School of Nursing

Situational Positioning: A Grounded Theory of Registered Nurse Decision-making in Western Australian Nursing Homes

Beverley Margaret Scott

This thesis is presented for the Degree of
Doctor of Philosophy
of
Curtin University of Technology

June 2003

ABSTRACT

This grounded theory study investigated how registered nurses (RNs) managed problem-solving and decision-making in residential aged care facilities (nursing homes) in Western Australia. The outcome of the study was the substantive theory of *situational positioning*, the process used by the RN participants when they were *trying to get things right*.

In-depth interviews were conducted with 25 purposefully selected registered nurses and nursing home management staff. The interviews were transcribed verbatim, and analysed using the constant comparative method. Other sources of data, guided by theoretical sampling, were selected documents such as government reports regarding aged care, and some field observations.

Situational positioning was a process that involved physical, cognitive, emotional, and moral dimensions, and reflected how the RN participants acted and responded when dealing with situations at work. *Situational positioning* was conceptualised as occurring along two intersecting continua of behaviours, and these behaviours emerged from the data as four interrelated categories. *Yielding* and *confronting* represented the poles on a continuum of action-oriented behaviour, with *being flexible* and *being rigid* on a continuum that reflected more affective or attitudinal responses. The four categories that made up the positioning continua had both positive and negative meanings in relation to the actions and responses of the participants, depending on the particular situation.

Yielding was a conceptual category that reflected participants' comments about stopping a particular action and trying something else or giving up completely and even leaving the situation. The term *confronting* was used to describe participants' actions that were based on assertiveness that was seen as a constructive behaviour, or anger that tended to be non-productive.

Being flexible meant that the participants were responsive to changing situational variables, and this was usually seen as a desirable attribute of effective nursing practice in aged care. However, it could also mean being pliant and ready to compromise in order to get through situations when the participants realised that they would be *unable to get things right*. At the other end of the response axis, the term *being rigid* was defined as the opposite of *being flexible*, that is, having firmly fixed or set ways of responding, or a tendency to respond to situations in the same way in all circumstances.

The basic psychosocial problem, *being unable to get things right*, had two properties. One property was temporal, in that the problem occurred when the participants were *getting behind or running late* because of *having insufficient time*, usually due to *interruptions*. The second property of the problem was more qualitative in that contextual and intervening conditions led the participants to feel that they were *not doing things properly* because of adverse conditions.

Conditions that varied *situational positioning* were those that led to the participants *being unable to get things right*, such as *having insufficient time*, working with unqualified carers, and trying to meet the differing expectations of various stakeholders. Situations that were easy for the participants to manage involved known routines and few, if any, interruptions. In those circumstances, *situational positioning* was intuitive and the phases of *recognising, prioritizing,* and *moving on* were negotiated quickly.

In more complex situations, or when significant interruptions occurred, the participants followed an alternative pathway, which involved *recognising* that something in the situation changed, then *compromising*, that is, choosing a new course of action. *Compromising* required tolerance, as the participants adjusted their expectations of what could be achieved in the circumstances. *Repositioning* then occurred before they moved on to the next task or to the end of their shifts. *Moving on*, the third phase in the process, involved *persevering* as they continued *trying to get things right*.

The adverse conditions that prevailed in nursing homes during the time of this study impeded nursing practice and the delivery of consistently good standards of care for all residents. *Situational positioning* enabled the participants to *persevere* in their efforts to *try to get things right,* but their capacity to maintain the effort was eroded by the apparently unrelenting nature of the adverse conditions that existed in nursing homes.

The main conclusion of this study was that the RN role in nursing homes in Western Australia was ill-defined, and inefficient in terms of best utilisation of nursing time. Recommendations included a review of the RN role in aged care and implementation of strategies that would enable aged care RNs to focus on their clinical roles.

ACKNOWLEDGEMENTS

The completion of a doctoral thesis is really a team effort and relies on the contributions of many people. This thesis was no exception and its completion is due to the support, generosity and assistance of the people acknowledged here, and I take this opportunity to thank them all very sincerely.

- To the study participants go my special thanks for their generosity in sharing their time and insights about aged care nursing, and for being willing to share more time during follow-up conversations.
- To the directors of nursing who approved my access to their nursing homes and showed their belief in the need for the study by encouraging me.
- For Professor Vera Irurita, my principal supervisor, I have the most profound respect and stand in awe of her mastery of grounded theory method. Her support, encouragement and excellent advice were very much appreciated.
- My thanks also to Dr Angelica Orb, my associate supervisor, for her support, her sound grasp of the issues in aged care nursing, and valued contributions during the writing stage.
- To Dr John Wallace and the team at the Science and Mathematics Education Centre, and Dr Audrey Martins, who got me started and helped move the exploratory phase of the study along with suggestions and advice.
- To Marie D'Mello, my thanks for transcribing the interviews so carefully and for making it easier for me to focus on the analysis of the data.
- The contribution of my fellow Capricornians was so significant that mere thanks do not seem to be enough, but I offer sincere thanks anyway, and I look forward to more networking.
- To my friend and colleague Gillian Evans go my thanks for helping with the final reading as a "critical friend" and for having such a good eye.
- Finally, to my family and friends go my love and gratitude for giving me space when I needed it, and for putting up with my one-track mind and distraction over the past few years.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

OVERVIEW

This chapter will introduce the study, beginning with identification of the issues of concern in residential aged care at the time of the commencement of the study in 1996. A brief word picture of the Australian aged care sector is followed by reference to the circumstances that led to the investigation, that is, concerns about registered nurse (RN) role performance in Western Australian nursing homes. The main concerns were about RNs' clinical problem-solving and decision-making, and their documentation skills. These concerns informed the study design and are therefore briefly addressed in the context of aged care nursing.

The next section of the chapter will discuss the significance of the research to residential aged care and will also examine deficits in research in this area. The purpose and objectives of the study are then outlined, together with the research questions that provided guidance during the study. Definitions of terms are provided, and an explanation of nomenclature related to the aged care sector. The final section of this chapter provides an outline of the organisation of the thesis.

REASON FOR THE STUDY

The phenomenon of concern explored in this study was nursing practice in relation to RN problem-solving and decision-making. Residential aged care in Australia was the subject of criticism about care standards during the late 1980s and most of the 1990s. Effective RN performance is a key factor in the provision of high quality resident care, and it was possible that RN skills deficits might contribute to poor care standards. Therefore, the issues of aged care standards and RN problem-solving and decision-making constituted the problem framework at the beginning of this study.

Issues of concern in residential aged care

Care services for older Australians were the subject of increasing debate during the last two decades of the 20th Century. The focus on aged care arose from two main concerns: (1) the escalating costs of nursing home care, and (2) negative reports about the standards of aged care (Courtney & Price, 1999; Fogg, 1999; Kendig & McCallum, 1990; Senate Select Committee on Private Hospitals and Nursing Homes, 1985). Similar concerns about the provision of quality aged care existed in the United Kingdom (Bartlett, 1993) and the USA (Vladek, 1996).

Residential care for frail elderly people was provided in public and private hospitals in Western Australia from shortly after Federation in 1901 (Sax, 1993). Called geriatric or "convalescent" hospitals until the 1960s, these facilities became known as "C" class hospitals in the 1970s, nursing homes by the 80s, and then "residential aged care facilities" by the late-1990s (Mannix, 1999).

These title changes reflected the evolution of aged care policy frameworks, from custodial approaches to care, to more holistic, person-focused care (Sax, 1993, Mannix, 1999). Custodial care is usually taken to mean care of basic or vegetative functions such as providing shelter, food and fluids, and hygiene care (Fine & Stevens, 1998). By the late 1980s care that was solely custodial was considered to be "entirely inappropriate" in aged care (Nay & Closs, 1999, p. 172).

Regulation of nursing homes received increasing attention during the 1970s, and it peaked in the early 1980s with a series of Government inquiries and reports (Sax, 1993). One such inquiry, the Senate Select Committee chaired by Senator Patricia Giles, addressed care standards more comprehensively than any previous report, and "noted persistent press reports of poor standards of care…" (Kendig & McCallum, 1986, p. 160). Those authors further commented:

> It was in presenting the diverse and at times dramatic material on poor standards of care that the Senate committee gave full recognition to the need for policy to address the quality of care and quality of life of residents in nursing homes.
>
> (Kendig & McCallum, 1986, p. 161)

These concerns will be discussed in more detail in Chapter 3 because the context in which the RN participants worked was significantly changed by the consequences of inquiries into aged care standards. As Percival (1999) stated, the policy and legislative changes that occurred after 1987 had significant implications for nurses working in aged care, especially their need for continuing education. She went on to state: "professionals working with the elderly have to be highly skilled, and their levels of skill will continue to rise as science and demography change the care landscape" (p. 334).

The characteristics of the nursing population in Western Australia will also be discussed in Chapter 3, but another issue of concern in aged care was the educational standards of nursing home staff. Expectations of RN performance increased significantly during the 1990s, especially in relation to their problem-solving and documentation skills, and also their ability to direct and supervise the care provided to increasingly dependent residents by unregulated care workers.

A small number of qualified nurses was employed in the aged care sector from the early years of the 20th Century, although most of the direct care was carried out by unregulated care workers (Rhys-Hearn, 1986), variously called nursing assistants, assistants in nursing and, by the mid-1990s, personal carers. The preponderance of unqualified and unregulated care workers in this sector continued until the end of the 1990s, when more personal carers began to complete the Certificate III course in Aged Care Work. However, personal carers continued to be unregulated, and there were no regulations that required personal carers to undertake formal education, such as Certificate III in Aged Care Work. In a study of "quality, staffing and dependency" in non-Government nursing homes, Rhys-Hearn (1986) reported that quality of care was positively influenced by having more qualified nurses than untrained staff. This was later reaffirmed by Nay and Closs (1999).

A number of inquiries into aged care (discussed in Chapter 3) led to the Aged Care Reform program that started in 1987. The program that was implemented included a

number of significant changes in the responsibilities of RNs working in residential aged care. The main changes that directly impacted on the RNs were:

1. The increased nursing needs of residents who were more dependent and frail (due to government policy restricting access to nursing home beds), which demanded skilled nursing and problem solving (Nay & Closs, 1999); and,
2. Markedly increased documentation requirements, particularly to substantiate funding claims under the Residential Classification Instrument (RCI), the funding tool introduced in 1988 (Braithwaite, Makkai, Braithwaite, & Gibson, 1992).

The documentation that had been maintained in many nursing homes prior to 1987 was very limited because there were no regulations requiring written resident assessments or care plans. Also, in the majority of facilities, daily progress notes about care were recorded as exception reports in a common journal or "day book" (Personal observation, 1986), so there was an urgent need for improved documentation procedures.

Therefore, from 1987 onwards, the RNs working in aged care needed new skills and to revive skills that had perhaps been dormant during the years of minimal regulation in aged care. The changes in their role expectations required effective skills in clinical care, problem solving, time management, interpersonal communication, and teamwork. There was also a need to shift care management away from custodial routines and towards individualised, holistic resident care, which required effective problem-solving and decision-making skills.

Problem-solving and decision-making

Registered nurses were expected to have effective problem-solving and decision-making skills, as reflected in the Australian Nursing Council National Competency Standards for the Registered Nurse (Australian Nursing Council, 2000). For the purposes of this study, the term problem-solving is used in the sense of the nursing role related to addressing individual health problems of nursing home residents. The term decision-making is used to refer to processes related to the care coordination and unit

management roles of the RNs. However, it is recognised that those terms are sometimes used interchangeably in the literature.

Development of a problem-solving framework for nursing occurred during the 1960s, when a group of nurses in the USA worked to formalise nursing concepts (Nursing Development Conference Group, 1973). These efforts, and those of other nurse researchers, led to the development of theories of nursing and nursing practice. Mills and Sauter (1986) cited Orlando (1961), who examined a number of processes in nursing and first used the term "nursing process" as follows: "When the nurse acts, an action process transpires. This action process by the nurse in the nurse-patient contact is called nursing process" (Mills & Sauter, 1986, p. 209).

In the USA, the Nursing Development Conference Group (1973, p. 202) discussed the "importance of incorporating all steps of the nursing process into nursing as practised… [for] high quality or even minimally effective nursing." The use of nursing process as an organisational and practice framework was introduced into Australian nursing curricula in the 1970s (Russell, 1990).

Nursing process was defined by Alfaro-LeFevre (1994, p. 3) as "an organised, systematic method of giving goal-oriented humanistic care that's both effective and efficient". Nursing process involves assessment (including problem identification), care planning, implementation of the plan, and evaluation of outcomes. The steps described for nursing process are very similar to the elements of the decision-making process, described by Marriner (1977) as problem identification, exploration of alternatives, selection of best alternative, implementation of the decision and evaluation of results.

While problem-solving was recognised as a core competency for nursing practice in Australia over 25 years ago, practice frameworks incorporating these techniques were not implemented in aged care in Western Australia until the early 1990s. The implementation of a nursing process framework in aged care occurred as a result of the policy and legislative changes associated with the Aged Care Reform program, begun in

1987. Changes in procedures included the requirement that written evidence of compliance with legislated standards and funding procedures be provided by nursing home staff (Braithwaite, Makkai, Braithwaite, Gibson, & Ermann, 1990). These matters are described in more detail in Chapter 3.

During the period 1987 to 2002, the researcher was a consultant nurse educator, providing education services for nursing home staff in metropolitan and rural Western Australia. The consultancy role included assisting nursing home managers to develop written policies, procedures, position descriptions, and other documentation, and also to develop and implement quality improvement programs.

The core business of the consultancy was to develop and coordinate staff education and training programs, and during the middle years of the 1990s, the researcher was often asked to provide education on nursing process skills and procedures. The main reason for the requests for RN education about nursing process was that a funding tool, introduced as part of the Aged Care Reform program in 1988, required specific documentation of resident care to substantiate funding claims. A discussion of funding and regulatory procedures in aged care is provided in Chapter 3 of this thesis.

Anecdotal evidence indicated during the early 1990s that many experienced RNs found that using a nursing process framework for documentation was difficult. The RNs were usually unable to articulate the reasons for the difficulty, apart from being unable to "get the documentation right". There were possibly dialectic, literary, and administrative issues involved in the application of nursing process as it was operationalized in the aged care sector at the time. For example, the documentation required to validate funding demanded high level reasoning and literacy skills, but few of the RNs working in aged care at the time had the educational preparation for such writing. In addition, expectations of what constituted sufficient evidence to substantiate funding changed quite regularly. Administrative issues included space and time constraints that impacted on the RNs' ability to maintain extensive documentation.

There seemed to be a range of factors that influenced the RNs' ability to complete resident care documentation to a standard that would satisfy both their nurse managers and government auditors. Nurses who worked at management level in nursing homes seemed to believe that the main problems were learning deficits, and that more education for the RNs was the solution. However, the disappointing outcomes of a range of educational activities over several years led the researcher to suspect that there were other reasons for the difficulties experienced by the RNs in relation to documentation of nursing care.

The concerns about RN role performance were, during the mid 1990s, recurring subjects of discussions between the researcher and nursing home directors of nursing and nurse managers, who were also struggling with the changes in aged care regulation and management. Those concerns related to both the actual role performance of the RNs and also the expectations of their performance by other stakeholders in the aged care arena. Consideration of the scope of RN practice led to exploration of a range of concepts that were relevant to the issues of concern, including problem solving skills/ application of nursing process, clinical decision-making, and care coordination.

Documentation and nursing process

Documentation is the only durable form of evidence of decision-making and is essential for professional accountability and quality assurance purposes (Staunton & Whyburn, 1993). In 1993, the Commonwealth Department of Health commissioned a "Panel of Experts" to address nursing home industry concerns about documentation requirements. Persistent difficulties had been reported by many aged care facilities in relation to consistently achieving the standards of documentation required to demonstrate accountability for funding or to meet quality (standards) criteria (Macri, 1993). The report included the following statement:

> … many nursing homes were over-documenting which detracted from resident care and desired outcomes and had a negative impact on staff morale. This was primarily a result of a lack of understanding of the type of documentation required to validate resident assessments, i.e. The Nursing Process, and a lack of knowledge and skills in the area of documentation and clinical records requirements.
>
> (Macri, 1993, p. 1)

The nursing process was endorsed as the appropriate model for documentation in nursing homes in Australia in 1994, and established specific requirements for nursing practice and recording in aged care. In discussing findings of a literature search, the Expert Panel concluded that

> No other model of documentation was found throughout the literature search in either aged care or acute care. The scientific method underpinning the nursing process appears to be universally accepted throughout Scandinavia, Europe, the Americas and Australia. The nursing process is therefore the basis for documentation in nursing.
>
> (Macri, 1993, p. 10)

The endorsement of nursing process as the required framework for nursing documentation again reflected the lag between aged care and acute care nursing practice because acute hospital nurses had been writing care plans since the early 1970s. By the time endorsement of nursing process occurred in aged care there was growing criticism of the limitations of this approach in nursing (Henderson, 1982; Lawler, 1991; McCoppin & Gardner, 1994). For example, one writer referred to the "persistent resistance among registered nurses to having this concept of practice imposed upon them", that it "can be used as an instrument of authority", and it may reduce the patient to a "set of problems, needs, or diagnoses" (Lawler, 1991, pp. 36-37).

Reflection on the issues associated with aged care nursing, and experience with teaching and applying nursing process, led to the researcher journalling the following ideas in 1995:

1. Nursing process relies on inductive reasoning (working from data to a conclusion) whereas many RNs learned nursing through a largely deductive model - prescriptive or general rules leading to decisions about what needed to be done in terms of general care routines. Those rules were usually generalised to all patients: They were not individualised.
2. Nursing process is represented in the literature as a <u>linear</u> activity, but nursing practice is not linear, it is potentially chaotic.

3. Nursing process relies on a logical progression of steps, while experienced nurses often use intuition.
4. Nursing process assumes rationality, while many factors in the aged care nursing environment are not rational.

It is possible to extrapolate from nursing workforce statistics that the majority of RNs working in aged care in WA during the 1990s undertook hospital-based training during the 1960s and early 1970s (Australian Institute of Health and Welfare, 1999a; Health Workforce Branch, 1996). This suggested that their training occurred before a nursing process framework was introduced, and they may not have had opportunities to develop these skills during their subsequent nursing practice, especially if they had worked in aged care for a long time. Exposure to on-going education and a willingness to learn new skills also seemed to be relevant, as some RNs resisted changing their work practices (Nay & Closs, 1999).

Nursing practice that was based on rule-focused procedures was not considered to be sufficient to meet contemporary standards and expectations (Nay & Closs, 1999). The RNs' practice may have been "automatic" rather than "deliberative" as described by Mills and Sauter (1986), when they outlined Orlando's theory of nursing, and described her differentiation between automatic and deliberative nursing actions as follows:

> Automatic nursing actions are those having nothing to do with finding out and meeting patients' needs for help. Deliberative nursing activities are those designed to identify and meet the patient's immediate need for help, and, therefore to fulfil the professional nursing function.
>
> (Mills & Sauter, 1986, p. 209)

The idea of automatic nursing actions expressed above seemed to be consistent with descriptions of "task-oriented" approaches to nursing that were the norm until the 1970s (Russell, 1990). At that time, when aged care was provided in what were called "C" class hospitals, care tended to be custodial (Rhys-Hearn, 1986).

Further reflection regarding discussions with aged care nurses and managers led the researcher to assume that the difficulties experienced by RNs would not simply be

addressed by more education or structured learning experiences in the use of nursing process. There seemed to be a number of other factors in the RNs' work environment that interfered with their ability to meet their role responsibilities effectively. For example, at the time of the study, the aged care environment in which RNs worked was complex, and they faced competing demands for their time from residents, the residents' families, subordinate staff, and organisational management. These "stakeholders" also had expectations about RN performance, as did external assessors and auditors. The RNs worked in a setting where health crises (including death) occurred frequently and medical practitioners and emergency services were not immediately available. They worked mainly with unqualified personal carers and had overall responsibility for nursing care, housekeeping, facility maintenance, and security requirements, especially after office hours. All of these factors had the potential to impede effective nursing practice.

Considering all of these factors, it was perhaps not surprising that RNs working in aged care seemed to have difficulties accommodating the changes driven by the Aged Care Reform program, while meeting their own and others' expectations of their work performance. Therefore, the intention of this study was to discover what problem or problems RNs faced in fulfilling their professional role responsibilities in the residential aged care sector, and what they did to resolve or manage the problems. The study focused on RNs working in nursing homes, primarily in the Perth metropolitan area.

SIGNIFICANCE OF THE STUDY

It is generally acknowledged that older people who require nursing home care are frail and vulnerable (Fogg, 1999), and that good nursing and personal care are essential components of quality aged care. However, the link between poor care standards and RN skills deficiencies in problem-solving and decision-making was not established in the literature that was explored before the study began.

Exploration of the literature related to application of nursing process and decision-making in nursing led to questions about nursing practice and care standards issues in

aged care, and subsequently to this study being undertaken. Most of the literature up to 1996, from both Australian and overseas sources, focused on general or specialist nursing settings in acute care hospitals, and no studies were found describing clinical nursing practice in the Australian aged care sector. Once the grounded theory methodology used in the study (see Chapter 2) was chosen, further literature searches related to RN decision-making were not undertaken until data collection and analysis were well advanced.

Recent literature and reports have identified issues related to quality of care (Cheek, Ballantyne, Jones, Roder-Allen, & Kitto, 2002; Nay & Closs, 1999), recruitment and retention of nurses in aged care (Pearson, Nay, Koch, Rosewarne, Ward & Andrews, 2002), nursing education (Heath, 2001) and nursing generally (Senate Community Affairs References Committee, 2002). However, when this study began there was little recognition of the broad range of impediments to effective nursing practice by RNs working in aged care.

Apart from a preliminary study undertaken before a larger project by Nay and Closs, (1998), no Australian research was found that explored practice issues from the perspectives of RNs working in nursing homes. The Nay and Closs (1998) study involved focus groups of nurses in Victoria, and found a number of issues of concern, including the negative image of aged care, inadequate educational preparation for the specialty, and a number of personal issues experienced by the focus group participants.

A recent study explored the reasons why RNs stayed in aged care (Stein, 2002), and found that they valued the flexible working conditions and satisfaction with caring for long-term residents. Also important were relationships with residents and colleagues, a finding that supported the Nay and Closs study reported above. However, no research or literature was found prior to 1996 that described how RNs managed the decision-making environment in aged care.

Henderson (1982) described clinical judgment as being both theory- and experience-based, as well as being intuitive. She went on to state that "to some extent clinical judgement is mysterious since health care providers with the same opportunity to develop it vary so greatly in the degree to which they demonstrate it" (Henderson, 1982, p. 107). Anecdotal evidence suggested that RNs working in nursing homes in Western Australia in the 1990s had diverse skills and abilities, and that they used a range of practical skills to manage resident care. However, the source of some apparent RN performance deficits was not clear, and seemed to be multi-factorial.

The nursing home working environment for RNs seemed to be difficult, with contradictions, ambiguities, and conflicting demands for both the RNs and the facilities in which they worked. Some RNs seemed to manage this care environment effectively, while others did not, and there seemed to be many factors that impinged on their role effectiveness. While offering further education and other opportunities for skills development was an obvious strategy, RN learning achievements were often disappointing, and seemed to be impeded by other factors.

Therefore, this research will provide new insights into how RNs manage the decision-making environment in Western Australian nursing homes. When the factors that enhance or impede problem-solving and decision-making in this sector are better understood, it will be possible to identify strategies, in addition to continuing education, that will contribute to more effective decision-making to improve resident care standards and outcomes.

PURPOSE AND OBJECTIVES

The purpose of this study was to generate a substantive theory about how RNs apply problem-solving and decision-making skills in nursing homes in Western Australia.

The objectives of the study were to:

1. Explore the problem-solving and decision-making behaviours of RNs in the nursing home setting;

2. Discover the interpretations and perspectives of RNs regarding problems they encountered in fulfilling their role responsibilities;
3. Produce a conceptually dense theory about how RNs performed their role responsibilities in this setting.

Research questions arose during the study, some at the beginning, and others as the data were analysed. These questions provided guidance for ongoing data collection:

1. What situations do RNs encounter at work?
2. What factors facilitate or impede nursing practice and decision-making in residential aged care?
3. How do RNs manage care situations in nursing homes in Western Australia?

DEFINITION OF TERMS AND NOMENCLATURE

Accreditation: The process of certifying that residential aged care facilities meet regulatory requirements.

Aged Care Standards and Accreditation Agency: The body established by the Commonwealth Government as the accreditation body under the *Aged Care Act 1997*. The core functions of the Agency are:

- Manage the residential aged care accreditation process using the Accreditation Standards
- Promote high quality care and assist industry to improve service quality by identifying best practice, and providing information, education and training
- Assess and strategically manage services working towards accreditation
- Liaise with the Department of Health and Ageing about services that do not comply with the relevant Standards.

The Agency fulfils its functions using processes and principles set down in legislation, notably the *Aged Care Act 1997*, the *Accountability Principles 1998*, and the *Accreditation Grant Principles 1999* (Aged Care Principles, 2001*)*.

Residential aged care facility: A care facility for older persons, licensed under State legislation and regulated under the Commonwealth *Aged Care Act 1997*. Since

1997, the term residential aged care facilities has been used to refer to both nursing homes and hostels. See "nursing homes" below.

Resident Classification Scale (RCS): An assessment tool used to classify residents in aged care facilities for the purpose of providing funding.

Patient: In the residential aged care context, the term patient is now used almost exclusively by medical practitioners to denote their clients.

Resident: term used to refer to an aged or disabled person living in a residential aged care facility.

Care recipient: A term used in Commonwealth Department of Health and Aging documentation to refer to a person living in a residential aged care facility.

Client: A term used to denote a person who receives services, and in this context, a person receiving community-based care services. The term is also used in specialist areas of nursing, such as hospice/palliative care units.

Registered nurse (RN): A person registered in Division 1 of the Western Australian nurses' Register and licensed to practise nursing autonomously in any setting.

Enrolled nurse (EN): A person registered in Division 2 of the Western Australian nurses' Register and licensed to practise nursing under the direction and supervision of a registered nurse.

Personal carer (PC): An unregulated care worker employed to provide personal care to older persons in residential aged care facilities. Some personal carers have a Certificate III in Aged Care Work, others have no formal training or qualifications. Other position titles include nursing assistant (NA) and assistant in nursing (AIN).

Nursing home: A residential aged care facility that is licensed by the State Department of Health to provide residential aged care services, and regulated and funded by the Commonwealth Department of Health and Ageing.

A brief comment on nomenclature related to aged care is warranted in this thesis because the Aged Care Reform program introduced in 1987 resulted in a number of changes in descriptive terms used in the aged care sector. This sector of health and social service is referred to in this study as the "aged care sector", and earlier terms such

as Extended Care, Continuing Care, Long-Term Care, and Permanent Care have not been used, unless directly quoting a literature source that used one of those terms.

The responsible Commonwealth department also changed its name regularly over the period of this study, as other portfolios were added to, and removed from, the central health portfolio. Therefore, a generic term "Commonwealth Department of Health" has been used to cover all of the versions of the Department that had responsibility for aged care services between 1987 and 2002. Government reports from the different periods are listed in the References section, and the full title of the Department at the time of the relevant reports is provided.

Persons who live in nursing homes are called residents in this study, although the term currently used by regulatory authorities is "care recipients". Other terms include "patients" and "clients", as defined above.

Finally, the term "residential aged care facilities" was introduced with the 1997 Structural Reform Package that is described in Chapter 3. During the 1980s and early 1990s, aged care facilities were called nursing homes or hostels, depending on the level of care provided. Most of the literature referred to in this chapter, including government reports, used the term "nursing homes" rather than "residential aged care facilities", so the former term is usually used, unless referring to a broader concept such as residential aged care that includes what were formerly called hostels. These choices regarding terminology were made in the interests of readability of the text.

ORGANISATION OF THE THESIS

Chapter 1, the introduction to the study, provided a statement of the concerns that resulted in the study being undertaken, including issues related to RN performance in relation to problem-solving, documentation, and supervision of care standards. This chapter also briefly discussed the deficits in research in this area and identified the significance of the study. The purpose and objectives of the study were provided, followed by definitions of key terms used in the study.

Chapter 2 describes the grounded theory methodology used to research the study questions. The epistemological origins of the method are discussed, as are its development and evolution over time. Details are provided regarding the study population and the sampling technique used to identify them, and data collection and data analysis procedures, including illustrations of how these were applied. The chapter concludes with a discussion of ethical considerations and how the study participants' rights and privacy were protected.

In Chapter 3 the context of the study is described, that is, the sector within which the study participants worked. This chapter represents the first part of the findings of the study because selected literature was used as data and analysed accordingly. The chapter begins with a review of ageing population demographics, and the characteristics of people living in aged care facilities, then there is an outline of the sociopolitical history of aged care in Australia, including a review of the numerous government inquiries held during the decade 1975 - 1985. A discussion about the Aged Care Reform agenda is followed by an outline of professional nursing in Australia, and Western Australian nurse demographics. The chapter is completed by drawing conclusions from examination of factors that related to the environment in which RNs worked.

Chapter 4 provides the second part of the findings of the study, that is, the problem experienced by the participants in their roles as RNs in nursing homes in Western Australia. The concepts and categories that constituted the problem are defined and described in detail, with relevant illustrations from the data.

Chapter 5 provides the third part of the findings, that is, the basic social psychological process (BSPP) used by the study participants to achieve care goals and work targets in their professional roles. Again, the concepts and categories that reflected the process are defined, and described together with their linkages, and illustrated with excerpts from the data.

Chapter 6 compares and contrasts the substantive theory of *Situational Positioning* in relation to relevant literature. This chapter also explores the literature related to other concepts that were important in this study, including decision-making and issues related to the RN role.

Chapter 7 describes the conclusion reached from the findings of the study and discusses the implications of the study. Finally, recommendations are made for further research and action to improve the potential for effective RN role performance in nursing homes.

CHAPTER 2

METHODOLOGY

OVERVIEW

This chapter describes the grounded theory methodology used in this study, and how the research was carried out. The grounded theory method is a qualitative research approach that was originally described by Glaser and Strauss (1967). In the first section of this chapter, the method and its epistemological origins are discussed, as are further developments and divergences in the method which have occurred since 1967.

The next section provides a description of the grounded theory method and its associated procedures, including a discussion of the process of theoretical sampling, and the rationale for the use of the method in this instance. The central part of the chapter describes the methodology applied to the present study. The study population and data collection methods are described, including reference to the development and evolution of the interview questions asked of the study participants.

Data analysis, using the constant comparative method that is central to grounded theory, is described in the next section of the chapter. For this study, the data were managed with the assistance of QSR NUD*IST (Qualitative Solutions and Research, 1997), a computer software program. Ethical considerations are then discussed, including informed consent, access to participants, and maintenance of confidentiality.

RESEARCH DESIGN

Constructivism was the chosen paradigm for this study because that position best provided the interpretive framework within which the research questions could be explored. Schwandt (2000, p. 197) used the term "social constructionism" (although the same author subsequently used the term "constructivism") to describe an epistemology where both the researcher and the subject receive information via their senses and use their minds to construct knowledge. These constructions include abstract ideas and concepts, and he went on to say:

> In this sense, constructivism means that human beings do not find or discover knowledge so much as we construct or make it. We invent concepts, models and schemes to make sense of experience, and we continually test and modify these constructions in the light of new experience.
>
> (Schwandt, 2000, p. 197)

The research design used in qualitative inquiry generally situates the researcher in the world of experience where the elements of the paradigm - its ontology, epistemology, and methodology - are consistent with the purposes of the study and the nature of the inquiry.

> The constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures.
>
> (Denzin & Lincoln, 2000, p. 21)

A relativist ontology accepts that interpretations of reality are not more or less "true" in any formal sense, but simply more or less informed and/or sophisticated (Denzin & Lincoln, 1994, p. 111). Macdonald and Schreiber (2001, p. 38) described this ontology as being part of the modernist phase in the development of qualitative research, into which the original version of grounded theory "fits neatly". The modernist phase was described by Denzin and Lincoln (2000, p. 14) as the "golden age of rigorous qualitative analysis" that followed the earlier traditional period in which qualitative methods were gradually formalized.

A subjectivist epistemology assumes that the investigator and the object of investigation are interactively linked, so that the findings are literally created as the investigation proceeds (Denzin & Lincoln, 2000). Therefore, the researcher is part of the context of the phenomenon that is being explored, and brings personal experience and perspectives to the investigation (Speziali & Carpenter, 2003).

Lincoln and Guba (2000) described the naturalistic research procedures used to operationalize constructivism as hermeneutic and dialectical. This suggests that individual constructions (interpretations) can be elicited and refined only through interaction between and among investigator and respondents. These varying

constructions are compared and contrasted through a dialectical (reasoning) exchange. The final aim is to distil a consensus construction that is more informed and sophisticated than any of the predecessor constructions (Lincoln & Guba, 2000).

Grounded theory method developed by Glaser and Strauss (1967) owes much to symbolic interactionism, described as "a theoretical perspective rooted in the philosophy of pragmatism" (MacDonald & Schreiber, 2001, p. 42). Symbolic interactionism became a qualitative social science research tradition that developed at the University of Chicago, where Strauss had studied, and was based on three premises:

> Human beings act toward things based on the meanings that the things have for them; the meanings of such things is derived from the social interaction that the individual has with his fellows; and meanings are handled in, and modified through an interpretive process and by the person dealing with the things they encounter.
> (Blumer, 1969, p. 2, cited in Robrecht, 1995, p. 170)

Symbolic interactionism is part of the ethnographic tradition which holds that people behave and interact according to how they interpret or give meaning to specific symbols (Hutchinson, 1986). Symbols may be anything that transmit messages that can be interpreted, and include language (e.g. words), objects (e.g. stethoscopes), specific garments (e.g. uniforms), and also tools or equipment (e.g. medication trolleys).

Qualitative research methods developed significantly after the mid-1980s, and there are now many approaches to researching phenomena that are not quantifiable (Morse & Richards, 2002). The three main qualitative research approaches cited in the nursing literature are phenomenology, ethnography and grounded theory method (Leininger, 1985, Munhall & Oiler, 1986, Speziali & Carpenter, 2003), and each of these approaches has evolved over time. The developments associated with grounded theory method will be outlined in the following section of this chapter.

ORIGINS AND DEVELOPMENT OF THE GROUNDED THEORY METHOD

The development of the grounded theory method arose out of the combined research histories of Barney Glaser and Anselm Strauss (Dey, 1999; Stern & Covan, 2001), who first published the method as "a process that articulated the discovery of theory from qualitative data" (Robrecht, 1995, p. 170). In particular, Anselm Strauss had worked

with the symbolic interactionist approaches used by anthropologists and sociologists (Robrecht, 1995).

The *Discovery of Grounded Theory* (Glaser & Strauss, 1967) was the original text written to explain the research approach they used when they studied dying patients. While these researchers were sociologists, the research team included a nurse sociologist, Jeanne Quint Benoliel, who also did individual work using grounded theory method (Hutchinson, 1986). Glaser and Strauss worked with other nurses undertaking doctoral research and this led Stern (1980) to begin work on explicating the method for nursing because she considered that the language used, particularly by Glaser – "the jargon of their profession" – was "all but incomprehensible to the uninitiated" (Stern, 1985, p. 149).

Over time, as more researchers began using grounded theory method, Glaser decided to fill in the gaps in methodological description in their first book, and this resulted in publication of *Theoretical Sensitivity* (Glaser, 1978). The content of this new book reflected materials developed for his seminars and work with doctoral students (Glaser, 1978). It detailed "the advances in procedures and thought in generating grounded theory" and also encouraged "the development of the necessary *theoretical sensitivity* in analysts…" (Glaser, 1978, p. 1).

In *Theoretical Sensitivity*, Glaser provided guidance on how to pace the research work, and on theoretical coding, basic social processes, and theoretical sorting. In the theoretical coding chapter he defined and described a variety of coding "families" including the "Six Cs" (causes, contexts, contingencies, consequences, covariances and conditions), and others such as process (stages, phases, etc.) degrees (limit, range, extent, etc.), dimensions, types, and strategies (Glaser, 1978).

Nine years later, Strauss published his own text, *Qualitative Analysis for Social Sciences* (Strauss, 1987), which was intended to make grounded theory more accessible because there were still criticisms about Glaser's use of "abstract terms and dense writing" in *Theoretical Sensitivity* (Charmaz, 2000). However, other writers disagreed with this

criticism and continued to recommend *Theoretical Sensitivity* as a good resource for the grounded theory student (MacDonald, 2001).

The divergence in the positions of the co-founders of the grounded theory method started with the changes in terminology and procedures introduced by Strauss in his *Qualitative Analysis* (MacDonald, 2001). This divergence led to continued debate regarding methodological issues, particularly in relation to data management (Babchuk, 1996).

The new coding paradigm introduced by Strauss in 1987 was elaborated in *Basics of qualitative research: Grounded theory procedures and techniques* (Strauss & Corbin, 1990, 1998). In that text, specific techniques were provided "for enhancing theoretical sensitivity" and "the conditional matrix was fully conceptualized and strategies for tracing conditional paths were introduced" (MacDonald, 2001, p. 124).

However, this divergence from what he saw as the original grounded theory method resulted in Glaser publishing a repudiation of the Strauss and Corbin (1998) work in his *Basics of grounded theory analysis* (Glaser, 1992). In particular, he maintained that "asking many preconceived, substantive questions of the data during analysis" resulted in "forced conceptual description" and not grounded theory (Glaser, 1992, p. 4 – 5). Robrecht (1995, p. 171) expressed concerns that the "increasingly complex set of operations and procedures" led to more attention being given to the operational procedures than to the data, so that researchers tended to "look for data rather than look at data".

While that fairly public disagreement over procedures continued, a researcher named Leonard Schatzman (a colleague of Glaser and Strauss) described a "better framework for the analytic processes intrinsic to grounded theory research" (Robrecht, 1995, p. 172). Schatzman called this approach "dimensional analysis" and it provided a model that showed relationships between the dimensions, conditions, actions and consequences associated with an "event", the perspective of the researcher and the subsequent naming of the concepts (Robrecht, 1995, p. 172, Dey, 1999).

Proponents of grounded theory research methods tended, until recently, to fall into one or the other "camp", that is, either the position taken by Glaser, or that of Strauss and Corbin (Dey, 1999). Concern about the imposition of rigid rules on judgements about whether a grounded theory was of value was one of the areas discussed by Wilson and Hutchinson (1996, p. 122) in their review of "methodological mistakes". Those supporting Glaser's stance emphasised the importance of "gathering data without forcing either preconceived questions or frameworks upon it" (Charmaz, 2000, p. 512). This was the position that was adopted by the researcher in the present study in that

However, other writers suggested that flexibility is desirable, and that it should be possible to maintain rigour in approach while the method evolves (Babchuk, 1996; Charmaz, 2000; Dey, 1999). As Morse and Richards said:

> Researchers develop new techniques when confronted by challenges in their data, and if these techniques are consistent with the methods, they are drawn into other researchers' strategies.
>
> (Morse & Richards, 2002, p. 5)

The same authors went on to suggest that changes within a research method should be developed carefully and cautiously, and should be properly evaluated and subject to critical review, rather than simply "mixing and matching…a bag of techniques unlinked by strategies and uninformed by method…" (Morse & Richards, 2002, p. 5).

GROUNDED THEORY METHOD

Grounded theory has been described as "both a way to do qualitative research and a way to create inductive theory" (Backman & Kyngäs, 1999, p. 147). Grounded theory research is intended to generate theories about phenomena through an inductive approach and by using the hallmark systematic procedures and constant comparative method of data analysis (Speziali & Carpenter, 2003).

The methodological debate outlined in the previous section resulted in considerable discussion in the literature and this greatly increased the volume of information about grounded theory. One such writer succinctly summarised the main thrust of grounded theory research as follows:

> The general goal of grounded theory research is to construct theories in order to understand phenomena. A good grounded theory is one that is: (1) inductively derived from data, (2) subjected to theoretical elaboration, and (3) judged adequate to its domain with respect to a number of evaluative criteria.
>
> (Haig, 1995, p. 1)

Grounded theory is a "research method used to search out factors (factor searching) or to relate factors (factor relating) that pertain to the research problem at hand" (Stern, 1985, p. 150). Grounded theories have been classified as either formal or substantive (Hutchinson, 1986). Substantive theories have also been called "middle-range" theories because they are relatively limited in the range and scope of concepts or aspects they address (Speziali & Carpenter, 1995, p. 147). While formal theories relate to broad conceptual processes, substantive theories are derived from particular empirical areas of enquiry, such as decision-making in aged care.

Dey (2001) listed a number of tenets that applied to grounded theory, including:

> - Theory focuses on how individuals interact in relation to the phenomenon under study
> - Theory is derived from data acquired through fieldwork interviews, observations, and documents
> - Data analysis is descriptive and begins as soon as data becomes available
> - Data analysis proceeds through identifying categories and connecting them
> - Further data collection (or sampling) is based on emerging concepts
> - These concepts are developed through constant comparison with additional data.
>
> (Dey, 2001, p. 1)

The tenets applied to the grounded theory method by Dey (2001) are reflective of those described by other contemporary writers (e.g. Charmaz, 2000; Irurita, 1996; Morse & Richards, 2002; Speziali & Carpenter, 2003).

Hutchinson (1986, p. 112) described the task of grounded theory researchers as discovering and conceptualizing "complex interactional processes" through analysis of data. Or, as stated by another writer:

> The goal of good grounded theory research is the construction of a parsimonious theory with concepts linked together in explanatory relationships that, in accounting for the variation in the data, explains how participants resolve their basic social problem.
>
> (Schreiber, 2001, p. 78)

Data are generated from a variety of sources, such as interviews, field observations, records, and literature. These data are analysed using the *constant comparative method* (Glaser & Strauss, 1967), which means that analysis begins when data becomes available and continues as more data are added, and then subsequent data generation can be planned to contribute to concept formation (Speziali & Carpenter, 2003).

One of the central concepts in grounded theory method is *theoretical sensitivity* (Glaser, 1978), which means that the researcher is alert to possible biases that might intrude into the analysis of data (Schreiber & Stern, 2001). It is important that researchers using grounded theory method recognise and acknowledge how their own perspectives might influence their interpretation of data. However, "[t]his is not the same as bracketing, as used in other interpretive traditions because grounded theorists recognize that the researcher and her or his experience cannot be removed from the process" (Schreiber & Stern, 2001, p. 61).

Therefore, it is suggested that, in developing theoretical sensitivity, researchers constantly check their interpretations against their own beliefs and positions, and thereby increase their confidence that their findings were, in fact, grounded in the data (Schreiber & Stern, 2001). As Hutchinson (1986, p. 115) said: "Only through self-awareness of mind-set can the researcher begin to search out and understand another's world".

The research process using grounded theory method is different from that of verificational research, where literature is searched to find hypotheses to test (Hutchinson, 1986). A grounded theory study tends to start with question(s) about a problem or a phenomenon, and study procedures include data selection and collection, theoretical sampling, constant comparative analysis and theory development, which includes consideration of relevant literature (Dey, 2001; Speziali & Carpenter, 2003). However, these steps are not linear because several parts of the research process may be occurring simultaneously (Stern, 1980). Specific aspects of the method are described below.

Selection of types of data

Since grounded theory method has its roots in field research, and relies on interaction between people, data are usually gathered through interviews and observation (Hutchinson, 1986). Most grounded theory studies reported in the literature used interviews for a significant part of the data collection, and these were described as formal or informal, semi-structured or unstructured, and being conducted with one person or with a group of people (Morse & Richards, 2002). Formal, unstructured interviews were usually described as starting with a general question, and continuing interactively with "unplanned, unanticipated questions… [and] probes for clarification" (Morse & Richards, 2002, p. 91). It has been suggested that there is no "typical grounded theory interview" because of the need for the researcher to be responsive to the circumstances of each interview (Wimpenney & Gass, 2000, p. 1488).

Another type of data used in grounded theory is observation in the context of the phenomenon being explored. As an observer, the researcher may be a participant in the scene, and may include informal interviews conducted during field observations in the data collection, or may be more distanced or less participating (Hutchinson, 1986; Morse & Richards, 2002). Observations are usually recorded as field notes, which may include the researcher's interpretations of what is happening (Morse & Richards, 2002).

Other types of data include documents and other records such as diaries and letters (Morse & Richards, 2002). Documents that yield data include organisational policies and procedures used to direct or guide employee action, and literature such as government inquiries and reports. Documents accessed for the present study included organisational documents and various government reports.

