behaviour, institutional ethnography takes the social as focus on how actual people are coordinating their activities. The focus on coordinating is extended to language so that it is understood as coordinating individual subjectivities, providing us with a way to avoid using concepts that hide the active of thought, concepts, ideas, and so on in people’s heads” (Smith, 2005, p. 223).

Data Dialogues

“The dialogue between interviewer and informant that evokes the informant’s experience or that between observer and his or her experience, always has a third party in back of the ethnographer, those from whom the ethnography is being written. The experiential dialogue becomes the researcher’s data [in the case of this project, the field notes from observations] in relation to the discourse in which researcher and his or her future readers participate in a further dialogue [the written account of the ethnography]” (Smith, 2005, p. 224).

Discourse

“For Smith, discourse refers to a field of relations that includes not only texts and their intertextual conversations, but the activities of people in actual sites who produce them and use them and take up the conceptual frame they circulate” Smith (as cited in Luken & Vaughan, 2003, p. 111). Discourse, Smith explains, can be examined as “actual social relations ongoingly organized in and by the activities of actual people” (p. 111).
Smith treats discourse as “a conversation mediated by texts that is not a matter of statements alone but of ongoing actual practices and sites of practices, the material forms of texts…the methods of producing [them], the reputational and status structures, the organization of powers intersecting with other relations of ruling” (Smith 1987, p. 214).

It is a sequence of coordinated activities starting from the extralocal and extending to the local, the participation in the textually mediated processes of the institution, and the work of its local and extralocal actors. Rankin and Campbell (2009) talk about a discourse of “efficiency and effectiveness” in their research on nursing work and hospital reform.

**Disjunctures**

A disjuncture is a misfit between what is happening versus what should be happening. It is a problem created between the dominant discourse and the everyday experiences of the knower (Luken & Vaughan, 2003). A disjuncture, for example, in the ED as observed by one nurse can be represented by the constant inability of nurses to “find time” to do basic elder care, at the same time, prioritizing quick and efficient patient discharges to help reduce the ED’s wait times, as mandated by senior nursing and medical administration.

**Institutional Capture**

“Institutional capture has the capacity to subsume or displace description based in experience. Institutional capture can occur when both informant and researcher are familiar with institutional discourse, know how to speak it, and hence can easily lose touch with the informant’s experientially based knowledge” (Smith, 2005, p. 225).

**Institutional Ethnography**
“Institutional ethnography explores the social relations organizing institutions as people participate in them and from their perspectives. People are the expert practitioners of their own lives, and the ethnographer’s work is to learn from them, to assemble what is learned from different perspectives, and to investigate how their activities are coordinated. It aims to go beyond what people know to find out what they are doing is connected with others’ doings in ways they cannot see. The idea is to map the institutional aspects of the ruling relations so that people can expand their own knowledge of their everyday worlds by being able to see how what they are doing is coordinated with others’ doings elsewhere and elsewhen” (Smith, 2005, p. 225).

Institutions

Institutions “identify complexes embedded in the ruling relations that are organized around a distinctive function, such as education, health care, and so on. The terms identify the intersection and coordination of more than one relational mode of ruling. State agencies are tied with professional forms of organization, and both are interpenetrated by relations of discourse, including the institutional discourses that are systematically developed to provide categories and concepts expressing the relationship of local courses of action to the institutional function. It is a specific capacity of institutions that they generalize and are generalized. Hence, in institutional settings people are active in producing the general out of the particular. The institutional is to be discovered in motion, and its distinctive modes of generalizing coordination are themselves being brought into being in people’s local doings in particular sites and particular times” (Smith, 2005, p. 225).

Intertextuality
“[Intertextuality] expresses the view that texts do not stand alone; their sense is not independent of other texts; they are essentially intertextual. In institutional ethnography, the notion of Intertextuality is borrowed to recognize the interdependence of institutional texts” (Smith, 2005, p. 226). Intertextuality can be used to illustrate hierarchy of texts (higher level texts establish the frames and concepts that control and shape lower level texts) (Smith, 2005).

**Mapping**

“Maps are always indexically related to actual territories. Analogously, institutional ethnography’s project of mapping institutions always refers back to an actuality that those who are active in it know (the way that the phrase YOU ARE HERE works on a map). A map assembles different work knowledges, positioned differently, and should include, where relevant, an account of the texts coordinating work processes in institutional settings (Smith, 2005, p. 226).