Sampling

Identification of data sources is a crucial part of a grounded theory study, and decisions about the study population should be based on the purposes and objectives of the study (Morse, 1989). Morse and Richards (2002) suggested that two principles guide sampling, one being "purposeful selection" of the setting and the study population, and

the other being "theoretical sampling" (Morse & Richards, 2002, p. 67). These procedures were also discussed by Glaser (1978).

The selection of participants in this way has been called *purposeful sampling* (Morse, 1989, p. 119), in that people are selected for interviewing because their characteristics (knowledge, experience, attitudes, motivations) will contribute to the generation of theory (Glaser, 1978; Morse, 1989; Schreiber & Stern, 2001). The intention with purposeful sampling is to get the best data possible to enable a "rich or dense description of the culture or phenomenon…" (Speziali & Carpenter, 2003, p. 24).

An aspect of participant selection in grounded theory is that the study population is not defined at the beginning of the study, either in terms of who will be included, or how many participants there will be (Morse, 1989; Schreiber, 2001). Data collection and constant comparative analysis of data (Glaser & Strauss, 1967) continues until no further data are required, so the actual number of participants is not pre-determined. As Schreiber and Stern (2001, p. 63) said: "The units of theoretical analysis are not the individual participants themselves, but may be incidents, stories, examples, and so forth."

The process of collecting and analysing data simultaneously and progressively is called *theoretical sampling*, and involves the progressive identification of data sources (participants, records, sites for field observation, etc.) according to the developing categories in the data (Glaser, 1978; Dey, 1999; Thompson, 1999; Schreiber & Stern, 2001; Morse & Richards, 2002). Therefore, the inductively developed categories emerging from the data guide the researcher in deciding "where to go next… in order to sample for more data to generate the theory" (Glaser, 1978, p. 37).

Constant comparative analysis

Data analysis requires systematic coding of concepts at several levels, starting with the raw data (interview transcripts or field notes) and proceeding through further analysis and interpretation to the identification of categories (Hutchinson, 1986; Speziali & Carpenter, 2003; Schreiber & Stern, 2001). The four stages involved in the constant comparative method of analysis as developed by Glaser and Strauss (1967) are

"characterised as (1) generating and (2) integrating categories and their properties, before (3) delimiting and then (4) writing the emerging theory" (Dey, 1999, p. 7).

Constant comparison of categories results in merging and linking of codes and categories, and with theoretical coding and memoing, a core category, or categories, emerge from the data (Schreiber, 2001). The application of this process in this study is described in subsequent sections of this chapter.

Going to the literature

The use of literature is another particular aspect of grounded theory method. This is because Glaser (1978) insisted that reading relevant literature too early in the study leads the researcher into a deductive approach which contaminates the generation of concepts from field data. "It is hard enough to generate one's own ideas without the 'rich' derailment provided by the literature in the same field" (Glaser, 1978 p. 31).

This position was also taken by Stern (1980), who stated that the usual literature search undertaken at the beginning of a verificational research study was inappropriate when using the grounded theory method. In a later work she specified the disadvantages of a "prestudy literature search" as follows: "(1) the research may lead to prejudgement and effect premature closure of ideas and research inquiry; (2) the direction may be wrong; and (3) the available data or materials used may be inaccurate" (Stern, 1985, p. 153).

Glaser's original proscription about going to the literature was very strong and continued to be so, as evidenced by his assertion that "There is a need not to review any of the literature in the substantive area under study" (Glaser, 1992, p. 31). However, other writers have suggested that it is important, for the novice grounded theory researcher at least, to make some explorations of the literature, in order to identify knowledge gaps or aspects of the area of interest that warrant further study. For example, Schreiber and Stern (2001, p. 58) suggested that "plunging into field research without delving into the relevant literature would be folly". She went on to discuss "sensitizing concepts" as the pre-existing ideas held by the researcher about the phenomenon to be studied, and recommended techniques for these to be explicated – brought into the open – before data collection begins (Schreiber & Stern, 2001, p. 59).

Hickey (1997) used literature and quoted Strauss and Corbin's reasons for reviewing literature as the study progressed, including using literature as secondary sources of data after categories have started to emerge and to direct theoretical sampling. However, there were some inconsistencies in that paper because the writer referred to how reviewing literature related to emerging themes could "develop these themes and offer new insights into questions and issues" (Hickey, 1997, p. 377). With that approach there may have been a risk of allowing the literature to direct analysis, rather than letting the categories emerge from the data inductively. Nevertheless, using documents as sources of data is potentially useful in circumstances such as those existing in the present study, where government inquiries and other reports provided data related to the working environment of registered nurses employed in the residential aged care sector in Western Australia.

Criteria for evaluating grounded theories

Where verificational studies are evaluated according to their validity and reliability, it was suggested that grounded theory studies must demonstrate fit and relevance, and they must also work (Glaser & Strauss, 1967; Glaser, 1978). Fit means that the codes and categories should fit the data, and do so naturally and without being forced, while relevance means that the theory should be recognisable by the participants and should explain what was going on in the study setting (Glaser, 1978; Hutchinson, 1986; Backman & Kyngäs, 1999). The criterion that the theory should "work" was defined as meaning that "it should…explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal inquiry" (Glaser, 1978, p. 4).

Hutchinson (1986) suggested that there should be two additional criteria, and named these as density and integration, and defined them as follows:

> A quality theory is dense, i.e. possesses a few key theoretical constructs and a substantial number of properties and categories. Good integration ensures that the propositions are systematically related to one another into a tight theoretical framework.
>
> (Hutchinson, 1986, p. 127)

Therefore, grounded theories should demonstrate fit and relevance and should work in terms of explaining the phenomenon of concern and how it was managed. Grounded theories should also be dense and integrated.

RATIONALE FOR USE OF GROUNDED THEORY METHOD

The grounded theory method was selected for this study for reasons indicated in the above discussions of the origins of grounded theory and the method itself. Specifically, "if little is known about a topic and few adequate theories exist to explain or predict a group's behaviour, the grounded theory method is especially useful" (Hutchinson, 1986, p. 112). In this study, methodological procedures, and particularly data analysis, followed the tenets advocated by Glaser (1978). The coding framework and conditional matrix of Strauss and Corbin (1998) were not used to guide data analysis.

The use of a symbolic interactionist approach in this study was appropriate because the questions that were being explored related to how registered nurses (RNs) interpreted their working environments. Only the nurses themselves could describe how they viewed their work, the problems they encountered, and the processes they used to manage situations at work. Therefore, the primary data came from interviews with practising nurses. Field notes from observations and examination of documents supplemented these data

The researcher's previous experience suggested that some RNs working in the aged care sector were neither confident nor skilled in articulating their thinking processes associated with decision-making. In nursing, with its traditionally oral mode of transmitting information, it was more likely that the nurses would tell a story, give an example, or use a particular situation as an illustration. Using this tendency as a guide, it was therefore appropriate to use a qualitative methodology, enabling the respondents to speak for themselves and account for care situations in ways that had meaning for them.

As described in Chapter 1, the research questions at the beginning of the study related to application of nursing process principles and how RNs managed the decision-making environment in aged care. Anecdotal evidence suggested that the difficulties

experienced by RNs were complex and included many contextual factors (see Chapter 3). In fact, it was possible that the decision-making environment in nursing homes might confound attempts to identify and verify nursing decision-making processes that emerged under verificational research conditions. Using the grounded theory method enabled exploration of the RNs' experience of managing working in aged care without imposing preconceived notions on how they saw problems and dealt with them.

Maintaining theoretical sensitivity means that the grounded theory researcher should develop "self-awareness of mind set" (Hutchinson, 1986, p. 115) by being aware of personal preconceptions, values and beliefs. Hutchinson (1986) suggested that keeping a journal in which thoughts and reflections are documented is a good way of maintaining a heightened awareness of mind-set during data collection and analysis. The researcher began such a journal before the first interview, and maintained it throughout the study. The reflections recorded in the journal were particularly useful during data analysis, as these ideas constituted another source of data as "memos" as described below (page 44).

METHODOLOGY

The Research Setting

This study was carried out with the assistance of nurses and personnel from 19 nursing homes and several nurse staffing agencies in Western Australia. Most of the nursing homes were situated in a range of suburbs in the Perth metropolitan area, and all of them were in the private, or non-government sector. The nursing homes ranged in size from very small (< 30 beds) to large (>100 beds).

The aged care sector will be described in detail in Chapter 3. The nursing homes in which the participants worked provided general care, and some had specialist wings for dementia care. All of the participants worked in nursing homes that were licensed under the Western Australian *Hospitals & Health Services Act 1927*, and funded, regulated and monitored according to Commonwealth legislation.

Study population

In the course of providing education services in nursing homes in metropolitan and rural Western Australia, the researcher met many RNs who worked in that setting. They willingly discussed aspects of their work both informally and as part of education sessions. As the idea for the present study began to develop, discussion with several RNs indicated their willingness to be interviewed for a study concerning clinical decision-making and application of nursing process principles. Their positive responses encouraged preparation of the study proposal. The participants were purposefully selected on the basis that they were familiar with the area of interest (aged care nursing), were willing to reflect on the phenomenon of interest, and were willing to make time to be interviewed and participate in the study (Morse & Richards, 2002).

Preliminary discussions with prospective participants included specific information that the participants should consider the invitation to participate in the light of the researcher being a graduate student, and not as a consultant nurse educator, and that therefore they should not feel any compulsion to accept the invitation. At the same time the way confidentiality would be maintained was explained if they did agree to be interviewed. Four RNs declined to be interviewed, citing a lack of time as the reason.

The majority of participants were RNs, and most of them were employed in a clinical role. Four of the participants were senior managers, of whom two were proprietors and two were nurse managers (Level 3). One of the senior management participants was not a nurse.

There were 25 participants in the study, with two participants being interviewed at the same time on one occasion (an experienced older RN unexpectedly came to the interview to "help" the new graduate who had agreed to be interviewed), and four participants were re-interviewed. Informal follow-up conversations (in person and by telephone) were held with six other participants, some on several occasions.

When the older RN joined the interview arranged with a participant, the impact of interviewing two participants at the same time was considered, but the alternative was to abandon the interview, and risk offending both RNs. Therefore because it was early in the study, the decision was made to proceed with the interview and see what emerged. The participants supported each other's remarks and generally stayed on "safe" ground, avoiding contentious issues. While these aspects of their interview were somewhat limiting, their insights into their roles and responsibilities were informed and well articulated, and were therefore useful data.

In addition to the interviews that provided the data for this study, another interview was conducted early in the study, but there were technical problems with the tape recorder, and the minimal data that was retrieved was discarded. Several attempts to contact the participant soon after the interview were unsuccessful, and she subsequently declined to be re-interviewed, citing lack of time as the reason.

Finally, an informal focus group of directors of nursing and nurse managers provided feedback on the emerging findings of the study at three critical points during data analysis. The first occasion was at the time of identification of the parameters of the decision-making environment, the second was explication of the problem experienced by the study participants, and the third was the emergence of the core variable and the basic social psychological process. The actual numbers of nurses involved in the focus group varied from nine to fourteen over the three occasions.

The participants provided some descriptive information about themselves, including their nursing qualifications, and employment level (registered nurse (RN), clinical nurse (CN), clinical nurse specialist (CNS) or nurse manager (NM), director of nursing (DoN)). Three other items of information they provided were the usual number of days/week that they worked, their post-registration experience, and number of years in their present job. The following table shows those descriptive statistics.

Table 1: Participants' descriptive statistics

Qualification	**Hospital-based diploma**	**Diploma in Nursing**	**Bachelors degree**	**other**
	17	3	4	1
Employment level	**Level 1 RN**	**Level 2 CN**	**Level 3 CNS/NM**	**DoN/ proprietor**
	14	5	2	4
Days worked	**2 days/week**	**3 days/week**	**4 days/week**	**5 days/week**
	2	7	7	9
Years post-registration	**0 – 10 yr**	**11 – 20 yr**	**21 – 30 yr**	**31 – 40 yr**
	5	3	7	8
Years present job	**0 – 2 yr**	**3 – 5 yr**	**6 – 8 yr**	**9+ yr**
	10	7	4	3

Data collection

Data collection began with interviews with Level 1 RNs who worked in clinical roles in nursing homes. The selection criteria were initially deliberately broad because theoretical sampling would result in narrowing or changing the criteria according to the developing categories. The criteria that guided the first selection of participants were that they should be RNs working in a nursing home in metropolitan Perth, have at least six months' post-registration experience in the aged care sector, and should be willing to be interviewed for about 45 minutes. By the time the study began it was not necessary to specify government or non-government (private) nursing homes because there were no longer any State Government-run geriatric hospitals or nursing homes in the Perth metropolitan area (these had closed by 1995).

Theoretical sampling in this study

As the study progressed and categories emerged, participants were specifically selected according to questions that arose from the data. For example, after interviewing six RNs who were employed at clinical levels (RN Level 1 and CN Level 2), questions arose about what was going on in the data that could be illuminated by a senior nurse manager such as a director of nursing. A director of nursing was purposefully selected, and

subsequent questions resulted in several other nursing home management personnel being interviewed as the study progressed.

Later in the study other questions arose, such as whether casual staff experienced things differently, or if working night duty or weekends made a difference. As a result of these questions, RNs who worked night shifts, evening shifts or only weekends were sought, and also several RNs who worked through staffing agencies were interviewed.

After completing 15 interviews, coding resulted in an emerging category that was called *yielding* or *backing off*, and this led to an exploration of philosophical ideas related to *yin* and *yang*, or feminine and masculine characteristics of things. The data supporting this category suggested factors associated with power and powerlessness, especially in dealing with "authorities" such as management or regulatory authority personnel, and it was possible that those factors were gender-related. To that point only female RNs had been interviewed, so several male RNs were purposefully selected for interview

After that point in the study, additional data were collected by re-interviewing some participants, and by talking informally with other RNs. On those occasions, hand-written notes were made after the conversations.

Interviews

Prospective participants were approached by the researcher, directly or by telephone, and they were invited to participate in the study, after an explanation of what was involved. The participants chose the location for the interviews and the date and time were negotiated. If participants chose to be interviewed away from their workplaces, other locations were arranged, as described below. Confidentiality was assured as described in a later section of this chapter, headed "Human Subject Protection".

All of the interviews were carried out by the researcher: There were no research assistants involved with any stage of data collection or analysis. The interviews usually started with a recapitulation of the interview purpose and procedure, and completion of

the Consent Form (see Appendix B). Interviews were conducted in a variety of settings where privacy could be assured and background noise would not interfere with recording, including empty rooms in the nursing home where the participant worked, in nursing home gardens, at the participant's home, or at the researcher's home.

Interviews were recorded using a small tape recorder. Hand-written notes were not made during the interviews, but were written after the interview was completed. The length of the interviews ranged from 40 to 70 minutes. After the interviews the recordings were replayed as soon as possible (within 48 hours) to get a general sense of the content, and to enable a telephone call to the participants, if necessary, to seek clarification while the interview was still fresh in their minds.

As stated earlier, there were technical problems with one interview recording, and while the first five minutes had recorded clearly, the rest of the recording was distorted. Unfortunately it took several days to contact the participant again due to her rostered days off, and when asked if she would be willing to repeat the interview, she declined, citing insufficient time.

The interviews were transcribed verbatim, and analysis (coding) began as soon as possible. The researcher transcribed the first seven interviews, but found this to be a laborious process, and subsequently a transcription typist, who was experienced in this work, was engaged. The transcription typist signed a confidentiality agreement. From that time the transcribed interviews were checked by the researcher by re-playing the recording and editing the transcript as necessary.

The decision about what questions to ask participants was influenced mainly by a perceived need to avoid "leading" them into the researcher's specific areas of interest. Glaser emphasised the need to enter the arena with an open mind in order to be "sensitive to the data by being able to record events and detect happenings without first having them filtered through and squared with pre-existing hypotheses and biases" (Glaser, 1978, p. 3).

As described in Chapter 1, the initial impetus for the study was associated with apparent difficulties experienced by RNs in applying "nursing process". Therefore, for the first few interviews, the participants were asked to describe an average day, giving examples of things that happened, and of what they did. This type of approach was called a "grand tour" question by Morse and Richards (2002, p. 91), suggesting that the participant could answer freely and lead the conversation.

Later, depending on the data analysis from earlier interviews, the emphasis in the question varied from "Tell me about your role in this nursing home" to "Describe what happens when you're managing residents with chronic problems". Still later, the participants were asked to talk about aspects of their work that they found interesting or challenging. Follow-up questions within the interviews were in response to what the participants said, and clarification questions or prompts were used to elicit strategies they used, and information about the outcomes of those actions or decisions (consequences).

Early in the study, it became apparent that working conditions or variables in the environment significantly influenced the participants' decision-making behaviours. The director of nursing who was purposefully selected for interview was asked to draw a word picture of the nursing home environment, and the sorts of issues faced by RNs. Three other senior managers were interviewed (including one proprietor who was not a nurse), in order to provide more depth in the emerging picture of the "adverse decision-making environment" in which the RN participants worked. Each of those participants was asked to discuss the aged care environment from their perspective, and their interpretation of those impacts on RN decision-making behaviours.

Observation data

During the course of providing education and consultancy services, the researcher had many opportunities to observe episodes of nursing practice and situations in which RNs seemed to be making decisions. Several such situations were documented after the

researcher acted to clarify the shift from consultant to graduate student, and gained the consent of the nurses who were observed. The specific situations were only recorded when it was clear that the RN was comfortable with the purpose of the observations and how it was to be recorded. More detail about the ethical issues associated with those situations is provided in a later section of this chapter. The observation data were recorded as field notes, and then treated in the same way as other data.

Documents

As the characteristics of the RNs' decision-making environment emerged, a number of specific documents were purposefully selected and reviewed specifically as data sources. Particularly relevant documents included the series of reports commissioned by the Commonwealth Government in relation to the Aged Care Reform program that began in 1987 (e.g. Braithwaite, et. al., 1992; Gregory, 1991; Macri, 1993). Analysis of these documents is presented in Chapter 3.

Later, as the problem experienced by the participants emerged from the data, selected organisational documentation was reviewed, specifically documents that directed RN work practices (policies, procedures, position descriptions), or that they used in the course of their work (resident care forms and records).

Time span of the interviews

For various personal and professional reasons, interviews were conducted over a six-year time span, from April 1996 to February 2002. After each pause in the study, all of the interview transcripts were re-read before embarking on the next interview because it was necessary for the researcher to be re-oriented to the data, and to pick up the threads of analysis. That process meant that data were compared and analysed both episodically and over time, and prospective participants were identified according to the emerging findings.

Another potential impact of the time span of the interviews was that there were major changes to the regulatory environment in residential aged care in 1997–98. These

included the introduction of the new *Aged Care Act 1997*, and implementation of procedures such as the new funding tool (the Resident Classification Scale) and accreditation of aged care facilities. These changes are detailed in Chapter 3.

At that stage of the study, the researcher had some concerns that such major changes could significantly influence the experiences of the RNs in relation to managing clinical care. However, the direct effect on the RNs was minimal as evidenced by the similarity of situation descriptions between the earlier and later interviews.

While some aspects of clinical nursing practice did change, there was no change in the way that the participants managed the situations that they confronted. For example, over the period 1996 – 2002 there was an increase in the range of technical nursing procedures carried out in nursing homes, such as the use of syringe drivers for continuous morphine infusions, and infusion pumps for intermittent enteral feeding via a gastrostomy tube. However, these and other changes did not alter the way that the participants dealt with situations, because the changes were specific tasks or procedures, and their decision-making processes accommodated the changes without being intrinsically altered. Therefore, the nature of the work of the RN clinician did not change, although the diversity of the work of nurse managers and directors of nursing had changed considerably, mainly due to accreditation procedures.

Data analysis

Interview transcripts and field notes were analysed using the constant comparative method (Glaser & Strauss, 1967). By the time that open coding of each transcript began, the interview had been experienced by the researcher three times: the first at the interview itself, the second time at the replay prior to transcription, and the third time during transcription or while editing the transcripts provided by the typist.

First-level coding

First-level coding means "carefully examining the data, and selecting phrases, words, or stories that, taken individually, contain a single unit of meaning" (Schreiber & Stern,

2001, p. 69). For this study, first-level or open coding involved reading the interview transcript and making line-by-line notations in the margin. These notations picked up key words or phrases, such as *I have come to know the residents* and *tried to negotiate with the doctor*. Some notations were single words such as *frantic* or *frustrated* while others were phrases or short sentences. This coding was manual, with hand-written notes being made in a wide right-hand margin on the transcript.

The following excerpt from an interview in the left column shows what the participant said, with relevant phrases underlined. First-level or open coding is shown in the right column. The excerpt used here shows the structure that was consistent with computer software used to assist with data management (described later in this chapter). For example, the transcript is preceded by "header" information, and provides an example of the descriptive detail recorded for each interview. In the transcript, hard returns were used to separate text-units, and some sentences were broken up into several text-units for coding purposes. In the interests of preserving confidentiality, some of the "header" information in the following excerpt has been edited.

ON-LINE DOCUMENT: P23
** RN 1.8 19 years post-reg. 10 years in present position.*
** (work patterns, number of days per week, etc.)*
** (Date), (time), on duty*
** Interviewed in empty activity room at nursing home.*

Usually, if anyone becomes ill you have to kind of, um, well you just	If resident becomes ill
evaluate it, mentally, you know, and I think, um -	Evaluate it – makes judgements
So you evaluate the situation, whether they can be treated satisfactorily	Evaluate situation OK to treat in facility
just on the ward here, or if you need to get a locum in, or if you need	Get locum doctor in
to, you know, go to the hospital.	Or transfer to hospital
For instance, last weekend because now we are responsible for the hostel, somebody came over - and you don't know the residents at all -	Now responsible for hostel (tone = anxious) Don't know residents in hostel
and they said "there's a gentleman over here with chest pain and he's had four - he self administered four	Resident with chest pain Self administered Anginine

Anginine in the last half an hour and he still has chest pain".	Recognises potential risk here
Well you have to think - I looked at him and he appeared all right, but I'm not taking the responsibility - not knowing him, you know, so I said "well you have to send him to hospital"	Assessed and made a judgement Not taking responsibility because of not knowing him Decision to transfer to hospital
and then one of the other RNs that was on at the time said "Oh, I probably wouldn't have sent him to hospital" but that was my call and I felt - so it's things like that, you know.	Decision criticised by another RN She wouldn't have sent him That was my call
And I think that I am always aware that I am doing the right thing legally as well. I really am aware of that. (P23)	Always aware of legalities Doing the right thing (tone = anxious)

Figure 1: Sample of interview transcript

During coding, memos were also written. For example, the following memo related to the concept "knowing the residents"

> *Knowing the residents and their needs is closely related to recognising when signs and symptoms are of concern or can be safely ignored. New residents are harder to form judgements about because the RNs don't know their usual patterns and responses.* (Memo)

The notations made during first-level coding were then distilled or abbreviated and listed on a separate sheet of paper. This involved interpreting the participants' statements in context and finding key words such as *knowing* and *negotiating*. Variations were also identified, such as *knowing the residents*, *knowing the doctors,* and *knowing the staff*, etc. Coloured highlighter pens were used to link similar ideas expressed by the participants. As more data accumulated with more interviews, this process continued, further refining the categories found in the data.

First-level coding was carried out with pen and paper initially, and then using NUD*IST computer software (Qualitative Solutions and Research, 1997). However, on-screen coding was a physically uncomfortable activity, and subsequently the coding that was

written in the transcript margins was transferred into the computer application as a means of storing the location of relevant text units. A further discussion of the use of this application is provided later in this section of the chapter.

Second-level coding

This means "examining and collapsing codes into categories or higher level concepts" (Schreiber & Stern, 2001, p. 70). As data collection and analysis continued, comparisons showed that there were convergences and divergences between categories. For example *knowing* and *not knowing* residents and their needs were usually polarised examples of conditions that facilitated or impeded *recognition* of features of situations. However, *not knowing* was a concept that also applied to other staff such as unregulated care workers and their lack of knowledge or skills in relation to care-giving.

In the early stages of the study, many of the first- and second-level codes related to the conditions in which participants worked. Most of them talked about having insufficient staff, or not enough staff to complete work on time, and having to work with budget restrictions. Continuing analysis drew these codes to the more abstract concept of *under-resourcing*. This process was referred to as "concept formation" by Speziali and Carpenter (2003, p. 116).

Third-level coding

Schreiber and Stern (2001) described this stage in the analysis as the point when relationships between the categories are forming, and ideas develop that lead to hypotheses. These hypotheses are tested with further analysis, further data collection and "moving back and forth between inductive and deductive thinking" (Schreiber & Stern, 2001, p. 71).

In this study, third-level codes were called categories, and these emerged in several ways. For example, some open codes continued through second-level coding with the same labels and became categories, such as *knowing*. This category gathered definitions, illustrations and variations along the way, and the meaning given to the term

by the participants led to it being seen as an intervening condition for recognising aspects of situations. In other words, participants needed to *know* or be familiar with aspects of situations (particularly people and their characteristic responses) in order to be able to *recognise* the overall pattern that was presented in the situation.

Other codes evolved into conceptual categories, which means that the naming of the category arose out of the analytical process, rather than the actual words of the participants. For example, categories such as *knowing* and *being flexible* were factual categories, in that these were words used by the participants, whereas *yielding* was a conceptual category. *Yielding* was made up of a number of properties, including backing off, giving up, or being submissive or pliant, and was reflected in the data in both the words used by participants and also in their voice tone and body posture.

Level three codes, called "theoretical constructs" by Hutchinson (1986, p. 120), move the research from descriptive to conceptual. Speziali and Carpenter (2003) described the steps involved in concept development that would lead to emergence of the core variable. These were reduction (convergence of categories), selective sampling of the literature (after concepts have been identified in the data) and further selective data collection.

In this study, theoretical coding occurred when analyses and interpretations were written as memos, and these were further compared in order to clarify and develop the meanings and linkages in the categories. This process led to the identification of the basic psychosocial problem experienced by the participants, i.e. *being unable to get things right*. Further analysis and memoing (see below) then led to the core category, or the central conceptual category that helped to integrate the categories and processes found in the data (Glaser, 1978; Schreiber, 2001; Speziali & Carpenter, 2003). In this study, the core category was called *getting things right*.

Theoretical saturation was achieved when no further properties or relationships between codes and categories were identified, even when new descriptive data (that is, two

additional interviews) were added. The additional data contributed to the richness of the description of the categories without expanding codes or adding new ones. At this point, the researcher achieved "a sense of closure" (Hutchinson 1986, p.125), or, in other words, the process of generation was complete (Dey, 1999).

Memoing

The reflective journal maintained by the researcher enabled ongoing theoretical sensitivity and also provided opportunities to conceptualise ideas about what was happening in the data (Hutchinson, 1986). This process is called "memoing" (Glaser & Strauss, 1967). Notes were written throughout the process of data collection and analysis, to record ideas about the data, to record interpretations of what was happening in the data, to make tentative connections, and to explore emerging relationships among the categories. Memos were also written to define terms that were used to label categories, such as *yielding* and *being flexible*.

An example of a memo is shown below. It involved reflection about the recurring code of *knowing* the residents and their needs, and the memo contributed to the decision to purposefully select RN participants who worked through staffing agencies and were unlikely to know the residents in the nursing homes to which they were sent.

> *Knowing residents – the participants had to act to discover or learn what the residents' needs were if they are going to effectively manage their care over time. What do new or agency RNs do to make up for not knowing the resident? (Note: P19 hated "doing agency" because of "not knowing" which suggested that she didn't develop strategies to manage and so returned to a permanent position.)* (Memo)

Another memo explored the participants' responses to questions about problem-solving technique (e.g. "How did you go about solving that problem?").

> *Some respondents have had real trouble articulating their decision-making processes – did not use nursing process/problem-solving terms or descriptions. About half of them so far haven't had any post-registration education – is this why? A couple of them were aware of the process but "didn't think about it" and seemed to be a bit ad hoc in applying it. Others clearly applied a systematic problem-solving approach to decision-making AND KNEW THEY WERE DOING IT (emphasis in original memo). P04 influenced other RNs to use nursing process because it was her own framework learned at Univ.* (Memo)

Diagramming

This was considered to be a useful tool to clarify the "relationships between and among emerging categories" (Schreiber & Stern, 2001, p. 73). Diagramming was used in this study to depict relationships amongst factors and categories or their properties. For example, it was helpful in conceptualizing the problem experienced by the participants, particularly the components of each of the two main streams of factors that led to *being unable to get things right* (see Chapter 4).

At a later stage in the theory development, the properties and categories that made up the core variable were visualised as bisecting continua, and *situational positioning* was seen as occurring at points along these continua (see Chapter 5).

Selective use of the literature

Literature was used selectively throughout the study, partly because the researcher's consultancy role required extensive reading of current literature, and partly because emerging categories needed to be defined. For example, the properties of the conceptual category *yielding* suggested that the participants sometimes adopted passive or submissive stances in work situations, and some early interpretations of participants' comments suggested a problem of "balancing" alternatives. This led to an exploration of Lao Tzu's *Tao Te Ching* (Freke, 1999) and thoughts about *yin* and *yang.* The feminine-masculine dichotomy in the concept of balance was explored and also contributed to *theoretical sampling* in that several male RNs were interviewed to explore these issues. Later in the study literature sources were also used to assist with definition of concepts, such as "flexibility" (August-Brady, 2000).

NUD*IST computer software

Computer software was used to assist data management, although it was not used for primary data analysis. NUD*IST means *Non-numerical Unstructured Data Indexing*

Searching and Theorizing and is an Australian product supplied by Qualitative Solutions and Research Pty Ltd (QSR, 1997).

This software was used mainly to locate and store segments of data at nodes that represented emerging categories. The excerpts from the interviews were stored in labelled "nodes" so that the data could be retrieved and further analysed, relocated or copied to other nodes. For example, there were 36 segments of data related to *knowing* and these referred to residents, doctors, staff, managers, etc.

In most instances, this second-level coding occurred from printed copies of the data segments stored at particular nodes. For example, a number of excerpts to do with interaction with families were linked to the category *interruptions* as well as to the category *expectations*.

NUD*IST was not used for third-level coding because it was found to be too limiting. That is, not enough data could be seen at one time, being restricted by the size of the computer screen, and because data were stored in different levels of nodes within the application and new views had to be opened on-screen to see other data. Then the original view was hidden, and the nodes could not be seen until it was opened, which hid other nodes. Having to move to a new screen interrupted the flow of thoughts and ideas about the data. Other software options were explored but ruled out. At this stage of the data analysis the need to be able to see a lot of data at one time was recognised, as was the need to be able to physically move it around to see new relationships visually.

Consequently, paper-based (3 x 5 and 8 x 10) cards were used to record codes, notes, memos and categories, and these recordings preceded and coincided with the use of NUD*IST. With dedicated space (an office) and time (sequestered periods of three or four days) it was possible to "see" a large amount of information and to physically move cards and notes about to represent different relationships among categories while writing new memos. The main value of NUD*IST in this study was the ease with which data could be retrieved from labelled nodes for constant comparative analysis, and to find

particular excerpts of the data during writing the main chapters that described the problem and the process of *situational positioning*.

HUMAN SUBJECT PROTECTION

Approval for this study was received from Curtin University's Human Research Ethics Committee, based on the thesis proposal, and approval was renewed based on annual progress reports.

Ethical issues are an important consideration for all researchers, and recent literature has addressed particular ethical issues that should be considered in qualitative studies. These issues included: "informed consent, participant-researcher relationships, gaining access, confidentiality, anonymity, sample size and data analysis" (Speciali & Carpenter, 2003, p. 311).

One area of concern has been that researchers should accord study participants specific recognition as people, rather than merely as subjects involved in the research. Brickhouse (1992), citing other writers, supported the idea that Kantian principles should be applied, and that:

> *... people should be treated as ends in themselves rather than as means to researchers' ends. This framework requires actions to be judged not only on the outcomes, but also on principles of autonomy, honesty, and justice.*
>
> (Brickhouse, 1992, p. 97)

A particular issue that the researcher needed to be aware of in this study was associated with the participant-researcher relationship because "[e]mbedded in qualitative research are the concepts of relationships and power between researchers and participants" (Orb, Eisenhauer & Wynaden, 2000, p. 93).

When seeking access to participants for this study, it was necessary to be aware of the potential for an imbalanced power relationship with the study participants because of the researcher's role as a consultant and educator in the aged care sector in Western Australia. In other words, there was a risk that some prospective participants might feel

coerced into accepting the invitation to be interviewed, especially if they worked at nursing homes where the researcher had provided education or consultancy services. The way that prospective participants were approached reduced the risk of their feeling coerced, and the issue was borne in mind when approaching all of the participants. They all confirmed that they understood this position and were willing to participate in the study.

Another writer also acknowledged this concern, especially when the researcher is "well known":

> *Of particular concern to nurse researchers is the question of to whom is the respondent giving consent – the nurse or the researcher – when the nurse is a more well-known entity than nurse researcher. The researcher role must be emphasised and defined.*
>
> (Robley, 1995, p. 46)

It was therefore decided that the explanation about the study and the purpose in inviting the RNs to participate should make it clear that the request was outside the professional role of the researcher, and was based on graduate student status. This information was illustrated in the letter that was provided to all participants at the time of the initial invitation. A copy of the letter is shown as Appendix A, and the Consent Form that accompanied the letter is shown as Appendix B.

The invitation-to-participate letter outlined the role of the researcher, the purpose of the study, and information about the interview process, particularly the fact that the interview would be tape-recorded. Prospective participants were advised that participation was voluntary, and that they could withdraw at any time, and also could request that the tape recorder be turned off if they wanted something to be "off the record". The letter also explained that their confidentiality would be assured by the use of code numbers rather than names, wording changes to disguise identifying situations, and the secure storage of recordings and transcripts in the researcher's home office. Finally, contact details for the researcher's thesis supervisor were provided.

The people (RNs and managers) who agreed to participate in the study confirmed that they were satisfied with the explanations and were willing to be interviewed. The tone of most of the interviews indicated that the participants felt a sense of control over the interview process. The one exception was a participant who said she wanted to help with the study, and frequently interspersed her remarks with the question: "Is that what you wanted?" The anxiety demonstrated by that participant did not seem to be related to nervousness about participating in the study, but more that she wanted to contribute useful information.

If the interview was to take place at the participant's workplace, a letter was sent to the director of nursing, seeking general permission to conduct an interview at the nursing home, without naming the participant. A copy of this letter is shown as Appendix C. Again, the decision to seek permission to enter the nursing home premises was necessary because of the researcher's visible role in the aged care sector in WA, and because some past consultancies had involved carrying out quality audits and investigations into incidents or staff performance. It was therefore appropriate that the researcher's presence in the nursing home be authorised by the director of nursing.

Participants who were interviewed at work acknowledged and accepted that being in the facility for the interview would be known by other staff, and, actually or potentially, by the director of nursing. For those participants, it was specifically reiterated that the content of the interview would not be revealed to other persons, and that any potentially identifying information or anecdotes would be disguised.

Up to the time that the interviews began, the researcher had provided education and consultancy services in the aged care sector for ten years, and had visited many nursing homes. The visibility of that role, and the range of services provided in many nursing homes meant that being in a nursing home would tend to be generally unremarkable, especially when the visit was authorised by the director of nursing. Therefore, being seen talking with a participant at work was unlikely to cause undue interest. Those participants who did not want their directors of nursing or other staff to know about their

participation requested alternative venues, and this also sometimes occurred for reasons of convenience.

Identifying information about the participants (their names and descriptive data) was written on separate cards that were also stored securely where the information would not be accessible to other people. Such information was not recorded on audio-tapes or transcripts, and the participants were identified by a code number for those purposes. Those code numbers were later randomly sorted before being used to identify excerpts from the data in the chapters discussing the findings of the study. This was done to limit the possible identification of participants by the data that they were interviewed (early or late in the study) because purposeful selection of participants led to later interviewing of agency staff and some men. Further, female pronouns were used when discussing and illustrating the data, to further limit the potential identification of participants because very few men worked in residential aged care in Perth at the time of the study.

Anecdotes provided by the participants were sometimes potentially recognisable by others who might read the study. These anecdotes were modified or disguised, without altering the meaning of the situation described by the participants. Identifying information about other people and nursing homes was not transcribed and the typist who assisted with interview transcription had signed a confidentiality agreement.

Recording field observations as data also resulted in specific consideration of ethical issues. As categories began to emerge from the data clinical situations that also illustrated the data were observed, and could potentially be used as data when recorded as field notes. While many situations that could have contributed to the study were observed, very few could subsequently be used in the study because the circumstances precluded the shift from a teaching or consulting role to that of researcher.

However, in some circumstances, it was appropriate to shift to the researcher role, and to ask the observed RNs if the observations could be used in the study. At a visual level, changing roles meant the researcher removing her name badge when approaching the

RN. Then, as with the interviewed participants, the nature and purpose of the research was explained, and also assurance of the confidentiality of the information. In such situations, the purpose of the study and the nature of the observations were discussed with the nurses who had been observed in the situation, and, if oral consent was obtained, a field note was written. In three instances, consent was withheld and the situation was not documented.

The circumstances in which these field observations occurred could not always be anticipated, and therefore it was not possible to alert the RNs in advance that the researcher's observations might be used for research purposes. The observations that were recorded were significant enough that a variation in procedures was warranted, and could be justified on the following grounds:

1. Neither the RNs nor the situation would be identified;
2. The situations in themselves were sufficiently generic in descriptive terms that readers of the study would not be able to identify the nursing home or the RNs; and
3. The observations were not "covert", as defined by Speciali and Carpenter (2003, p. 316) because informed consent was obtained, albeit after the observation had occurred.

Finally, the role of the focus group, described in the Study Population section of this chapter, was mainly to provide a "reality check" for the emerging findings. Their feedback was used for validation rather than as data. Nevertheless, they consented to being consulted about the ongoing findings of the study, and their confidentiality was also assured. There was also an unwritten agreement within the focus group that matters discussed by the group would not be discussed outside the group, and, by mutual consent, this agreement was re-stated at each gathering of the focus group.

SUMMARY

This chapter described the methodology used in this study, beginning with a description of the grounded theory method and its epistemological origins. Further developments and divergences in the grounded theory method were discussed.

The next section described the research procedure, including a discussion of the process of theoretical sampling, and the rationale for the use of the grounded theory method in this instance. Application of the method to the present study was then detailed, including a description of the study population and data collection methods. Specific information was provided about data analysis using the constant comparative method, where data were analysed while interviews and observations continued. Descriptions and illustrations were given of different levels of coding and associated memoing, and reference was made to diagramming which appears in later chapters of the study. The final section of the chapter described the process of Human Subject Protection as it was applied in this study.

CHAPTER 3

THE AUSTRALIAN AGED CARE CONTEXT

OVERVIEW

This chapter describes aspects of the Australian aged care sector, that is, the participants' working environment, and therefore provides the context for the study. A description of the Australian aged care sector was warranted because of the complexity of the aged care environment in terms of sociopolitical factors, regulatory requirements, the nursing demographics, and the potential impact of those factors on nursing practice.

The chapter also provides an analysis of selected literature, one of the data sources for the study. In particular, a range of Government reports, published between 1975 and 2001, were analysed to understand the context in which registered nurses (RNs) worked. For example, a series of reports described in the section titled "Socio-political history of aged care in Australia" suggested that issues of concern in relation to caring for frail-aged people in residential settings had existed for at least 25 years. These long-standing and pervasive concerns were relevant to the present study because they contributed to the RNs' practice environment. Concepts identified in participants' data also helped to guide this selection of literature.

The chapter begins with a review of population demographics related to older people in Australia. There is an outline of the characteristics of people living in aged care facilities, followed by a brief discussion of the concept and consequences of "ageism". The next section provides an overview of the sociopolitical history of aged care in Australia, including a review of the numerous government inquiries held between 1975 - 1985. The development of the aged care regulatory environment is then described, with particular reference to the Aged Care Reform program that began in 1987.

The next section of the chapter provides an outline of the demographics of the nursing population in Western Australia and the educational preparation of the general

population of RNs working in WA during the time of this study. The final section of the chapter describes how the aged care industry in Western Australia was structured, with its public, private, residential, and community elements. Finally, conclusions are drawn from the examination of the factors that potentially impacted on the nursing practice environment in aged care.

AGED POPULATION DEMOGRAPHICS AND CHARACTERISTICS

Australians aged over 60 years made up 12 per cent of the population in 1996, and the majority of them lived independently in the community (Australian Bureau of Statistics, 2000). Census figures have indicated a steady increase in the proportion of older people in the Australian population, particularly those over 75 years of age (Australian Law Reform Commission, 1995). The population trends identified at the 1981 census (Kendig & McCallum, 1986) provided the basis for a number of reports on population ageing, as outlined below.

The term "Greying Australia" was used as the title of a report of the Migration Committee of the National Population Council (Kendig & McCallum, 1986), and it was subsequently picked up by media commentators and has entered the socio-political arena as a descriptive term (Stevens & Herbert, 1997). The Kendig and McCallum report looked at the relationship between population, immigration, and the economy, and used the terms "young old" for the age group 60 - 74 years and "old old" to refer to people aged over 75 years (Kendig & McCallum, 1986, p. 1). Stevens and Herbert (1997, p. 6) drew attention to the trend for sociologists to divide the older population into the "young old, middle old and old old" based on predicted functional capacity as well as actual age.

Kendig and McCallum (1986) predicted a more rapid increase of the "old old" group in the population than for any other age group. This statistic is relevant in light of the increased prevalence of dementia in older people, and the impact of this trend on the provision of aged care services. "Studies of the elderly as a total group hide the fact that the prevalence [of dementia] is much higher in the "old old" than in the "young old" (Jorm & Henderson, 1993, p. 9). According to Kendig and McCallum, the probability of

having severe dementia by age 90 is 30 per cent, although this statistic is not a predictor of residential care placement as only one fifth of these older persons were in residential care in 1981.

The Jorm and Henderson (1993) paper suggested that the majority of elderly Australians were generally healthy, active members of their communities. Media reports seen during the period of the current study also suggested that many older people were well educated, articulate, and politically aware, so it could be assumed that as their numbers increase, their ability to influence politics and public policy would also increase (Fogg, 1999). With social and lobby groups such as the Pensioner's Action Group, older people are having more to say about aged care standards and service provision, and are influencing government policy (Fogg, 1999). For example, the expectation that all new nursing homes will have single-room accommodation with en-suite facilities has resulted mainly from the changing standards of personal privacy expected by older Australians and their families (Gregory, 1994).

The social justice principles that underpinned government policy over the 20 years prior to this study continued to focus on the needs of "at-risk" groups in the population (Kendig & McCallum, 1990). These included people with low incomes, such as women, people of Aboriginal or Torres Strait Island background, and people with cognitive impairment such as dementia.

> The major vulnerabilities of older people, which place them at risk of poor quality of life, are the reduction of income on retirement, and the combination of disability and social loss which is most likely to occur in advanced old age.
>
> (Kendig & McCallum, 1990, p. 3)

In Australia in 1995 the life expectancy for females was 81.3 years and for males 75.6 years. This represented a 20 year increase in life expectancy since 1910 (Australian Bureau of Statistics, 2000). People were thought to be living longer because of the more proactive approach towards health and ageing that began during the latter half of the twentieth century; moreover, significant improvements in population health and increased awareness of lifestyle factors have also contributed to healthy ageing (Ory,

Abeles & Lipman, 1992). These authors attributed increased longevity mainly to infection control:

> With the triumph over the lethal, acute diseases of childhood during the first half of the twentieth century, ever greater proportions of each successive birth cohort have survived to old age.
>
> (Ory et al., 1992, p. 1)

According to the 1981 census, only seven per cent of elderly people lived in "non-private" accommodation, which included nursing homes, hostels, hospitals, and boarding houses (Kendig & McCallum, 1986). The proportion remained similar at the end of the 1990s (Australian Institute of Health and Welfare, 2000), although the rate of admission to residential care changed because of the increase in community care options (Sax, 1993). In spite of such a small proportion of aged people living in residential care facilities generally (hostels and nursing homes), both government and media reports have suggested concern about the economic impact of the increasing health care needs of the ageing population.

> Just as the future health of the aged can be seen from a number of points of view, so the current health status of the aged can be reported from the point of view of how good it is despite their age, or how bad it is relative to younger age groups. The stereotype of the older Australian as generally frail, sick and disabled can be dismissed as overly negative.
>
> (Kendig & McCallum, 1986, p. 44)

One important consequence of the negative view of ageing was the belief that older people would receive a disproportionate share of public resources because of their chronic health problems and greater care needs (Stevens, 1999). This led to alarmist reports of the increasing cost burden of aged care as the population aged further (Sax, 1993, Stevens, 1999). The perception that there should be some "rationing" of health care resources was reflected in government decisions for at least the last 30 years of the 20th century. These notions, based on economic rationalism, led to suggestions that older people should be expected to pay for the services they receive in nursing homes, depending on their financial assets (Sax, 1993). Consequently, the introduction of formalised, means-tested "user pays" principles in aged care occurred in 1997 (Commonwealth Department of Health and Aged Care, 1999).

Many of the reports and publications discussing the ageing population have focused on statistics and predictions about health care and increased social welfare expenditures (e.g. Kendig & McCallum, 1990; Gregory, 1991; Sax, 1993; Australian Law Reform Commission, 1995). However, these predictions did not sufficiently consider the tide of self-help, health promotion, and disease prevention activities that began in the 1980s (Mannix, 1999). Furthermore, concerns about declining family involvement in aged care were also false: "although populist myths exist concerning the decreasing role of the family in caring for elderly relatives, the evidence suggests family care and support remains integral in aged care" (Mannix, 1999, p. 3).

Characteristics of people living in nursing homes

According to Australian Institute of Health and Welfare (AIHW) statistics for June 1999, 72 per cent of nursing home residents were female and 49 per cent of residents were aged over 85 years (AIHW, 2000). People admitted to nursing homes were assessed as needing 24-hour nursing care because of a range of physical disabilities and/or cognitive impairment. For example, Jorm and Henderson (1993) reported that a survey of Sydney nursing homes found that at least half of the residents had moderate cognitive impairment (dementia).

One of the effects of the Aged Care Reform process introduced in 1987 was the significant increase in dependency levels of people in nursing homes. This was a consequence of the Commonwealth policy decision to reserve admission to only the most dependent persons, and this policy was implemented by screening people seeking admission to nursing homes (Gregory, 1991).

Apart from residents with a primary diagnosis of dementia, the most frequent core diagnosis of people in nursing homes was associated with cardiovascular disease (stroke and heart failure), and these conditions were the leading cause of illness and death in older aged groups (Australian Bureau of Statistics, 2000). Other, sometimes concurrent, conditions include Parkinson's disease, Diabetes Mellitus, arthritis, osteoporosis, and the

sequelae of fractures and metabolic dysfunctions such as hepatic and renal disease, conditions that were consistent with increasing dependency in older people (AIHW, 1999b). Other writers have predicted that the trend for nursing home admissions in future will continue to change, focusing mainly on people requiring "palliative care, rehabilitation following an acute medical occurrence, respite care, and dementia [care]" (Heinrich, 1999, p. 27). With a significant proportion of residents needing complex nursing care, the RN participants in this study faced many challenging situations in clinical decision-making, and particularly in the daily care of people with dementia.

Care of people with dementia posed particular challenges for RNs working in aged care. Older nursing homes were not designed with dementia sufferers in mind, so the architectural design was thought to impede quality care, especially for residents who demonstrate wandering behaviour (Jorm & Henderson, 1993). While each person with dementia is different and responds differently to their disabilities and living environment, there are common dysfunctions which have consequences for care-givers (Jorm & Henderson, 1993). The main concerns in caring for people with dementia were the behaviours that result from progressive cognitive impairment (Mace, 1990). These include impaired memory, altered perception (agnosia), inability to organise movement (apraxia), and loss of language skills (particularly word finding and sentence constuction) (Mace, 1990).

The combination of an ageing population and more people being admitted to nursing homes because of dementia means that RNs, including the participants in this study, faced many issues and challenges in achieving expected standards of care. Added to this were problems of lack of space and poor design of older nursing homes, which were recognised as impediments to effective dementia care (Bowles & Fleming, 1994). Older facilities did not have a good environment for managing the behavioural consequences of dementia, particularly those nursing homes with multiple shared rooms (four to six beds) and limited communal space for diversional activities.

The phenomenon of ageism

Ageism is a phenomenon that influences the views of people about ageing and expectations of what older people can do. Stevens and Herbert (1997, p. 1) described it as "a process of systematic stereotyping and discrimination against people because they are old." This stereotyping has negative effects on societal attitudes and expectations, and:

> … influences the health system, the attitudes and practices of individual health professionals and the attitudes of older people themselves. It can lead to an acceptance of the inevitability of poor health or disability, the provision of lesser quality services for older people and the acceptance of this by older people.
>
> (Fogg, 1999, p. 102)

Since the beginning of recorded history, there has been some sort of discrimination against unproductive members of a community, whether this was because of age, illness, or incapacity (Sax, 1993; Stevens & Herbert, 1997). However, changing population demographics by the 1970s caused a particular focus on older people and the sociopolitical impact of the increasing numbers of this group within the older population (Fine & Stevens, 1998). Hence the increase in literature and reports about "Greying Australia" (Kendig & McCallum, 1986; Sax 1993). There was an increasing awareness, at least within government, that "greypower" would influence policy directions and was "already testing the mettle of politicians" (Davis, 1994, p. 172).

Ageist behaviours demonstrated by nurses were usually subtle, often unconscious and unrecognised actions and attitudes, and could "take the form of harmless jokes, patronising gestures and the language nurses use when addressing and describing older people" (Stevens & Herbert, 1997, p. 11). Ageism in nursing was considered to be widespread and had significant influences on nurses' attitudes and practices. In particular, nurses working in aged care felt that they were devalued, and often carried the same stigma as the devalued people for whom they cared (Stevens & Herbert, 1997; Stevens, 1999). As Stevens and Herbert (1997, p. 11) described it, ageism may be an almost hidden kind of "horizontal violence against those who work in aged care…".

Stevens and Herbert (1997) went on to discuss the findings of the Marles Report which investigated professional issues in nursing in Victoria. The issues identified in the Marles Report remained relevant through the 1990s, according to Iliffe (2001). Stevens and Herbert listed a number of indicators of ageist behaviour that impacted on nursing, and also suggested that the nursing profession itself did not value aged care nursing. The indicators were:

- Inadequate funding in the face of change and complexity of nursing work;
- The workloads this had created;
- The low status assigned to what nurses working in the area considered to be highly skilled work;
- Reliance on unskilled staff; and,
- The paucity of specialist gerontic education for nurses.

(Stevens & Herbert, 1997, p. 13)

Nurses working in aged care were aware of the attitudes of nurses who worked in other health sectors, and there was evidence to suggest that they considered the negative stereotyping of their work to be unfair and hurtful (Hall, 1999), this aspect being supported by the participants in this study. There was an interesting dichotomy in the position taken by some members of the nursing profession because while they devalued the role of their aged care sector colleagues (Stevens, 1999), it was in aged care that professional nursing was most autonomous. Meanwhile, in the "acute" health sector nurses remained subordinate to medical orders and technology (Stevens & Herbert, 1997).

SOCIO-POLITICAL HISTORY OF AGED CARE IN AUSTRALIA

In colonial times the care of frail aged persons was generally the responsibility of the family (Sax, 1993). For those people without family, and particularly for chronically ill or disabled aged persons, care was provided by charitable institutions, public hospitals, or the local community. As Sax (1993, p. 85) stated, the colonial administration was reluctant "to take direct State action to relieve individual need...", which reflected the English social values of the time.

By the time of Federation in 1901 there had been some changes in approaches to welfare systems overseas, and these influences resulted in legislation in Australia which provided for old-age pensions (Stein, 1999). Federation launched the Commonwealth /State division of responsibilities affecting aged care because the Commonwealth managed the welfare budget, including aged pensions and nursing home subsidies (when these were introduced in the 1950s), while State Governments were given responsibility for health and hospitals (Stein, 1999). Nursing homes were licensed under State regulations as private hospitals, initially classed as "C" Class hospitals (*Hospitals and Health Services Act 1927*).

While policy-makers of the early 20th century believed that aged care was a family responsibility, nevertheless, frail and chronically ill elderly people were admitted to public and private hospitals, often because they had no family to provide their care (Bolton & Joske, 1982). Sometimes their admission caused problems for public hospitals, such as the Perth Public Hospital (later Royal Perth Hospital), especially when epidemics of infectious diseases over-stretched their resources (Bolton & Joske, 1982). In 1901, the Perth Hospital Board urged the Government to find alternative accommodation for some of their long-staying patients. They referred to "…those who because of age or feebleness or long-term incurability were likely to occupy beds for a long time, requiring constant attention and at times excluding the admission of more urgent cases" (Bolton & Joske, 1982, p. 71). The result was the opening of the Home of Peace in Subiaco in 1903, the first of three large public residential care facilities which eventually developed in Perth (Hobbs, 1980; Bolton & Joske, 1982).

Other State Governments also provided institutional care for destitute aged and chronically disabled people. A New South Wales example was the Rookwood geriatric hospital, established in 1893:

> …to provide substantial hospital-type care for many of the state's destitute sick people as well as dormitories for those who were not acutely ill in the technical sense, but were in need of support which they were unable to find in the general community.
>
> (Fine & Stevens, 1998, p. 52)

During the first half of the 20th century, some private hospitals and "rest homes" provided permanent accommodation and care for those people who could afford it (Fine & Stevens, 1998).

After the second World War, the Commonwealth Government began to influence aged care service provision through "benefits" paid for patient care and financial grants to some aged care service providers (Sax, 1993). Post-war Labor policies focused on establishment of a "welfare" state where all age groups would be assisted according to need, and then the later Liberal Government provided more specific assistance for aged people (Kendig & McCallum, 1990). For both sides of politics, the policy debate was about the extent to which government should intrude into what were still considered to be family matters (Sax, 1993).

During the 1950s and 60s there was a steady and significant increase in Commonwealth Government funding support for aged persons and residential care service providers (Sax, 1993). The service providers supported by public funding were church and charitable or voluntary organisations who managed nursing homes. A distinction was made in that this funding support was provided only for "not-for-profit" organisations, while private "for profit" nursing home patients received funding support through private health insurers or were self-funded (Kendig & McCallum, 1990; Sax, 1993).

In 1963 the Commonwealth began to fund or subsidise "approved" nursing homes for the care of frail aged people:

> At times since Federation, the sharing of responsibility for health and welfare services has created tensions with inter-governmental relations between federal and state levels of government. Not surprisingly, most of the tensions have tended to centre around the economic costs associated with providing aged care services in Australia, and have coincided with changes in the political landscape, either with a change of government at federal level or changing economic circumstances.
>
> (Mannix, 1999, p. 4)

One response to the increased Commonwealth financial support for nursing homes was that patients were transferred from state psychiatric hospitals to the nursing homes (Sax,

1993), thus shifting the burden of the costs of their care from State health budgets to the Commonwealth welfare budget (Willis & Morrow, 1995). The impact of this influx of frail, institutionalized people with "senile dementia" and other chronic mental health disorders was significant because few RNs working in nursing homes had psychiatric nurse training or experience. Until the mid-1980s, psychiatric nursing was a separate course with separate registration and general nursing students had minimal if any psychiatric nursing experience (Russell, 1990).

Criticism mounted during the 1970s and early 80s regarding the dominance of nursing homes over other community care options, and also about the lack of means testing for access to the subsidised "not-for-profit" care sector (Sax, 1993). There were also concerns about the generally *laissez faire* approach to regulation of the growing aged care industry (Howe, 1990). It may have been assumed that, at least for the "not-for-profit" sector, their beneficent motives would ensure reasonable standards of care and accommodation for their "patients".

By the 1970s, health literature began to represent ageing as a problem for the health care sector and ageing itself was represented in the media in universally negative terms (Sax, 1993). Further, physical and mental decline, chronic illness and the disproportionate "consumption" of health care resources were presented as characteristics of ageing (Sax, 1993). While acknowledging that health care costs usually increase towards the end of a person's life, Podger and Hagan (1999) stated that:

> …population ageing is only expected to contribute about 0.6 percentage points to the annual growth rate in health care expenditures over the next two decades – the same as in the past two decades… The extent to which there is an 'ageing' problem for health care expenditures will continue to be debated in Australia (as elsewhere), as will appropriate policy responses.
>
> (Podger & Hagan, 1999, p. 34)

While society in general didn't seem to want to know too much about end-of-life care, preferring it to be invisible if possible, the family and friends of frail-aged people needing nursing home care began to be vocal about their concerns. One example of those concerns being heard was as a result of a phone-in conducted by the Local

Government Welfare Association and the School of Social Work at the then Western Australian Institute of Technology (now Curtin University). "A total of 600 calls were received during the weekend ... The majority of calls received (350) were related to abuse, neglect, or poor living conditions within institutional care" (Senate Select Committee (Giles Report), 1985, p. 121).

The era of government inquiries 1975 - 1985

Explicit Commonwealth Government policies on aged care provision, regulation and funding controls did not emerge until the 1980s (Kendig & McCallum, 1990). Various inquiries into specific matters had occurred earlier, including the Social Welfare Commission on the Aged in 1975 (Coleman Report) and the Committee on the Care of the Aged and Infirm in 1977 (Holmes Report) (both cited in Kendig & McCallum, 1990). While these made some specific recommendations, it wasn't until the 1980s that two further inquiries considered a much more broad range of issues related to the provision of residential aged care (Kendig & McCallum, 1990). These were the reports of the House of Representatives Standing Committee on Expenditure (McLeay Report) in 1982 and the Senate Select Committee on Private Hospitals and Nursing Homes (Giles Report) in 1985.

The Coleman Report found that subsidising nursing home care had resulted in an oversupply of nursing home beds (Kendig & McCallum, 1990). The report also concluded that "nursing home care for the aged was not only the most unsuccessful but also the most financially unsatisfactory of the various areas in which the Government had provided assistance for elderly people." (Clare, de Bellis & Jarrett, 1997, p. 23).

The McLeay Report (1982) focused mainly on aged accommodation and housing and inequities in funding between states. The recommendations dealt mainly with controlling the increase in nursing home beds, introducing assessment of persons before admission to a nursing home, and providing mechanisms "for complaints against low standard nursing homes" (Howe, 1990, p. 160). The general opinion was that the McLeay Report did not go far enough in terms of addressing long-standing problems,

particularly in relation to regulation of standards (Kendig & McCallum, 1986; Clare et al., 1997; Braithewaite, et al., 1992).

The Giles Report (1985) dealt more broadly with service provision and care issues. The six Senators from all parties who made up this Committee were responding to "increasing expressions of concern in the community about the ownership and operation of private hospitals and private nursing homes..." (Giles Report, 1985, p. xiv). This Committee undertook observations in nursing homes and received submissions from a wide variety of interested persons; this provided a new viewpoint:

> The entry of representative advocacy groups and alliances of professionals and their clients into the policy process introduced new perspectives on many issues and was especially influential in bringing issues of standards to the fore.
>
> (Kendig & McCallum, 1986, p. 161)

An interesting aspect of the all-party Senate Committee was that all of its members were women, and it's chairperson, Senator Patricia Giles, was a nurse. The choice of Committee members may have been because the substantive area of enquiry was considered to be "women's work". Whatever the reasons for the make-up of the Committee, the Giles Report contributed more cogently to Government understanding aged care issues than previous reports.

Several recommendations of the Giles Report (1985) were particularly relevant to nursing practice and working conditions in aged care because they addressed nurse staffing in terms of minimum hours, qualifications and education of staff, non-nursing duties, and limiting the role of "nursing assistants". However, the key recommendation was for the establishment of formal resident care standards monitoring:

> In the wake of a change of government, renewed consumer and welfare group activism on the issue of nursing homes and hostels, and continued media attention, the Giles Report recommended the development of new Commonwealth standards for nursing homes and the establishment of a Commonwealth nursing homes inspectorate.
>
> (Braithewaite, et al., 1992, p. 14)

The Giles Report, together with the McLeay Report, resulted in the "shaping of a more directed and integrated policy" about aged care (Sax, 1990, p. 91). The subsequent Nursing Homes and Hostels Review (Department of Community Services (Rees), 1986) that was commissioned because of the two earlier reports led directly to the first Aged Care Reform program that began in 1987.

Aged care reform

The Nursing Homes and Hostels Review (Rees, 1986) was a wide-ranging review that resulted in a series of recommendations to control the growth of the nursing home sector. Broadly, the recommendations dealt with licensing nursing homes, access to nursing home beds, funding arrangements, the introduction of standards monitoring, and provision of mechanisms for the assurance of residents rights (Kendig & McCallum, 1990).

By the 1980s, aged care was on the social agenda, due at least in part to the "baby boomer" generation being old enough to consider their own ageing and future needs (Stein, 1999). This population group was becoming vocal, and also politically active. For example, the Greypower Party contested the State election in Western Australia in 1989, and this "ushered new actors into the political arena" (Kendig & McCallum, 1990, p. 1). The politics of social welfare - "the balance between taxpayers and claimants for public expenditure" - by then included an educated and articulate group of older people who had the capacity to influence the outcome of elections (Kendig & McCallum, 1990, p. 1).

The move towards greater Commonwealth control of aged care funding and service provision was something of a watershed. In the early decades of the 20th century, neither Commonwealth nor State Governments wanted to get too involved in aged care services, apart from essential provision of accommodation and care for those needy people who would otherwise occupy general hospital beds (Bolton & Joske, 1982; Stein, 1999). However, following the stream of committees and reports during the 1980s, and the rising influence of consumerism, the Commonwealth Government began to reform

aged care in 1987. The Government subsequently adopted the recommendations of the Aged Care Reform Strategy Mid-Term Review report (Gregory, 1991) to take full responsibility for all residential aged care services in Australia.

The structure of the reform program that began in 1987 will be described in more detail in the next section. The main components of the program involved controlling access to nursing home beds, establishment of accountability procedures to ensure control of expenditure and demonstration of quality standards, and introducing the concept of user rights in aged care (Fogg, 1999).

A significant part of the reform program was the establishment of a Charter of Residents' Rights. This arose out of another report commissioned by the Commonwealth Department of Health, which commissioned an investigation into issues related to the rights of elderly residents in Australian nursing homes and hostels (Sax, 1993). The main themes that emerged from that report were the needs of residents for individual consideration, information, and consultation, together with more formal approaches to advocacy, accountability of service managers, and conflict resolution procedures (Ronalds, 1989).

The importance of the principles that underpinned the strategies to enable residents to exercise their rights lay in the occurrence of a subsequent power-shift in favour of older people. In the ten years that followed the Ronalds Report, there was a steady increase in consultative mechanisms in aged care services (Fogg, 1999). The real impact of this was erosion of the "institutional" culture of care that dominated most nursing homes until the 1990s.

> The user rights strategies may be flawed in their ability to actually enforce appropriate behaviour by service providers, and it is seriously unrealistic to rely on older residents or their family members making complaints as a prime way of identifying problems. However, the power of rights is that it can help change the attitudes of older people themselves as regards what they can expect and the attitudes of providers and staff as to what constitutes best practice in the industry.
>
> (Fogg, 1999, p. 106)

The main impact of these developments on the RNs working in nursing homes was that the reform program introduced significant changes in accountability and documentation procedures and there were many years of uncertainty about what was actually required as the changes were introduced, then modified several times (Price & Taylor, 1998). The changes and uncertainty that resulted from the reform program resulted in many RNs feeling that their competence and standards were being questioned when Government inspectors questioned nursing practice (Source A, personal communication, January, 1998).

The introduction of new documentation requirements set many RNs on a steep learning curve and a sudden awakening to a range of issues that they hadn't previously had to consider (Scott, 2000). For example, the evidence required to substantiate nursing home funding claims was based on resident care records (assessments, care plans and progress notes), within a nursing process framework, as described in Chapter One. Few RNs working in aged care at the time had mastered nursing process documentation, and there were also expectations that consultation with residents or their representatives would occur during care planning (Scott, 2000). These markedly changed expectations amounted to a type of "reality shock" (Kramer, 1975) for many of the RNs, which tended to interfere with their learning of new skills.

Aged care industry concerns about the Standards Monitoring program were finally acknowledged after the introduction of the new Structural Reform Package of 1997. "Rigid and intrusive monitoring processes based on point in time assessments focused nursing home providers on minimum standards rather than care or innovation" (Gray, 2001, p. 5).

A number of tensions and dichotomies arose out of the sociopolitical changes of this period. The main tension for the RNs was the need to change their approaches to work and to learn new procedures, particularly in relation to documentation. There were also tensions in the sharp increase in inspections and monitoring of care and documentation by Commonwealth Government nursing officers.

Analysis of the reports discussed in this section of the chapter suggested that the main dichotomy for the RNs was the expectation that nursing homes should be transformed into "homelike" places, while at the same time providing professional care that could be substantiated through audits of care records. Further, residents and their families were increasingly being seen to be partners in both nursing care and facility management, while organisational cultures still supported an institutional approach to care and a matriarchal management style (Stein, Jackson & Mannix, 1999).

AGED CARE REGULATORY ENVIRONMENT 1987 - 2001

Until 1987, regulatory activities in aged care facilities consisted mainly of financial, medical, and licensing inspections (Braithwaite, et al., 1992). Financial inspections checked the accuracy of claims for nursing home benefits, backed up by medical assessments to determine benefit levels: Before 1987 the two levels of funding were for what was then called "ordinary care" or "extensive care" (Rees, 1986). The licensing inspections checked building standards, hygiene, and staffing levels. This regulatory environment was completely changed by the Aged Care Reform Strategy launched by the Commonwealth Government in 1987.

Aged Care Reform program 1987 - 1996

The 1987 Aged Care Reform program was implemented in stages (Gregory, 1991; Braithwaite et al., 1992; Sax, 1993). From the point of view of aged care service providers, the stages consisted of the following changes:

- The introduction of Geriatric Assessment Teams (later called Aged Care Assessment Teams) in 1987 to screen applicants for admission to nursing homes. These teams worked to implement the "stay at home" principle adopted by the Commonwealth Government, and therefore limited approvals for nursing home admission to only the most dependent elderly people (Sax, 1993).
- Nursing home funding was divided into two components, or "modules", in 1987: The Standard Aggregate Module (SAM) provided a daily rate to cover infrastructure costs, and the Care Aggregate Module (CAM) covered the costs of employing

nursing and personal care staff. The CAM component of the funding was calculated through the use of the Resident Classification Instrument (RCI). The RCI was an assessment tool for determining the relative care needs of residents for funding purposes. RCI funding claims were validated by Commonwealth Nursing Officers, who retrospectively audited resident care records.

- Standards Monitoring Teams (SMTs) assessed nursing home compliance with 31 outcome standards that were gazetted in the *National Health Act 1953* in 1987.
- Strategies to promote residents' rights (Ronalds, 1989) included the implementation of a Charter of Residents Rights and Responsibilities; legal contracts between residents and the service providers; and the introduction of a formal complaints mechanism administered by the Commonwealth Department of Health.

Other stages were related to the introduction of Home and Community Care (HACC) services, the introduction of hostel standards and a funding instrument for hostel service provision, called the Personal Care Assessment Index (PCAI).

Each stage of the Aged Care Reform program had its own impact and an overall cumulative effect on all levels of nursing home staff. The cumulative effect, based on anecdotal evidence, was to leave many nursing home directors of nursing and registered nurses almost "shell-shocked" by 1991. The learning curve they found themselves on was very steep and the challenges were compounded by frequent and largely unexpected (at nursing home level) changes in Commonwealth Department of Health procedures and interpretations. During that period directors of nursing sought help from education service providers to set up training programs for their staff to enable them to comply with the progressively changing regulatory requirements. Anecdotal evidence suggested that many directors of nursing were overwhelmed by the enormity of the task confronting them, when they had for so long worked in a slow moving aged care sector that had functioned as a virtual "cottage industry".

One example of the impact of the reform program was that the introduction of Aged Care Assessment Teams resulted in a significant change in the pattern of nursing home

admissions. New residents were more physically dependent on staff, requiring more nursing care and higher levels of assistance with personal care, and this was recognised by the authors of a South Australian study:

> Further, as a consequence of changes in aged care and health policy, the aged care residential population has changed in terms of greater acuity and levels of dependency. In addition, the trend for early transfer of residents from the acute care sector to residential aged care has contributed to the increased acuity of residents. Consequently, the registered nurse in residential aged care is dealing with a relatively rapid decline in the health status of the residential population with all its associated demands, in tandem with the push for greater accountability in terms of documentation and meeting complex standards. At the same time the complexity of care required by residents (for example in the area of palliative care) is increasing but the number of registered nurses is not.
>
> (Cheek, et al., 2002, pp. 33-34)

To some extent, nursing home managers preferred more dependent residents because they attracted higher funding through the RCI. However, the impact on workloads was significant, and all staff had to be involved in managing daily care, especially to assist feeding dependent residents at meal times (Source C, personal communication, August, 1996). Such marked increases in workloads did not result in increased staffing for some time because nursing home managers tended to be conservative with their decisions to increase spending on staffing. One reason for this was the fear that subsequent RCI audits would reduce funding, but staff numbers could not be reduced without industrial turmoil (Source B, personal communication, Aug. 1996).

The SAM/CAM funding model described earlier also had a number of impacts, the most significant of which was the gradual transition from a minimalist "daily diary" system of resident records, to comprehensive, professional, and voluminous documentation to support the funding tool, that is, the RCI. The care documentation that was required to be maintained to validate the first version of the RCI took several years to develop because early validations were carried out infrequently by Commonwealth Medical Officers. Checklists of care needs were acceptable "evidence" for the first two years, but then were ruled as not acceptable, and descriptive data were required to substantiate funding claims (Macri, 1993).

The second version of the RCI was introduced in 1993, following educational workshops conducted by Commonwealth Health Department staff. Subsequent audits proved to be frustrating for nursing home staff and Departmental auditors alike, as both parties worked to different agendas. For example, nursing home staff tried to make sense of the RCI questions within a nursing care framework, while the auditors tried to find the very specific evidence required to validate the nursing home's funding claims (Mannix, 1999).

By 1996 nursing homes staff had become used to providing documentation for RCI purposes, but there were ongoing problems with documentation styles, form design, interpretations of what was "sufficient" evidence, and also with auditing processes used by Commonwealth Nursing Officers. Many directors of nursing and RNs believed that the process of auditing was capricious, and it was true that inter-rater reliability of the RCI auditors was considered to be problematic (Braithwaite, et al., 1992).

The transition of nursing home regulation from the *laissez faire* approach of the 1960s to a tightly controlled process after 1987 (Howe, 1990; Clare, et al., 1997) took many years to develop in regulatory terms, but the actual impact on nursing home staff was quite sudden. RN roles and workloads changed significantly from 1988 onwards as they began to come to terms with the new documentation and practices to comply with funding and standards requirements.

In 1990 Professor Gregory was appointed by the then Commonwealth Minister for Health to carry out a Mid-Term Review of the Aged Care Reform Strategy (Gregory Report, 1991). The review endorsed the achievements of the program to that point, and made recommendations for further changes, mainly associated with integrating planning and financial management for community and residential aged care services (Gregory, 1991).

> The third approach is for the Commonwealth to accept full responsibility for policy development and financing of aged care. This approach would involve the Commonwealth taking over the financial obligations of the States' share of home and community care expenditure under HACC. This is the approach that best suits the spirit of the recommendations of the Mid-Term Review which are

> directed to achieving an improved planning framework to develop a better balance of care on a consistent and equitable basis for all older Australians.
> (Gregory, 1991, p. 16)

The Gregory Report (1991) apparently satisfied the Minister and his Department, but other stakeholders were less than pleased, and this displeasure came from all sides of the arena, including consumer groups, aged care industry associations, and nursing organisations (Mannix, 1999). Anecdotal evidence from meetings in WA during that time suggested that aged care service providers continued to be unhappy about funding levels, while older persons' action groups continued to be dissatisfied with monitoring and improvements in quality of care, and resident participation in decision-making. Nursing groups were vocal about the excessive demands for documentation and the changes in expectations about the documentation from one audit to the next, and between different service providers.

The focus of the reform program continued to be on monitoring funding, structural change, and improvements in service quality. At the same time, RNs working in nursing homes continued to provide professional nursing care in an environment of increasing budgetary restrictions and other impediments to practice. "Through regulation and standardisation, the reforms have given the Commonwealth Government tight control over the nursing home industry and aged care" (Clare, et al., 1997, p. 27).

Residential Aged Care Structural Reform Package

Inquiries continued during the 1990s, including the review of aged care legislation that was carried out by the Australian Law Reform Commission (1995). Until the promulgation of the *Aged Care Act 1997*, the initial Aged Care Reform program was "governed by a complicated array of legislation, delegated legislation and funding agreements between the Minister and service providers" (Australian Law Reform Commission, 1995, p. 14). The new legislation was intended to overcome the complexity and inconsistency in the old legislation, and also to ensure that the legislation covered the range of aged care matters governed by the Commonwealth Government.

Another report that had direct implications for nursing in aged care was the Productivity Commission's Inquiry into Nursing Home Subsidies (1999). There was considerable anticipation amongst industry and nursing groups that this report would finally bring some rational changes to the vexed question of funding of aged care services, if the Government adopted the recommendations (Ireland, 1999). The report certainly suggested an awareness of the issues, but the end result was disappointing for both industry and nursing organisations. The awareness of problems faced by nursing homes was expressed as follows:

> … the current regulatory regime has the effect of disguising underlying cost drivers between homes providing different quality care or facing different input prices. As nursing homes cannot respond to increases in the prices they need to pay for inputs (such as staff, goods and services) by increasing their revenue – this is controlled by the Government – they can only respond by improving efficiency, reducing their services or by reducing their surplus (if any).
>
> (Productivity Commission, 1999, p. 56)

According to one commentator, the aged care industry was also aware that the Government might not follow through:

> Failure to proceed with the spirit of the recommendations would undermine the credibility of the Productivity Commission. More significantly, it would be viewed with cynicism by those who recall the reference to the Committee being made just prior to a Federal Election campaign, getting a troublesome issue out of the public spotlight.
>
> (Ireland, 1999, p. 13)

One consequence of this report, and the Commonwealth Government's position on funding, was that nursing homes were required to make more efficient use of the subsidies they received, including making decisions about the levels of staff that should be employed. This notion of staff mix refers, in particular, to the relative proportions of qualified nurses to unregulated care workers (personal carers). In any cost-driven system, it seemed to be inevitable that nursing home managers would move towards employing greater numbers of "cheaper" staff in order to achieve both budget and work targets (Nay & Closs, 1999). Decisions in this direction were further encouraged by the shortage of qualified nurses applying for jobs in nursing homes (Mannix, 1999).

The Structural Reform Package was implemented with the promulgation of the *Aged Care Act 1997*. The main parts of the package that were relevant to nursing homes were the introduction of:

- "User pays" principles with accommodation bonds or accommodation charges (based on income testing), although this plan was subsequently abandoned and a modified version applied only to Extra Services facilities and Hostels. (Some nursing homes were authorised to charge extra fees for nominated "Extra Services".)
- A new Resident Classification Scale (RCS) to determine the level of Commonwealth subsidy for each resident (replacing the previous RCI for nursing homes and PCAI for hostels).
- Accreditation procedures based on newly legislated standards (44 expected outcomes) and using a process of assessment that was designed to actively involve nursing homes in continuous quality improvement. The new accreditation procedures were to have significant down-stream effects for nursing staff, with increased demands on their time as they carried out non-nursing work associated with internal auditing and maintenance of evidence of quality improvement activities.
- Revised "user rights" principles, including formal Residents' Agreements and improved access to external (anonymous) complaints resolution procedures.
- Certification of residential care services to ensure environmental safety (fire and security), standards (ventilation, heating, cooling, lighting, homeliness), personal privacy (number of beds per room and number of bathrooms), and community access.

(*Aged Care Act 1997*; Aged Care Principles, 2001)

Some aspects of the previous reform program were continued, including Aged Care Assessment Teams to approve admissions to residential care. By 1997 the impact of "ageing-in-place" principles was clearly apparent in the changing profile of new residents. People admitted to nursing homes were very dependent, with complex care needs. With the trend for frail or chronically ill older people to be cared for at home or

in hostels for as long as possible, the goal of "only the most frail elderly people [being] admitted to nursing home care" had been achieved (Sax, 1993).

There was also a demand for older people to be discharged from acute hospitals as quickly as possible, especially if the Aged Care Assessment Team approval for nursing home admission had already been completed (Cheek, et al., 2002). This meant that some residents were still relatively "acute" in terms of their health problems, which put extra pressure on nursing home RNs. For example directors of nursing reported that residents could be discharged from hospital to a nursing home within 36 hours of orthopaedic surgery, or within hours or days prior to their death (Source C, personal communication, December, 1998).

One significant implication of the abolition of the previous CAM/SAM funding system was that protection of the "nursing" staff wages component of the nursing home budget was lost (McDonald, 2001). Under the previous CAM system, facilities were required to spend a minimum of 95 per cent of their CAM budgets on employment of nursing and personal care staff. After 1997, there was no distinction between staffing and infrastructure costs, which meant that some managers could use the opportunity to either reduce staffing hours, or to replace qualified nurses with less expensive personal carers (McDonald, 2001).

The removal of the requirements to maintain particular levels of nursing staff was considered by some nursing groups to have led directly to poor standards, especially the widely publicised incident involving the use of kerosene to treat Scabies at a Melbourne nursing home (Sellers, 2000). What came to be called the "Riverside Nursing Home fiasco" (Quinn, 2000, p. 15) drew national attention to issues related to funding and staff mix in nursing homes. One writer commented:

> More regulations, more funding and more trained staff. Is that the answer? Will the reintroduction of expenditure controls and nursing ratios improve the quality of care? This is in addition to the accreditation, certification and user rights controls. The answer is yes, but only if we are prepared to pay more into the system through increased government funding and/or resident fees.
>
> (Quinn, 2000, p. 15 – 16)

Another factor that influenced budget management in nursing homes was that the *Training Guarantee Act 1992* was suspended in 1996, so there was no longer any compulsion for managers to spend at least one per cent of their budgets on staff training. However, the new Aged Care Accreditation Standards mandated staff training requirements, so by 1999, training was back in the budget, albeit without the prescriptive requirement regarding expenditure.

Summary of issues arising from the reform program

Several dichotomies emerged as a result of analysis of reports and literature concerning the aged care reform program. The main one was the expectation that nursing home staff would be able to provide excellent care and meet the expectations of key stakeholders in an environment of strictly controlled budgets and under-qualified staff. Further, financial controls made no allowance for variances in resident care needs, staff skill levels, or individual facility capacity to manage change (Productivity Commission, 1999).

A related challenge was that staff should be able to respond quickly to residents' illnesses and seek medical assistance or transfer them to acute hospitals when required. However, nursing homes were relatively "doctor free zones" (Stevens & Herbert, 1997, p. 18) and medical practitioners tended to be reluctant to take aggressive medical action for a frail, dying patient. This view was supported by data from the study, when RN participants expressed concerns about trying to manage ambiguous expectations of medical practitioners, residents' families, and their own managers.

Another dichotomy seemed to be associated with the fact that private ("for profit") nursing homes were funded with "public" money. There was an overwhelming perception in the aged care industry that people in the community believed that the funding of charitable, or "not-for-profit", organisations as "OK". However, the same system of funding applied to private "for profit" enterprises was seen as deserving of greater scrutiny, although there was no research or literature to support that

interpretation. However, it may have contributed to the related dichotomy of the highly valued role of nursing in Australian society, but there tended to be public mistrust and criticism of all nursing home care, even though many nursing homes demonstrated satisfactory care standards. This negative valuing was, to some extent, passed on to the nurses working in the industry, who felt that they did not have the same valued status as their public sector colleagues. Anecdotal reports of the belief that "not-for-profit" care was superior to that provided by "for profit" organisations persisted in the public view of aged care, although published reports (e.g. Braithwaite, et al., 1992; Gray, 2001) did not support that belief.

NURSES AND NURSING IN WESTERN AUSTRALIA

Qualified nurses in Western Australia were registered nurses (RNs) and enrolled nurses (ENs). RNs were registered in Division 1 of the Register of nurses in WA, while the EN was registered in Division 2. The RN "utilises nursing knowledge and skills gained through approved nursing education programs and experiences in nursing, to plan, implement, and evaluate care provided to individuals or groups based on assessment of client needs" (Nurses Board of Western Australia, 1998, p. 1). At the time of this study the EN was the second level nurse and worked under the direction and supervision of the RN, providing nursing care delegated by the RN (Nurses Board of Western Australia, 1991). RNs and ENs worked in all health care sectors, including nursing homes and hostels.

Two factors related to nurses and nursing in the Australian aged care sector guided the selection of literature for this chapter, and these were the shortage of RNs, and the need for ongoing education and professional development of RNs employed in nursing homes.

The registered nurse shortage

The National Nursing Workforce Forum (2000) identified the key challenges for nursing in the new millennium, including the worldwide shortage of nurses, and difficulties in

recruitment and retention of nurses. There was specific recognition of the shortage of nurses in the aged care sector.

The shortage of nurses in long-term care was identified as a problem in the US during the 1980s, when Reif and Estes (1982) predicted a serious shortage in aged care nursing, and identified the following factors:

> (1) growth of the elderly population… and concomitant increase in the population that requires long-term services, particularly nursing home care;
> (2) non-competitive salaries, limited opportunities for career advancement, and unfavourable work conditions for nurses working in nursing homes…;
> (3) anticipated expansion of nursing roles and functions…;
> (4) expansion of agencies and programs providing non-institutional long term services;
> (5) decreases in applicants to and graduates produced by nurse training programs;
> (6) the limited numbers of nurses prepared to work in long-term care;
> (7) the relatively small number of programs that provide training in gerontologic nursing and long-term care; and
> *(8)* limitations in the amount of funding available for nurse training in these speciality areas.
>
> (Reif & Estes, 1982, p. 164)

Those factors were as relevant in Australia in 2002 as they were in the US twenty years earlier (Spetz, 2001), and applied equally to Western Australia. For example:

- There was an increase in the number of high-care residents in aged care facilities (AIHW, 2000);
- wage parity for nurses working in aged care was not achieved (Iliffe, 2001);
- more nurses were working in domiciliary and community care, and were therefore not part of the residential aged care labour pool (AIHW, 1998);
- recruitment and retention of students in undergraduate programs was a continuing concern (Pearson, et al., 2002); and
- access to post-registration education was extremely limited (Pearson, et al., 2001).

The collection of accurate nursing labour force statistics was given a higher priority by the mid-1990s, particularly as the nursing shortage became more acute at the same time as the demand for places in pre-registration courses in universities fell (AIHW, 1999). In 1996, a survey conducted by the Health Department of Western Australia showed that

91 per cent of nurses were female, their average age was 40.6 years, and 77 per cent were hospital trained (Health Workforce Branch, 1996). This compared to 95 per cent female nurses in 1989, and an average age of 36.8 years. For the period 1993 to 1996, the Australian Institute of Health and Welfare showed a declining number of RNs and ENs working in nursing homes, and an average age increase for nurses working in that sector from 42.8 years in 1993 to 43.7 years in 1996. This was compared with public hospital figures which showed an overall increase in RNs employed in the sector, and an average age in 1996 of 37.7 years (AIHW, 1998).

Concerns about the RN shortage led to the establishment, by the Commonwealth Department of Health, of the Nursing Workforce Project, and the report of the project was published under the title "Recruitment and retention of nurses in residential aged care" (Pearson, et al., 2002). The findings of the report will be discussed in more detail in Chapter 6 because it was published towards the end of this study and its findings are more appropriately reported with the overall findings of this research.

Ongoing education and professional development

In 1996 in Western Australia, 80 per cent of the then population of RNs working in "geriatric nursing" had completed hospital-based training (Health Workforce Branch, 1996). Hospital-based nurse training programs ceased in WA in 1985, so it is possible to extrapolate that the majority of nursing home RNs trained before then. While there were no published statistics regarding completion of post-registration qualifications by these RNs, there was anecdotal evidence that only a small proportion, perhaps less than 20 per cent, had completed any formal post-registration courses.

Based on nursing labour force statistics (AIHW, 1999a), most of the RNs then working in nursing homes would have undertaken their initial nurse training during the 1960s and 70s, when the apprenticeship system of nurse training was being reviewed. Entry into nursing at that time required completion of three years of secondary education (equivalent to Year 10). This was not considered to be a sufficient level of education according to a respected Australian nurse:

> It had become increasingly evident with the passage of each decade that the hospital-based apprenticeship system was unsuitable for the preparation of competent nurses in a 20th century world of escalating social, educational, scientific and technical change.
>
> (Parkes, 1997, p. 13)

RNs who trained during the 1960s and 70s were socialised into a hierarchical view of nursing roles. In the apprenticeship training system, junior student nurses provided basic cleaning duties, assisted with patients' meals, and provided routine hygiene and elimination care (Russell, 1990). Senior students supervised the juniors and carried out more complex tasks such as wound care, giving medications, and managing intravenous therapy, while the RN, or "sister", supervised the student nurses. "A sister's duties included doing rounds with the medical staff, writing patient reports and ensuring that all needed equipment was available" (Russell, 1990, p. 65).

The transfer of nursing education to the university sector began in Western Australia in 1975 and was completed by 1985 (Russell, 1990; McCoppin & Gardner, 1994). By the early 1990s graduate study courses were available in aged care nursing. However, few of the RNs working in aged care qualified for these courses because they had not completed an undergraduate degree. Also, anecdotal evidence suggested that nursing home RNs generally did not believe in their ability to succeed in "university" courses. A post-registration certificate course was offered in Extended Care Nursing during the 1980s in Perth, but the course was discontinued with the closure of Mt Henry Hospital in 1985, a public geriatric hospital which had been the venue for the course.

At one level, the transfer of nursing education to the university sector excluded RNs from further formal education because, as RNs described at professional meetings, it took a significant commitment to part-time study to first complete an undergraduate degree, and then post-graduate studies. The Nursing Labour Force report (AIHW, 1999a) showed that most RNs were female and in their early forties, therefore many of them would have had significant family commitments at that time of their lives. Anecdotal evidence suggested that, for RNs working in aged care, the combination of family commitments and working part-time was as much as they could manage.

There also seemed to be a sense of larger events having passed them by, and that it was now too late to join in the education revolution in nursing. For many RNs who trained in a hospital, and were by then practising in a very different health care system, the challenges were perhaps seen to be insurmountable (Source A, personal communication, April 1998). The next generation of nurses, those who completed their pre-registration education at university, tended to have a foot in both camps because their professional socialisation encompassed both eras: "Today's nurses are the children of transition" (Parkes, 1997, p. 14).

THE STRUCTURE OF THE AGED CARE INDUSTRY

Historically there were three main players in residential aged care provision. These were State Government hospitals and nursing homes, private, "not-for-profit" services run by church and charitable organisations, and private, "for-profit" enterprises.

With the move to Commonwealth funding of aged care in 1987, some State health departments began to move away from large-scale aged care services, and, in Western Australia, two of the large geriatric hospitals were closed by 1990. The third, and largest, was restructured and incorporated as a non-government entity. During this study, the WA Department of Health continued to have a role in rural residential aged care, where these facilities were usually small (<10 beds) permanent care units attached to district hospitals.

The two private sector groups were, until 1987, dealt with differently under Commonwealth funding arrangements, and during the early 1980s they tended to be competitive in their quest to improve the level of Commonwealth subsidies and financial grants that they received. Kendig and McCallum (1990) suggested that the standardization in costing and reimbursement, introduced with the Aged Care Reform program in 1987, resulted in a realignment of the industry interest groups. However, while "peak" councils of industry associations and special interest groups were

established at about that time, there wasn't very much real cooperation between the groups until the second wave of reforms were introduced in 1997.

Concerns about private enterprise organisations receiving public funding to provide health care was not limited to aged care services, as reflected in a "Background Briefing" episode on Radio National (ABC, 1996), where concern was expressed that public health care would be run by corporations seeking a financial return. This arose from proposals that private hospitals could be funded to help reduced public hospital waiting lists.

At the time of this study, aged care services in Australia were provided at four levels, ranging from "in home" care to residential care.

1. Home and Community Care Programs (HACC), run with Commonwealth funding, were specifically designed to keep people at home and "avoid inappropriate admission to residential care" (Sax, 1990, p. 110).
2. In-home care, including domiciliary nursing and personal care services, meals, and home help was funded through Commonwealth-funded Community Aged Care Packages and was mainly initiated following consultation with the person's medical practitioner.
3. Hostels, called "low care facilities" in the new system, provided residential care for people who needed accommodation support and some supervision with activities of daily living (ADLs).
4. Nursing homes (called "high care facilities") provided 24-hour nursing and personal care services along with lifestyle and other services.