**Power**

“[In institutional ethnography, institutions are seen as generating power through the coordinating functions of language and texts. Even the uses of physical force to control others, such as that by the police or military, are intertextual coordinated. The texts that constitute and regulate institutions establish agency, that is, textually specified capacities to control and mobilize the work of others. Textually sanctioned agency produces capacities for action accountable within the institutional hierarchy creating powers that are generated by the textual concerting and mobilization of people’s work” (Smith, 2005, pp. 226-227).
Problematic

The problematic of an institutional ethnography, Campbell and Gregor (2002) explain, is not the problem as an informant might tell it. It is not the research question either. Formulation of the problematic begins with people’s local experiences, the problems that disjunctures in the everyday/everynight world pose, and directs the research to point to a set of relations not visible at the local level but do direct and dominate the local happenings. “The problematic of the everyday world arises precisely at the juncture of particular experience, with generalizing and abstracted forms of social relations” (Smith, 1987, p. 157). It is the puzzle of the social organization of a particular institution, established as a result of certain disjunctures that the ethnographic inquiry will set out to address.

Processing Interchange

Processing interchanges are work processes, “particularly characteristic of institutions in which a text enters a work setting of a given individual and is processed or incorporated into a new text to become the focus of another or others’ work” (Smith, 2005, p. 227). For example, the nurse activates the CTAS guideline, a boss text, during the triage process, and then a hospital policy (lower level text) in accordance with the “acuity” of the patient as dictated by the CTAS. This activation of the second text based on the first is a processing interchange.

Regulatory Text

“Regulatory texts are higher-order texts that regulate and standardize texts that enter directly into the organization of work in multiple local settings” (Smith, 2006, p.
Lower level texts become permeated with these regulatory texts, or boss texts, (D. Smith, personal communication, August 26, 2009), such that the lower level texts become dependent on the regulatory texts to organize local work. Refer to Figure two for an example on an intertextual hierarchy.

**Ruling Relations**

Ruling, Campbell and Gregor (2002) state, takes place “when the interest of those who rule dominate the actions of those in local settings” (p.36). The analytic core of institutional ethnography, they assert, is to explicate the relations that exercise such ruling. The relations of ruling are those relations (work processes/actions/texts) by which the extralocal regimes generalize the knower’s experiences, thus, control the local happenings. The ruling relations manifest through the activation of institutional texts, engagement in ideological language and institutional discourse, and organization of work around a dominant form of institutional knowledge, usually managerial, to achieve its interests. Rankin and Campbell (2006 & 2009), in their research on nursing work and hospital reform illuminate the *Bed Utilization Program* (hospital patient tracking system) as a relation of ruling, one that socially organizes health knowledge, but in an abstracted, generalized form that objectifies local knowledge and dominates the knowledge, judgment, and experiences of the local knower (the nurse).

**Social Relations**

“The term does not refer to relationships such as those between instructor and student, boyfriend and girlfriend, or parent and child. Rather, it orients the researcher to viewing people’s doings in particular local settings as articulated to sequences of action that hook them up to what others are or have been doing elsewhere and elsewhen. It is
useful analytically to think of social relations as temporal sequences in which the 
foregoing intends the subseq, and in which the subseqent “realizes” or 
accomplishes the social character of the preceding. It reminds the ethnographer to attend 
to how the object of focus is embedded in sequences of coordinated action” (Smith, 

Texts and Text-Mediation

Texts, Smith (1987) affirms, are, in material form, “journals, reviews, books, 
conferences, classroom, laboratories, etc.” (p. 214). Other material forms of texts specific 
to the health care discourse are patient charts, patient tracking systems including triage 
softwares, aggregates of electronic patient records, institutional policies, Managerial 
guidelines, departmental and institutional training and orientation curricula, and 
municipal, provincial, and federal health policies and laws. Rankin and Campbell (2009) 
assert that almost all texts are managerially generated. This is strongly suggestive of the 
ability for texts to wield power, especially over those who activate them, also, most of 
whom had little to do with their creation. Activation of texts is an entry point into the 
relations of ruling.

Work

“The term is generally used to refer to what people are paid to do. The Wages for 
Housework group expanded the concept to refer not only to housework but to anything 
that people do that takes time, effort and intent. Institutional ethnography has adopted 
this conception of work in exploring the actualities of institutions. It orients the 
researcher to what people are actually doing as they participate, in whatever way, in 
institutional processes” (Smith, 2005, p. 229).
Work Knowledges

“The term refers simply to what people know of and in their work and how it is coordinated with the work of others. Work knowledge is a major resource for the institutional ethnographer. It is dialogically evoked in the interviewer-informant exchange when it is based in the informant’s own experience or in the observer’s experience/observations of people’s activities in a given setting. The different work knowledges that are produced in the researcher’s dialogues are fitted together so that the organization of the sequence, circuit, or the organizational form can emerge” (Smith, 2005, p. 229).