Community care

HACC programs, jointly funded by Commonwealth and State and Territory Governments, were designed to provide coordinated support services to aged and disabled people living in the community. State health services (e.g. WA Department of Health) administered the programs and monitored the service provider organisations. The support services started with home help, home nursing, delivered meals and

paramedical services and "have now been supplemented by respite care, services for dementia sufferers, laundry services, shopping, food services, training and other services" (Sax, 1990, p. 112).

In Western Australia domiciliary care was provided by the Silver Chain Nursing Association, and a number of more recently established private enterprises. Access to domiciliary care services was facilitated by the Government's "Staying at Home" funding package, which funded a range of services to enable frail older people to remain at home (Department of Health and Aged Care, 2000.) The Community Aged Care Packages basically funded the cost of employing paid carers to assist people at home with personal care and some limited domestic support such as bed-making.

Aged Care Assessment Teams, established under the original Reform Strategy in 1987, contributed to the support systems for elderly people living in the community by reassessing their needs from time to time, especially during transition from home to hospital and back home again (Department of Health and Aged Care, 2000).

Residential care

According to the AIHW (2000, p. 1), "at 30 June 1999, there were 3,018 residential aged care facilities in Australia providing a total of 140,651 places." The residential care places in that report referred to nursing homes and hostels covered by Commonwealth funding and regulatory procedures.

At the time of the present study, hostels provided care for people who needed assistance with some activities of daily living. Their dependency levels ranged from needing minimal assistance, to those requiring significant levels of nursing and personal care. Nursing homes provided complex nursing and health care services for high-dependency residents. With the Government's "ageing in place" policy, residents were enabled to stay in hostels, as long as the service provider was able to comply with standards in meeting their care needs (Gray, 2001).

Aged care facilities in Western Australia were extremely varied in size, structure, and building age, and these factors impacted on the working environment for RNs. For example, nursing homes with less than 40 beds usually had only one RN on duty on each shift, with the director of nursing performing management duties. Larger nursing homes (e.g. 50 – 75 beds) tended to have had two or three RNs on duty on the day shift, with fewer on the evening shift, and only one RN on duty at night. In nursing homes that were larger than 80 beds there tended to be more RNs on duty, but their access to other RNs on the same shift was limited because of distance or the multi-storey design of the building (Source A, personal communication, April 1998).

Older buildings, especially those that started out as large private houses, provided particular challenges for managing resident privacy and staff safety. Some older purpose-built facilities also provided architectural challenges with narrow corridors, small rooms, minimal space for administration duties (such as documentation), and little space for storage of equipment such as hoists and medication trolleys. Even modern facilities tended to have inadequate office space allocated to allow RNs to complete documentation requirements. There was anecdotal evidence that nurse managers were rarely consulted in the design phase of new nursing home development.

Industry associations and interest groups

There were two main industry associations who represented the interests of the two branches of residential care, that is, church and charitable organisations, and private nursing home proprietors. While at one time there was a distinct demarcation between the church and charitable and the private sectors, this became blurred after the 1997 Structural Reform Package was implemented. By 2001, an organisation's choice of industry association seemed to depend on the member's alignment with the vision, mission, and values of the chosen association, rather than organisational affiliations (Source E, personal communication, March, 2002).

Aged care industry and interest groups set up the National Aged Care Alliance in 2000 to "address growing community concern about the quality of aged care services in

Australia" (NACA, 2000), and to present a more united voice when influencing government policy. The Alliance included professional associations, employer organisations, unions and consumer groups, and aimed to move the aged care system towards it's stated vision.

Summary of issues arising from industry structure

Analysis suggested that several issues arose out of the structure of the aged care industry, and included the recurring concerns about the poor image of aged care. Although the 1997 Reform Strategy blurred the distinctions between the voluntary ("not-for-profit") and private ("for-profit") sectors, RNs working in nursing homes reported feeling devalued by suspicions (by relatives and government auditors) that private service providers would misuse public monies (Source C, personal communication, July, 2000).

At professional meetings attended by the researcher during the period covered by the present study, RNs working in aged care also discussed the stringency of the accountability requirements and auditing procedures. Some suggested that the negative tone of those procedures was based on government suspicion that private nursing home proprietors "cheated" when claiming subsidies under the funding system. A common theme at network and committee meetings, where nurses discussed their grievances about the onerous regulatory requirements, was the perception that their professional integrity was being questioned by government auditors. Those feelings of lack of professional respect were identified as one of the factors contributing to difficulties in recruitment and retention of RNs in residential aged care (Pearson, et al., 2002).

SUMMARY AND CONCLUSIONS

Population ageing caused significant changes in the provision and regulation of aged care services during the 1980s and 1990s, particularly in the residential aged care sector. The economic rationalist philosophy, which underpinned government budgetary decisions regarding aged care from the early 1980s, resulted in tight funding control of aged care costs (Sax, 1993). This financial stringency was introduced at the same time

as other policy decisions that resulted in the increase in dependency of residents in nursing homes, and resulted in a requirement that aged care providers, and especially nurses, "do more with less" (Bradley, 1999).

Ageism in nursing also impacted on how nurses valued their own roles, and how aged care nursing was viewed by nurses and by society. Negative stereotyping of older people was also applied to the nurses who cared for them, and several consequences followed, such as the assumption that aged care nurses didn't need advanced skills and knowledge, and that they were not sufficiently competent to work in the acute care sector (Nay & Closs, 1999). These attitudes had negative effects on aged care nurses' professional self-concept, and also on their belief in their abilities to learn and change.

One of the tensions that arose out of the sociopolitical changes of the 1980s and 90s included the significant learning curve upon which nursing home RNs were required to embark. This requirement was made more challenging by the level of educational preparation of most of the RNs, and by their resistance to changing the way they worked in nursing homes.

An expectation of the Aged Care Reform process was that nursing homes would be transformed into "homelike" places where residents and their families were partners in both care and management, while the organisational culture still supported an institutional approach to care and had a matriarchal management style. Most of the RNs had trained in the hospital-based system, and so were comfortable with institutionalized care-giving, and with their roles as " nursing sisters". The titles "matron" and "sister" persisted in some nursing homes during the time of this study. Analysis of the selected literature discussed in this chapter led to the conclusion that, in the nursing home environment in which RNs practiced, there were many impediments to the achievement of expected resident care and organisational standards, and that RNs had difficulty achieving those standards.

CHAPTER 4

THE PROBLEM: BEING UNABLE TO GET THINGS RIGHT

OVERVIEW

This chapter describes the problem experienced by the participants in their roles as registered nurses (RNs) in residential aged care facilities in Western Australia. In Grounded Theory, the main concern or problem is what the participants experience in their lives that leads them into the particular patterns of behaviour which constitute the basic social psychological process, to be described in the next chapter. In this study, the core category that emerged from the data was called *getting things right.* This category presented as a central phenomenon with two manifestations, that is, the participants experienced a problem of *being unable to get things right* and then adopted strategies to *try to get things right*.

The first part of the chapter describes the problem, its properties and sub-categories, and these are illustrated with examples from the data. The main conditions influencing the problem were temporal and quality factors, that is, the participants talked about not having enough time to complete required tasks, and not being able to complete these tasks according to their own and others' expectations.

These and other factors influencing the problem, including contextual, causal and intervening conditions, are then described and illustrated with examples from the data. The participants' views of consequences of *being unable to get things right* are also presented.

In this chapter and chapter 5, participants' statements and the main categories that emerged from the data are written in italics. Participants are identified using the chosen coding system, that is, P + the randomly assigned number (01 – 24). For example, the excerpt shown in Figure 1 (pp. 40-41) was from the interview provided by the participant identified as P23.

GETTING THINGS RIGHT

During the interviews the study participants alluded to *getting things right* on many occasions and in relation to a wide range of situations. *Getting things right* was the core category that emerged from the data conceptually and was defined more by its absence than its presence. When the participants talked about *getting things right*, the word "things" referred mainly to procedural aspects of their professional roles, and getting the procedures right meant having enough time to do those things properly, according to their own and others' expectations. The core category *getting things right* was defined in terms of four properties: *knowing, planning, task completion,* and *time management.*

Knowing the residents, staff, and doctors was important for the participants because it made many aspects of their work easier to do, and not knowing them made the participants' work more difficult. As qualified nurses, the participants knew what they were supposed to do, to what standard, and why, and they also knew what was expected of them, but these factors were context-free, that is, they applied in any setting. The context-specific aspects of *knowing* included the characteristics and needs of residents in their particular situation, and this knowledge was especially important to the participants.

The dimensions of *knowing* ranged from not knowing to being confident. For example, a participant (agency nurse) said: "The hardest thing I find is going to a new place [nursing home], being there five minutes and having to speak to relatives when you don't know the resident at all" (P16). Another participant felt confident in her knowledge, and said: "I've been here for a few years and I've learned a lot about what works and doesn't work [with dementia care]. You build up a sort of a repertoire" (P18). This property was also a sub-category in relation to how the participants dealt with the problem, and is defined and illustrated in more detail in Chapter 5.

Planning was an integral part of the participants' days, and they described a range of planning activities, from resident care planning to planning their own duties. *Planning* ranged from being *reactive*, that is, acting quickly in emergency situations, to being

proactive, when there was time to assess situations and consider alternatives. For example, a participant described how she responded to finding a diabetic resident semi-conscious, and she said: "So, obviously I had to change my routine of what I was planning to do, to attend to him first of all" (P08). When describing more proactive planning, another participant described calling a "case conference with the staff to come up with a management plan" (P04) for a resident with challenging behaviours associated with his dementia.

Another property of the core category was *task completion,* and again, the participants considered this to be very important. Some tasks were more important than others, for example, medication rounds were considered to be more important than routine documentation, and some tasks had to be managed on schedule (again, medications) while others could be deferred: "No, [the wound] is all right. I can leave that for another day or two…" (P23). Another participant illustrated prioritizing when she said: "I get the work done – what's going to make them [residents] comfortable first, then the documentation, and maybe some of that will be left for another day" (P14).

Time management was the fourth property of *getting things right* and this was the most problematic factor for the participants because they often felt that they did not have much control over the timing of events and situations they managed. For example, medication administration was fixed in time, and participants worried about not giving residents their medications on time. One participant, who was not familiar with the residents or their medications, said: "So I will get somewhere at half past nine with an anti-Parkinson's [drug] that was due at seven and there is another one due at eleven… I get quite stressed about it!" (P16). *Time management* was either *uncontrolled*, in the sense that participants reacted to situations as they arose, or *controlled,* where they were able to anticipate other events and reschedule some activities accordingly.

In this respect, time management was linked to planning, and participants were familiar with care schedules and the fact that routine care tasks were relatively inflexible in terms of timing. As a participant said: "The reality is in long-term care there are the tasks that

have to be performed… and there are time management areas that have to be adhered to" (P05). A number of participants felt that their time management skills were not very good, as illustrated by the following: "but time management is one of my big things – I'm not a good time-manager, I know I'm not!" (P23).

Getting things right meant that the participants should believe that they were doing things properly (according to their own and others' expectations) and that they were getting everything done on time and according to required schedules. However, when the participants talked about their work, they usually qualified statements about being able to get things right, as one participant said:

> *A good day is when you feel you've done your job to the best of your ability. It might not always go right all the way, but you get there in the end – mostly.* (P14)

The participants were competent and confident nursing practitioners in a range of nursing homes in Western Australia. They described encounters in their daily practice with residents, the residents' families and friends, doctors, facility managers, and other staff. In these situations, the participants carried out nursing care and administrative duties, responded to problems or unexpected occurrences, and tried to keep things running smoothly. Most of their decision-making was considered to be of a day-to-day nature, such as whether or not to call the doctor or what needed to be done for a particular resident.

There were some descriptions of situations when the participants felt they were able to *get things right*, but factors that contributed to this success were not always within their control. For example, a participant talked about being "lucky" when managing an unfamiliar shift:

> *I was very lucky because I had a very experienced EN [enrolled nurse] on with me, so that was just everything - that was everything, so I could concentrate - I could focus on the medications. And, she said it had been the best shift because nothing had gone wrong, no one had fallen - it was just a very smooth shift. So everything - there was nothing, no emergency and all went very well, so I was very lucky (laugh).* (P23)

Another participant commented: "On the whole we are very lucky here because we've got good staff so we manage very well" (P21). That did not necessarily mean that she was able to get everything right, rather that situations were usually managed to her satisfaction.

The participants were aware, at different levels, that they didn't have very much control over the environment in which they worked, and that they usually had to react to situations and events that were presented to them, with little planning or time to consider alternatives. The participants seemed to lead a largely day-to-day existence managing residents' care needs and organisational procedures. In an environment where funding and staffing were considered to be inadequate, and where expectations of what they could achieve seemed to be higher than they could deliver, the participants did their best, but often felt *unable to get things right*.

A nurse manager talked about how RNs, who she considered to be "good" nurses, knew what they should be doing, but often couldn't achieve that because of contextual and other conditions. She said:

> *Those registered nurses I was talking about - the good ones, they take their role very seriously, they are really the pathfinders, I think, as far as gerontological nursing goes. They can see past the standards, and past the everyday stuff, you know, and they have a vision of what it should be. We are so far from that, that they are always having to reconcile what they are seeing in their head with what is actually happening on a day-to-day basis. They're pushing back boundaries, trying to get there - inch their way there slowly. And then of course, there are all of the constraints. They're trying to reconcile OSH [occupational safety and health] regulations with residents' rights, they've got budgetary constraints - it never stops!* (P13)

In its manifestation as the problem experienced by the participants, the core category was called *being unable to get things right*, and this came from the participants *getting behind or running late*, and feeling that they were *not doing things properly*.

BEING UNABLE TO GET THINGS RIGHT

The basic psychosocial problem experienced by the study participants was that they frequently experienced *being unable to get things right* in the context of their

professional practice in nursing homes. There were two properties associated with *being unable to get things right*, that is, *getting behind or running late* (a temporal phenomenon), and *not doing things properly* (a qualitative phenomenon), and the two properties often co-existed in situations, but could occur independently of each other. These properties are defined and illustrated below.

The two sub-categories that emerged from the data were causal conditions that led to the problem. These were that the participants described *having insufficient time* to complete their work, and they also described feeling that there were *unreasonable expectations* of what they could achieve in the circumstances. These factors were, in turn, influenced by a number of intervening conditions that were linked to a number of contextual factors, and these are shown in Figure 2 (page 93).

Definition of the problem

The phrase *being unable to get things right* was defined, for this study, as the participants' state of awareness that their actions at work were not always consistent with their expectations of their performance. The meaning of "unable" in this context is related mainly to the concept of "power" and "powerlessness", rather than to notions of ability or competence (Macquarie, 2000). The RN participants were considered to be skilled and experienced nurses who had both the propositional knowledge (the facts that underly nursing principles), and procedural knowledge (how to practise nursing) (Benner, 1984, 1996). However, in the nursing home context in this study, the participants felt unable to complete some aspects of their role as they thought they should because of the circumstances present in their work environment. These factors are discussed in more detail below.

Figure 2 depicts the relationships between the properties and conditions that defined the problem experienced by the participants. In the next section of the chapter, these will be described and illustrated with excerpts from the data.

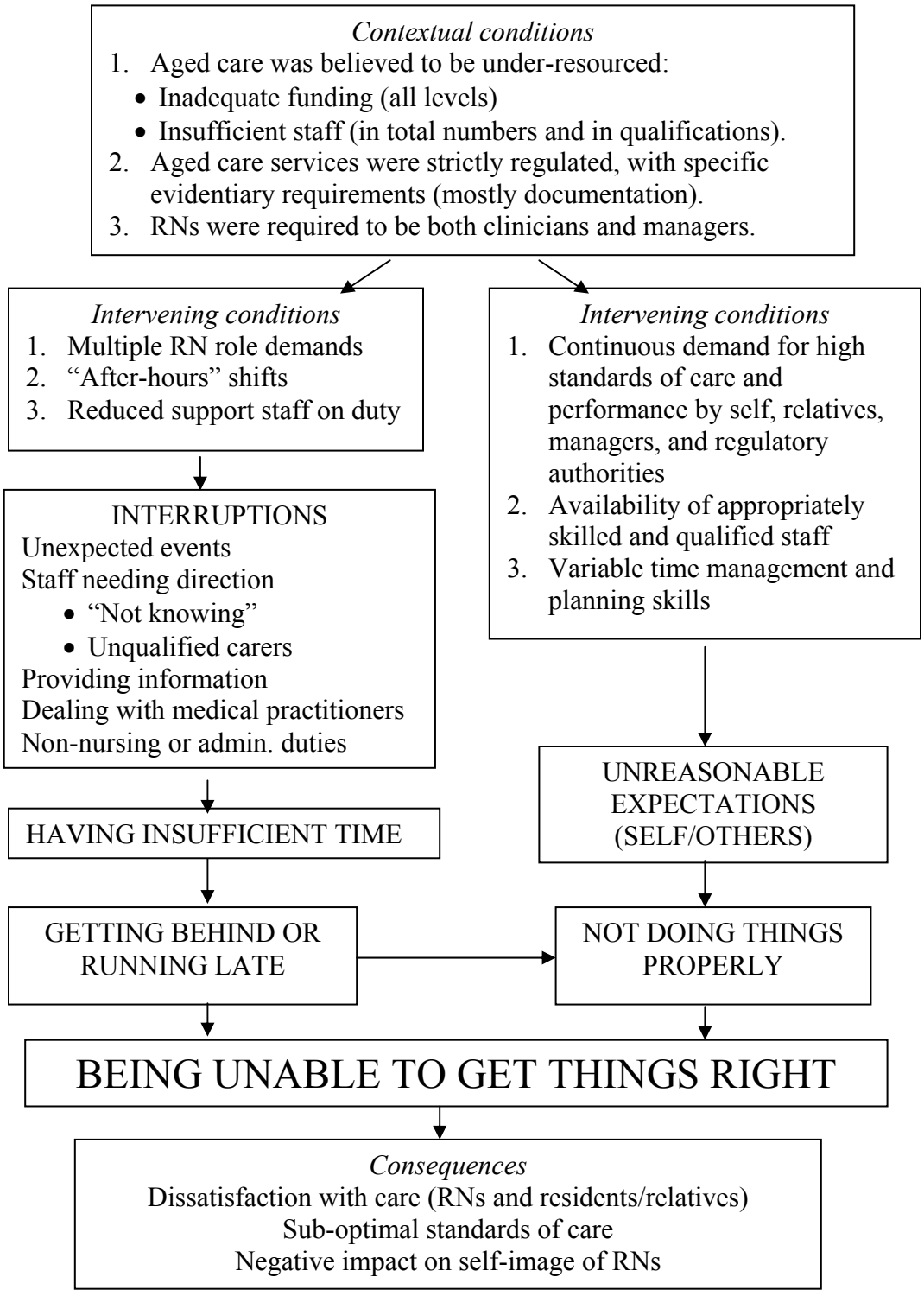

Figure 2: The problem schema

Being unable to get things right was a conceptual category that was constructed through constant comparison between several levels of categories. When describing their work, the participants made statements such as: "You have to learn to work within the system – and accept second best" (P17), and "Some problems you can't solve and that's hard to handle" (P14). Another participant said "… decisions are made on the basis of what you've got [wound care products] and not what you'd like to use" (P19).

Getting behind or running late

Getting behind applied to discrete tasks within the shift, such as not completing the morning medication round within the expected time (but hoping to catch up later in the morning). The sense of running out of time could also apply to the whole shift, where all of the activities of the shift were *running late*. A participant, who was describing a fairly typical day, said:

> *So then I have the medications, and that is, that is, (very emphatic) the key, that's the whole thing. Two to three hours out of your day will be that morning medication round and that's - you get your little interruptions there! And I try to get it done by 10 o'clock, at the latest, to complete medications. So from 10 until lunch time, that's the time that, um, if I am assessing somebody I would like to do - maybe get them [personal carers] to shower somebody, or if there is somebody [resident] really ill, I will do some sort of nursing care in that time. So if interruptions come in there, it is not so bad. Um, then as I say, after lunch I like to do documentation, but if that is interrupted, documentation doesn't get done and you don't get back on track.* (P06)

Most of the participants accepted that the morning medication round would not be completed until after 0900 hr, and perhaps not until 0930 hr. Only two participants expressed concern that some residents' medications ordered for 0800 hr were not given until over an hour later. Other participants seemed to just focus on completing medication rounds.

When the shift was *running late*, most of the participants described staying on at work after the end of their shift to try to complete required tasks, particularly the documentation. For example, a participant said: "I always do the paperwork last, which we all kind of tend to do (laugh) and I work late!" (P23).

In a similar vein, another participant described a bad day when several things had gone wrong and she was running very late:

> *And that is really the only way you can do it, leave all the paperwork until your relief staff has come on in the afternoon. Give them a hand-over, then you have to sit down and start on your paperwork.* (P07)

When they recognised that they were *getting behind*, the participants sometimes had options available to them to try to "catch up", but at other times more interruptions occurred that resulted in them *running late* through to the end of their shifts. This caused significant distress for some participants, for example:

> *Yes, that panics you because you can see that it's going further and further away, as the time clicks by (laughing). You're not getting your work done, where you find - I find that, um because I like to be set a task and I like to complete it, and I find it very hard when I can see - I'm not going to complete it.* (P14)

The reasons that the participants found themselves *getting behind or running late* were *interruptions*. Their work was interrupted by unexpected events, needing to direct subordinate staff, particularly personal carers, being asked to provide information (e.g. to relatives), and having to complete non-nursing or administrative duties.

Interruptions

Interruptions were a daily experience for the study participants, and were considered to be a normal part of nursing practice. As one participant said: "And I think, with, um, particularly with nursing, that you do have interruptions, and it is inevitable that you will have interruptions" (P23). Some interruptions were not seen to be particularly problematic. These were related to when the RN participants were asked for information that they had at their fingertips, such as where specific people or items of equipment were located. Such interruptions were brief and easily managed, and the participants were able to get back to the interrupted task quickly. Characteristics of interruptions were that they:

- Caused a break in concentration;
- Diverted the participant's attention; and

- Sometimes resulted in a change in activity (having to carry out another task).

The participants acknowledged that interruptions were an expected part of their workdays, but the extent to which these were a problem for them seemed to depend on the individual participant's need to achieve particular work targets. For example, even "routine" interruptions were considered distracting by one participant, who suggested that each interruption was just another one in a series that complicated the medication round. In the following situation she gave an example of having her concentration broken and her attention diverted during a medication round, which she had to abandon temporarily:

> *Like Mr W - his glasses were missing so it takes you ten minutes to find them! Before he would take his tablets you had to find the glasses for him. So it's not a straight "round" of just giving pills out.* (P14)

Interruptions were often caused by factors that involved time-consuming intervention by the participants, and some time would elapse before they were able to return to their previous activity. Some interruptions were considered to be relatively minor, and fairly easily dealt with, such as the example given by P14 above, while others accumulated into major disruptions that sometimes resulted in significant rescheduling of planned procedures.

The participants felt that they had very little control over the extent to which interruptions interfered with their workdays. For example, working in dementia-specific wards had particular challenges:

> *It is nothing to have four or five people [residents] pulling at your drug trolley, while you are doing it [the medication round], another one fighting, another one walking around with no clothes on. So you've just got to make the decision at the time of what you do.* (P12)

Interruptions occurred on every shift and had many sources, including

- unexpected care needs of residents, such as falls, health crises, or being asked by one of the staff to see a resident in order to assess a care problem;

- needing to direct subordinate staff in care-giving, particularly if the staff member did not know the residents or their care needs;
- telephone enquiries about a wide range of subjects, including relatives asking about residents, availability of a place for a new resident, or staff asking about their work rosters, etc.;
- relatives seeking reassurance, commenting about care, or simply wishing to chat;
- dealing with medical practitioners, whether trying to contact them by telephone or assisting them when they visited their patients in the nursing home; and
- unscheduled administrative duties, such as replacing sick staff, arranging for repairs or replacing shortfalls in care requisites (e.g. linen).

Interruptions occurred most frequently during medication rounds, partly because a large part of day and evening shifts was spent administering medications, but also because the RN was most visible during medication rounds. This was because medications were usually stored in, and dispensed from large trolleys, and, as these were cumbersome, the RNs tended to stand in the corridor to dispense and record medications, leaving the trolley in the corridor when they took the medications to the residents.

Dispensing medications in the corridor made the RNs visible and so other people interrupted them. One nurse manager described concerns about the RNs leaving the medication trolley in the corridor, mainly because of safety issues, and she considered that the RNs should make the effort to take the trolleys into the bedrooms, although furniture and other equipment tended to limit the available space.

> *... they leave the trolleys in the corridor instead of taking them into the rooms. They dispense in the corridor and then take the medication into the room and they say it's because they can't fit in. I think it is actually following habit, one person does it so everybody does it.* (P22)

Unexpected events

Attending to residents' needs was considered to create interruptions when they occurred while scheduled tasks were being performed, for example, during medication rounds, and the need was reasonably minor. In other circumstances, attending to residents'

needs was seen as a normal part of the RN role, and therefore not an interruption. It is for this reason that it was important to consider these events in the aged care context, where staffing levels were generally considered to be insufficient in relation to the increasing complexity of resident problems and care needs.

Residents' care needs had immediate priority for the RN participants, especially when the need for attention was urgent. In the participant's statement below, the morning medication round was in progress, and residents were eating breakfast when she was interrupted:

> *Like yesterday morning I had Mrs X choking there on me, so it was a matter of clearing her throat and sitting her up, and then staying a while with her - this is in the middle of giving the tablets out! Until she'd cleared, and she was then eating properly, and then I sort of ran backwards and forwards to her the whole time I was finishing the drug round.* (P14)

If the participant was a new staff member in the nursing home, or a staffing agency RN, then the interruptions could result in significant delays in medication administration. In the following anecdote, the participant reflected concern about the lateness of the medication administration managed by both RNs on duty. Again, the specific context is important because in that facility there was only one medication trolley, so the other RN had to wait until the participant finished her round:

> *... and someone fell and hit his head and I had all of that to deal with as well. I ended up not distributing tablets until sort of half ten, and the [other RN] didn't get her morning ones finished before the lunch ones were due, and things like that don't help at all.* (P16)

When asked how she felt about the late medications, the participant shrugged and said that she felt bad and didn't cope very well, and commented: "it was not something that I'd particularly like to get used to" (P16). This comment implied that being late with medications was a common occurrence, particularly in some facilities she attended as an agency RN.

A participant described unexpected events that involved either resident or staff accidents, and what had to be done in these situations:

You know, a resident might have a fall and then you are faced with having to get the doctor to come in and then get them to an X-ray. You know, that all takes time. You have to book an ambulance and do all of that which is another job that you never expected to happen. Or if a staff member has an injury you then have to give the time to maybe giving some first aid. Then making sure that the Incident Forms are filled in, contacting the Occupational Safety and Health manager and, you know, investigating all that happened as much as you can in the meantime. (P21)

Such interruptions were unexpected and did not give the participant time to reschedule any procedures. In other situations, the crisis occurred before the medication round was started, such as when problems occurred at the start of a shift:

When we came on and had the report from the night staff, it transpired that one or two patients weren't very well. So after the staff were allocated to their appropriate jobs, I went to investigate to find out whether or not we were going to get them up - and just find out exactly where we were with their conditions. One lady was actually better [sitting] up and so I decided that, rather than have her lying in bed, it would be better for her - more beneficial for her to be up. The other gentleman appeared to be going into a diabetic coma - well he was very warm and, um, when I walked into the room I could smell the ketones right away! This was 7.15 in the morning! (P08)

While unexpected events were often interruptions in themselves, they could also trigger a series of other demands on the time of the participants, for example:

If anything - if somebody gets really sick - now when that man was very sick last Saturday week (pause), yes, last Saturday week. I had to ring a locum [doctor], talk to the family, um, ring the Pharmacist - you know, quite a lot to do, plus I had somebody else who had very high needs on that particular evening… (P15)

Another participant expressed feelings of guilt if residents needed attention, suggesting considerable internal conflict about these situations, especially when the request could have been dealt with by another staff member. “If the bell rings or the resident wants something, I mean it is terrible, even in the middle of medications, I cannot ignore it - I've got to stop” (P06).

Therefore, while unexpected events interrupted the participants, they understood that dealing with the new situation was a part of their role and responsibilities. However, during these interruptions they knew that scheduled procedures were being deferred, and

could result in them *getting behind* and leaving some tasks incomplete at the end of the shift.

Staff requiring directions

In the nursing home environment, the RNs were both the nursing clinicians and the unit managers for their wards, or, in smaller nursing homes (i.e. less than 50 beds), they were responsible for the whole facility during evenings, nights and weekends. They managed both nursing and personal care, and domestic services, and therefore provided directions to ENs (if any were employed), personal carers, as well as to cleaning, catering, and maintenance staff. Most frequently, the participants directed personal carers.

One participant described monitoring and directing the activities of personal carers in very specific terms because some of them didn't do things properly.

> *As I am pushing my [medication] trolley up the corridor I'm saying, "such and such can go to bed now, why don't you do that". "She looks wet, put her in her pyjamas, don't get another set of clothes, but make sure she has got a dressing gown on" (laugh) - Because they often send people out without dressing gowns to sit up to the tea-table.* (P12)

In the above example, the participant was simultaneously administering medications and coordinating care for residents. She needed to concentrate on the medications to avoid errors, but was also mindful of the care needed by the residents, and the need for direction of the care staff. In many situations described by the participants, they were the only RN in the area (wing, section), and were responsible for their own work, administrative duties, and also directing and supervising care given by personal carers.

Other interruptions were considered to be almost part of the routine of a shift because they happened so often, and were virtually an expected part of managing care, such as a medication round.

> *The staff come to you, and I know that there's a 'do not disturb' sign [on the trolley]. But, I mean, if they need to know whether a resident needs to be turned, or has eaten, or they need to tell me something, they are going to do it during the medication rounds.* (P12)

Personal carers also sought direction from the RN participants, but not always at times that were appropriate for the RN. Participants described how the role responsibilities of the personal carers were limited to managing residents' activities of daily living, such as washing and dressing, and getting the residents out of bed. During these care activities, the personal carers might notice something about the resident that they should refer to the RN, and rather than wait, they'd go and interrupt the RN as the observations occurred. In the following situation the participant described being interrupted several times during the same medication round by personal carers coming to tell her something about different residents:

> *... but it does interfere with your work - you can't get a straight go at it [medication round] - where, they might have the washes and that to do, well they can get the resident up and go straight through and do it, where YOU'VE got to stop and start, stop and start, and then forget where you're up to!* (P14)

In that situation, the participant's concentration was broken and her attention was diverted. In those circumstances, she needed to secure the medication trolley and go to the resident to assess the problem, before returning to the medication round. Another participant described a similar situation in which there were conflicting demands on equally important aspects of the RN role:

> *Sometimes - one thing that really annoys me, sometimes the interruptions are the nurses coming to say "so-and-so's got a skin tear; come and have a look at this, come and have a look at that". And of course they're in the middle of washing and dressing the resident, they are getting them ready [for the day], so you can't say "I'll come later" - you've got to do it right there and then.* (P06)

If staff did not know the residents, such as when agency personal carers were on duty, they were more likely to interrupt the RN participant by seeking direction or information. The agency carers were sometimes unable to respond to resident requests or behaviours without getting advice. They would also interrupt the RN by asking where equipment and other care requisites were kept. This compounded the problem of working with unregulated care workers for one participant, and she said: "Um, I suppose the most difficult thing I find is having untrained staff and then a lot of them not being regular staff" (P12).

A nurse manager participant considered that the personal carers did not understand that medication rounds shouldn't be interrupted, and that, unfortunately, the RNs did not discourage these interruptions. She said:

> *Being asked by other people [carers] to help because I don't believe sometimes that the carers, um, perceive that the medication round has risk factors involved. They [the RNs] allow themselves to be interrupted.* (P22)

Conversely, an agency RN described being very conscious of the need to concentrate while administering medications in an unfamiliar environment, and had developed a strategy for dealing with interruptions:

> *I just ask people to leave me while I am [doing medications]. As I said, I really don't like being distracted during the medication round. Unless it's urgent, I say that I'll attend to it after I've completed the round. But I say, because I am not familiar with the residents, "I really must not be disturbed". So I just ask people not to disturb me while I'm doing it.* (P02)

The ability to focus on a particular task was a skill that this agency RN valued because of the unfamiliar situations in which she usually worked. Her interpretation of what constituted an interruption was something that took her away from the medication trolley. Her attention was diverted by requests, but she didn't leave the trolley unless it was "urgent" (P02).

In contrast, another participant, who was a permanent staff member at the nursing home, adopted a different strategy and used the morning medication round as an opportunity to observe what was going on with the residents, and to be available to the staff for questions:

> *I don't have much of a problem with medication rounds because I use my medication round also as a therapy round, where I talk to the residents. I take nearly an hour and a half to do my medications in the morning and I make no bones about it. Because I am slow - I dish out one resident's [medications], give it to them, and have a chat with them. Find out what are their issues. I have come to grips - again, I'm different from (nurse manager) who wants to get it done, and she gets wild with me and says "it's taking hours!" And I said "No, no, I am working with the nurses"*, I find it is time I can spare for the residents - the time when the nurses can come because it is around breakfast time - they are feeding and they can say "look, we are having difficulties feeding this resident." I can be here while they are doing it.* (P03) [*Note: This participant used the term "nurses" to refer to personal carers.]

At the same time, participant P03 stated that she did not allow interruptions when she was dispensing or giving medications, and she made sure that the staff knew that. "I don't get interrupted while I am dispensing and when I am giving, and the staff leave me alone [then]" (P03). This was another interpretation of what constituted an interruption, and how the participants managed these situations.

Other nurse managers were also inclined to disapprove of RNs' tolerance of interruptions, but were ambiguous about RN performance. On one level they acknowledged that there were not enough RNs to carry out required nursing work, but they also wanted their RNs to improve their care management and supervision of carers. One director of nursing said:

> *I don't know how they [government department] expect us to meet our duty of care when we can't afford to employ more RNs. My residents are really sick - we're like an acute medical ward! But what we have to work with are plenty of AINs [assistants in nursing/personal carers]. They're willing workers but they're not nurses! At the same time, I wish my RNs would take on more responsibility for supervising the AINs - half the time they've got no idea what the AINs are doing! The other half they're [the RNs] out there making beds and feeding residents because the AINs are complaining about not being able to get finished in time!* (Source D, personal communication, September, 1998)

Providing information

The RN participants reflected in their comments the belief that nurses are usually the most reliable source of information about residents, staff, and organisational matters. They considered it to be part of their role to provide whatever information was requested. The telephone was considered to be particularly intrusive, and impacted on the participants' management of their work. For example, a participant said: "Well today is a public holiday, which means there is no director of nursing, Level 3 [nurse manager] or receptionist and there were all these phone calls asking where they were!" (P08).

Many of the participants talked about the amount of time taken with telephone enquiries, which was an expected part of the RN role in aged care. In some facilities, portable

telephones were provided by management so that RNs could have the telephone on the medication trolley, and save them running backwards and forwards to the office (Field note, Jan. 99). In other words, interruptions during medication rounds were both expected and tolerated by some managers.

One participant described part of her role as being to "look after the front desk" while the receptionist was having a break. In response to a question about what she was doing while at the front desk, she said:

> *Answering the telephone (laugh). People ringing up enquiring about the nursing home, making appointments to come and look around, families asking questions, you know. All sorts of things really. When the receptionist goes for her breaks somebody has to be there to answer the phones, so if the DON is busy then I will do it and if I can't then she'll do it and that kind of thing.* (P21)

Relatives and friends of residents also sought information or reassurance from the participants, and this often occurred during medication rounds because the RNs were visible, standing at the trolley in the corridor, as previously described.

> *As we talked about the other day, the family are at you, an incredible amount in that ward, um, some wives in particular - all of them will talk to you during the medication round.* (P12)

Providing information was also an expected part of the RN role, but there did not seem to be any ground rules regarding which interruptions were unreasonable, and whether the RN could be very firm, or had to continue to be polite and helpful. An occasion witnessed by the researcher involved a very distressed RN pleading with a resident's wife to leave her and let her get on with the medication round. The resident's wife went on talking for several more minutes, until the RN turned away and moved the trolley into another room. When we talked about the situation, the RN said: "Oh, I feel so guilty about brushing her off, but what am I supposed to do? She just doesn't hear me!" (Field note, Sep. 2001).

Interruptions were also an ongoing problem for nurse managers because they were usually the central source of information or directions. They too had to juggle their routine tasks around interruptions, as one manager said:

> *There is no such thing as a beginning or an end of any job in a nursing home. There are so many interruptions that you can never finish off a job and put it away tidily. And for a lot of the jobs there's no clear start or finish to the jobs anyway. Like, you do the roster, put it out, then they come and ask for shift changes, so you do that, get it to balance again, then someone goes off sick and you have to replace her!* (Source B, personal communication, January, 1998.)

Dealing with medical practitioners

The services provided by medical practitioners to their patients in the nursing homes were considered to be so essential that the residents' general practitioners (GPs) were key stakeholders in resident care. Therefore it was important to the participants that the GPs be available and cooperative, especially as the RNs were responsible for coordinating their attendance and implementing treatment orders:

> *And your doctors have got to be a very cooperative bunch in our environment or they don't always, well certainly, don't last too long because you know you've got to have a committed team. Yes, the RN really drives that - they really need to be all things to all people in our environment.* (P05)

While most of the participants reported consistently good working relationships with medical practitioners, they were concerned about the difficulties involved in getting some doctors to visit the care facility. Attempts to contact the doctors were often time-consuming, and they often had to telephone several times, which not only caused delays in the resident receiving medical attention, but also interrupted the RNs' plans for the day.

> *I tried to get onto Dr X - left messages, and all that, and he never rang back – for days… Um, eventually, he would come, but what I find frustrating is that he's always - always in a hurry, and not able to spend time so that you can explain things to him.* (P11)

The participants were aware that the GPs were very busy, and that making "home visits" to the nursing home was time-consuming for them. However, a participant described having difficulties when trying to get a doctor to attend: "…when I've pushed and pushed and pushed to have something done - particularly doctors - doctors don't like you calling them day after day" (P07). Again, contacting GPs was an expected part of the RN role, but this participant had to interrupt other activities to remember to telephone the doctor's surgery repeatedly until there was a response.

Some participants suggested that there was sometimes doubt about whether the doctor received the messages, for example, that perhaps the doctor's receptionist didn't pass on the request. The same participant called this "gate-keeping" (P07) by the receptionist at the surgery, as a way of protecting a busy GP. So, for many of the participants, getting the doctor to visit was sometimes difficult:

> *... interestingly enough, the surgery where we have had most difficulty with, um, and once the doctor's actually got here it's fine, but we have a lot of difficulty actually getting doctors to come. But once we've got them here, then usually they are quite agreeable and quite easy to work alongside.* (P19)

In other situations, participants were concerned about whether the doctor was even interested in attending to the patient. This phenomenon is also reflective of the "nothing more to do" stance adopted by doctors when they felt that their effectiveness is reduced by the patient's terminal condition (Glaser & Strauss, 1965, p. 177). An illustration of this was provided by a participant who talked about a resident who was in end-stage dementia and had severe contractures. A contracture of the resident's fingers had caused a Grade IV pressure area on her hand*:* "I've been on to her doctor for over a week to come in and do something about this. 'Oh yes, I'll be in, I'll be in, I'll be in.' He has not come in" (P07).

As illustrated above, dealing with GPs impacted on the participants' planning and activities by adding to their work and contributing to their *getting behind or running late*. The actions of GPs were based on their own busy schedules, but the timing of their visits was often difficult for the RN, as reflected in the following field note:

> *On an evening shift, the RN had usual staff (reduced from daytime numbers), administration staff had gone home and front office was shut down. During the medication round, two GPs turned up at tea-time, as usual, and the RN had to go with them, relatives were visiting and stopping to chat with her or ask for information and there were telephone calls to respond to. When the GPs came, the RN cleared off the top of the medication trolley, locked it, and parked it in an alcove before going with the GP. Those were significant interruptions, especially with only one RN on and the medications still to be done.* (Field note, Aug. 1998)

Non-nursing and administrative duties

While some administrative duties were part of the RN participants' role responsibilities, they were not related to clinical nursing, and they could occur at unexpected or unscheduled times. For example, finding replacement staff was sometimes very difficult and time-consuming for participants. Both of the following participants performed combined clinical/management roles on the days they described, being on duty (usually by 0700hr) before management staff arrived. They would therefore have to at least initiate the process of replacing the sick or absent staff member.

> *You come in, in the morning, and the first thing that greets you when you come in the door that the night staff are saying that they haven't got enough staff and the agencies can't supply. So then you've got to spend maybe an hour ringing around staff that you know that might be available, that might come in if you ring them up and say "Oh, please", you know.* (P21)

The other participant described a similar situation, but, in that instance, the facility management preferred that their own staff be approached to fill the vacancy in the shift before a staffing agency was contacted.

> *What happens is that one of the staff rings, says "I'm not well - I'm not coming in" - and then you basically say to them "Oh that's unfortunate, I hope you'll feel better soon. Please ring and let me know when you're coming back to work - before you're coming back to work". Then you need to look at the roster, and see if there's any way that we can - um - reorganise it so that somebody can cover that shift.* (P18)

Other administrative duties included initiating repairs and dealing with maintenance problems, which sometimes caused concerns if the participant also needed to consider the cost of "after hours" tradesmen. In these situations, the participants were expected to consider budget issues, and to take the time to find an appropriate solution. As one participant, who worked weekends, said:

> *I might think "Oh gosh, do I get the plumber in", and, you know, it's going to cost this much on a public holiday or the weekend or whatever.* (P23)

Non-nursing duties, such as being responsible for general administration, usually occurred because maintenance and clerical office staff hours were limited in most nursing homes to five or six hours per day on weekdays. After "normal" office hours,

the RN was expected to manage all aspects of the facility: "Well, we also look after the building and security and all of that. On some days it really adds to the problems" (P08).

Some RNs were also expected to participate in the performance appraisal of subordinate staff, which involved periodically writing evaluative comments. In the following situation the nurse manager participant was aware of interrupting the RN's day by asking that evaluative comments be written to contribute to a performance appraisal, and also that other interruptions happened as well.

> *Where you've actually asked the registered nurse to try and do maybe a couple of paragraphs on a particular staff member. And so she has to do that and then of course the doctors arrive, so maybe a new medication chart that needs to be written up so she has to be there for that to be done and so it goes on.* (P21)

Having to do resident care documentation was, in itself, considered to be an interruption of more important nursing care, and created conflicting demands for the participants. This situation was described by a nurse manager who was sympathetic to the position of the RNs, and the conflict they felt in prioritizing their activities:

> *...because then they are divided, you know, between [the resident and the documentation] - and what sometimes does happen is that the registered nurses then decide to jump the other way and get out on the floor and do some work and then the documentation suffers. You know, and at the end of the day what's the most important? Well, to nurses, the care of the residents is the most important but unfortunately because of the funding tool, the most important thing for the nursing home, to keep it flowing and running and giving us the staff, is the documentation.* (P21)

Completing documentation requirements also put significant pressure on the RN participants because they perceived their main role as care-giving and not administration. The following comment is reflective of statements made by many of the participants:

> *Um, I think as an RN you are spending far more time on documentation, to the expense of being able to go to the residents.* (P03)

A clinical nurse participant who also had some management responsibilities believed that time management skills were variable among RNs, and that some managed their time badly. However, she also believed that being unable to complete documentation

was not necessarily an indicator of poor time management because this could happen to any RN:

> *I just don't feel that it's the bad managers that get behind with their documentation – it is the documentation requirements that puts them behind.* (P20)

One participant described a conversation with a colleague when they were complaining about the changes in nursing work that they had both experienced:

> *And she said today that she now finds that she spends at least half of her shift, and I mean she is here for eight and a half hours, well, eight hours I suppose because of her break, and at least four of those hours she spends sitting down writing…* (P21)

Documentation, because it was usually focused on the RCS funding tool, tended to be described as time-consuming, meaning that it interrupted nursing work, so it became an issue to find time to do the documentation. Some participants completed documentation after they finished their shift, or even took it home, as stated by one participant who was describing consulting with another RN:

> *I'll ring up the other RN that works during the week mainly, to talk about the RCS, or she'll ring up and say "I'm doing this one's RCS" – she'll have taken it home to look at.* (P23)

One participant described the plans of the nursing home proprietor to refurbish a small space where the RNs could go to do their documentation. This indicated that the proprietor had been made aware of the problems caused by interruptions, and planned to improve the situation: "It will be more secluded, so we won't be stuck at the nurses' station - interruptions happen all the time in the nurses' station" (P03).

Participants couldn't control or predict unexpected events such as resident illness or falls, telephone calls, or doctors' visits. They knew that they would have to stop what they were doing and attend to the situation that interrupted them, and just hope that they would be able to get back on track in a reasonable time. A nurse manager said:

> *In fact some days, you know it's amazing, I find that I can have a whole day where everything that I've done has been totally unplanned. Because I've come in in the morning and my whole day has been taken up with one thing happening after another, you know, maybe not all crises. But sometimes you can have a day when one crisis happens and you have to deal with it and then something else happens you have to deal with that. So then sometimes I have to say - I have to draw the line*

and say "no" I'll go and spend some time downstairs and then I'll come down here and hide in the office and try and catch up. (P21)

Even the phrase "hide in the office" (P21) suggested a feeling of guilt about being away from direct resident care. The RN and nurse manager participants all made some sort of reference to the RNs' preferences for performing direct nursing care, rather than completing documentation or carrying out administrative duties.

Contextual and intervening conditions that contributed to the problem *of getting behind or running late* due to interruptions included having insufficient staff to manage the workload, or the staff being new or from a staffing agency and therefore requiring more direction. Other intervening conditions also played a part, including the RN being both clinician and manager, and having to attend to non-nursing duties, including finding staff replacements. These factors could be minimised during weekdays when support staff were available to take on some of these tasks, but the impact was more significant during evenings and weekends, especially in smaller facilities where there may have been only one or two RNs on duty.

The usual consequence of significant interruptions was that the participants felt that they were getting further behind in their clinical care and they would have to omit some care-giving or not do the procedures as well as they wished to. That is, they were dissatisfied with their care-giving and their own performance, and were *unable to get things right*.

Not doing things properly

The second property of the category *being unable to get things right* was *not doing things properly*. The contextual conditions that led to the participants feeling dissatisfied with what they were able to achieve at work were related to limited resources and regulatory requirements. These resulted in what most of the participants considered to be *unreasonable expectations* of what they could achieve in the prevailing circumstances. Figure 2 (page 93) showed the relationship between the conditions and the problem.

Resources required for nursing home management included funding (as described in Chapter 3) to purchase services and supplies, and to employ staff. There was a widely held belief in the industry, including amongst the participants, that there was insufficient funding to achieve expected standards of service provision. A senior manager said "Well, I would always complain that there is not enough funding, and I think it's too rigid – bureaucrats are too rigid in how they implement it [the funding system]" (P24).

The knowledge and skills of staff were another type of resource that was also considered to be insufficient to meet standards. This particularly applied to the shortage of RNs: "Most service providers want to employ the best skilled registered nurse that they can find. The market place is quite bereft!" (P05). There was also concern about the supply of ENs and the educational preparation of personal carers.

A nursing home manager was also concerned about the educational standard of the available RNs, and linked the issue of insufficient funding and RN wage disparity in aged care with the incapacity to recruit new staff. She was reflecting the opinion of other nursing home managers in relation to one aspect of the impact of the wage disparity when she said:

> *The other aspect I guess, is registered nurses - their professionalism and level of qualifications, etc. I think in aged care, in my experience, I don't think they have probably kept up to where the pace of change and all the regulations are. Most of them probably did their formal education ten or twenty years ago and a lot haven't kept up with the changes. I don't think that reflects terribly well on the industry, but, I mean it gets back to what you can afford to pay. You know, if we had wage parity, etc. with the acute sector, then we could entice people out of that sector into our sector and get the expertise and the up-to-date people. If you could do that well, then you wouldn't get this block of people sort of locked into aged care that probably haven't got many options outside of it.* (P24)

A number of regulatory requirements impacted on the management of nursing homes, as described in Chapter 3. The factors that particularly impacted on the roles of the participants were the aged care accreditation standards (*Aged Care Act, 1997*), and the documentation required to substantiate the Resident Classification Scale (RCS). Both the accreditation standards and the documentation requirements generated work for the RNs and influenced expectations of their performance.

The participants' perceptions of their ability to *get things right* was also influenced by the expectations of various stakeholders, including themselves, that residents would consistently receive high standards of care. Other stakeholders included residents and their families/friends, nurse managers, peers, subordinate staff, allied health practitioners, medical practitioners, regulatory authority personnel, such as accreditation standards assessors, and the nurse registering authority.

The participants' expectations of their own performance were based on their nursing education and subsequent experience, and also on their knowledge of what was expected of them in their RN role in the nursing home. Contextual and intervening conditions led some of the participants to adopt a narrow view of their roles, and they focused on scheduled tasks and procedures. For example, medication administration was a key responsibility, and many anecdotes about the participants' work were based on these procedures.

The following excerpt is from a participant who emphasised wanting to "do things properly", particularly medication administration (P23). The tone of her voice indicated some anxiety, so while the text referred to "getting it right", the sub-text was that this was not always possible.

> *I think I've always liked to do things - um, like, properly. And I know we are supposed to! But I'm really one of these people that when you are taught this kind of way, you kind of like to do things that kind of way! (laugh) like, I think the medicine round is always huge in the morning. I mean, it is notorious anywhere, and I just like to get that completely right.* (P23)

This concern was stated more specifically by another participant, who said: "Medication rounds are, I suppose, and I know it is not totally correct, are never managed properly here" (P12). Another participant's comments indicated concern about the number of factors involved in correctly administering medications, and also implied having little control over residents' medication regimes:

> *I just seem to spend the whole time giving out medications, ensuring they are given at the right time, that they are given AC [before meals] or PC [after meals] or with*

> *meals depending on what the instructions are. Sometimes that's very difficult, realistically, in a nursing home because you've just got so many medications.* (P15)

With inadequate staffing and a concurrent demand for high standards of care and performance, the participants felt that they were under constant pressure to achieve more than they could. They wanted to be able to "do things properly" (P15), which meant carrying out care and procedures correctly and getting everything done on time. They felt that the contextual factors were outside their control because funding and staffing were controlled by Commonwealth Government fiscal policy, and also by budget decisions taken by facility management. Insufficient funding was seen to lead to insufficient staffing and therefore insufficient time to "do things properly". One participant, who worked in a small facility and was usually the only RN on duty, said:

> *There's never enough time really to do things as well as one would like, um, and that's very frustrating. That's probably the most frustrating, um, aspect of working in a nursing home - is you go home often feeling "I could have done things better", but there hasn't been enough time.* (P15)

Unreasonable expectations

This sub-category was a causal condition for *not doing things properly*, and was influenced by expectations about continuously high care standards, the availability of appropriately skilled and qualified staff, and the participants' time management (or interruption management) skills.

In general terms, the participants often felt that expectations of what they could achieve were too high in the adverse circumstances prevailing in nursing homes. Their own expectations of what constituted reasonable standards of care seemed to be adjusted according to particular circumstances, and they sometimes narrowed their focus to particular procedures or situations, and did not see the "big picture".

Unreasonable expectations, as perceived by the study participants, were those expectations that could not be met because of adverse conditions, especially those that were considered to be outside the control of the RN. One participant described the working environment for RNs as "difficult", in that "they are continually being pulled

by quite conflicting demands" (P13). The participants' own expectations and what they thought were the expectations of others were very influential in their perceptions about how well they were doing their jobs.

One facility manager considered that the expectations of RNs' performance were reasonable, and that inspections or audits had beneficial effects, and, while this opinion was not generally shared by other participants, it was reflective of the opinion of other stakeholders, and also regulatory authority personnel:

> *I mean, they [RNs] are professionals, so a lot of the things the inspectors are looking for are the things they should be doing anyway. Obviously at the time [of audit] it puts pressure on, but from my point of view, I find that most of the time they [audits] are good exercises because everyone lifts their game, everything looks good and gets done.* (P24)

The category *unreasonable expectations* comprised participants' interpretations of what was expected of them by significant others, the impact of the burden of documentation, under-resourcing, and issues related to working with unregulated care workers.

Expectations of significant others

Participants tried to meet the expectations and preferences of the residents and their families, the medical practitioners, and also the other staff and management, if they could.

> *It might be something that a resident wants, who's able to make that decision, or it might be something the DoN wants. Or a doctor, or it might be something that the family want, so you have to take that into consideration.* (P18)

It was more difficult for agency RN participants, who did not know the residents or the skills or performance characteristics of the personal carers, to anticipate the needs and preferences of others. A participant, who always worked through a staffing agency, but spent blocks of time working in the same nursing home, said that the early period of a new assignment was the most difficult. She said: "It is mainly where you are starting on a new ward, say for the first time, and you really don't know that much about your nursing staff or about the residents" (P07).

Other participants reflected on the problems associated with not knowing the residents, and how that impacted on the effectiveness of their care, and one said:

> *Because our residents - I feel that our residents need special care, they're high-dependency, and they respond much better to the faces that they know - that's a big thing as far as I can see. And it's very difficult for someone to walk in and have some idea of the running of the place, [looking after] the residents - and whatever.* (P18)

Knowing was one of the central concepts associated with the participants' descriptions of their working days, and was a condition that influenced the category *interruptions*. *Knowing* was also a factor in recognising and meeting the expectations of significant others, but it didn't help participants if the expectations were considered, by them, to be unreasonable or unrealistic in the particular circumstances. In the following illustration, the participant was describing conservative care decisions made by the doctor during the terminal care phase for residents, but the families were expecting more active treatment.

> *Then you've got the other side of the coin with the families, where the families want something [treatment] to happen, whereas the resident and the doctor really feel that it is probably not in the best interest of the resident. Like[the family wants] to maybe send them to hospital or actually give them antibiotics but [we think] maybe we should let nature takes its course - that kind of thing.* (P21)

The situation described above was sometimes complicated by reluctance on the part of the doctor or the nursing staff to declare the imminence of death, and to make explicit their decision that "there is nothing more to do" (Glaser & Strauss, 1965, p. 177). The expectation that all of the residents will die sooner or later is understood by staff, families and doctors alike, but there were occasional misunderstandings which were made worse by insufficient explanation of decisions, and by locum doctors not knowing the resident, as described in the following anecdote:

> *I wasn't sure what the family - or the resident's thoughts were, and this man was obviously dying, so I rang [the director of nursing] up and said "Have you spoken to the family?" And she said the family did not want him to go [to hospital] - he'd actually previously been sent off to an acute hospital and the staff hadn't wanted him to go [then] either - but the doctor had insisted. And the man hated it, and it caused a lot a trauma in the hospital - he kept pulling out his IV, he wouldn't eat and drink, he was fed with a nasogastric tube and, you know, there was no quality.* (P15)

The participant went on to describe her thinking and decision-making in relation to this situation, and how she circumvented the need to leave the treatment decisions to a locum doctor. She said that the resident was returned to the nursing home, but needed some narcotic analgesia to be ordered in case the resident had pain during the night:

> *And he came back [from hospital], and he was so glad to be back, and the family had expressed their satisfaction with that. Anyway, I needed somebody to write up a subcutaneous injection, or I was going to give Panadol suppositories, actually - I had ordered them from the pharmacy. But I thought, you know, he might have a bit of diarrhoea or something in the night, and I just didn't want him uncomfortable. So I rang the DON first because, I thought if I get a locum [doctor] in, the chances are he might send him off to hospital again, and I just didn't want that. But um, and I didn't think he [the resident] wanted it - I was pretty certain he didn't - but I didn't know what the family's views were, and I knew there were some family dynamics. She said "No, he didn't want to go to hospital, and the family didn't want him to go", but she hadn't had it documented because she hadn't had a chance to actually get them [the family] aside and get them to write it down, so would I ring them. Actually there was a relative there at the time, so I asked her if I could speak to her before she left and I got her to sign the form.* (P15)

Sometimes the expectations of family members resulted in conflict with staff, and in the following illustration the RN participant described a situation when she advised a subordinate staff member (a personal carer) to avoid discussion with a particular family member:

> *I just advised her - she was getting pulled into a conversation with this lady who is looking for trouble. This relative is always looking for trouble. I mean she had to move her Dad from another nursing home to this one because they basically said "look we can't be bothered with these problems any more, take him out if you are not happy" so they did and it is starting again. I just said to this girl, don't get pulled in because you might say something that would be used against you and that's happened too. There are just so many things and you are always covering your bottom!* (P01)

The above situation also suggested an expectation that relatives should be satisfied with care, and not "cause trouble", and if they did complain, the staff would probably consider those complaints to be unreasonable in the prevailing circumstances.

On other occasions, family expectations about how care would be managed led to concerns for participants, particularly in relation to the use of physical restraints to reduce the risk of resident injury:

She has had a number of falls and, um, we did approach the family about the restraint but they are, um, they're unhappy to have her restrained. They want her to be free to wander about. She did have quite a severe fall where she ended up with a huge haematoma on her head. But the family insisted that she be allowed [to wander] - the only problem with that is that - I mean we may get them to sign the Risky Activities form. But, I mean if she falls and there is nobody about then (grimace)… (P19)

Sometimes the expectations of families were thought to interfere with care planning, such as when a participant wanted to reschedule a particular resident's morning care because of the overall workload in the ward, but the resident's wife disagreed because of her own preferred schedule of visiting. Again, the wife's preference was reasonable, and could have been accommodated, but the participant felt that she had to juggle the individual preferences of all of the residents and their relatives. Therefore, she opted for meeting a goal that was achievable, that is, to reduce the workload of the care staff so that they could work more effectively, and she interpreted the objections of the resident's wife as being unreasonable.

The women [wives of residents] become very one-eyed. I suppose what I find the most difficult, and the most upsetting, is you try to put procedures in place to make the life of the nurses a little easier, but by no way compromising any patient care, and the families become quite angry. (P12)

The participants viewed the family as part of the resident's life and included them in consultations about care. There was a widely held belief that relatives who complained about care or were demanding of staff time were demonstrating guilt in relation to relinquishing the care of their partner or parent. This stance enabled the participants to justify to themselves why they considered some relatives to be difficult.

Well, they're reacting [to the situation] and you have to - you are looking after family members and you have a lot of other issues come up from families. The guilt of having a family member placed in a nursing home facility. And so you try to include them into - and you try to give them the information but then sometimes you still have to make decisions that family don't think is the best care (laugh!) for residents. (P18)

The participants were sensitive to the emotional needs of the residents' families, and were usually very tolerant of their demands, but at times they found it frustrating to be criticised unfairly. Participants described variations of this situation, relating to

unrealistic expectations of what could be achieved, and the following statement illustrated the belief that some families did not understand the circumstances:

> *And we have to temper the care of 50 people - and they only have to consider the care of one person. And that's where things come in, and it is very difficult when you have families who are saying "My mum tells me that she has been ringing the bell for two hours, and nobody will take her to the toilet… You try to explain about her dementia, and her changed awareness of time, but … there is a lot of denial. The family will tend to believe Mum or Dad".* (P09)

There were also circumstances when the care staff were busy with other residents, and did not answer calls for assistance. Sometimes relatives would seek out the nurse manager and complain about the delays, which resulted in the manager needing to justify why attention couldn't be given immediately. One nurse manager described such a situation that had occurred on a Sunday, with staffing at normal levels, when she said:

> *I think they [relatives] also get frustrated because they may have to wait sometimes for things to happen. I don't think they really understand how physically hard it [the care work] is. I had a relative here the other day saying that on Sunday afternoon she had rung the bell and had to wait ten minutes, and did we have enough staff on. I said we had a registered nurse and two, um, carers, in that section, I said, but they could all have been held up with one person, or with two people. And they said, "but if there were three of them on?" and I said "but often you need two people before you can do anything" - and they just, they don't understand.* (P13)

In another situation, another participant considered the relatives' expectations to be unreasonable if they didn't visit very often and the resident was not alert and responsive:

> *Now you may have a son that only ever sees Mum or Dad twice a year, comes in for a visit, and of course Mum's had a dose of Morphine, or whatever, she is a little dreamy or quiet. Or looks a little knocked out, and that person doesn't understand fully. Um, relatives can be difficult, and you can't always please everyone…* (P05)

Participants were also aware that subordinate staff had expectations of their performance, and that sometimes the personal carers made unreasonable demands on the RNs, as a nurse manager participant described:

> *So, yes I think the registered nurses get a lot of flak on occasions from the staff, that they are not able to go out there and actually do the showers. And it's sad because if they only knew how much the registered nurses would appreciate being able to do that, more so than they are actually able to - it's sad. They'd [RNs] like to be out on the floor more, but I think that the way things are at the moment, that time is just*

so limited. Then they are divided, you know, between the one and the other. You know, the residents and the documentation. (P21)

RNs also imposed conflicting expectations on themselves: "Finding the time – like, I can't sit and document in the morning – they [carers] are out there running around, I can't sit!" (P06). At the same time, the participants often commented how important it was to retain a sense of humour, and this is reflected in the following statement: "I find it difficult because I wear a clinical nurse's hat and a management hat and I disagree with myself sometimes!" (P09).

Service managers were aware of the impact of the expectations of the various players, including government auditors and inspectors, and one participant admitted to being cynical about how some demands were generated. The participant was a manager in an older facility, with few single rooms, and no en-suite bathrooms, so was feeling the pressure of the building certification standards that had been introduced during the previous year. The new standards would necessitate significant (and costly) renovations or rebuilding the whole facility.

Yes, well I think it is probably a deliberate thing by the government, a lot of it, but I mean, I think they fuel a lot of the expectations of, um, you know, of consumers and that suits them to do that, it keeps pressure on us. (P24)

Documentation

Another *unreasonable expectation* discussed by the participants was the nature of the documentation required to substantiate funding, and they had problems doing documentation according to facility expectations and/or regulatory requirements. Most of the participants described being concerned about the volume of documentation required to substantiate the RCS. As stated previously, some of the participants considered the documentation to be just another source of interruptions that took them away from providing nursing care for residents.

A participant expressed frustration regarding conflicting expectations of the volume and quality of documentation required to substantiate the RCS:

> *You know when you look at the amount of [documentation] - I know that the Health Department probably says that there shouldn't be a lot of documentation required for the RCS, but I think you only have to speak to any registered nurse out there and they'll dispute that. Even myself. To make it claimable, the kind of documentation and the way you write is very focused on that funding tool. No matter whether you try to ignore it or not, at the end of the day, if you don't write it in a certain way the director of nursing or whoever's looking at the notes - to assess the category - can't get the information that they want out of the documentation, so you have to focus it towards the funding tool.* (P21)

All of the participants referred in some way to on-going concerns in the aged care sector about "doing the RCS" correctly because the consequence of "getting it wrong" was a financial penalty that potentially translated to reduced staff numbers. One participant worried about the potential for the financial penalty, calculated retrospectively, that the facility would be required to repay to the Commonwealth.

> *And if you don't get that instrument [RCS] correct as per the interpretation (laugh) of the Commonwealth officers [RCS auditors], you can have huge amounts of money pulled away, you therefore don't have the income to employ staff!* (P05)

Senior management staff often felt that the funding system and its associated auditing procedures were capricious, and this caused feelings of frustration and anger that some services were dealt with unfairly by auditors.

> *You know when they want to save dollars they'll - you know - if you haven't crossed the 't' and dotted the 'i' then that's an excuse, you know, to claw back the money*. (P24)

Concerns about completing the documentation according to expectations were described by several of the participants. They also referred to the time pressures and the perceived need to stay at work to finish the documentation. As one participant said:

> *And I think that I am always aware that I am doing the right thing legally as well. I really am aware of that. And so are the others - one of the RNs who works here during the week, she works hours and hours [of unpaid] overtime and it is to get the RCS right. To get it right.* (P21)

Those participants who worked at clinical levels described feeling upset and even angry about the documentation requirements, especially as they felt they had no power to influence the situation. The following comment was representative of the feelings of most of the participants. "It's something that I feel quite strongly about – it's having to

document to get funding!" (P08). This suggested that the documentation to substantiate the RCS funding tool was considered to be a non-nursing duty, and that the time would be better spent on providing resident care.

Sometimes the participants seemed to blame facility management for not passing on the benefits of improved (higher) RCS categories, and therefore higher funding, by increasing staff numbers:

> *It makes me very angry that we do all this paperwork - and I've seen in the year that I've been there some much heavier, high-need residents admitted, and yet we've not had any extra staff or any extra hours.* (P15)

Some participants were also sensitive to the negative comments of subordinate staff, particularly the personal carers whose remarks challenged the RN participant's own role perception:

> *Well sadly, you do occasionally hear it coming through at meetings and on the odd comment, and it's really sad that the AINs' [assistant in nursing/personal carer] perception of the registered nurse is someone who sits in the office and does paper work.* (P21)

Inadequate funding

Participants considered the funding of aged care services to be "inadequate", in the sense that expectations of standards of care and level of services could not be met within the available funding levels. This was supported by reports of industry concerns about the consequences of inadequate funding. The participants' most frequently voiced concern regarding funding was about staffing levels. As one participant stated:

> *But there really aren't enough pairs of hands in nursing homes today, and I think it's unrealistic, um, the staffing-resident ratios, and I know it's not going to get any better.* (P24)

Material resource limitations that were specifically mentioned related to equipment such as beds, linen, and wound dressings. While they said that they understood the reasons for the limitations, most of the participants found them frustrating. For example:

1. Height-adjustable beds were considered to be a minimum standard for safe manual handling of people, but many older facilities were still trying to slowly replace old fixed-height beds, sometimes at a rate of two to three per year. The preference was

for electrically operated beds because beds that could be adjusted manually were also a safety risk for staff. "I mean, we're 1998! Why are they [staff] having to deal with beds that either aren't adjustable, or if they are, are wind-up beds?" (P13).

2. Bed linen and towels had high wear and tear because of frequent laundering at high water and dryer temperatures and with high bleach concentrations. For budget reasons, linen purchasing tended to be distributed over the year, but the consequence was that worn linen was frequently seen. "And I really am upset when you can shoot peas through the linen (laugh) and we haven't got nice things to offer the residents" (P02).

3. The range and cost of wound dressing products available was a concern for the participants, and those with responsibility for ordering wound dressings tried to rationalise the quantity and type purchased. However that didn't necessarily allow for individual RN preferences for wound care materials and it seemed to be particularly difficult for agency RNs, as the same participant described:

   I get extremely frustrated with the, um, lack of equipment and um, dressing packs and dressings full-stop. I think I get extremely upset by the fact that, you know, you just have to chase around sometimes to get a piece of Duoderm or get some of what they call 'fancy dressings' because they are expensive. And even sometimes finding a nice bandage to put on a skin tear. (P02)

Concerns about insufficient or inadequate supplies and equipment provided a continuous background to the participants' sense of dissatisfaction with the standards they could achieve in the circumstances in which they worked.

<u>Insufficient qualified nursing staff</u>

Registered and enrolled nurses together were classified as "qualified" staff, and participants discussed the shortage of both of these classes of nurses. The shortage of qualified nurses in aged care was discussed in Chapter 3, and all of the participants were aware of this influence on *getting things right*. One participant felt that her workload had increased because of the increased complexity of care needed for residents, along with a relative decrease in the number of qualified staff:

> *I think the RN's load has increased - I'd even say ten-fold, in the last five years. Because we no longer have any [other] trained people to share the load with - no ENs.* (P17)

The effect of the shortage of RNs, particularly for evening and night shifts, was of concern both for the RNs who worked those shifts and also for the nurse managers who were responsible for the rosters.

> *And sometimes on an evening roster, even with 70 people [residents], there might be one or two registered nurses. More often than not it's one with an enrolled nurse and a team of AINs - assistants in nursing - um, and night duty staff, well, we carry ENs to the night role as well as a registered nurse.* (P05)

The shortage of RNs in nursing homes considerably worsened during the time of this study, to the point where, in some instances, the director of nursing or nurse manager had to work a night shift when no agency RNs were available. One participant said: "We often - (DON) and myself and the Level 3 [nurse manager] work double shifts to fill the gaps that the agency simply can't fill. Um - the RN shortage is such, that - we've tried everything" (P09).

In the employment market that existed at the time of the study, RNs were able to be selective in their choice of employer. Some nursing homes had few difficulties attracting and keeping qualified nursing staff, while others seemed to have few permanent RNs on the roster and relied mainly on agency staff. The reputation of the facility for providing high standards of care seemed to be a key factor for RN employment in aged care, an assumption supported by survey results from a New South Wales study (Stein, 2002).

ENs were also considered to be in short supply, but the RN participants did not seem to be as clear about whether the EN shortage was particular to aged care in WA, or was more general: "You just don't get them! I don't know if they - are all gainfully employed elsewhere, or what. But we can't get them" (P17). Another participant had a similar comment: "ENs are a non-existent species that the government hospitals have gobbled up, so you are lucky if you can get an EN" (P09).

Participants described frustration with under-resourcing and considered that documentation requirements, particularly to support the RCS, were making the RN shortage worse. One participant described how some of her nursing friends had left aged care nursing because they were dissatisfied with not being able to do things properly because of under-resourcing. The impact of this was that, with fewer "good" nurses, those who continued to work in aged care found it even harder to manage, so this was a consequence of the problem. She said:

> *Good nurses are leaving the system and that is very, very sad. You know, people who have got a lot of wisdom who don't want to be in the acute area - perhaps they've - they've had the acute system. They want to care, they like elderly people and I have got friends and colleagues who have left - good nurses because they just can't cope with it any longer. They are just worn out - tired out. Compromising all the time and they just don't want to do it.* (P15)

Working with unregulated care workers

Another intervening condition that contributed to the participants' view that expectations of what standards could be achieved were unreasonable, was the availability of appropriately skilled and qualified staff. Personal carers usually made up over 50 per cent of the care staff in nursing homes, as described in Chapter 3, and that proportion of unregulated care workers to qualified nurses applied for many years prior to the study (Rhys-Hearn, 1986). Until 1998 the majority of personal carers had no formal training at all, and by the end of 2001 a proportion (perhaps 25 per cent) had completed a Certificate III course in Aged Care Work. The main concern for participants was that the unqualified personal carers did not have the knowledge to be able to make judgements and decisions about resident care needs, and yet they provided virtually all of the direct care in mostly unsupervised circumstances.

While the RN participants valued the efforts of the personal carers with whom they worked, they were often uncomfortable about their inability to supervise the carers properly. Participants expressed their concerns about working with unqualified staff, particularly from the point of view of their own time management. For example, one said:

> *And that's why I feel that we need to have qualified nurses to look after them. I don't mean that through lack of respect for the staff here because they work very*

well. But they don't have the knowledge, and to try and start to educate them in the middle of trying to attend to a person who needs a one-on-one attention, then it's very difficult. (P08)

Another participant was tolerant of carers' lack of knowledge, but was frustrated by the resulting interruptions:

Or they'll come to you when you're trying to gather your thoughts to do your documentation. That's when they'll run in and out - or they'll run off and not tell you something that is important - they'll do the opposite! That's frustrating, but then, you've got to allow that they haven't had the training, and they don't really know what you - well they do know what you want, but they don't know what is important and what isn't. (P14)

Alternatively, some participants had concerns about carers' work practices and their performance standards, especially as the participant did not feel that supervision was sufficient:

The only problem that I have is being one registered nurse for X number of people [residents] ranging from, for here, 25 up to 40, with, um, with nursing assistants [carers]. And - a lot of the things that the nursing assistants do, I don't approve of. I can't - I am not sure they are doing the right thing, but I can't - I am not there to check them. (P06)

Another participant described trying to supervise the carers, but found that her own workload prevented this: "Trying to follow them up while you are doing your workload is actually nigh on impossible" (P12).

Some participants also found it quite difficult to insist on particular standards, especially when they did not see the episode of poor care first hand, but saw the outcome, and then tried to find out which staff member was responsible.

It is very hard, if it has already happened, when you pull them up, they've always got an answer. There is always a reason, so you never get anywhere. (P06)

Consequences of the problem

As a result of the adverse context and many inter-related conditions, the participants frequently experienced the basic psychosocial problem that was described in this chapter, i.e. *being unable to get things right*. The main consequences of this problem for the participants was that they tended to be dissatisfied with their own performance

standards (although they could justify those), and they were aware that there were sub-optimal standards of care provided by other staff.

The negative image of aged care and the participants' own perceptions that they were often unable to get things right resulted in lowered self-image. For example, participants described feeling dissatisfied with their own performance such as "I felt bad about that" (P06), " I was really down after that" (P02) and "At times you do come home in the evening and you are just as flat as a tack" (P07).

There was also a tendency for the participants to be sensitive to implied criticism about aged care work, and their competence. Several participants alluded to the negative image of aged care nursing: "I wish it [the negative image] would change because I think it is as highly skilled as any other area [of nursing]. It is very different, but I don't feel it is a lesser area" (P17).

Another participant, who had been working in aged care for two years after many years in a general hospital, said she had changed her opinion about the skills required for aged care nursing and was offended by suggestions of acute sector colleagues that she had "lost" her skills:

> *But I never realised how much went on in a nursing home until I came here. I certainly - my eyes were certainly opened. And also the fact that there's also the perception from some people in the acute hospital that nursing home nurses are not terribly attuned to what's going on, and you get silly questions asked of you. Like you know "can you change the catheter?" (laugh). And "would you be able to do that dressing?" and, you know, whether they think we are all stupid or - I don't know what it is. I just sometimes (laugh) I just - have to bite my lip and think "don't say anything" (laugh).* (P21)

Resident care standards were also compromised when participants were unable to supervise the personal carers, usually because of pressure of their own work and having to complete scheduled tasks such as medication rounds. The participant who commented above also said:

> *And it's a shame because a lot of things that happen in the nursing home are as a consequence of lack of supervision and lack of direction. And, um, sometimes correcting something that's happened because of something that an AIN has done,*

takes time that is precious that you needn't have spent if - if only you'd been able to give them directions in the first place. (P21)

Other participants felt similar concerns, including one young part-time RN who also worked some shifts at an acute general hospital. She couldn't reconcile her perceived inability to achieve care standards with what she had learned was the right thing to do. She said: "I don't like not doing what I have been trained to do, and that's part of the reason nursing home work isn't my best – not my cup of tea!" (P01).

The consequences of not *getting things right* caused significant concern for a participant, who described a difficult situation that resulted in a formal complaint by the relatives to the Commonwealth Complaints Resolution Unit, and subsequent Departmental investigation. The participant described it as "like walking a tightrope" (P09):

So what I am constantly doing is playing the line between keeping the staff member happy and maintaining ing the residents' safety and our duty of care. And it's like tightrope; you walk it every day, and one wrong decision - you fall! (P09)

Relatives who were dissatisfied with care sometimes complained directly to the RNs, or to the nurse managers, as described earlier in this chapter. At other times they complained to regulatory authorities, as described above, although not all complaints resulted in negative findings. However, nurses and others working in aged care tended to be distressed by complaints because they felt that they were doing their best in the circumstances. As a director of nursing said:

Look, I know that they've [relatives] got a right to complain, and if we're doing something wrong I want them to come to me so that I can fix it. But when they go straight to the Department [Complaints Resolution Unit] it just puts you in the wrong to start with. Then you feel cranky about the relative for doing that and you can't really get back onto a reasonable footing after that. So it is really damaging. (Source A, personal communication, October, 2000.)

SUMMARY

The circumstances that led to the participants *being unable to get things right* were time-related (*getting behind or running late*) and related to concerns about *not doing things properly*. The main reason that the participants found themselves *getting behind or running* late was *interruptions*, and these came from many sources. *Not doing things*

properly was perceived to stem from conditions in the aged care environment, particularly inadequate funding and insufficient qualified nursing staff. These two factors were interrelated, in that *getting behind or running late* often resulted in the participants feeling that they were *not doing things properly*. A common factor in both sub-categories was a perception of insufficient time to *get things right*.

In this study, *interruptions* were defined as any occurrence that stopped the RN participant in the midst of doing something else, particularly scheduled tasks such as medication rounds, treatments such as wound care, and scheduled duties such as documentation. The circumstances that resulted in interruptions that were problematic were when:

- Other residents needed urgent care or attention during medication rounds;
- Staff required directions in care-giving, work-related tasks, or where to find things;
- The RN had to deal with telephone or other enquiries; and/or
- The RN had to complete administrative tasks such as last-minute staff replacements.

Not doing things properly was primarily a perception of the individual participant, who measured her/his performance against the expectations of how, or how well, a task or procedure should be carried out. "Doing things properly" meant that a task or care procedure was carried out according to the participants' original training, or standards learned in subsequent education and experience, so *not doing things properly* was the reverse of this perception. Another aspect of *not doing things properly* was not applying organisational policies and procedures correctly. Some participants suggested that their assessment of what could be achieved was often different from what they perceived to be the expectations of significant others. Thus, knowing what were the expectations of others was an important factor in the participant deciding whether things had been done properly or not.

Inadequate funding was seen to contribute mainly to having insufficient numbers of qualified staff to maintain nursing care standards, as perceived by the participants. Low funding was also seen to limit resources such as supplies and equipment, and building

design and space. Insufficient staffing was an issue both in terms of numbers of staff required to provide adequate care, and also the qualifications and experience of staff. For example, most of the participants described their concerns about providing adequate supervision and direction for unqualified carers because they had insufficient time to spare from completing their own duties. Underpinning these concerns was a generally held belief that with better funding and more qualified nursing staff there would be more time to do things properly and so better standards of care could be achieved.

Participants also described situations where both aspects of the problem co-existed, that is, they were concerned about *getting behind or running late* and were *not doing things properly* because of insufficient time. In essence, the RN participants described situations where they were dealing with constant pressures to provide nursing care, supervise unregulated care workers, meet documentation and regulatory requirements, manage resources and administrative procedures, and be a central source of information about residents, procedures and the location of both people and equipment.

The RN participants tried to balance their knowledge of what should be done (at least their perception of it) with what they could actually do in the circumstances. This depended on their familiarity with the situation or the people involved in it (*knowing*), time pressures, resource availability (personnel and material), and perceived objectives or expectations of significant others, such as other registered nurses, medical practitioners, or facility management staff.

CHAPTER 5

SITUATIONAL POSITIONING: TRYING TO GET THINGS RIGHT

OVERVIEW

This chapter describes the core process used by the study participants when trying to resolve the problem of *being unable to get things right*. *Trying to get things right* was the positive manifestation of the core category (*getting things right)*, and was important for the participants as they tried to fulfil their professional and work responsibilities. The basic social psychological process that was discovered in the data was called *situational positioning*, and was used by the participants when *trying to get things right*.

The first section of this chapter describes and illustrates *situational positioning*, which was a theoretical construct made up of four categories. These categories emerged from the data as paired behaviours, with *yielding* to *confronting* on one continuum, and *being flexible* to *being rigid* representing the range of another continuum of behaviours. The data suggested that the participants positioned themselves on these continua when dealing with situations and *trying to get things right*, and in this sense, *situational positioning* was the process that facilitated decision-making in *trying to get things right*. The bipolar, intersecting positioning continua will be described and explained using excerpts from the data.

The next section of the chapter will describe how the participants dealt with situations when *trying to get things right*, and how *situational positioning* was incorporated in these phases. There were three phases in the process used by participants when dealing with situations, and these were *recognising* salient features of situations, *prioritizing* and implementing actions, before *moving on* to the next task or situation. The conditions and consequences that were associated with variations in the way the participants moved through the phases will also be described. These included *knowing* or *seeking help* in the first phase, and in the second phase, *tolerance* was a condition for *compromising*. *Repositioning* occurred after *compromising*, usually by *being flexible* and *yielding*, and

these behaviours enabled *moving on*. A condition for *moving on* was *persevering*, and that will also be described in relation to the third phase.

TRYING TO GET THINGS RIGHT

According to Glaser (1978, p. 93), the goal of grounded theory "is to generate a theory that accounts for a pattern of behaviour which is relevant and problematic for those involved", and this "occurs around a core category". In this study the core category that emerged from the data was called *getting things right*, as described at the beginning of Chapter 4.

The phrase *getting things right* meant the participants were trying to do something (the verb "getting") in a physical, cognitive, or emotional sense, involving nursing or administrative procedures or tasks ("things"), according to their own and other peoples' expectations ("right"). The participants' interpretation of what constituted "right" behaviour or performance was informed by their education, past experience, and understanding of others' expectations of them. A discussion of the participants' interpretation of expectations of their performance was provided in Chapter 4.

As stated in the overview to Chapter 4, the core category presented as a central phenomenon with two manifestations, that is, the participants experienced a problem of *being unable to get things right* and then began *trying to get things right*. For example, a participant said:

> *I mean I think some people take short cuts, but I'm not prepared to because, you know, with accreditation we have got to do things properly. And um, and I don't - I really want to do things as well as I possibly can to maintain a high standard of care.* (P15)

The data suggested there were two particular tasks that the participants tried very hard to get right, and these were medication administration and supervising care given by personal carers. These activities were frequent subjects for discussion in the interviews. A task that was seen to be more difficult to get right, and therefore more likely to not be

achieved successfully, was specific documentation required to support funding claims (the Resident Classification Scale (RCS) – described in Chapter 3).

Situational positioning

In this study, a core variable emerged from the data that was different from the core category. Glaser (1978) called core variables basic social processes (BSPs) and said: "The prime distinction between [a core category and a BSP] is *that BSP's are processural* or as we say, they 'process out' " (Glaser, 1978, pp. 96-97).

The basic social process that emerged from the data in this study was called *situational positioning*, which was processural as it "suggested change and movement over time" (Glaser, 1978, p. 97) and was used to try to overcome the problem of *being unable to get things right*. *Situational positioning* was a process that enabled the participants to deal with situations, by *recognising* the salient features of the situation, then *prioritizing* their actions before *moving on* to the next situation. When dealing with situations, the participants tended towards either *yielding* or *confronting* actions while being more-or-less *flexible* or *rigid* in their responses. These categories and their inter-relationships are described in detail below.

For the purposes of this study, the term "situations" referred to context-specific occurrences involving the participants in decision-making and action in relation to their nursing or administrative responsibilities at work. Making decisions was an intellectual activity that occurred throughout the process of dealing with situations. An illustration of the participants' use of the term "situations" is as follows:

> *Well, our director of nursing leaves you to [get on with things] to quite an extent because you're actually out on the floor and dealing with situations. So I would deal with it, and then tell her about it - in most cases. If there was something I was really unsure of, I would go and ask her what she thought - about the situation. Um, now last week I was the acting DoN anyway, so I just did what I felt was the appropriate thing for each circumstance that arose.* (P18)

In that excerpt, the participant defined situations in both narrow terms, including specific care-giving episodes, and more broadly, such as being acting director of nursing.

The situations experienced by the participants were context-specific, meaning that each situation was different because it involved different people interacting with contextual conditions in different circumstances on different days, or even at different times on the same day. Situations could also overlap, such as occurred when participants were interrupted during medication rounds, that is, the medication round was one situation that overlapped with the interrupting situation such as the need to attend to a resident or respond to an inquiry from a relative.

Situational positioning was defined, for the purposes of this study, as the way the participants viewed and responded to combinations of circumstances to meet the demands of the situations that occurred in the course of their work (Macquarie, 2000, pp. 611, 742). It usually occurred when the participants realised that, in a particular situation, they might be *unable to get things right*, so they acted to "get back on track" (P14).

Situational positioning was a process that involved physical, cognitive, emotional and moral dimensions, in that the participants used their experience of similar situations to choose how to deal with the situation. As one participant said: "Well, I know where I stand when it comes to the medications. I don't compromise with those" (P03). This attitude translated, for that participant (P03), into particular behaviours during medication rounds, including focusing, checking medication orders carefully, and trying to minimise interruptions. However, the participants' assertions about what they would do in particular situations were not always reflected in their actions, as suggested by another participant:

> *Well, the thing is, (rueful smile) I've been told to just get things ready earlier, (pre-dispense medications on evening shift) but I feel that in nursing here, I like to do everything as 'by the book' as I can, but you really are almost forced to take short cuts. That's what I feel.* (P23)

The positioning continua

Four categories that emerged during third level, or theoretical coding, were inter-related pairs of behaviours. Two of those categories were *yielding* and *confronting*, and they emerged conceptually as the participants described doing something in an actual or implied physical sense. At the same time, the categories were polarised and represented either end of a continuum of behaviours, and that continuum was the "action" axis of the positioning continua.

The other two paired categories were *being flexible* and *being rigid*, which were also bipolar and had properties that were more intellectual, affective or attitudinal. This was called the "responding" axis of the positioning continua. Figure 3 shows a diagrammatic representation of the positioning continua.

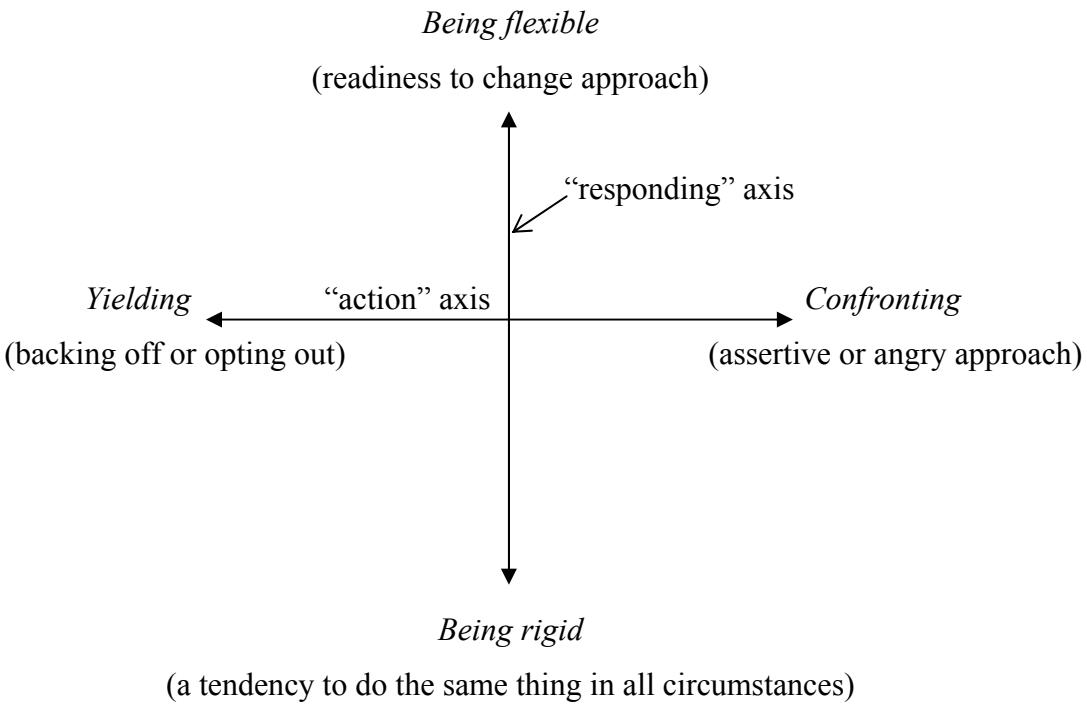

Fig 3. The situational positioning continua.

The data suggested that the two continua were intersecting, rather than parallel because of the inter-relationship of the behaviours, especially *yielding* and *being flexible*. The

action axis was conceptualised as horizontal, while the responding axis was vertical. The four categories that made up the positioning continua had both positive and negative meanings in relation to the actions and responses of the participants, depending on the particular situation.

Yielding

For the purpose of this study, the term *yielding* was used in the sense of giving up or surrendering, or giving way to a force or pressure (Macquarie, 1999, p. 943). *Yielding* was a conceptual category that reflected participants' comments about stopping a particular action and trying something else or giving up completely and even leaving the situation.

In a positive sense, *yielding* meant giving way in a problematic situation in order to try a different approach, or to aim for different goals. For example, when describing attempts to rehabilitate (improve mobility for) a resident who had suffered an extension to an already disabling stroke, a participant said: "When you can't achieve [improvement] you have to accept that too. Then you go for comfort…" (P17).

In a negative sense, *yielding* was seen as an unsatisfactory way of dealing with some situations because problems would not be solved, as stated by a participant who said:

> *Well, you have to [problem-solve] – because otherwise you are not going to solve the problem. By continuing to back off you are still going to end up with the same situation. You are not making a change for improvement.* (P20)

The properties of the category called *yielding* included behaviours such as being relatively submissive, and being prepared to consider alternative approaches to dealing with a situation. *Yielding* involved being prepared to "back off" (P20), and be more *flexible* if necessary, and this suggested that participants were prepared to change their position on the continua in order to *try to get things right*.

For example, in a situation where a participant (P11) had not succeeded in speaking to a medical practitioner (GP) when she tried to telephone him, she tried another approach.

Instead of persisting with trying to telephone him by being assertive with the medical practice receptionist (moving along the action axis towards confrontation), the participant chose to back off and ask another RN to discuss a resident's problem with the doctor. This choice was based on her knowing the doctor and how he would be likely to respond to a non-urgent request for review of a resident's problem. "And he always comes in on the weekend. I don't see him, so I spoke to [weekend RN] last week, and I told her what I thought, so she spoke to him [for me]." (P11)

Yielding or "backtracking" (P18) was a deliberate strategy for another participant, whose assessment and review approaches reflected a "trial and error" approach to wound management. She said:

> *I would try something out, and if it didn't work, I'd probably backtrack a bit and try something else, um, because usually you can tell how something's going. So, if you're not getting anywhere there, then there's no point in continuing with it. So then you might have to backtrack a little and take another - another tack.* (P18*)*

However, *yielding* could also mean withdrawing, to the point of "walking out" (P15), which was a more extreme action and had a negative meaning, because it potentially involved the person resigning from the job or even leaving nursing. The data suggested that this "opting out" had occurred when *being unable to get things right* became too difficult to tolerate (P17). One participant described resigning in disgust when a previous employer was "cheating the system" (possibly defrauding the Government). She said: "I worked in one [nursing home] for two months and walked out". (P15) This was an example of refusal to compromise personal standards, a moral position, that was more towards the confronting and being rigid ends of the continua to start with, but resulted in a shift along the action axis to *yielding* (opting out).

Another participant described a stressful situation, and expressed her frustration with the many demands on her. In that situation, she expressed a desire to opt out, but her comments were interpreted more as concern about *being unable to get things right*. She said:

> *Sometimes you think "I could just walk out of here and leave them to it"(laugh). It does get to you because - [sometimes it feels like] sixty different people are at you! You're in the middle of it, and you think "I can't solve everything", you know.* (P14)

Another example of *yielding* arose when participants distanced themselves from situations. For example, virtually the whole interview with one participant suggested that she was somewhat "disengaged" from organisational life in the nursing home; that she was almost a spectator, except for particular situations when she became passionate about the rights of individual residents (Memo). She described the shift times and proximity to the workplace as suiting her family at the time, and went on to say:

> *I'm not really necessarily happy working in nursing homes. It does impact upon my attitude and depression. You know, I love them to bits and I don't like the way our society handles the elderly, but I mean, well, hopefully I can make a little difference, you know. I prefer surgical settings because it is positive [laugh]. There is nothing much you can do for these people, except, you know, what I believe is, keep them happy, comfortable and pain free 'til their last days*. (P01)

The conditions in which *yielding* tended to occur were therefore associated with circumstances in which the participants recognised that they would probably be *unable to get things right* by persisting with the planned course of action, and this led to alternative actions. Those actions could lead to positive outcomes, such as *getting things right,* or negative outcomes such as opting out and continuing to be *unable to get things right*.

Confronting

The term *confronting* was used to describe participants' actions that were based on anger or when they were being assertive (Macquarie, 2000, p. 164), such as when they stood up for themselves or for a resident. Positive aspects of *confronting* were situations when participants described being assertive and strong in their defence of the position they were taking. For example, a participant described a situation where she was unusually assertive with a GP, and was successful in achieving her aim in getting a resident referred to a specialist. She said: "I think possibly because I was just very forthright about asking - and not beating around the bush and not trying to make it his suggestion" (P10).

In another situation, the same participant described an occasion when she needed to act differently from her usual approach, and positioned herself more towards the confronting end of the action continuum in a situation where she disagreed with the GP's treatment of a resident's condition.

> *... it just got to the point were Dr X had been ordering the vinegar douches, which I really didn't accept. And I think it was at that point where I started thinking "No, I've got to do something further than doing douches which are going to make the problem worse".* (P10)

Negative examples of *confronting* occurred when participants were angry and reacted emotionally, such as when P15 (cited earlier in this section) resigned when she believed that her employer was cheating, and she was powerless to do anything about it. Other participants described situations when they acted in ways that interfered with achievement of their aims in the situation. For example, a participant described pushing hard to implement a particular care plan for a resident, but was not successful because the plan was considered to be unrealistic for the aged care setting.

> *Because I got opposition from the Physio, I got opposition from the boss [director of nursing] - and many, many times I was virtually screamed at! 'You are not in the acute sector now, Sister!' – so you get put back in your box.* (P17)

This participant described other situations where she "rocked the boat" (P17), and tried to force change, sometimes successfully, but as a consequence she felt that she was labelled a "trouble-maker" (P17). "No, it takes someone to rock the boat! Literally. I really did have to - I caused trouble!" (P17). Extreme positioning that occurred in some situations tended to be counter-productive and to increase the possibility of *being unable to get things right*.

These examples illustrate that a condition for *confronting* was risk-taking, in that the participants were prepared to be assertive if they felt strongly enough about a situation such as described by P10 in a previous excerpt. In another situation, a participant who was usually assertive described being more *confronting* by threatening to make a complaint about a doctor, when she adopted a moral stance as resident advocate:

> *I've been on to her doctor for over a week to come in and do something about this [problem with a resident]. "Oh yes, I'll be in, I'll be in, I'll be in." He has not come in and [the problem is getting worse]. So I phoned there [surgery] and said "if he doesn't come in I am going to put in a complaint about it." So I'm expecting a little bit of repercussion on that. Well, so what? Um, you know, that resident must be in awful pain!* (P03)

In another excerpt relating to knowing the doctors, a participant anticipated difficulties with getting the GP to change what she considered to be an inappropriate order for intramuscular antibiotic injections for a severely cachectic resident. She said that she knew from previous experience that the doctor could be contrary, and would resist changing his order, so she acted in a way that enabled her to adopt an assertive position. The situation also involved risk-taking, because it meant challenging a doctor's orders:

> *Normally I would have just rung the doctor and discussed it then. But, knowing this doctor, and knowing what we were about to go through [with him], I then got the physiotherapist to assess this person to see if she thought there was ANY muscle that we could inject into. She said "Absolutely not!" so I got her to document that. Um, and I then rang him and said that no-one from this facility would be, um, giving the injections; that I had assessed her, I'd had the physio assess her; that we didn't feel comfortable in doing it. ... If he wanted to come over and give it himself, then of course, that was fine by us.* (P13)

The situation described above also illustrated the core process as demonstrated by this participant, in that she recognised the situational variables from past experience, and was able to position herself to deal with it. Therefore, *knowing,* an intervening condition for recognising situations (described in the next section of this chapter), was also a condition that influenced *situational positioning*, and enabled the participant to *try to get things right*.

Being flexible

The concept "flexibility" was defined by August-Brady (2000, p. 12) as "…the integrative, evolving, resilient response to recognised change and uncertainty, based upon openness and willingness to change…". The key element in this definition, as applied to the present study, was the suggestion of readiness to change attitudes or approaches to dealing with situations. As one participant said: "I think to be a nurse, and to be good at your job, you have to be flexible" (P03).

In a positive sense, *being flexible* was seen as a desirable response that enabled participants to more effectively manage changing situations. Suggesting a "trial and error" approach, one participant said: "I would play it by ear, see the sort of response that I got, and then take it from there*"* (P18).

In a negative sense, flexibility meant being pliant and ready to compromise in order to get through the situation. One participant described her approach as follows:

> *It is kind of just making yourself available when and where you can. I mean even to the extent that I have been known to go out and fold linen in the laundry (laugh) when they've been really busy and short staffed or something's happened that's, you know, has put them behind. I turn my hand to anything really, as long as I know that I can do it.* (P21)

However, *being flexible* had a cost for the same participant in terms of not getting her own work done, i.e. *getting behind and running late*, because being very flexible could exacerbate the problem of being *unable to get things right*. She said:

> *...and that means that everything else that you would normally have been doing, that you've planned to do that day, you know - maybe some audits to do or whatever, and you can't do any of that because the resident care is the most important thing and you have to get on with it.* (P21)

Being rigid

At the other end of the response axis, the term *being rigid* was defined as the opposite of *being flexible*, that is, having firmly fixed or set ways of responding, or a tendency to respond to situations in the same way in all circumstances (Macquarie, 2000, p. 681). Again, this category had both positive and negative meanings for the participants. *Being rigid* was sometimes a response to the complexity of situations, when the participants relied on routines and rituals as an anchor for parts of their days, so in that sense, it was seen by the participants as a positive position. For example, a participant said: "My days are pretty scheduled, and if I don't fairly rigidly stick to that routine, I'll end up in trouble and there's not a lot of room for anything to go wrong" (P12). However, while "sticking to the routine" provided structure for the shift, the participants might still be

unable to get things right, resulting in detrimental outcomes for the residents and the participants' self-esteem.

Other participants found that when managing time in the presence of other limited resources, such as insufficient staff to manage the workload, there needed to be "structure" (P23) or "routines" (P20) for the staff to follow. For example, some participants described the need to plan care activities around meal times because these were set points in time, and usually could not be altered. For one participant, structure meant following a routine to get care tasks completed because there was so much work to do and some tasks could not be deferred, so "… for it to run smoothly in a certain kind of time frame… you have to have structure. …like showering times, meal times, and toileting times and things like that" (P23). In those circumstances, the participant's comments suggested situational positioning towards the *being rigid* end of the responding continuum.

This was echoed by another participant, who had experienced the consequences of staff not following a routine "… if they do not work to a routine and a time, you will pay for it later". (P12) This latter remark referred to the risk that the behaviour of residents with dementia could become more challenging and unmanageable by mid-evening if their care routines were not followed.

However, most of the participants valued flexibility, and so, by inference, continued rigidity of response was seen as a negative behaviour. For example, a participant described another registered nurse whom she considered to be rigid and felt that this approach was inappropriate: "… she was very rigid - arrived on time, left on time, had all her breaks, wanted things to go her way. And consequently it didn't go that way." (P20) In that instance, the RN didn't get things right according to the expectations of the participant that RNs should be flexible, helpful, and team players in order to be part of *getting things right*.

In that situation, the participant went on to say that the RN in question "had a rough ride for six to eight weeks until she decided to leave" (P20), indicating that she was penalised by other staff for her behaviour. P20's comments suggested that she saw the other RN's position starting at the *being rigid* end of the responding continuum, and then polarising to the *yielding* end of the action continuum when she resigned from the job (opted out), probably as a consequence of negative feedback. Therefore, the position on the responding axis influenced positioning on the action axis and vice versa.

Another participant talked about working with staff who were rigid in their thinking, and contrasted "firmness" with "rigidity" in her own thinking. The participant indicated that safety concerns (e.g. manual handling with drowsy or "wobbly" residents) were an acceptable condition for "firmness", and went on to say:

> *I have seen other people [staff] being very rigid. Um, I'm at the firmest in safety issues but I don't call that rigid, I just call that very firm. When I was talking about that carer we had to let go [dismiss] - she was probably - her life was rigid, and had little compartments that she worked in and she tried to do her job like that. Like she had one to six residents to look after, one must be done first, two must be done second. And we tried to say "now hang on, it may be better to do six instead of two because two is still asleep and a bit drowsy and a bit wobbly - do six first." So yes, in that case [there was] rigidity, but it doesn't work, you have got to be flexible.* (P07)

Positioning and repositioning occurred according to participants' assessments and reassessments of situational variables, and their interpretation of what constituted correct standards. For example, a participant indicated awareness of moving along both continua when dealing with situations that involved supervision of personal carers:

> *I try to use a reasoning approach but I am a bit of a hot head. In that other situation, I let things fester a little bit, and in the end, I don't think I actually snapped or anything like that, but she actually snapped back at me because she was tired of me wanting her to do things correctly. And, um, just because I asked her to do certain things. I found her very difficult because the rest of the staff, well most of the staff at that place were really, really lovely and I didn't like to see them being upset by her, and me as well!* (P02)

In summary, when positioning themselves on the action axis, the data indicated that the participants' behaviour ranged from *yielding* to *confronting*. *Yielding* involved giving

way or withdrawing from the situation by distancing the self or disengaging from interactions. *Confronting* involved asserting the self or acting out of anger or frustration.

Being flexible suggested a willingness to change the approach to a situation, to see things differently, or to be pliant, while *being rigid* was associated with standing firm on issues, or continuing usual habits and practices, either because, or regardless of, situational variables.

Positioning on each axis was dependent on situational variables, and positioning on one axis sometimes influenced positioning on the other axis. While the four categories reflected conceptual extremes, most of the participants tended to position themselves towards the middle, or intersecting points of the continua, and moving towards the poles without necessarily going to the extremes. Acting or responding that reflected positioning at the extremes of the continua tended to be unusual occurrences.

Situational positioning facilitated decision-making for the participants when they were *trying to get things right*, especially when the situation changed, or a new situation intervened. Contextual and intervening conditions that influenced the participants' positions were those that contributed to the problem of *being unable to get things right*, as described in Chapter 4. For example, interruptions were the usual reason for the participants needing to change the way they were dealing with a situation. This was illustrated by a participant who said "But sometimes you can have a day when one crisis happens and you have to deal with it and then something else happens you have to deal with that" (P21). Related passages in that interview suggested that she often adopted positions at the *yielding* and *being flexible* ends of the continua, until she realised that she would be *unable to get things right.* Then she would re-prioritize and reposition herself more assertively and stop helping other staff so that she could complete her own work: "I have to draw the line and say 'no'" (P21).

DEALING WITH SITUATIONS

As stated above, *situational positioning* facilitated decision-making when the participants where *trying to get things right* and dealing with situations. The three phases that were involved in dealing with situations were (1) *recognising* salient features of situations, (2) *prioritizing* and implementing actions then (3) *moving on* to other tasks or situations. The participants used *situational positioning* during these phases when *trying to get things right*.

Recognising salient features, or aspects, of situations meant that *knowing* about the situation, that is, being familiar with its characteristics, was important. If they were unable to recognise situational characteristics, it was necessary for the participants to seek help from someone else who did know these characteristics. In some situations, the data suggested that some participants did not "see" what was happening, and therefore did not recognise features of the particular situation, and this influenced their subsequent action (or inaction).

Prioritizing was the second phase in dealing with situations. Having identified the priorities in the particular situation, and acted to carry through the plan, the participants were usually able to *move on* (the third phase) to the next situation, or complete their duties for the shift and go home. However, sometimes the situation changed or new variables intervened and the participants described needing to change their plans or actions according to changing demands or expectations. This usually involved compromising and re-prioritizing as required to try to *move on* to complete tasks by the end of their shifts. Tolerance was a condition for *compromising*. As a concept, tolerance was related to *being flexible,* in that the participants needed to be responsive to changes in situations and to adjust their expectations of what was achievable while still *trying to get things right*.

The approach the participants adopted varied from one situation to another because there were many situational variables that could influence their judgement. Because most situations varied to different degrees, the data suggested that the participants used

situational positioning as a strategy to try to maximise the outcome of each decision-making episode. Maximising the outcome was either for the benefit of the residents, or for the participant, or both, and if this occurred they *moved on*. If maximising the outcome of the situation could not be achieved, then the participants accepted an unsatisfactory outcome, and *moved on* anyway, usually because of time constraints (e.g going off duty).

Situational positioning was involved in each of the three phases through which participants moved when dealing with situations. For example, participants adopted familiar positions when they *recognised* aspects of situations, but had to adjust their positions if they did not know some situational characteristics. The relationships between these categories are discussed in more detail below.

The following excerpt is used to outline the process, and illustrates how *situational positioning* was used by a participant while dealing with events during a morning shift. The anecdote was related by the participant as follows:

> *And I can give you an example of that if you like? Um, a week ago on Sunday, my colleague wasn't available and I had to give out two lots of medications, the phone was ringing and when I answered it, it was someone wanting to know about his Aunty Betty; he couldn't tell me his Aunty Betty's name! They wanted the fax number for here so that someone in Vietnam could send Aunty Betty a fax ! (laugh) And I had someone from the kitchen telling me that - this is all at exactly the same time! - that she couldn't get any response from a resident in the [co-located] hostel. And I had a new visitor for a patient on the other side and I didn't know anything about this! And I didn't want to put the new visitor off because she was a volunteer and I knew the resident didn't have many visitors. So I wanted to deal with her, attend to the phone and attend to the problem at the hostel. (laugh) So I had to make a quick decision, (snapped fingers) and do the hostel first, then explain to the lady that I would be with her in a moment. Then have a discussion with the man on the phone, um, and then attend to medications after I found out that everything was alright at the hostel.* (P08)

The participant began the Sunday morning shift as the only RN on duty because her co-worker had telephoned to say that she was sick, and this resulted in extra medication administration responsibilities. The participant knew that RN staff replacements were

not usually available at the last minute, especially on a Sunday, so she accepted both workloads rather than wasting time telephoning an agency.

In this case, the context was a medium-sized (50 – 75 bed) nursing home in the Perth metropolitan area. The intervening conditions were that it was a Sunday morning with no receptionist to answer the telephone, the participant was the only RN on duty and therefore had an extra workload, and she also had responsibility for residents in the co-located hostel. Figure 4 shows the conditions that were present in that situation.

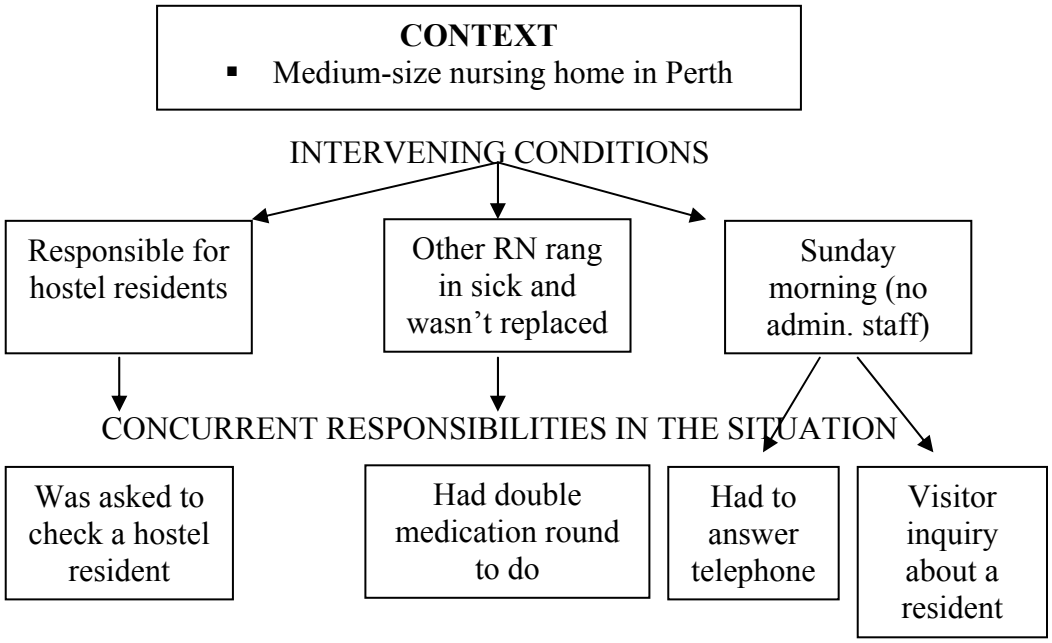

Figure 4: Example of contextual and intervening conditions in dealing with a situation

The core situation in which the participant was engaged was administering medications to residents, and the situation was not routine because she had both medication rounds to complete (each area with approximately 30 residents) within the time usually allocated for one round. When the interruptions began, the participant was already positioned towards the *yielding* and *being flexible* ends of the continua because, in her experience, "the mornings always get interrupted" (P08). Therefore, the situations included medications, handling telephone inquiries, visitor inquiries, and concern about a resident in the hostel next door.

The participant then began to move through the phases of the situation, dealing with each event and *trying to get things right*. *Recognising* salient features of the situations drew on her knowledge about residents and relevant procedural rules. For example, she knew that a particular resident did not have many visitors, and didn't want the community volunteer to be discouraged from visiting in future. She also knew that information about residents could not be given to unknown callers, according to the facility policy on news media and "stranger" inquiries, and that such inquiries should be referred to the director of nursing.

When dealing with that aspect of the situation she moved towards the *confronting* (assertive) and *being rigid* ends of the continua. For this participant, *prioritizing* to deal with the interruptions seemed to be relatively easy, and she was able to return to the medication round within a relatively short period of time, i.e. to *move on*. Figure 5 shows the components of her decision-making.

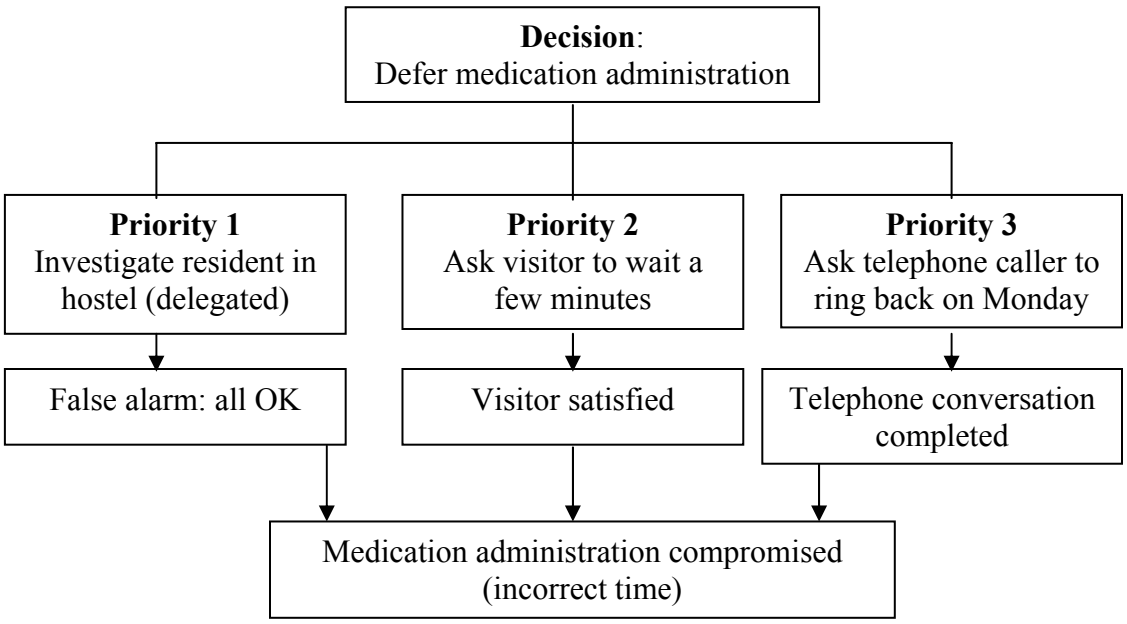

Figure 5: Example of prioritizing

The participant said "you just have to prioritize each thing that you are doing" (P08) and felt that she'd been able to get things right when dealing with the interruptions. This comment also reflected the idea that *situational positioning* could vary according to each

situation. In another situation, another participant acknowledged that she had been *getting behind and running late* all day, and knew that she had compromised by deferring the medication round, but she was tolerant of variances in medication administration, and did not see the late medication administration as a procedural error (P23). Other participants who described being late with medications suggested that the risk to residents was low, as a participant said: "…if you're late with medications… you just have to prioritize, … and it doesn't usually have detrimental effects" (P23).

P08 recognised the fact of the late medications, but she did not see any immediate negative consequences for the residents. The main negative consequence of the events of the day from her point of view was that she was late off duty. She said:

> *Well, the medications were very late of course, and, um, I hadn't really caught up with everything by lunch time. So I had the dressings to do after that, and didn't get to the notes until the afternoon RN came on. So, I was late off, um, but that's the way it goes sometimes.* (P08)

Analysis and description of that excerpt illustrated *situational positioning* when dealing with situations by *recognising* salient features, *prioritizing* and then *moving on*.

Phase 1 – recognising salient features of situations

The first phase used by the participants to deal with situations was *recognising* salient features of each situation. For the participants in this study, recognition meant that, as they experienced a situation, they perceived features in the situation that they had seen or experienced before. They rapidly became aware that some or all features or aspects of the situation were familiar to them. For example, if they were working in a familiar area or section of the nursing home, with the usual residents, staff and management, with familiar policies, procedures and equipment, they could quickly analyse what was happening and decide what needed to be done.

The verb "recognise" means "to identify from knowledge of appearance or character" (Macquarie, 2000, p. 659). Being able to recognise the needs of residents, the capabilities of staff, or the characteristics of situations was a necessary first step for most the participants to be able to effectively position themselves to make decisions.

In familiar situations, the participants' perceptions and interpretations were intuitive and automatic. An intervening condition for recognition was described by the participants as *knowing,* a category that included both intellectual and experiential dimensions. *Knowing* was a significant factor in more complex situations. This category is defined and illustrated below.

The data suggested that the participants observed what was happening around them as they also carried out specific assessments of residents and situations. In the following excerpt, a participant described the broad range of factors that she recognised as contributing to a decision regarding calling in a medical practitioner (in this instance, a locum doctor):

> *It creates the challenge where you have to assess the situation, whether you call a locum. But sometimes you think twice because a locum wouldn't know the background of the resident. And like one of the doctors - Dr X - he works usually Saturday morning - some of them work Saturday mornings now! The other [weekday] staff, if they think something is brewing or not right, that they'll get them checked before the weekend and I usually try and get things sorted out before the evening - like on a Saturday, if I think there is something. You know, usually things can wait till Monday, and usually they do – usually.* (P23)

In this situation the participant talked about the importance of recognising early signs and symptoms of residents' health problems, and was simultaneously aware of other factors such as the usual availability of GPs and reduced administrative support on weekends. An element in the decision-making described here was the participant's experience with similar situations and confidence in her judgement about what situations were non-urgent, or when she needed to intervene quickly.

Participants also described being aware that not *recognising* aspects of situations made it more difficult to determine priorities, such as when a resident was recently admitted, or when a participant was new to a specific nursing home. Other aspects of situations that could be new or different were unfamiliar staff (e.g. agency staff), or new procedures (e.g. tracheostomy care). In these situations, the participants needed to seek help - to get information to enable them to make decisions. *Seeking help* meant doing a more

detailed assessment, asking someone (usually another staff member), or looking up written information. For participants, needing to seek help was a consequence of not *knowing* and therefore being unable to recognise some situational characteristics.

Knowing

Knowing was an intervening condition for *recognising* aspects of situations because it enabled participants to rapidly assess a situation, anticipate residents' or staff responses, and identify possible consequences of their actions. This category also influenced *situational positioning* in that, if participants knew what to expect, it was easier to prioritize. For example, a participant said:

> *...we have a lady at the moment who has frequent TIAs [Transient Ischaemic Attacks] and we are getting to know her and identifying the pattern of when she is going to have a more major one. So we are actually able to identify and put into place the plan to protect her so she doesn't become at risk of falling during the episode, or choking during an episode.* (P04)

Knowing meant that the participants had become familiar with the residents and their ways of responding, the policies and procedures of the facility, and the capacities and preferences of staff and other health professionals, including GPs. For example, knowing about a resident's usual responses to health problems was considered important by a participant who worked in a dementia-specific area:

> *I mean, for instance, Mrs [X] - a lot of the time when her behaviour has become more agitated or aggressive, it is highly likely she has a UTI [Urinary Tract Infection]. So I should go and do a ward urinalysis, and if there's anything showing in that, I'll phone the doctor and request that an MSU [mid-stream urine specimen] is sent off. Um, so in that case, perhaps somebody else who hasn't been [in that area] and doesn't know her very well wouldn't associate it with her having a UTI.* (P10)

In this situation, the participant knew the resident, and also knew what she should do about the health problem once she recognised it, so the *prioritizing* seemed to be effortless and she was able to *move on* quickly to the next situation. In this situation, she positioned herself towards the *confronting* (assertive) end of the action continuum, and seemed to be near the mid-point of the responding (*being flexible-being rigid)* continuum and this enabled her to get things right as she saw it.

The category *knowing* included the participants' nursing knowledge or previous experience with similar situations. For example, the same participant (P10) described having read a journal article about lung cancer, and then noticing that a resident had a hoarse voice. Further investigation led to a diagnosis of cancer:

> *And, I remember I was reading it in - I think it might have been a nursing magazine - and, er, it was [an] article saying that the early symptoms of lung cancer [included a] hoarse voice. It just triggered - triggered in my head, and I mentioned it to the doctor, and we sent her for an XRay. And she at least - OK, she didn't have treatment to cure it, but at least we could treat her with palliative care*. (P10)

Participants also described situations when their experience of similar situations was helpful in *trying to get things right*. In the following example, the participant was able to respond flexibly because of previous experience.

> *I've been here five or six years ... [and] I've learned a lot in that time with what works and doesn't work with people with cognitive deficits. Everybody is different and you can't use a blanket approach to everything because it doesn't - it's like, I mean, people are all different, and they have different needs and you need to look at it from an individual level. But you need to sort of build up a repertoire, if you like, of what you can do.* (P18)

When a new resident was admitted, the participants' responses indicated that they (the RNs) tended to be less sure of themselves and likely to adopt a more *yielding* position. In the following situation, none of the staff knew the resident, so they had to use another approach, such as trial and error, as one participant explained:

> *And if it is a new person, then we all then have to, I think, just work by trial and error with a lot of things. Like with wound dressings and things that, you know, will this work or not, or go back to the beginning and start again*. (P19)

Knowing or not knowing subordinate staff members and their capacities and attitudes was also an important part of recognising aspects of situations. Working with the regular nursing home staff meant that one more thing could fall into place in the recognition of factors that occurred in the first phase of dealing with situations. For example, a participant considered that it was important for staff to know the residents, and therefore she needed to manage staff replacements from within the permanent staff

roster whenever she could because this was better for the residents, most of whom had dementia. It would also make her day run more smoothly, and improve her chances of *getting things right*. She said:

> *Because our residents - I feel that our residents need special care, they're high-dependency, um, and - they respond much better to the faces that they know - that's a big thing as far as I can see. So I prefer to use our staff from that point of view - you know, for the residents.* (P18)

Some participants considered that the success of their working day was affected by the personal carers who were on duty, and whether these were from a staffing agency or not because this could impact on how the day unfolded. This suggested that the attitude of personal carers to their work could influence the extent to which participants felt they could get things right. A participant said:

> *[It depends] on whether you've got agency staff on or whether you've got regular staff on. So [it depends on] the staff you've got on and how they are feeling on a particular day affects things… whether they are prepared or willing to do something.* (P19)

Therefore knowing the staff was a condition that allowed the participants to position themselves to deal more effectively with situations as they arose, including managing subordinate staff.

Participants also considered it important to know the medical practitioners' preferences and usual responses because, again, it allowed them to position themselves to deal with the situation. For example, in the following excerpt, the participant described the importance of knowing what the doctor was likely to do:

> *Say it was something as simple as somebody falls and needs sutures. There are some doctors that we know that we can ring and say "This person's fallen and can you bring a suture pack with you?" And then it's less traumatic for the person, it gets done on the premises, that's it. It's over and done with. Um - but there are other people [residents] you know their doctor isn't going to come and suture them so you have to call an ambulance and send them to hospital. So, I mean, that is a lot more traumatic. Then you have got to ring the family and get the family involved. Let the family know when they are going, which hospital they are going to, that they might sit in accident and emergency for a couple of hours. And then they might be returned, you know, at some ungodly hour and they haven't had anything to eat (laugh). I mean it's much simpler if you get it done on the premises. But, some doctors you just know aren't going to come in, so you*

call for an ambulance. So, it's about knowing the doctors and what, sort of - their limits are, what they're prepared to do and what they are not prepared to do. (P19*)*

In such situations the participants needed to be relatively submissive (prepared to back off) and flexible in order to prioritize their actions. *Getting things right* in those situations was more difficult because of the number of stakeholders involved and their varying expectations, so there tended to be smaller variations in positioning, with less likelihood of moving towards the *confronting* (assertive) end of the action continuum. For example some doctors were flexible and would attend the nursing home, as indicated by P19. Other stakeholders included the families of residents, and whether they were available to go to the hospital to be with the resident. In those situations, the participants needed to be able to provide information and reassurance to a number of different people.

In another situation, a participant described getting to know the doctor's expectations over time, and by the third meeting with one locum doctor, was prepared for him.

Well to be honest, I would have preferred his [the resident's] own GP because he [the GP] would have known the gentleman, he would have known more about him. Um, however, this particular locum has come out here before and the first time I met him it was quite a trying experience. The second time it wasn't too bad and today I had actually worked out what this locum wanted from me. And also because I had actually gone in and basically found the gentleman, I knew what observations I had carried out so I was on top of the situation, so it was easier from that point of view. This particular locum likes, um, an immediate history of the resident and everything about it. And even if you say, "shall I get the medication chart?" he'd say, "No just tell me what he's on, what's wrong with him" blah, blah, blah. So in actual fact, I had everything ready, I had his medication chart, I had the diabetic chart and everything, all to hand, before he came and it was a lot easier - everything went very smoothly. (P08)

The above anecdote also illustrated positioning towards the *yielding* and *being flexible* ends of the continua, and in that instance it helped the participant to get things right and feel satisfied with the outcome of the situation.

Nurse manager participants also had expectations of the RN participants, and, as described in Chapter 3, RNs were expected to exercise more autonomy with decision-making in a nursing home than in a general hospital. A participant said:

> *Now here, working within this environment, they have to think, and you're expecting them to act as independent practitioners, in that "will I ring the doctor or will I deal with this myself".* (P13)

Knowing preceded recognition of aspects of situations, and the data suggested that quick recognition led to confident positioning for *prioritizing*. However, *not knowing* usually resulted in the participant deciding to seek help.

Seeking help

If the participants were unable to recognise salient aspects of a situation, or some aspects were ambiguous, they needed to know when to seek help and from where to get it. This involved *yielding* and *being flexible*, and the actual positioning was influenced by previous experience. Seeking help included asking for information from others, including the meaning of abbreviations, and where equipment and stationary were kept. For example, a participant, who was a new graduate and also new to Australia and to aged care nursing, described having to rely on other staff for information about most things, including what form to use to report a resident fall:

> *You do have to rely so much on other people, in fact like the guy who fell and hit his head. [After completing observations and care] I went into the office and sort of stood there, and it was the Ward Clerk… because I was the only one [only RN], I had to rely on the Ward Clerk [to know which forms to use].* (P16)

Her comment that she "sort of stood there" (P16) suggested a submissive approach to the Ward Clerk, whereas in another situation, when another participant did not know the resident very well, but did know the other RNs, she sought help from another RN. However her positioning seemed to be further along the action axis away from yielding and towards assertiveness. She said:

> *Well I didn't know the lady [resident] and I have to trust the judgement of other RNs, considering they work with her – [RN] works with her five days a week - she knows her far better than I do. I have to respect that.* (P10)

In the above situation, the participant was familiar with a number of aspects of the situation, including the capabilities of another RN who knew the resident and could confirm ambiguous symptoms. The intervening conditions were also different from the previous excerpt, in that P10 had another RN available for support and advice.

Another difference between the two situations would have been in the consequences of not knowing, and needing to seek help. The first participant (P16) was more likely to be *unable to get things right* because of the time it took to seek help in many situations throughout the day: "You very often find yourself wasting time looking… for things" (P16). This then impacted on her correctly completing medication rounds that should have been about four hours apart: "…it takes a long time, and you find you have just finished one and you have got maybe half an hour and you are starting the next one…" (P16).

Being responsive to the personal carers was an important strategy for participants who regularly worked through a staffing agency, and they positioned themselves accordingly, adopting a more flexible approach to receiving assessment information from personal carers. A participant commented that she was aware that some RNs preferred not to rely on the observations of carers:

> *But I do rely quite heavily, obviously, on the regular staff [carers] who are out there doing the work. Um, I find that most people [carers] in aged care are very caring people, and as long as you can ask them questions and they feel free, they can come to you and you can listen to them. They'll often come and tell you that someone's got a rash, or someone's got a limp - because they are very observant, and I always like to take on board what they are telling you about a particular thing rather than brush it off. I always like to report it and make sure that it is handed over verbally at the hand-over time too because that encourages the carers to come to you about specific problems or concerns of the residents*. (P02)

In this situation the participant justified a relatively more flexible (pliant) and yielding (submissive) position because she did not know enough about the residents and needed to seek help in order to deal with situations that occurred. The fact that she was often the only RN on duty was an intervening condition that contributed to her positioning.

In some situations, participants asked personal carers for help with identifying residents' care needs, in order to gather information quickly, especially when they felt that they did not have time to do a detailed assessment themselves. For example, the participant (P02) cited above in relation to relying on carers, said that she relied on them to inform her about residents' needs and abilities. She described a situation involving a newly admitted resident for whom she had to write a care plan:

> *... and there was one particular lady who had only just been admitted and I needed to go and find out how many nurses to transfer her and what her capabilities were, whether she could eat independently and shower, what degree of assistance she required for her ADLs, and how she was settling in.* (P02)

Another participant recalled that, when she first started working in a nursing home, soon after she finished her training, she was prepared to rely on the knowledge of the carers (called nursing assistants by this participant). However, she found that their knowledge and interpretations were not always reliable:

> *... and even the nursing assistants - it is so different from general [training] and I thought - well they're likely to know the resident, and they'll say "Oh they're not right" or "they're sick"... That was initially, but now I find that often they weren't always correct! But not having any experience in that situation, you don't realise, and you think, Oh, they know because they have been here for years, but you realise they don't.* (P23)

Sometimes, not knowing how to do something was a cause of distress, and participants relied on being able to ask another person, usually another RN, for help, as illustrated by the following excerpt. In this situation, the participant telephoned a friend at home to ask for her advice:

> *And it's nice to have another RN because you can always consult, um, well there was this woman [who] came in with a tracheostomy and I had never looked after a tracheostomy, and I was in charge and I felt so - I just felt so ill-prepared. In fact I felt a li'l bit angry about it (laugh). It was like a - I felt really incompetent and I felt that that was unfair. So I, um, I rang up my friend that worked in [geriatric hospital] and I knew she was home and I asked her about it and I said "tell me, am I doing the right thing?" Because, um, this woman needed suctioning and... I just didn't have any experience and - let alone expertise, absolutely none!* (P23)

In that situation, the participant's position on the action continuum fluctuated as she swung from *yielding* to ask for help by contacting her friend, to being angry about

feeling "incompetent" (P23) because she felt that she had been let down by the nurse manager, who did not inform her of the new resident's special needs. Therefore her positioning was ambivalent in that she was tending towards being *confronting* (angry) but had to be *yielding* to seek help.

Getting help also involved decisions about staffing, such as maintaining staff numbers in areas within the facility when required, as described in the following situation when the participant needed to be flexible when *trying to get things right*:

> *I think you have to judge every situation - what it is, I mean ultimately, the residents' safety has to come first. And I would try to access another RN [in the other wing] or another nurse - there's an EN - if they can provide me with backup, if that was what it required. For example the other night I brought the RN down to help me with the catheterisation, so we sent one of our nurses [carers] up to do her[turning] round that she was actually meant to be doing. Um, yes, I mean you try to adhere to policies as well as you can.* (P12)

Seeking help was sometimes part of the process of teamwork, of reaffirming one's role in relation to other RNs. One participant said that she often discussed clinical care decisions with more senior RNs, mainly as a way of confirming that her decisions were appropriate.

> *I'll usually run the trickier ones past X [clinical nurse], sometimes Y [nurse manager] and just say "look," you know, "This is this, whatever, whatever, so what do you think". Actually most of the time I'd say that's what I do - is talk to them and say "look, I'll ring the doctor". You know, I don't keep it all to myself, and think this is what I'm going to do - I'll discuss it with them.* (P11)

One of the aspects in those situations for the above participant was that she was considerably younger than the other RNs and felt "fairly junior" (P11). Therefore the data suggested that she adopted a position towards the *yielding* end of the action axis while being fairly central on the responding axis as a way of conforming to expectations about her performance.

Participants also described occasions when other people sought help from them. For a participant with considerable experience in palliative care, being able to discuss care with other RNs was important because she said that both they and the doctor tended to

rely on her specialist knowledge. So, while she was fairly new to the aged care sector, in these situations others sought her help.

> *So I'm sort of fairly confident in that area and fairly comfortable - there are other areas I'm not as comfortable with, but that area I worked for six years and I'm sort of pretty au fait with that. But it's good to have other RNs to bounce, you know, ideas off, and [drug] doses because sometimes the doctors come in and say "what do you want?" (laugh) you know, and so it's quite a big responsibility.* (P15)

"Not seeing"

Observational data, recorded as field notes, related to recurring situations in nursing homes and suggested that there were occasions when RNs did not seem to pay attention to episodes of poor standards or unacceptable care practices even when they were physically present in the area. Episodes of RNs apparently "not seeing" were observed by the researcher in nursing homes on a number of occasions. The data from some participants' interviews also suggested that they occasionally chose not to see some events, or to not react in some situations, possibly in order to avoid repercussions from staff.

For example, a participant described her response to some situations in which supervision of care was needed as depending on several factors, including whether other carers would support her. The implication was that if she was "feeling vulnerable" (P08) and other staff did not "support" her, she would probably not react:

> *I suppose it would depend on how I'm feeling, as well whether I'm feeling strong or whether I'm feeling vulnerable (laugh). Yes, and I suppose if you've got one particular staff member [that you need to correct] - it would depend on what other staff you've got on, whether they can support you.* (P08)

In the following excerpt, the participant had earlier described having had "union problems" when staff were criticised for their work practices, and she was concerned that further criticism might provoke a recurrence. In one sense, the participant was aware that she did "not see" what was happening, and avoided confirmation of her concerns. In those circumstances her positioning was at the *yielding* and *being flexible* ends of the positioning continua, but she was still *unable to get things right* and remained dissatisfied. She said:

> *I can't - I am not sure they are doing the right thing, but I can't – [when] I am not there to check them, I can't, um, I probably don't confront them because I am aware if I do I can create a problem.* (P22)

"Not seeing" also seemed to occur in situations when RNs "focused in" or limited their attention to the task in hand, usually a medication round. In a situation that the researcher observed, the RN was working from a large medication trolley that she had pushed to a strategic location in a dining room. She then dispensed medications, administered them to a resident and returned to the trolley to sign the chart and dispense the next medication. The following field note was written:

> *I noticed a lady having difficultly with her lunch. The RN entered the dining room with the medication trolley, and didn't notice the resident's problem. The resident was slumped to one side in a wheelchair, using a fork to scoop up a "minced/mashed" meal from an ordinary [not 'lipped'] plate that was on the tray table at arm's length. Most of the meal had already gone into her lap. She had no dentures in. A carer (who was feeding another resident) said she'd had them [dentures] put in that morning. I found the dentures in the resident's lap, under the clothing protector. The RN had not noticed this situation until she heard me ask the carer about the resident's dentures. I was aware of her shift in concentration as she focused on the resident and away from the medication charts. We talked about the situation and she said she hadn't noticed because she was doing the medications. I offered to assist the resident and suggested that the RN continue with the medication round.* (Field note, Feb. 1999*)*

In that situation, the researcher moved to a clinical role to assist the resident with her lunch while the RN continued with the medication round and the personal carer continued feeding another resident. That type of situation was difficult for RNs because they knew they needed to observe and supervise resident care, but they also knew that they needed to concentrate on medication administration to avoid errors. Therefore, *trying to get things right* was situation-specific because the RNs might be unable to perform satisfactorily in other, concurrent, situations. It may have also become a habit for the RNs to "not see" episodes of poor care that they felt powerless to change.

Observations over time, in different nursing homes, suggested that RNs seemed to be aware of some activities occurring around them, and unaware of others. The following memo illustrated this:

What do RNs "see" as they move around the ward/wing? Do they notice things differently at different times of the day? For example, why is it that a range of standards deficits will be overlooked? Is it because the RN does not "see" things that she feels powerless to change?
For example, carers wheeled a poorly covered resident down the corridor to the shower – the RN saw it (looked up from dressing trolley and looked directly at the carers) and did not comment. Another resident was sitting up in bed with bare shoulders, thin cotton nightdress, hunched and cold to touch. The RN gave her medication, but did not interrupt her medication round.
The RNs focused on the task at hand - medication rounds, treatments, ringing GPs, and answering inquiries from family members. Carers were left to get their own work done and to go to the RN if they needed help or information.
Sharpened perceptions seem to happen when lots of residents are "sick" with the 'flu' (Memo 10/99).

"Not seeing" seemed to be both an avoidance mechanism and a coping strategy that enabled the participants (and other observed RNs) to position themselves to deal with the situations over which they did have control, and therefore to *try to get things right.* Those situations usually involved completion of scheduled procedures such as medication rounds, wound care, and documentation.

In summary, the first phase of the process used by the participants to deal with situations was *recognising* aspects of situations, and this recognition involved either being familiar with situational variables (*knowing*), or seeking help to identify relevant factors. When *recognising* salient features of situations, most of the participants relied on their familiarity with the context, the routine procedures and people (residents and staff). They positioned themselves to act depending on their familiarity with situational characteristics. The data suggested that confident recognition gave the participants more options for *prioritizing*, the next phase of the process of dealing with situations and *trying to get things right*.

Phase 2 - prioritizing

The second phase of the process of dealing with situations occurred when the participants determined their priorities for action. The word "priority" was defined as "something given or meriting attention before competing alternatives" (Merriam-

Webster On-Line, 2002). The term *prioritizing* was used in this study in the sense of choosing the best course of action in a given situation.

The data suggested that *prioritizing* was necessary to complete required tasks, as one participant said:

> *Yeah, so, it's like, when the nursing home is absolutely flat tack,…and you do what you can to get things done - I mean you have to prioritize things to get things done.* (PO4)

Therefore, *prioritizing* meant deciding what needed to be done, what could be done, and in what order. Those decisions were based on the participants' knowledge, experience and understanding of the standards required in particular situations. In some situations the participants were able to prioritize, to complete the planned actions and move on to the next task, or return to the core situation, such as a medication round.

However, if *prioritizing* was difficult to start with, or there were conflicting or new demands in the wider situation, participants said they usually needed to *compromise*, either in terms of what could be achieved in the available time, or in how a task would be carried out. *Compromising* usually led to *repositioning*, which was a strategy that facilitated re-ordering of priorities. For example, when *repositioning*, participants described responses or actions such as being more flexible or more ready to yield in order to deal with the changed or new situation. In these situations, participants continued *trying to get things right*, but they narrowed their focus regarding what they would try to get right to more specific aspects of their work, such as completing specific tasks.

Participants relied on their knowledge and previous experience when *prioritizing*. While in some situations their choice of an appropriate action was almost automatic, most of the time the participants were consciously aware of needing to set priorities because of limited time. One manager was aware of the extent to which RNs needed to set priorities:

> *I think there are very definitely time pressures, of trying to reconcile what they should do in the way of assessments, documentation and then finding the time to actually do any nursing care at all! And to base that on appropriate assessment - I think they find that very difficult.* (P13)

Prioritizing was considered by the participants to be an important skill. One participant's remarks indicated that it was a recurring activity and that it required knowledge, flexibility and a continued awareness of role responsibilities:

> *Well you just have to decide which things are most pressing and prioritize the things - the task at hand - I shouldn't really be talking about tasks! (laugh) Um, you just have to prioritize, um, each thing that you are doing. If someone's in danger attend to that, um, remember that other people have got to be given medications at a specific time.* (P08)

Prioritizing also meant assessing the whole situation, and being aware of competing factors, such as a resident's need for bed rest as opposed to the need for stimulation and distraction. A participant described a situation involving those competing factors and said that she would achieve the best balance that she could in the specific situation.

> *I think a lot of decisions are based on more than just the issue at hand. [If] somebody [has] got a sacral sore or something, then what we might decide would be best for them physically would be to keep them in bed and off that area completely so it can heal. But when you start keeping somebody in bed then you've got all the social isolation, so you are restricting somebody to their bed and then they will start to feel unwell a lot of the time because they've been restricted to bed. Whereas where you get people up, then I feel, you know, they feel better within themselves. I suppose that's that holism thing, that we are looking at the person as an entirety, rather than someone with a wound, or whatever.* (P19)

In that situation the data suggested that the participant was positioned at mid-point on the continua, that is, neither *yielding* nor *confronting*, and at the same time holding to care principles without being rigid. She also showed awareness of being *unable to get things right* in all respects, and therefore having to prioritize to achieve a desirable outcome in at least one area (e.g. residents' sense of well-being).

Prioritizing was discussed explicitly by several participants whose comments indicated that it was a routine or "normal" part of their practice. For example, a participant described *prioritizing* as part of her usual approach to managing care for the group of

residents for whom she was responsible, and then dealing with the situations that arose. She said:

> *We are actually having to assess each day nearly all 40 residents that we have here, trying to identify any needs ... and problems and then prioritizing each one. And knowing what we have to do for each person and then following that through with some form of treatment and making sure that treatment is OK.* (P04)

The data suggested that some participants were also aware of the whole situation, that is, they recognised a broader range of situational variables than did other participants, such as the impact of the working styles of other staff members. For example, a participant discussed the importance of knowing what the carers were doing and how they organised themselves during the shift. This reflected aspects of time management as well as priority-setting.

> *I think that's the hardest thing with the older AINs [carers], or the ones who have been there a long time, is prioritizing. Sort of realising that if there is somebody dying or somebody in pain or someone with special needs, um, it doesn't matter if [they] usually start at Room 1 and end at Room 30, you know, they have to change their routine and that person [must be attended to]*. (P15)

For P15 it seemed to be important to be flexible and also reasonably assertive when she supervised the carers because their approach to their work was influential in her *trying to get things right* for the residents.

Participants remained aware of their progress towards achieving work targets, and were ready to move on when they had dealt with specific situations. Sometimes they also had the option of seeking help if they were still running late close to the end of their shifts. As one manager participant said:

> *Well they've got to prioritize and just gradually work through the routine for the rest of their shift. If there's something they may not have got done, or it's getting towards the end of the shift and things are not looking good and they are not going to make it, we'll get an SOS call [for help]*. (P20)

At other times, the situation was complex or changing and the participants' options were not so clear cut. This ambiguity usually resulted in *compromising*:

> *Um, simply because more than one thing happens on the ward at any given time. And if somebody starts choking on something, you are helping out there, and*

> *somebody has a fall somewhere else around the ward, and they've hurt themselves, you are very stuck, in this situation, trying to - um. You've got one person where you know exactly what's happening, but you don't know what is happening further down the ward. If you haven't got somebody experienced on with you, it can get very difficult, running between the two, giving orders of what you are doing in each case.* (P07)

The type of situation described above was reasonably frequent according to the participants, and was one of the reasons why they valued *being flexible* in relation to reassessing new or changing situations. Their perceptions of *getting things right* depended on the actual situational variables, and most of the participants indicated that they were satisfied with what they did achieve because they had done their best: "you can only do what you can do" (P11).

Compromising

A consequence of the participants *being unable to get things right* was that they often felt that they had to moderate their expectations of what could be achieved in the circumstances. This usually involved some sort of compromise: "So, you know, you are compromising all the time". (P15) Therefore *compromising* was a consequence of changing situational variables and a causal condition for *repositioning*, as described later in this section.

The sense in which the participants used the term *compromising* was invariably negative, in that, as they saw it, the available options involved sub-optimal courses of action. *Compromising* usually left the participants feeling dissatisfied with their performance and what they were able to achieve. These negative outcomes were discussed in chapter 4, as part of the consequences of the problem of *being unable to get things right*.

A condition for *compromising* was being tolerant, which was semantically linked to the concept *being flexible.* Tolerance was defined as "the disposition to be patient and fair towards those whose opinions or practices differ from one's own" (Macquarie, 2000, p. 848), and included being tolerant of one's own limitations in particular circumstances.

Being able to tolerate other people's different perceptions and expectations was considered by the participants to be important when dealing with situations, and implied that the participants needed to be able to respond flexibly. A nurse manager participant described a calm approach by RNs as "maintaining social composure" (P22) and defined this concept as:

> *Social composure … I would see that they, um, are seen to be fair and equal to the staff, fair and equal to the residents, pleasant and approachable by the relatives and are willing to listen to the senior staff. So that they're, um, basically smilingly available to everybody!* (P22)

Tolerance was reflected in the participants' willingness to be interrupted, such as when they felt sympathy for the residents' relatives. In the following excerpt, a participant was talking about how visitors frequently interrupted the evening medication round to chat socially:

> *Yeah - there's a few [visitors] in particular, that talk to you, 'specially when you're trying to do a drug round. Mmm - of an evening, its a bug-bear really because you haven't got time - and yet you want the time for it - yeah - because they just want to be reassured.* (P14)

Therefore, the participants needed to compromise, and that involved risk-taking, which was also a condition for *confronting* positions. However, unlike when participants adopted a *confronting* position, risk-taking associated with *being tolerant* was a more passive, or submissive position, such as letting interruptions happen in spite of the potential risk of medication errors.

In another example, an agency RN described having learned to tolerate some staff who were noisy, or who didn't do things properly. However, the tolerance was finite and she would intervene if necessary.

> *I find that most difficult because I don't like to go in and start stirring up (laugh) and um, sort of putting myself offside because they are still assessing me - as the agency RN. And I just - but if it gets out of hand, I will definitely go and say something to them, just quietly. Or just take them off quietly somewhere and say "well you do need to be quieter" or I will just say to pull the curtains or close the door or something like that and say '"you really do need to observe the privacy*

and dignity". Um, but I often let it ride for the start, unless it's really out of hand. (P02)

The participant quoted above indicated with her comments that she was prepared to alter her *situational positioning* and correct the behaviour of some staff (being more *confronting*) if the carers exceeded her personal limits, such as being too noisy or breaching residents' privacy. She was prepared to compromise but only to a certain point, as she was aware that she risked "getting them [the carers] off-side" (P02), which could reduce their willingness to cooperate with her and further reduce her chances of *getting things right*.

Another situation in which participants felt it was necessary to be tolerant in order to get through the shift was in dementia care. A participant said that she felt it was important to be flexible in relation to the care of dementing residents, and that both she and the staff needed to be tolerant of unusual behaviours and to compromise if required:

... for example, there is one gentleman who will often go to bed with his shoes on, and I don't see the point in distressing him so much because he should go to bed without shoes on! And I'll encourage the nurses [carers] to turn a blind eye to that um, you know, if it would cause too much distress for him, and it does, sometimes he doesn't understand why he has got to take them off. (P12)

In that situation there was little risk-taking because the participant had the authority to direct the carers, and she knew that the carers would understand when she gave them permission to be tolerant. At the same time, the phrase "turn a blind eye" (P12) indicated awareness of *compromising*. The same participant expanded further on that theme with the following comment:

I think you have got to treat it [dementia care] with a sense of humour, and you have got to let a fair bit of water run off your back. Because if you become anxious, or raise your voice, or become aggressive, or anything, you will end up upsetting the residents, and then you will have a terrible, terrible night. (P12)

At the same time she still had to compromise because standards associated with cleanliness and maintenance of linen would normally require that residents did not wear shoes to bed.

Another participant talked about being tolerant and approachable when managing staff during the weekends. She said that they worked hard, and while she wanted them to maintain standards, she was fairly flexible and made herself available to help them if they needed it.

> *That's how I feel anyway, and in a way I think it's nice to be more relaxed about things because it's a hard job. It's hard physically for them [carers] and I think, mentally for them - for any workers here. I think, on the weekends it's nice [to be relaxed]. I don't want anyone to feel pressurized. Have a standard but just let me know if things are difficult, and hopefully I'm approachable with things like that.* (P23)

In those situations the participant's position was towards *being flexible* but her qualifying phrase, "…have a standard" (P23), suggested that she was probably at mid-point on the positioning continua, and could move towards *confronting* (being assertive) and *being rigid* if required, or if further compromises were unacceptable in her view.

This was also reflected by another participant who described seeing inappropriate manual handling techniques being used, but having judged that the resident and staff were not at risk, compromised and decided not to correct the situation, rather than risk staff reacting negatively to the criticism.

> *...if I see it[incorrect manual handling] happening, and the [resident's] shoulders are not at risk of subluxing [partial dislocation], and I know the resident is not going to suddenly grab them and go down on them, then I'll close my eyes to that.* (P09)

Participants were also able to be tolerant of their own mistakes, as long as they felt that these had minimal impact on the residents:

> *You do make wrong decisions at times, but generally nothing disastrous, so if you've used the assessment process correctly and gone through it, most of it has ... worked out quite well. (P04)*

Another participant indicated that she probably positioned herself more towards the *yielding* end of the action axis, as suggested by the use of the word "placate" (P01), and also referred to this as being tolerant.

> *Oh, well, I've learnt to count to 10, and I've got a lot of tolerance. My life - in my background, it has gone a lot into helping me to be very, actually extremely*

tolerant and patient… I'd rather placate someone than, you know, start an argument. I mean what's the point [laugh]. (P01)

Setting priorities in non-routine situations often seemed to require tolerance and compromises, particularly in relation to deciding what tasks could be completed in the available time. A participant said that she had changed her way of working over the years, and that earlier in her career she would "run like the clappers to get it all done" (P14). However, she had learned that that approach didn't work because "… if you are panicking, you're only going to upset the residents" (P14). At the same time, her comments indicated some discomfort with *compromising*. In this statement her expression was worried and her tone uncertain:

So, I do now - just pick the priorities out - and things you've just got to leave - because - I mean it's 24 hours [care], so, what you don't achieve, the next shift will pick up on - hopefully! (P14)

The above statement also reflected *situational positioning* towards the *yielding* and *being flexible* ends of the positioning continua. It suggested that the participant may have been dissatisfied with her performance, while realising that referring some care on to the next shift was an acceptable strategy as far as other RNs and nursing management were concerned.

Another participant described a particular day when she was "an hour late off duty, and some of the eye drops I had to skip" (P15). She related a conversation she had with another RN, and reflected on feeling stressed about having to compromise standards. The participant specifically commented on the difficulty associated with doing things properly in a nursing home:

And she [other RN] said, you know "in other areas, acute hospital or a nursing home - you sometimes leave thinking I could have done things better". And that's just the stress that I feel - in a nursing home - that all the time you're having to compromise, you can't do things properly so often. I think the AINs find that too - there isn't the time! (P15)

Participants were aware of *compromising* their own standards and increasing the risks for residents, particularly during medication administration. While her remarks started

in the third person, this participant continued in the second person and her tone suggested that this was her own feeling of frustration:

> *I think when people can get frustrated, you know, they feel that they are lowering their standards because they have to stop* [doing medications]*, you know, stuff like that. If you are in the middle of a medication round, ideally you can't - you shouldn't stop. But, um, sometimes you have to* [helpless tone] *and you just have to accept that.* (P23)

In another situation, a participant expressed concern about *compromising* standards in relation to wound care, which resulted in her positioning herself more towards the *yielding* end of the action continuum while still *trying to get things right*:

> *Well, sometimes you have to put on a sub-standard dressing. You certainly report it to anyone that you are working with, and if you can find the order book [laugh]. I would put it in the communication book that a certain dressing is required. Um, but often you just end up putting on a dressing that you are not really particularly happy with.* (P02)

On some occasions, *compromising* was regarded as the only available option, but the participants set priorities to ensure that this usually involved tasks that did not involve direct care, such as documentation. In that situation, *compromising* was less uncomfortable. A participant described this less worrying type of *compromising* as "trading off". (P06) In this situation she was describing the process as it applied to other RNs:

> *Um - what they will trade off is most probably the documentation - yes - they'll get their medications right, they'll get the wounds done. They may even trade off some wound management from time to time, depending on what dressing is there - other treatments will get done, but, you know, the important things (laugh) watered, fed and cleaned! And medications, yes.* (P06)

Compromising was often required because of time constraints. For example, a participant who worked through a staffing agency was aware of potential legal liability because of not being able to read resident care plans. In this situation, the participant felt vulnerable, resulting in a *yielding* position which suggested that she continued to feel *unable to get things right.* She said:

> *... well strictly speaking, according to the word of the law, you are supposed to then read through all of your residents' care plans, um, on how to treat every*

resident. Unfortunately, your day is only 6 to 8 hours long and you don't have a chance to do this. (P07)

Participants were also prepared to revise their expectations of what other staff were able to achieve with residents, such as a situation involving a resident who benefited from being sat out of bed at regular intervals during the day, but staff objected to this increase in their workload. The participant's response was to be more pliant, or flexible, and to avoid confrontation with the carers by backing off, that is, moving towards the *yielding* end of the action continuum:

Sometimes decision-making is influenced by the nurses' [carers] response to something. Um, because they are under pressure, work times and things. So maybe what would be best for somebody [a resident], is to get them up in the morning for an hour and then back to bed, and then get them up [again] in the afternoon, um, which puts a lot of pressure on the nurses. And a lot of it depends on the staff you've got on, whether they are prepared or willing to do something. (P19)

The participant expanded on the situation by describing her recognition of its salient features, including preferred options to meet residents' care needs. However, experience had shown her that directing the carers to carry out additional work could be counter-productive, and she tended to yield to their preferences. She said:

...We tend to have similar situations and it tends to be - that the physio ideally would like lots of people to go back to bed after lunch and then ideally would like the majority of those people back up again, so that their posture is correct for their evening meal. Which all sounds great, but practically it just doesn't work. Um, so there would be times when um, if staff are grumbling about putting people to bed and getting up again or whatever, then I might just find it easier to say "Well for today leave them in bed for their tea". Or that "you can't get everybody up" so, you know, depending on whether you've got agency staff on or whether you've got regular staff on. So the staff you've got on and how they are feeling on a particular day affects things. (P19)

This situation may have compromised care standards for the residents and also the participant's own performance standards. However, she had recognised factors in the situation that would obstruct her efforts to get things right (carer's attitudes) and decided that *compromising* at least allowed her to move on to the next situation that needed to be dealt with. The anecdote described by P19 also inferred that the physiotherapist had

unreasonable expectations, but this may have been a way of transferring the blame for not being able to achieve better care standards.

Repositioning

When circumstances resulted in the participants needing to compromise or change their plans or approaches, their *situational positioning* usually changed as they continued *trying to get things right,* in at least some aspects of the situation. For example, a participant described changing her priorities and being more flexible in the way time and other duties were managed, especially when she needed to abandon her management responsibilities to help out with clinical care

> *…and you can't do any of that because the resident care is the most important thing and you have to get on with it. So I've had a day where I literally couldn't find staff and I've just had to just go out on the floor and become one of the workers on the floor, basically, and help with all the showering, and dressing of residents and being with residents.* (P21)

However, she was also aware that she needed to return to her management responsibilities, and so she repositioned herself more towards the *confronting* (assertive) and *being rigid* ends of the positioning continua. Her comments showed her awareness that she wouldn't be getting everything right, and that other staff might feel that she had let them down, so she was uncomfortable with her *repositioning.*

> *Well it's easy to say to actually try and be available to everybody at all times, but sometimes you actually have to say to people "look I'm really busy and I really can't do that now". I'm afraid I have a tendency to - not to do that. I tend to stretch myself to the point where I then have to say [to myself] "No, you've got lots of work that needs to be done you need to get on with", and you've got to draw the line somewhere.* (P21)

The second phase of dealing with situations involved *prioritizing* and this was sometimes quite easy and routine for the participants, and they were able to move on to the next task, but at other times it was difficult. The participants acknowledged that they needed to be tolerant about having to adjust their expectations of what could be achieved in changing situations. When situational variables changed, the data suggested that *compromising* and *repositioning* were necessary for the participants to be able to move on to the third phase in the process of dealing with situations.

Phase 3 - moving on

The third phase in the process used by the participants to deal with situations was called *moving on*. This conceptual category reflected participants' statements about getting on with things or moving towards achievement of care goals or work targets. *Moving on* also meant accepting the limitations of situations and "doing what you can" (P11), or as another participant said "you just go with the flow and hopefully it all turns out... (P23).

Moving on was described as being able to "get through the day*"* (P14), and included the condition *persevering*. When the situation involved *persevering*, participants used phrases such as *"*keep going" (P06), or "just get on with it" (P20), and "plodding along" (P03), which reflected the effort required to keep trying to achieve at least some desired outcomes.

Persevering

The interview data suggested that, having prioritized care and administrative tasks, the participants then persevered to achieve their goals and to get things done. Therefore, *persevering* was a condition for *moving on*. As one participant said "…you've always got to try - you can never give up". (P06)

Persevering was defined as trying to "maintain a purpose in spite of difficulty or obstacles" (Macquarie, 2000 p. 584). Therefore, the participants needed to focus on completing assigned tasks and procedures, even if that meant "not seeing" new situational variables as described earlier in this chapter.

A property of *persevering* was being pragmatic about dealing with situations and accepting that not all situations could be dealt with to everyone's satisfaction. Being pragmatic meant "being concerned with practical consequences or values" (Macquarie, 2000, p. 615), and this definition was reflected in a participant's comment: "I usually think I'm going to have a good day – we usually manage to get through everything – in the end" (P03). In that sense, being pragmatic was semantically linked to being tolerant.

A participant suggested that she had developed a pragmatic view of what RNs could achieve between the first interview for this study when she was in a clinical role, and the second interview, when her role involved more personnel management responsibilities. She said: "Well, they've got to prioritize and just gradually work through the routine for the rest of their shift" (P20).

A nurse manager talked about being aware that some RNs managed their days by doing assigned tasks, and that this was part of how they maintained "balance" (P13).

> *I think for the rest, because they either have a limited exposure* [part-time work]*, or they reconcile what's happening at work, with what's happening at home, so they're able to keep a balance. You know, they can come to work, do what they think is a good day's job - they will have their good days, their frustrations, and they will go home again.* (P13)

In other words, she felt that some RNs focused on routine tasks and concentrated on getting those right, while not anticipating new assessments of resident functional patterns, such as setting up a three-day continence assessment for a resident whose voiding pattern had changed.

Staying calm while *persevering* was considered to be important, such as when a participant described how she couldn't resolve problems when she "lost her cool" (P18) because people [staff] stayed angry:

> *[If] you do that with your staff, you don't get anything done - you have more chance of getting the outcome that you want if you have a more friendly, calm approach, than ranting and raving and jumping up and down.* (P18)

Therefore, positioning at the *confronting* (being angry) end of the action axis of the positioning continua was likely to be counter-productive. The above comment also indicated that the participants tended to direct the personal carers carefully, mainly because the participants considered that the carers had "hard, thankless jobs" and "didn't need to be hassled" (P23).

Persevering was necessary when new problems arose, and interrupted the participants' schedule or plans:

> *And I think that goes for the residents, and I think that goes for any of the problems that arise - you just sort of go (soft groan) you know, OK, well let's get on and sort it out…"* (P04)

Persevering calmly was part of the repertoire of skills that some of the participants felt they brought to their roles. As one participant said: "So, um, yeah, you are trying to do it sensibly and sort of calmly so you don't make mistakes, but you have always got the time factor to contend with" (P16). For that participant, being calm was an aspect of *being flexible* and tolerant of interruptions, and this helped her to deal with situations, and look as though she knew what she was doing. She was aware that having insufficient time interfered with her *getting things right*, and that it was necessary to persevere.

The idea of *persevering* in the sense of "plodding on" was also expressed by a participant when talking about trying to identify the needs of a resident with impaired communication (dysphasia) following a stroke. She said:

> *Well, you've just got to keep plodding on, 'til you find out what he wants, or like today, handing over to the afternoon staff and they are gonna have to find out what he wants because it is just - just a matter of trial and error.* (P03)

Participants' comments also reflected their awareness that problems recurred and were not always easily solved, so there was a need to persevere with problem solving, as one participant said: "You are not going to resolve things forever. You are going to resolve them for a short period, and then we start again" (P23). In those situations, the participants tended to return to the beginning of the process by reassessing the situation before *prioritizing* their actions again, and *moving on* to another situation. Their *situational positioning* therefore depended on specific variables, and sometimes *persevering* meant focusing on procedures and routines, in other words, moving towards the *being rigid* end of the responding continuum. In other situations *persevering* could mean trying another approach to get things right by being more flexible.

A sense of determination was expressed by participants who faced adverse situations and persevered in *trying to get things right*. In the following situation, the participant had described being threatened and verbally abused by a medical practitioner:

> *... right through I kept saying to [RN colleague] "No matter what happens, we are always going to remain very professional. No matter what he does and what he says, WE are going to remain professional"*. (P13)

In that situation the participant and her colleagues were positioned towards the *confronting* and *being rigid* ends of the continua, and she considered that positioning to be necessary to maintain her professionalism and personal standards.

Persevering often helped with *getting things right*. For example, a participant reflected on *persevering* with learning about the documentation required to support RCS ratings, and found that it had become much easier to do:

> *I suddenly - I mean, it probably happened a long time ago, but I suddenly thought to myself "this is much easier now than it was" and I thought "I wonder how long that's been for"? You know what it is like when something happens, you don't know when it started to become easier. I mean it has probably been easy for months, but I have never really realised it [until this week]*. (P03)

Therefore, *moving on* to the next situation in the day, or to completing their role responsibilities before going home usually involved *persevering*. This involved *situational positioning* near the mid-points of both continua which enabled the participants to continue to recognise situational variables, prioritize their actions, and move on. *Situational positioning* helped the participants to feel that they were getting things as right as they could in the circumstances.

SUMMARY

Getting things right was a central and recurring concern of the RN participants in the study setting, and the problem they often experienced was *being unable to get things right*. *Trying to get things right* was the positive manifestation of the core category, and all of the participants referred or alluded to trying to carry out their role responsibilities correctly.

Situational positioning was the basic social process discovered in the data, and it was used by the participants when they were *trying to get things right.* It was a theoretical construct that was made up of four interrelated categories: *yielding* and *confronting* on a continuum of action-oriented behaviour, with *being flexible* and *being rigid* on a continuum that reflected more affective or attitudinal responses to situations. The positions adopted by participants to deal with situations were based on their recognition of situational variables, usually derived from their previous experience of similar situations.

The RN participants interviewed for this study used a process of *situational positioning* when dealing with situations and *trying to get things right*. There were three phases involved in dealing with situations, and these were *recognising* the salient features of situations, then *prioritizing* before *moving on* to the next task or situation.

Knowing was an intervening condition for *recognizing* situations, and *seeking help* happened as a consequence of not knowing about some or all of the situational characteristics, such as resident needs, staff capabilities and doctor's preferences.

The phases of *recognising*, *prioritizing* and *moving on* were simple and easy for the participants in uncomplicated situations involving known routines and few, if any, interruptions. However, the data suggested that this was not often the case because the participants dealt with changing situations as they were frequently interrupted during the course of their days.

In those situations, the participants followed alternative pathways, which involved *recognising* that something in the situation changed, then *compromising*, that is, choosing a new course of action. *Compromising* required tolerance, as the participants adjusted their expectations of what could be achieved in the circumstances. *Repositioning* then occurred before they moved on to the next task or to the end of their shifts. *Moving on*, the third phase in the process, involved *persevering* as they continued *trying to get things right*.

Therefore, the basic social process of *situational positioning* enabled the participants to deal with situations by acting and responding according to changing situational variables while *trying to get things right*. This involved adjusting their stance in relation to *yielding* or *confronting*, and *being flexible* or *being rigid*.

CHAPTER 6

SITUATIONAL POSITIONING: DISCUSSION OF RELATED LITERATURE

OVERVIEW

This chapter will provide a discussion of the substantive theory of *situational positioning* in relation to other relevant theories or literature. *Situational positioning* was the process used by registered nurses (RNs) when they were *trying to get things right* in their professional roles in nursing homes in Western Australia.

In this chapter, as in Chapters 4 and 5, the significant categories that emerged from the data as conditions, the core category and its manifestations, and the core variable, are typed in *italics* to emphasise the words and phrases that arose from the data as concepts or categories.

The core category discovered in this study was *getting things right*, and this manifested as a problem of *being unable to get things right* in an adverse decision-making environment, as described in Chapter 4, and then the participants *trying to get things right*, as described in Chapter 5. *Situational positioning* was the process that was used by the participants when *trying to get things* right and it explained the variations in how the participants dealt with the situations that were part of their everyday nursing work and administration duties.

The first section of the chapter provides a summary of the theory of *situational positioning*, then later sections compare and contrast the findings of this study with other situational theories. Relevant situational models are discussed in the next section, including Contingency Theory, Situational Leadership theory, and the model of skill acquisition applied to nursing by Benner (1984). Selected literature related to decision-making is then explored in relation to the findings of the present study.

The final section of the chapter continues exploration of relevant literature, particularly related to the core category, that is, *getting things right,* and includes consideration of recent reports that discussed concerns about nursing shortage in the aged care sector. The marked increase in published literature about nursing and aged care services after 1999 supported the findings of this study regarding the adverse decision-making environment in which the RN participants worked, and also reflected the problem they experienced, that is, *being unable to get things right*.

SITUATIONAL POSITIONING

The purpose of grounded theory method is to generate theory that is grounded in data, and the resulting theory may be formal or substantive. Where formal theories are said to relate to broad conceptual processes that occur in many different situations, substantive theories are derived from more specific situational contexts (Strauss & Corbin, 1998). *Situational positioning* is therefore a substantive theory of the RN participants' decision-making and work activities in nursing homes in Western Australia.

Situational positioning was the process used by the participants to facilitate dealing with situations, especially when they experienced *being unable to get things right* because of situational variances. This was the basic psychosocial problem that emerged from the data in this study, and it had two properties, as shown diagrammatically in Figure 6 on the next page.

The first property of *being unable to get things right* was temporal, and it occurred when the participants were *getting behind or running late* because of *having insufficient time*, usually due to *interruptions*. The second property of the problem was more qualitative, in that contextual and intervening conditions led the participants to feel that they were *not doing things properly*. This feeling was related to their perception that there were *unreasonable expectations* of what could be achieved in the circumstances. Expectations about their performance came from the participants' experience and knowledge of required standards, and also from other stakeholders in the care

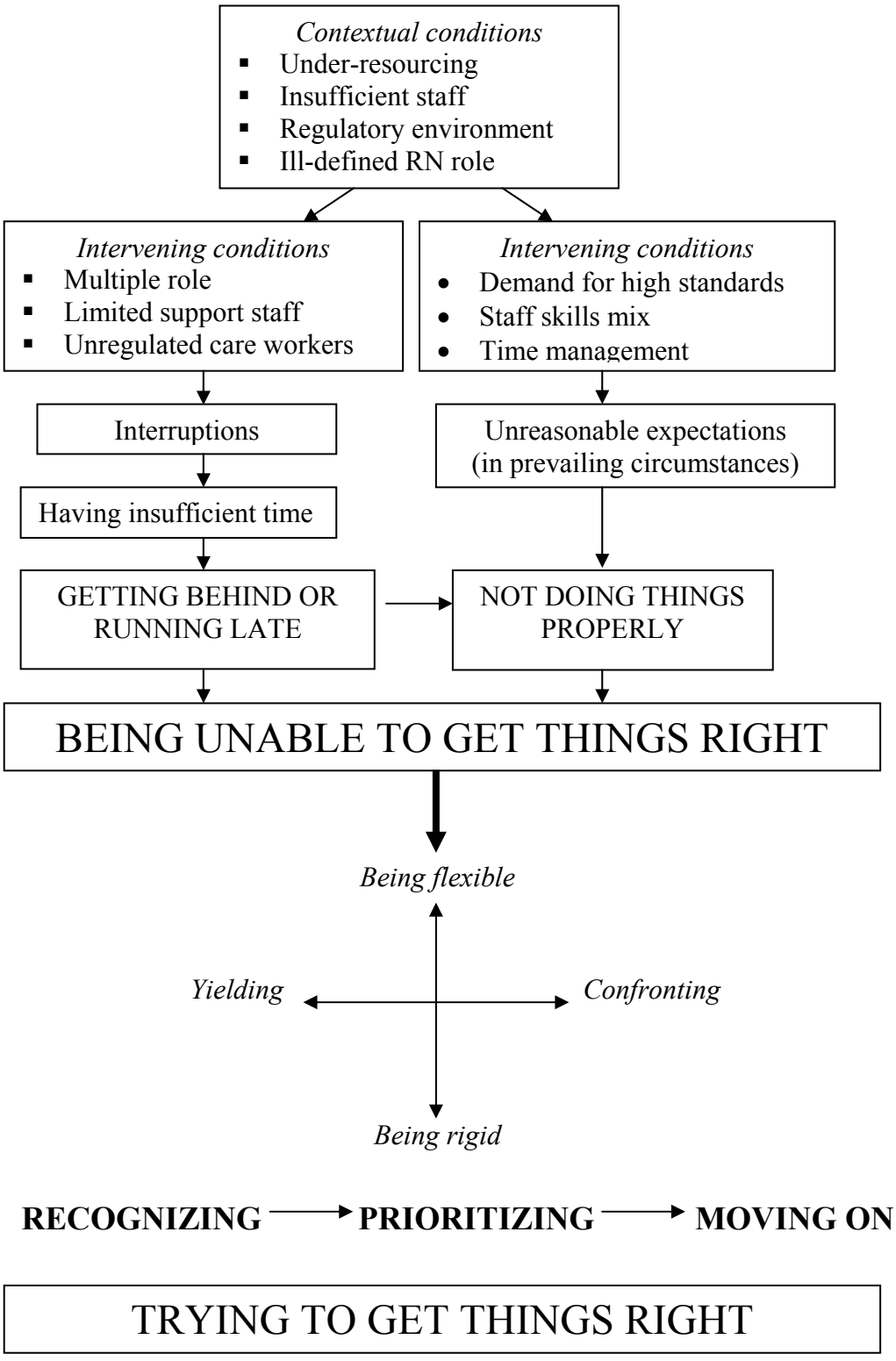

Figure 6: Situational positioning to try to get things right

environment, including residents, their families, other staff, facility management, and regulatory authorities.

Getting behind or running late could also lead to the participants feeling that they were *not doing things properly*. When conditions resulted in having *insufficient time*, the participants had to decide what they could do and what could be left undone, or else they completed tasks in a hurry or not as well as they would have preferred. Therefore the two pathways to the basic psychosocial problem had common contextual conditions and also shared some causal conditions, especially *having insufficient time*

When the participants realised that they would be *unable to get things right,* they positioned themselves to deal with the situations and to *try to get things right.* Decision-making was a pervasive phenomenon, in that the participants were aware of constantly making decisions, ranging from deciding if a minor interruption required a change of focus, to deciding how to manage a resident's health crisis.

Situational positioning meant that the participants acted or responded in ways that helped them to complete nursing or administrative tasks, and their decision-making was often reactive. Whether their subsequent completion of tasks would meet expected standards also depended on situational variances. *Situational positioning* was conceptualised as occurring along two continua of behaviours, one continuum ranging from *yielding* to *confronting* actions, while the other continuum involved the participants being more-or-less flexible or rigid in their responses. Each of the four categories that represented the poles of the continua had both positive and negative attributes. The positioning continua were depicted graphically in Figure 3 (page 134).

Yielding behaviours tended to be associated with giving way or backing off, and trying other ways of dealing with situations, and these actions often reflected a trial and error approach to problem-solving. It was associated with reassessing aspects of situations and continued efforts towards *trying to get things right*. *Yielding* could also mean opting out

or giving up, so that the problems encountered in the situation were not resolved. Opting out included resigning from the job.

Confronting behaviours tended to be assertive or based on anger. Participants were usually satisfied with how they dealt with situations when they were assertive, but found that confrontation based on anger was not productive. Assertive behaviour often seemed to result in the participants feeling that they were *getting things right*. *Confronting* behaviour based on anger could, on the other hand, result in a polarising shift in *situational positioning* to the *yielding* end of the continuum if the participant opted out or resigned from the job.

Deciding to *be flexible* was a frequent response to the participants' working environment, and they considered it to be an essential attribute for dealing with situations in nursing homes. It involved the participants being prepared to adjust their priorities, to try other strategies, and also to accept less desirable outcomes. *Being flexible* was part of a continuum of responses and therefore could range from some participants being very pliant and trying to be all things to all people, to other participants describing being reasonably flexible, but having limits in how far they were prepared to compromise.

Being rigid was the category that represented the other end of the response continuum and was suggested when the participants described having firmly fixed or set ways of responding, such as following particular routines regardless of other situational demands. It was seen by some participants to be a survival technique in particularly adverse working conditions, but, on the whole, participants felt that *being rigid* did not often contribute to *getting things right.*

Positioning on the continua enabled the participants to deal with situations, by *recognising* the salient features of the situation, then *prioritizing* their actions before *moving on* to the next situation. Situations appeared to the participants with a number of recognisable features, including the problems and needs of the residents, the

performance capabilities of other staff, organisational policies and procedures related to particular situations, and other attributes that varied from one situation to another.

A condition for *recognising* salient features of situations was *knowing*, and this was based on the participants' knowledge and previous experience. If the participants were unable to recognise aspects of the situation they sought help, usually by asking someone else, such as other RNs or personal carers. In some situations the participants did not appear to see, or perhaps avoided seeing, aspects of the situation that could have resulted in interruptions, and this usually seemed to be an unconscious mechanism to avoid distractions.

In the second phase of dealing with situations, the participants prioritized their actions, and, if there were no changes in the situation, such as interruptions, the participants completed the required tasks or procedures and moved on to the next task. However, if they were interrupted, the participants usually compromised and re-prioritized, although this was perceived to be sub-optimal in terms of *getting things right*. A condition for *compromising* was being tolerant, which meant being flexible and prepared to yield, and therefore to adopt different *situational positioning*. The third phase of dealing with situations involved *persevering*, in that the participants needed to move on to other tasks or responsibilities, even if they were dissatisfied with the outcomes of earlier situations.

Conditions that varied *situational positioning* were those that led to the participants *being unable to get things right*, such as *having insufficient time*, working with unqualified carers, and trying to meet the differing expectations of various stakeholders. For example, when dealing with situations in which interruptions occurred, the participants talked about *compromising*, and *re-prioritizing* what they could do in terms of essential and non-essential tasks. In those circumstances the participants usually adopted more *flexible* and *yielding* positions on the continua as they adjusted their perceptions of what tasks were more or less important on the day. Similarly when there were differences in expectations between stakeholders in the aged care environment, the

participants again tended to be more *flexible* and *yielding* as they tried to accommodate the different requests.

While the participants talked about *trying to get things right,* it was apparent from their comments and body language that they were often dissatisfied with their own performance standards. They were also aware that sub-optimal standards of care occurred, especially care carried out by personal carers, but were able to justify their inaction on the grounds that they had little control over resource allocation, staffing, skills mix or even their own activities. This "sense of powerlessness and lack of control" was also identified by Cheek, et al., (2002, p. 39). The participants often felt that there was not enough time to do everything that needed to be done for the very frail and dependent residents in the nursing homes, and that constant *interruptions* impeded their efforts to get things right.

Therefore, resident care standards were often compromised, and the participants knew this, which resulted in them being sensitive to actual or implied criticism about aged care work and their own competence as nurses. They appreciated the gratitude of residents' families and friends, while at the same time feeling that the expectations of the families and friends were often unreasonable. Most of the participants seemed to feel that *trying to get things right* was the best they could do in the prevailing circumstances.

OTHER SITUATIONAL MODELS IDENTIFIED IN THE LITERATURE

A search of the literature led to three relevant situational models, and the findings of the present study will be discussed in relation to each of them. The first was Contingency Theory, which was developed in the 1960s as a new approach to designing organisational structure (Donaldson, 1995), the second was the Situational Leadership model developed by Hersey and Blanchard and first published in 1969 (Hersey, Blanchard & Johnson, 1996). The third model discussed here is the model of skill acquisition that was applied to nursing by Benner (1984). The common factor in each of these models is that situational factors guide decision-making.

The range of references to "situational" factors in organisational structure, leadership, and clinical care seemed to have a common element, and that was the notion that decision processes and outcomes varied according to changing situational variables. Other writers have discussed "situational inferences" (Krull & Dill, 1996, p. 951) when studying a person's interpretation of another's mood, "situational anxiety" (Freudenberger & North, 1982), and "situational constitutionalism" (Piper, 1994), or flexibility in interpreting aspects of the constitution of the United States.

The term "situation" was defined in this study as a context-specific circumstance involving the participants in decision-making and action in relation to their nursing or administrative responsibilities at work. In other words, the situations described in this study occurred in specific clinical contexts (nursing homes) and involved the participants in acting or responding to situational variables such as residents' needs, actions of other people, and demands imposed by organisational policies and programs.

This use of the term "situations" has embedded in it the interaction between the actor (e.g. the RN participant) and the context within which the action occurred (nursing homes), and is similar to the definition used by Fiedler and Chemers (1974) when they discussed leadership. "The term *situation* generally refers to aspects of the environment which affect the individual" (Fiedler & Chemers, 1974, p. 56).

The aspects of the intra-organisational environment that Fiedler and Chemers (1974) included in their definition were physical objects, such as equipment, interpersonal relationships, and commonly held attitudes and perceptions of employees. What they called "extra-organisational aspects of the situation" included the location of the organisation, access to sufficient numbers of workers, and types of competitors (Fiedler & Chemers, 1974, p. 57). To this could be added other extra-organisational factors such as regulatory authorities and legislation (Luthans & Stewart, 1977).

Contingency theory

The Contingency Theory of organisational structure (Donaldson, 1995) involved consideration of varying situational factors (contingencies) that determine organisational effectiveness. The contingency approach "…held that the most effective organisational structure would vary according to the situation of the organisation… The structure that the organisation needs to adopt to be effective is contingent or dependent upon the contingency factor or factors" (Donaldson, 1995, p. xi).

Contingency Theory has mainly been applied at organisational level, and the situational variables, or contingencies, discussed in the literature have been those that impact on the organisation as a whole. However, contingency theory has also been considered from the point of view of the decision-maker who is striving to contribute to organisational effectiveness (Tarter & Hoy, 1998). This application was relevant to the present study, and will be described later in this section of the chapter.

Situational circumstances that influenced organisational effectiveness were called "contingency factors", and "prominent among these are size, strategy, task uncertainty, and environment" (Donaldson, 1995, p. xi). Consideration of each of the main contingency factors for organisational effectiveness was relevant to the present study because the RN participants were *trying to get things right* in what was considered to be an adverse decision-making environment. Therefore, organisational contingency factors impacted on the participants' ability to get things right.

Contingency of size

"Contingency of size" referred to the scale of an organisation, especially staff numbers (Donaldson, 1995, p. xiii). Studies cited by Donaldson (1995) suggested that an "increasing economy of scale" applied in larger organisations and that this allowed for relatively fewer administrative support staff (Donaldson, 1995, p. xiii). However, administrative support staff hours in most of the nursing homes represented in the present study were already limited, and many of the RN participants performed both clinical and administrative functions "after hours".

RNs have historically performed a variety of non-nursing functions, especially after office hours, and the participants' comments revealed that such practices continue. The issue of non-nursing duties was a key factor in an industrial dispute in the Australian State of Victoria in 1984 (McCoppin & Gardner, 1994), and such duties included maintenance of supplies, clerical work, laundry duties, and other housekeeping work. Industrial agreement on what constituted non-nursing duties was reached during the 1980s (McCoppin & Gardner, 1994), but tended to apply to the acute health sector, while RNs working in private nursing homes have continued to perform a wide range of duties.

In a study of staff turnover in nursing homes in Victoria, Carter and Phillips (1987) found that RNs and ENs were concerned about working conditions and heavy workloads. They commented: "Without the administrative support structure found in a large hospital, geriatric nurses may find that their role is ill-defined, duty specifications less strictly adhered to, and direction from management less forthcoming" (Carter & Phillips, 1987, p. 51). A large study conducted in the United States reported that "nurses were tired of settling for less and simply 'making do'" and that they were often "tied up with non-nursing work" (Mee & Robinson, 2003, p. 52). Therefore, concerns about the impact of non-nursing work are long-standing and may be an international problem in aged care.

It has probably been convenient for nursing home managers to allow RNs to continue to perform multiple roles because of their acceptance of historically determined RN functions, and also because of budgetary constraints. However, an intervening condition for the *interruptions* that contributed to the participants *being unable to get things right* was when there were no support staff on duty, especially a clerical person or receptionist to answer the telephone and find replacement staff. The potential cost of employing clerical staff for "after hours" work was probably considered to be greater than the value of providing such administrative support.

Contingency of strategy

Contingency of strategy refers to "the plans and resource allocations made by the organisation to position itself advantageously in its field relative to competitors" (Donaldson, 1995, p. xiv). This contingency was relevant to the organisations in which the present study participants worked because their nursing home employers and managers went through a period of significant change following the implementation of the Aged Care Reform process from 1987 onwards. New portfolios of activities were introduced in most nursing homes to meet new regulatory requirements and the associated documentation expectations.

Participants described being responsible for "portfolios", such as infection control, occupational safety and health, and continuous quality improvement. Management of these portfolios was expected to be achieved within rostered hours, in addition to clinical nursing care and supervision responsibilities. Sometimes the participants had to choose between doing clinical nursing work or administrative work, and this resulted in feelings of dissatisfaction and the potential for sub-optimal care standards.

Not all nursing homes underwent the structural change that this aspect of contingency theory predicted, and, when "structure lags behind their strategy… resulting poor performance triggers structural adaptation" (Donaldson, 1995, p. xiv). Several of the participants experienced structural change in their organisations, as their nursing homes were acquired by larger groups of aged care service providers. Some of the role responsibilities of the participants broadened as the "contingency of size" came into play when administrative support staff numbers were reduced as administration activities were centralized.

Contingency of task uncertainty

According to Contingency Theory, "when the task of an organisation was certain and predictable, then centralization and formalization were appropriate" management structures (Donaldson, 1995, p. xii). From the point of view of nursing home management, it could be said that the organisation's task was certain, in that they must

meet regulatory requirements in the provision of residential aged care services. However, the parameters of such service provision tended to be unpredictable because of the changing population of residents with different needs and expectations, changing staff with different capabilities, and, in the 15 years to 2002, changing regulatory requirements. Therefore, the contingency of task uncertainty did apply, and so "decentralization and lack of formalization were required" (Donaldson, 1995, p. xii).

Given the controlled regulatory environment, lack of formalization was not an option in the nursing homes in which the study participants worked. There were formalized policies, procedures, and documentation requirements, and all of these impacted on how the participants positioned themselves to deal with situations. There were also formalized job specifications and duty statements, and those documents were illustrative of formal systems.

Defining the primary task of "helping" or service organisations was considered by Roberts (1994) to be difficult. There was a risk of "inadequate task definition which provide little guidance to staff or managers about what they should be doing, or how to do it, or whether they are doing it effectively" (Roberts, 1994, p. 30).

Roberts (1994) suggested that people sometimes pursue different kinds of tasks: normative, existential, and phenomenal. Normative tasks related to the official aims of the organisation and are usually formally documented, such as the policies and procedures that existed in nursing homes in the present study (Roberts, 1994). Existential tasks are what the workers believe they are doing, based on the interpretation of their roles (Roberts, 1994), and in the present study these would have been illustrated in oral information handed over between nurses. Phenomenal tasks can be inferred from the behaviour of workers, and they may not be consciously aware of those (Roberts, 1994). In the present study, phenomenal tasks may have been associated with the phenomenon of "not seeing" that occurred when some of the participants tried to avoid interruptions.

The issue of task uncertainty can be translated to aspects of situations that impacted on individual decision-makers. For the RN participants in the present study, task uncertainty occurred when conflicting expectations about resident care goals, documentation procedures and task priorities contributed to the perception that there was *insufficient time* to *do things properly*.

Contingency of environment

Another contingency factor specifically discussed by Donaldson (1995) was related to the organisational environment including the resources needed by the organisation, such as personnel. A parallel in the present study were the concerns about RN staffing because of the overall shortage of qualified nurses, and this was a significant factor because the study participants described *being unable to get things right* when such contextual conditions existed.

The RN participants in the present study were concerned about working with unqualified or unregulated care workers, mainly because they did not have the time to direct and supervise the carers' work. This was recognised as an issue related to recruitment and retention of RNs in aged care, according to several reports published 2001-2002, and was defined in one report as follows:

> The increasing stress and responsibilities experienced in association with working with and supervising an increasing number of unqualified nursing staff is an important issue in the retention of qualified nurses in the aged care setting… Nurses expressed difficulties with their job performance depending upon the cooperation from low status nursing home staff.
>
> (Pearson, et al., 2001, p. 4)

During the period of the present study, the RN shortage in nursing homes was manifested in two ways. Firstly, the global shortage of RNs impacted on the number of RNs applying for employment in aged care, further exacerbated because aged care nursing was considered to be a less attractive employment option because of poor pay and conditions (Horner, 2002; Pearson, et al., 2002; Quinn, 2000). Secondly, the combination of the RN shortage and budget constraints made it attractive for managers to employ less-qualified or unqualified staff (Nay & Closs, 1999).

The shortage of nursing and support staff was one of the intervening conditions that led to the RN participants feeling that they had *insufficient time* and that they were not *doing things properly*. This was also a finding of a survey of nursing home staff in Sydney, where Peisah (1991, p. 39) found that "insufficient time to give proper care" was cited by respondents as a cause of stress at work.

Shetty and Carlisle (1972) suggested that role prescription and role discretion could be presented on a continuum ranging from mechanistic to organic-adaptive types of organisation patterns.

> The resulting dichotomy can be represented by these distinctions: closed system v. open system, formal v. flexible, programmed v. non-programmed, mechanistic v. organic (or organismic), habit v. problem solving, and structured v. unstructured. The mechanistic structure is likely to be less open, more formalized, and so on, while the organic structure is likely to be open and less formalized.
>
> (Shetty & Carlisle, 1972, p. 40)

Therefore, it could be argued that the regulatory environment in aged care contributed towards some nursing homes having, or developing, organisational patterns that were positioned more towards the mechanistic, formalized, programmed, and structured ends of the continuum proposed by Shetty and Carlisle (1972), and that this was a reaction or response to environmental forces. However, such an organisational pattern was inconsistent with contemporary demands for open, flexible, and adaptive aged care organisations that were responsive to consumer demands and also satisfactory work places for staff. Such a dichotomy presented management challenges, and, for the RN participants in the present study, resulted in varied *situational positioning* according to situational variables or contingencies, often with unsatisfactory outcomes.

Shetty and Carlisle (1972) proposed a contingency model of organisational design, and included a range of interacting forces, such as forces in managers, the task, the environment, and in subordinates. They suggested that analysing these forces (contingencies) could result in development of a framework that would allow the

organisation to be "sensitive to individual situational needs" and maintain "a balance determined by the situation in question" (Shetty and Carlisle, 1972, p. 44).

Luthans and Stewart (1977, p. 181) proposed a "general contingency theory of management" which they described as "generically situational in orientation". The model on which they based their theory included environmental, management, and performance variables, and the functional relationships that existed between these variables. They proposed that the general contingency theory was an "overall framework that integrates the diverse process, quantitative and behavioural approaches to management … (Luthans & Stewart, 1977, p. 181).

Longenecker and Pringle (1978, p. 680) suggested that contingency theory was merely the most "recent contender for the position of the integrating concept [in management] that will hold everything together". Further they criticised the theory proposed by Luthan and Stewart (1977), and suggested that the key concepts were too vague and ambiguous to be called a general theory because the contingency approach to management is, in itself, dependent on situational variables (Longenecker & Pringle 1978). Luthans and Stewart (1978, p. 684) responded to this criticism by suggesting that the general contingency theory should be seen as "a meta-theory that attempts to integrate these more specific or limited elements of theoretical information into a unified body of knowledge".

Nevertheless, the discussion between these authors highlighted the relationship between situational factors, as summarised by the critics:

> Within this theoretical structure, situational variables are defined as outcomes of the interaction of environmental variables (e.g., culture, technology, education, suppliers, competitors, etc.) and resource variables (e.g., human resources, attitudes, group dynamics, raw materials, capital, etc.). Management variables include process, quantitative, and behavioral concepts (e.g., planning, organizing, motivational techniques, leadership styles, decision-making models, etc.). Performance criteria variables result from the interaction of environmental and management variables.
>
> (Longenecker & Pringle, 1978, p. 680)

While the theoretical propositions and matrix presented by Luthan and Stewart (1977) were dense, algebraic, and difficult to interpret, the combination and suggested interrelationship of situational variables were relevant to a nursing home organisation. Applying contingency theory to nursing home management helped to group or classify the variables present in the RN participants' decision-making environment, including environmental, resources, management variables, and performance criteria.

The impact of favourable or unfavourable contextual conditions on nursing practice was a key factor in RN *compromising*, as found in Western Australian research reported by Irurita and Williams (2001). They found that as contextual conditions became more unfavourable, including insufficient staff and insufficient time to complete care, the nurses compromised more and care standards were jeopardised (Irurita & Williams, 2001).

Considering the organisational structure in nursing homes, it could be argued that prevailing situational variables in the present study dictated the conditions that led to the RN participants *being unable to get things right*. Their attempts to get things right were likely to be successful only when conditions were favourable, such as when there were sufficient other staff to allow the participants to complete their own role responsibilities without interruptions.

At the same time, the RN participants themselves defined their roles in historical terms and accepted their poorly defined roles as "normal". For example, they accepted the need to answer the telephone, find staff replacements, or to help staff in catering or laundry services as needed.

The participants also accepted that most of their time was spent carrying out routine procedures, especially medication rounds, and that they had little time to spend with individual residents, unless there was a health crisis. This could be contrasted with the roles of other health care professionals, such as physiotherapists, occupational therapists, and speech pathologists, who were able to focus their efforts on their clinical roles. It

was generally recognised that other health professionals who provided sessional services in nursing homes were able to take the time to assess an individual client, identify problems and goals and complete the documentation, all as part of their allocated time for paid service provision.

There have been critiques of the application of Contingency Theory to organisations, including that of Child (1995), who suggested that most of the relevant literature focused on organisational characteristics while ignoring the underlying processes. He argued that failure to include the capacity of decision-makers to make choices limited the application of the theory to consideration of functional aspects of the organisations (Child, 1995). The concept of strategic choice by decision-makers in an organisation could impact on organisational structure, suggesting that managers' choices could influence some organisational functions and goals. One proposition was that some "organisational decision-makers may prefer to satisfice: to "trade off" some potential gain in performance for a congenially structured mode of operation" (Child, 1995, p. 414).

The term "satisfice" was relevant to the findings of the present study because it reflected the flexible position adopted by RN participants, in circumstances where they perceived that flexibility was necessary when *trying to get things right*. For example, during weekend shifts, when working with agency staff, or completing documentation, participants described being prepared to "trade off" some tasks.

Satisficing was a decision-making strategy described by Simon (1993), referring to decisions that are reasonably satisfactory and rational to the extent that they contribute to meeting specific objectives. In that sense, satisficing was taken to mean choosing a course of action that was good enough in the circumstances. Simon (1993, p. 393) said: "Action is rational to the degree that it is well adapted to those goals. Decisions are rational to the extent that they lead to such action".

A satisficing strategy was one of the six decision-making models described by Tarter and Hoy (1998). They asked what were "the contingencies for selecting an appropriate decision strategy" and analysed six contemporary decision-making models (p. 212). This opinion paper summarized the models and their relationships in the following statement:

> The decision-making process can also be arrayed along a continuum from optimizing organisational decisions to achieving personal ends. Classical decision-making optimizes decisions. Administrative decision-making satisfices. Mixed scanning uses adaptive satisficing, a more flexible version of satisficing. The incremental model successively compares outcomes. Chance connections solve problems in the garbage can. But it is politicking and personal preferences that drive the political model.
>
> (Tarter & Hoy, 1998, p. 215)

The contingencies that influenced satisficing strategies according to Tarter and Hoy (1998) were generally related to task uncertainty, as described by Donaldson (1995). Uncertainty was a contingency that applied in the present study, and included the aspects described by Tarter and Hoy (1998), such as uncertainties due to not knowing some aspects of the situation and variances in interpretation of what was achievable in the circumstances. The RN participants in the present study could be said to have adopted satisficing positions when *trying to get things right*.

Contingency Theory was usually related to organisational structures and processes, and only by inference to the decision-making activities of individuals, except for the contributions of Tarter and Hoy (1998) and Child (1995), who suggested that decision-makers' strategic choices added another dimension. From that point of view, *situational positioning* by the RN participants in the present study had some similarities to contingency theory if contingencies of task uncertainty, resources, and environment were to be considered.

Firstly, the contingency of task uncertainty was relevant in situations dealt with by the participants, mainly because of their ill-defined roles and consequently the range of duties that they usually carried out during their work shifts. Secondly, the contingency of resources was relevant, especially in relation to the participants' concerns about the

availability of qualified nurses, and working with unregulated care workers, most of whom had no formal training. Thirdly, the contingency of environment was relevant in the impact of Commonwealth legislation and its consequential procedural demands, and also in the broad expectations about the quality of life and care for residents in nursing homes. Other situation models have tended to focus on the individual and so fall at the other end of the organisation-individual spectrum.

Situational Leadership

Situational Leadership was described as an example of a theoretical model from the symbolic interactionist perspective (Hersey & Duldt, 1989), and was:

> …based on the modern assumption that there is no one, singularly successful leadership style, but that leaders need to have a variety of styles that can be adapted to the unique combination of variables present in each situation.
>
> (Hersey & Duldt, 1989, p. 5)

The symbolic interactionist theoretical perspective underlying Situational Leadership (Hersey, et al., 1996) belongs to the same ethnographic tradition that gave rise to the grounded theory method (Glaser & Strauss, 1967). Situational Leadership is a general theory of leadership behaviour in that it can be applied in different types of organisations and different field of endeavour, and in this respect may be parallel to "grand theories" discovered through grounded theory research.

A similarity between Situational Leadership (Hersey, et al., 1996) and *situational positioning* was the notion that situational variables influence how people respond to situations. However, the difference was that, whereas situational leadership theory suggests that leaders demonstrate particular task and relationship behaviours in response to conditions of follower ability and willingness to be led (Hersey, et al., 1996), the RN participants in the present study adopted different positions according to a broader range of situational variables. This was because, in addition to being clinicians and care leaders on particular shifts, they also had other administrative responsibilities.

Another similarity between *situational positioning* and Situational Leadership theory was that, given the same conditions, similar decisions were made. For example, in the present study, recurring conditions tended to lead to similar choices in positioning by the participants, especially when they moved to more *yielding* and *flexible* positions in response to having *insufficient time* due to *interruptions*. Hersey, et al. (1996) suggested that leaders should also choose to lead in the same way whenever the situational conditions are the same. Therefore, when follower readiness (ability and willingness to perform a task) are high, the leader should adopt a delegating leadership style, while if readiness is low the leader should be more directive (Hersey, et al., 1996).

Flexibility was said to be an important attribute of leaders, and different management styles were considered to be necessary. Keenan, Hurst, Dennis, and Frey (1990, p. 25) stated that management style should be varied "… with the same or different people depending on the nature of (1) the situational tasks, (2) the level of individual or group expertise, and (3) degrees of confidence and willingness to act". The findings of the present study were similar in that the participants described situational requirements being changed by factors such as admitting a new resident, working with agency staff and locum doctors who did not know the residents, and working with unregulated care workers.

However, the conditions that led to changes in *situational positioning* by the participants in the present study were not as defined or predictable as in the Situational Leadership model. Variances in conditions occurred on a daily basis, and participants could adopt different positions even in similar situations because positioning depended on their awareness of the salient features in specific situations. For example, participants who were carrying out a medication administration round would generally be flexible and tolerate interruptions, even though they were aware of the risk of errors. The extent to which they would be tolerant depended on other conditions present on a particular day, such as having regular or agency staff on duty, which was one influence on the rate of interruptions that occurred. Individual interpretation of the level of risk, and the balance between risk and outcome, varied between participants and situations, so there was no

"constant" that could be applied, seemingly unlike the Situational Leadership model (Hersey, et al., 1996).

Hersey, et al. (1996, p. 188) stated that leaders must have the ability to identify environmental clues, a skill they referred to as "diagnostic ability", and then needed to be able to adapt their leadership styles to meet the demands of the particular environment. This also applied in the present study because the participants needed to be able to recognise salient features of situations, (i.e. to identify environmental clues or recognise patterns) in order to be able to position themselves to deal with situations in ways that were most likely to help in *getting things right*.

A situational model of skill acquisition

Patricia Benner's (1984) pioneering work examining nursing expertise has become a landmark in qualitative nursing research. Benner (1984) applied a five-stage skill acquisition model to nursing. The model was concerned with how nurses move "through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert" (Benner, 1984, p. 13), and was based on an original skill-acquisition model developed in the early 1980s by Dreyfus and Dreyfus (1996).

The premises of the Dreyfus model were described as situational and experience-based "which distinguishes between levels of skilled performance that can be achieved through principles and theory learned in a classroom and the context-dependent judgments and skill that can be acquired only in real situations" (Benner, 1984, p. 21). Benner (1984, p. 3) referred to "clinical situations" as occurrences requiring interpretation, and that this required expertise in complex human decision-making. While not specifically defined in Benner's work, the term "situation" was considered to have a similar meaning to that used in the present study, mainly because it was said to be context-specific. For example, she said: "Common meanings become apparent when narrative accounts of diverse clinical situations are given with the intentions, context, and meanings intact" (Benner, 1984, p. 6).

Benner (1984, p. 7) described the development of "sets" by nurses, and defined a "set" as a "predisposition to act in certain ways in particular situations". She suggested that the way nurses relate to situations develops over time, and that this orientation or set in relation to particular types of situations influences the way the situation is perceived and described. In Benner's (1984) work, the idea of "sets" related to recognition of clusters of aspects or attributes in clinical situations, and led to formulation of "paradigm cases". "Past concrete experience therefore guides the expert's perceptions and actions and allows for a rapid perceptual grasp of the situation" (Benner, 1984, p. 8).

The role of particular situations in the skill acquisition model is that they contribute to the accumulation of "paradigm cases" (Benner, 1984, p. 8), and this helps the nurse to progress from one level of performance to another. However, most of Benner's (1984) situations seemed to be associated with clinical decision-making in relation to specific patients, whereas the RN participants in the present study were dealing with situations that were more broadly defined and included other people (relatives and staff), and the working environment itself.

Compared to Benner's (1984) model of skill acquisition, the *situational positioning* theory that emerged in the present study was a more immediate, day-to-day process that led to participant actions that were concerned with dealing with the specific situation before *moving on* to the next situation. However, past experience and proficiency were necessary attributes that were related to nursing knowledge and were necessary for dealing more effectively with situations. The data from the present study suggested that the more proficient or expert RN participants, as defined by Benner (1984), seemed to be more confident about *trying to get things right* than were the less experienced participants. For example two of the participants were new graduates, and were possibly "advanced beginners" because their experience to that time enabled them to note "the recurring meaningful situational components that are termed aspects of the situation" in the Dreyfus model (Benner, 1984, p. 22). However, they seemed less aware of the range of factors present in some situations.

On the other hand, some of the more experienced RN participants were probably at "proficient" or "expert" levels of performance as evidenced by their "intuitive grasp of each situation", although "[c]apturing the descriptions of expert performance is difficult because the expert operates from a deep understanding of the total situation" (Benner, 1984, p. 32). In a study of how nurses manage time and work in long-term care in the United States, Bowers, Lauring and Jacobson (2001) found that the study participants were not able to articulate the detail of the process that they used to manage time, just that they did it. They went on to comment:

> Yet … the nurses we studied had developed complex processes for managing and organizing their time, processes that were highly responsive to changes in work conditions and had important consequences for the nurses' experience of their work and the care received by residents.
>
> (Bowers, et.al. 2001, p. 486)

This was consistent with Woolley's (1990) comments about factors that influence reasoning processes, including experience, probability issues, and contextual issues. Contextual factors included role expectations and the difficulties faced by nurses when there is a significant contrast between idealised views of nursing practise, and the reality that exists in some situations.

> The reasoning process may be hindered when the reality of an individual's role within the care environment fails to match that individual's expectations or perception of the role. For example, consider the nurse working within a ward area where the workload is constantly high and the staffing levels always inadequate. Because of the increased work pressure, she [sic] constantly finds herself making conflicting decisions as to how to best allocate her time.
>
> (Woolley, 1990, p. 115)

Situational positioning also relied on experience and recognition of salient features of situations, and such recognition may have been based on "paradigm cases" (Benner, 1984, p. 8) of similar situations, although in the present study situational variables included factors other than those related to individual residents. At the same time, similar situations or paradigm cases recalled by the participants in the present study may have included other situational variables, which may have facilitated recognition of the salient features of the situation.

Another aspect of expert nursing performance that was of concern to the participants was the requirement that they use the nursing process as the framework for their documentation. However, most of the RN participants were resistant in relation to the demand that documentation be maintained within a formal nursing process framework because it was laborious, repetitive, and interfered with their ability to provide nursing care.

Other writers have criticised the use of the nursing process, including Henderson (1982), who suggested that the process used in formal nursing process tended to dominate nursing activities so that intuitive or subjective aspects of nursing care tended to be ignored. The findings of a Western Australian study of acute care nursing practices also found that "the nursing process structure as explicated in textbooks was unable to be implemented due to a number of prevailing conditions found in clinical settings…" (O'Connell, 1998, p. 24).

DECISION-MAKING

A large volume of literature addressed decision-making processes, and there was a general assumption in the literature that managers are decision-makers (Lewis & Boldy, 2001). Nursing literature also addressed decision-making at both management and clinical levels (e.g. Bailey & Clause, 1975; Holle & Blatchley, 1987; Marriner, 1977; Matteson & Hawkins, 1990). In a discussion of the "individual as a decision maker" Lancaster and Beare (1982) stated that:

> Personal differences are seen in the varying ways in which people perceive problems, the extent of their search for alternative solutions, the quality of the data analysed to arrive at a decision, and ultimately, the choice that is made.... More specifically, each decision maker is influenced by the following set of factors: perception of the problem; personal value system; ability to process information; various personality factors, including confidence, self esteem, dogmatism, propensity for taking risks, and the ability to tolerate dissonance; and several personal and physiological factors.
>
> (Lancaster & Bear, 1982, p. 162.)

The participants in the present study were individuals who worked in similar environments, and had broadly similar nursing education and experience, but they did

have different abilities and values, and also different levels of confidence, self-esteem and tolerance of dissonance. Those similarities and differences resulted in the variances in their *situational positioning* and how they dealt with situations.

Holle and Blatchley (1987) described three approaches to decision-making: "historical", or following tradition/ritual; "parasitic" or copying other people; and "professional" or using a theory-based approach to problem solving. They suggested that the historical and parasitic approaches usually try to "force fit" new problems into old solutions and therefore do not often have satisfactory outcomes (Holle & Blatchley, 1987, p. 92). In the present study the participants demonstrated each of these approaches to decision-making, depending on situational variables. For example, historical decision-making was used when following well-learned routines, such as medication administration. Parasitic decision-making seemed to occur most often when the participants did not know the residents or were not familiar with some aspects of the situations they managed. The third approach, called "professional" decision-making by Holle and Blatchley (1987), was reflected when the participants used a problem-solving process.

Conrick (1998) discussed the bi-modal nature of nursing decision-making, with delegated responsibilities for biomedical care that must be managed concurrently with managing the clients' daily needs in their particular environment. It could be said that there is a potential for ambivalence in nurses' decision-making if there is conflict between the two domains.

Using the same sort of framework, it could be argued that a third domain of decision-making existed in Western Australian nursing homes during the present study, and that was the area of facility administration. In some situations the participants experienced decisional conflict as they tried to reconcile different, but simultaneously presented, situational goals in the biomedical, nursing, and administrative domains. This ambivalence was also found by Cheek, et al., 2002):

> … there were significant dilemmas and ambivalence about what aspects of the registered nurses's work/role should have greatest priority and what did have

> greatest priority. Whilst resident care was seen by many participants as central to the role of the registered nurse, the need to document for funding to provide adequate staffing levels has become an increasingly important role.
>
> (Cheek, et.al., 2002, p. 34)

Concept analysis of decision-making

Matteson and Hawkins (1990) performed a concept analysis of decision-making and described its attributes and characteristics. In tracing the development of decision theory, Matteson and Hawkins (1990) discussed prescriptive and descriptive theories. Earlier prescriptive theories of decision-making provided rules for making decisions, and such literature is well reflected in nursing (e.g. Holle & Blatchley, 1987; Marriner, 1977; Buckingham & Adams, 2000a).

Descriptive theories "have sought to discover patterns, regularities, or principles in the way people actually decide in given situations" (Matteson & Hawkins, 1990, p. 6). Decision-makers develop individual approaches, preferences, and predilections or "sets" (Benner & Tanner, 1987, p. 7), and descriptive decision theories explore how people actually decide rather than suggesting how they should make decisions (Matteson & Hawkins, 1990).

Matteson and Hawkins (1990) defined a number of attributes of decisions, including that they involve deliberate mental choices, commitment to particular actions or inactions, and expectations that certain goals will be accomplished. They also identified antecedents of decisions, including being aware that there are choices or options in the situation, consideration of alternatives, and weighing the risks and consequences of the decision (Matteson & Hawkins, 1990). Finally, they listed the consequences or outcomes of decisions, including resolution of the doubt or mental debate that preceded the decision and "consideration of subsequent decisions in response to ever-changing circumstances and desires" (Matteson & Hawkins, 1990, p. 9).

The decision-making reflected in the data in the present study illustrated the attributes, antecedents, and consequences described in Matteson and Hawkins' (1990) concept analysis. More recent work on classifying clinical decision-making was carried out by

Buckingham and Adams (2000a, 2000b) and they proposed a framework to unify the many decision-making theories that have been applied in various clinical and academic disciplines:

> Within the unifying framework of psychological classification, the overall aim of the two papers is to clarify and compare terms, concepts and processes identified in a diversity of decision-making theories, and to demonstrate their underlying similarities. It is argued that the range of explanations used across disciplines can usefully be re-conceptualized as classification behaviour.
>
> (Buckingham & Adams, 2000a, p. 981)

Of particular relevance to the present study was Buckingham and Adams' (2000b) assertion that intuition is rational decision-making behaviour, and that pattern recognition is an important factor. They also referred to "heuristic reasoning" as "methods for simplifying complicated likelihood judgements about different outcomes" (Buckingham & Adams, 2000a, p. 984). Heuristic reasoning was also discussed by O'Neill (1995) and Wurzbach (1991).

The participants in the present study often relied on their judgement about residents' needs and care priorities to position themselves to deal with the situations that arose. However, using judgement and intuition did not always result in formal evidence (e.g. documentation) for accountability purposes because many of the participants resisted the demands to document their nursing care using a nursing process framework. This was partly because of time constraints, but also because resident documentation tended to focus on the Resident Classification Scale (RCS) and was not oriented towards clinical nursing practice or problem-solving.

Schön (1983, p. 43) used the analogy of "swampy lowlands" to describe situations when professionals "deliberately involve themselves in messy but crucially important problems, and, when asked to describe their methods of inquiry, they speak of experience, trial and error, intuition, and muddling through". It could be argued that nursing frail, ill older people presents problems that are of the "swampy lowlands" type.

Intuition was found to be an important factor in expert nursing practice by Benner and Wrubel (1982), Benner and Tanner (1987), and Tanner, Benner, Chesla, & Gordon (1993). The use of "intuitive judgment" was said to include six key aspects: "pattern recognition, similarity recognition, commonsense understanding, skilled know-how, sense of salience, and deliberative rationality" (Benner & Tanner, 1987, p. 23). All of these aspects were relevant to the issue of clinical decision-making and the use of *situational positioning* by the participants in the present study.

Wurzbach (1991) discussed judgement theory and applied those ideas to nursing. She described judgement theory as assuming that decision-making is "predictive, inept, and error prone" (p. 28), and that judgements were often made under conditions of uncertainty. This was similar to the contingency of task uncertainty that was discussed earlier in this chapter, and provides the opportunity to link the notion of task uncertainty to other uncertainties that were inherent in the decision-making environment that existed in the present study. However, most of the research described by Wurzbach (1991) came from laboratory experiment and simulated decisions where the decisions tended to be hypothetical, rather than based on reality.

Decision-making in home health care

Using the grounded theory method, dela Cruz (1994) explored clinical decision-making from the perspective of 21 home health care nurses in California. The decision-making styles that emerged were called "skimming", "surveying" and "sleuthing", and she found that "experienced home health care nurses switch from one style to another when managing varying patient care situations" (dela Cruz, 1994, p. 222). These situations were context-specific, and were similar in definition to situations in the present study, but the context was in home-based or domiciliary care.

What dela Cruz (1994) called skimming involved delivery of service that was considered to be minimal but adequate in the circumstances. When skimming the nurses needed to know the patient, the medical care orders and the progress to be expected as care and treatment continued. This was similar to the first phase in dealing with

situations in the present study, which involved rapid recognition of salient features of the care situations where *knowing* was an intervening condition. When recognition was easy and rapid, the RN participants were able to prioritize, act or delegate, and move on to the next task or situation.

The second decision-making style discovered by dela Cruz (1994) was surveying, and this was required when the home care nurses were not familiar with some aspects of the situation, such as when visiting a new patient. Surveying involved carrying out specific assessments that provided "concrete observable data… to infer specific and distinct patient problems", and these were managed with "routine and proven approaches…". The resulting action was considered to be "generally reactive and geared to the present and near future" (p. 224).

The aspect of surveying that was reflected in the present study was that it involved routine activities in situations where problems were well-structured and the salient features of the situations were recognisable, such as completing medication rounds and wound care procedures.

Sleuthing was the third decision-making style discussed by dela Cruz (1994, p. 224), and it was used by the nurses in her study "when managing ambiguous, uncertain, complex, ill-defined, and unstructured problems". In those situations the nurses needed to be more flexible and to seek different sorts of information to change ambiguous problems into well-structured ones in order to facilitate decision-making. This was similar to the approach used by the participants in the present study when they explored options for dealing with complex problems, such as large wounds or residents' challenging behaviours.

Ill-structured problems

Voss and Post (1988) reviewed work on the solution of ill-structured problems. Ill-structured problem statements are those that are poorly defined in terms of input information (initial states) and desired outcomes (goal states). They stated that "[t]he

solution of the ill-structured problem thus involves specifying the information especially germane to the solution, thus reducing the ill-structured problem to a well-structured problem…" (Voss & Post, 1988, p. 264).

In the present study, the participants experienced many ill-structured problems in the situations they faced, and when *prioritizing* they had to choose between alternative actions (or inactions) depending on their perception of the situation. When they sometimes did "not see" some aspects of the situation, this may have been analogous to reducing an ill-structured problem into a well-structured one. For example, "not seeing" some sub-standard work practices demonstrated by personal carers would resolve the issue of needing to deal with the situation.

Voss and Post (1988, p. 281) also mentioned "stop rules", meaning that ill-structured problems may be regarded as solved depending on the situation, and if the decision-makers think that they have gone far enough. They gave examples of magistrates deciding when there has been enough evidence, and that this point may vary between magistrates; also that composers will vary with respect to when they stop making revisions to a musical composition. Again, the participants in the present study had to decide in some situations that they had done as much as they could, and that it was time to move on to the next situation, or go home, even though they had not been able to get things right.

Situational reasoning

In a study of reasoning strategies used by occupational therapists, Fleming (1991) described a situational approach to solving problems, including narrative, procedural, interactive, and conditional reasoning. Narrative reasoning was not discussed in the journal article, but the other three types of reasoning were described. The findings of that ethnographic study suggested that therapists used "different modes of thinking for different purposes or in response to particular features of the clinical problem" (p. 1007).

The reasoning strategies used by the therapists were different from the *situational positioning* used by the RN participants in the present study in that the therapists used the different types of reasoning to "address different aspects of the whole problem" (Fleming, 1991, p. 1007), referring to the whole situation of one patient. In other words, the variations in the strategies were applied in problem-solving related to one patient. The focus on patients was similar to Benner's (1984) study, and therefore was a more narrow application of the term "situations" than in the present study. As stated earlier, the RN participants used *situational positioning* to deal with situations that potentially had many variables, including residents, staff, visitors and organisational factors.

A significant factor in the difference of focus between occupational therapists described in the Fleming (1991) study and the RN participants in the present study was that, unlike the therapists, the RN participants were usually responsible for more than clinical care for a specific case-load of patients. Where the therapists had a well-defined clinical role, the RN participants' roles were ill-defined because in addition to carrying out routine nursing procedures for an average of 30 residents, they were often also responsible for managing staff allocation and replacement, ensuring adequate supplies and equipment were available, and information-sharing on a wide range of topics.

At the same time, there were similarities between the therapists in Fleming's (1991) study and the findings of the present study. The therapists used procedural reasoning when considering the patient's condition and deciding what procedures would be appropriate (Fleming, 1991). Similarly, in the present study, the RN participants used a process that was like procedural reasoning to decide on the relative flexibility of their approach to particular procedures, such as what wound care product to use, or whether a dressing needed to be changed or not.

Then, where the therapists used interactive reasoning to facilitate communication, the RN participants positioned themselves to act and interact when dealing with situations, and *yielding* and *confronting* involved interaction styles that were consistent with those positions. *Being flexible* or *being rigid* also influenced interaction styles, such as when

the participants were willing to be more tolerant when responding to interruptions associated with visitors' needs for information or reassurance.

Finally, where the therapists used conditional reasoning to draw in the range of social, environmental, and family factors that impacted on the patient's rehabilitation (Fleming, 1991), the RN participants expanded or contracted their awareness of situational variables according to the demands of the situation. For example, some participants described being aware of many variables simultaneously, including regulatory and administrative requirements, the needs of the residents under their care, and the capacities of the care staff on duty, while others narrowed their focus to the present task. The scope of the participants' awareness seemed to depend on a number of factors, including their knowledge and experience, and whether they felt emotionally strong enough on the day to cope with the range of situational variables.

Schell and Cervero (1993) reviewed the literature related to clinical reasoning by occupational therapists, and suggested that Fleming's (1991) findings may have been incomplete in that they did not address reasoning processes associated with the personal context of the therapist and contextual factors within the practice setting. Broadening the scope of the situations in which clinical reasoning occurred begins to approximate the scope applied in the present study.

Schell and Cervero (1993, p. 608) added "pragmatic reasoning" to the definition of clinical reasoning and cited a number of authors who explored personal and environmental influences on therapists' reasoning processes. Contextual variables that affected therapist decision-making included budgetary and personnel shortages that resulted in rationing of therapy services, and having to follow "prescribed intensities of treatment to meet federal policies, regardless of the apparent patient need for that intensity" (p. 608). Those contextual variables also existed in the present study and led to participant *situational positioning* that was a consequence of compromising and needing to be more flexible when *trying to get things right*.

TRYING TO GET THINGS RIGHT

When dealing with situations, the participants in the present study were continuously observing and assessing the care environment, and extending or retracting their awareness of situational variables. The phase of recognising salient features of situations included the cognitive process of pattern recognition and the phenomenon of *knowing*.

Pattern recognition

Recognising salient features of situations was the first phase used by the study participants when dealing with situations, and this was facilitated by having had experience of similar situations in the past. The participants in the present study were more confident about *getting things right* if they were familiar with the characteristics of the situations they faced. This involved *recognising* salient features of the situations, and the recurring patterns that these presented.

Corcoran (1971) suggested that pattern recognition is a process involving perception, classification, and memory. He said:

> To state that a pattern is recognised implies firstly that it has been perceived, secondly that it, or a pattern of the same class has been previously perceived, and thirdly that the past perception of the pattern has been remembered. In its broadest sense, pattern recognition encompasses nearly the whole of the perceptual experience of the adult.
>
> (Corcoran, 1971, p. 18)

It was apparent from the data in the present study that the participants recognised situational features based on both their nursing and life experiences. For example, some participants attributed their tolerance for challenging behaviours in dementia sufferers to their experience with their own children. Their judgements about when to be firm and when to be flexible was also based on experience and pattern recognition. Dewey (1933) discussed reflective thinking and judgement, and he stated:

> To be a good judge is to have a sense of the relative indicative or signifying values of the various features of the perplexing situation; to know what to let go as of no account; what to eliminate as irrelevant; what to retain as conducive to the outcome; what to emphasise as a clew [sic] to the difficulty.
>
> (Dewey, 1933, p. 123)

This is exactly what the participants in the present study had to do when confronting difficult situations at work, and they were skilled at knowing what to let go, what to ignore or retain, and on what aspects of the situation they should focus. This skill helped them with *prioritizing* and *moving on* although they were not always satisfied with either their own performance or the task outcomes. In some instances changes in situational focus included "not seeing" some aspects of the situation.

"Not seeing" was similar to the process of "selective focusing" that was identified by Williams (1996) in a grounded theory study. She discovered that this was the core process used by hospital nurses to deal with their inability to consistently provide quality nursing care to all patients, mainly because of insufficient time. Selective focusing involved prioritising according to the time available and enabled the nurses to focus on "certain patients, or on certain needs of patients, to deliver quality care" (Irurita & Williams, 2001, p. 580), although this often involved compromising quality of care. Williams' study also found that unfavourable contextual conditions threatened the integrity of patients and nurses in hospitals (Irurita & Williams, 2001), and similar unfavourable conditions were found to impede effective nursing practice in the present study.

Benner and Tanner (1987, p. 24) described pattern recognition as "a perceptual ability to recognise relationships without pre-specifying the components of a situation", and suggested that expert nurses learn to recognise the patterns of responses presented by patients. Most of the RN participants in the present study had extensive experience of nursing situations in aged care, and therefore could recall a range of patterns and variations of patterns.

This suggested that pattern recognition and knowledge of expected outcomes were helpful for the RN participants, and that was sometimes the case if they were dealing with a minimum of situational variables. However, in the situations where they were most likely to be *unable to get things right*, they were often trying to achieve several

goals simultaneously, and therefore needed to sort quickly through a lot of input information. In those situations there were often competing demands for their attention and time, and their decision-making was more likely to be "satisficing", or reasonable decisions in the circumstances (Simon, 1993, p. 397).

Simon (1993, p. 402) discussed problem-solving expertise and referred to "chunks" of information that are linked in memory and are accessed by specific cues. These chunks are connected pieces of information that work like an index to memory. "Any one of us in our area of expertise can recognise cues in the situations that we encounter in our daily work, and those cues immediately access, in our memory, all the things we knew about them" (Simon, 1993, p. 403).

The data in the present study suggested that most of the RN participants had stored in their memories many chunks of information about nursing, care situations, and administrative procedures. With sufficient chunks of information, pattern recognition was rapid and the participants could quickly prioritize and act or delegate as required. Simon (1993) suggested that thinking is sometimes intuitive, and sometimes analytic, depending on the situation, and on the person's recognition of patterns.

> In particular, the thinking of experts dealing with ordinary situations is highly intuitive. It becomes analytic only when the going gets tough, when novelty enters into it, when new problems have to be solved.
>
> (Simon, 1993, p. 405)

A number of studies have examined pattern recognition in nursing and generally concluded that experienced nurses use their knowledge and experience to interpret situations as they change over time (Benner & Tanner, 1987; Jenks, 1993; Peden-McAlpine, 2000; Peden-McAlpine, 2002; Rew, 1987; Thompson, 1999; Welk, 2002). The literature suggests that nurses use pattern recognition to rapidly focus on the relevant chunks of information available to them in order to decide what needs to be done, and the data in the present study showed that the participants were adept in this skill.

Peden-McAlpine (2002, p. 145) referred to the "temporal nature of thinking" used by critical care nurses to learn patients' needs over time and to recognise situational changes. Temporal factors also influenced the participants in the present study, especially those who worked in dementia-specific care units because they recognised that resident care needs varied at different times of the day, and also that they (the nurses) needed to have enough time to provide care in an unhurried way. This suggested at least two aspects of time were relevant, including time according to the clock, and how the work or care was paced.

A final concept related to pattern recognition was "sense-making" (Lewis, 2001, p. 59), and this was defined "as an interpretive process in which people assign meanings to ongoing occurrences". Sense-making occurs when people face ambiguous events where uncertainty is a factor and more than one possible meaning could be attached to situational variances (Lewis, 2001). The meanings that are assigned were called "schemas" (Lewis & Boldy, 2002, p. 176), or mental maps of concepts and events that guide further information-seeking and subsequent action (Schwenk, 1988).

Knowing

In the present study, *knowing* was an intervening condition for *recognising* salient features of situations, and was considered by the participants to be an important part of *trying to get things right*. The concept *knowing* has been the subject of a great deal of nursing literature, particularly revolving around Benner's (1984) work. Carper (1978) described four patterns of knowing: empirics, aesthetics, personal knowledge, and moral knowledge and these explain how we construct nursing knowledge (O'Connell, 1996).

Personal knowledge was said to include experiential, interpersonal, and intuitive knowing components (O'Connell, 1996), and to involve pattern recognition (Sweeney, 1994). Many writers cited the work of Polanyi (e.g. Benner, 1984; Benner & Wrubel, 1982; Carper, 1978; Guba & Lincoln, 1981; Jenks, 1993; Tanner, et al., 1993; Sweeney, 1994). Polanyi drew "a distinction between propositional knowledge, that is, knowledge that can be stated in language form, and tacit knowledge, that is, intuitions,

apprehensions, or feeling that cannot be stated in words but are somehow 'known' by the subject" (cited in Guba & Lincoln, 1981, p. 70).

The distinction between propositional knowledge and tacit knowledge was relevant to the present study in that the RN participants were comfortable with their tacit knowledge about residents' needs, but had difficulty framing this more formally for documentation purposes, particularly in relation to the RCS. It could be argued that applying nursing process to the documentation of residents' behaviour and its management created a dilemma for the participants because many of their conclusions about residents' behaviour tended to be intuitive and difficult to substantiate.

Most of the literature about knowing in nursing related to knowledge about nursing practice and patients. Jenks (1993) broadened the sense of the term *knowing* in nursing when she included other staff and context in the factors necessary for nurses' clinical decision-making. She said:

> Knowing patients, fellow staff and, in some instances, physicians was a major influencing factor in the nurses' clinical decision-making ability. In addition, factors present in the patient care environment that influenced nurses when establishing interpersonal relationships also influenced their clinical decision-making abilities.
>
> (Jenks, 1993, p. 401)

These "multiple patterns of knowing" (Jenks, 1993, p. 399) were demonstrated by the RN participants in the present study who felt that they had more chance of *getting things right* when they knew, or were familiar with, the residents, other staff, the medical practitioners, and organisational policies and procedures. The participants considered that it was particularly important to know the residents and their needs because this enabled them to more effectively position themselves to deal with situations that arose.

Radwin (1995) carried out a study, using grounded theory method, to explore how nurses used holistic understanding of the patients to plan care. Conditions that facilitated knowing the patient "included time, the nurse's experience, and other nurses' input" (Radwin, 1995, p. 364). The RN participants in the present study also found that

time was a significant factor, and, if they didn't know the residents, they relied on other nurses or carers for rapid help in identifying what the residents needed.

Other relevant literature

Two main factors led to increased scrutiny of nursing and of aged care in the late 1990s, and these were growing concerns about the impact on health care of the global nursing shortage, and ongoing issues related to standards in nursing homes. Improvements in care standards were achieved during the 1990s with the introduction of Standards Monitoring Teams (Braithwaite, et al., 1992). The aged care accreditation process, introduced in 1999 to replace Standards Monitoring, broadened the scope of the standards to include resource management and staffing, and to require a focus on continuous quality improvement in all aged care facilities (Vesk, 2002).

Nursing shortage

Concerns about the nursing shortage led to several inquiries and studies that examined nursing as a whole, nursing education, and recruitment and retention of nurses. Two inquiries established by the Commonwealth Government were conducted virtually concurrently during 2001 and 2002. The Senate Community Affairs References Committee (2002) reported on nursing in general and recommended *inter alia* that there was a fundamental and urgent need for national nursing workforce planning, and that pay, conditions, and image issues should be addressed. Those concerns had been recognised in earlier reports, including the Rhys-Hearn Report (1986), the Marles Report in Victoria (cited in Stevens & Herbert, 1997), and the National Nursing Workforce Forum (2000).

The Senate Committee report also stated that aged care nursing "was singled-out as the sector of nursing in greatest crisis" because qualified nurses were leaving the sector and not being replaced (Senate Community Affairs References Committee, 2002, p. xv). The recommendations of the Committee that were relevant to aged care were summarized as follows:

> The Committee has made a number of recommendations in aged care, including reducing the burden of paperwork required under RCS funding, the need for pay

> parity, the increasing use of unqualified workers in aged care, introducing measures to reduce occupational injuries to nurses working in aged care, and to improve educational opportunity in aged care at both undergraduate and post graduate levels.
>
> (Senate Community Affairs References Committee, 2002, p. xv)

Many of the issues identified in the Senate Committee report, and cited above, were conditions that emerged from the data and led to the RN participants in the present study feeling that they were *unable to get things right*. Other reports and writers identified the same concerns, including Bowers, et al., (2001), Cheek, et al., (2002), McDonald (2001), Nay and Closs (1999), Pearson, et al., (2001), and Pearson, et al. (2002).

The National Review of Nursing Education (Heath, 2002) was released two months after the Senate Committee Inquiry described above. This review also examined nursing supply and demand issues, and looked particularly at education and training models that were required to meet future demands. Similar concerns were expressed to those of the Senate Committee cited above, and again, aged care was singled out for specific comment:

> Over-regulation (and associated paperwork) was identified as one of the many factors that compound to act as a disincentive for potential staff to seek qualifications and positions in aged care, and that caring for our ageing population in the future needs a total review in and of itself. A number of comments reflected the need for changes to the existing structure in which a few registered nurses are responsible for the activities of a larger number of unqualified and unregistered workers. This structure particularly reduces the attractiveness of working in aged care for registered nurses.
>
> (Heath, 2002, p. 201)

The findings of those national inquiries were reflective of an earlier report in Western Australia. A small survey was carried out for the Nurses Board of Western Australia "to further understand the issues and concerns of nurses within the Aged Care Sector" (Hardcastle, 2000, p. 4). The survey involved a series of focus groups, and the findings suggested both professional practice and system issues. The author observed that:

> There is an overwhelming sense of "incapability" and inability to achieve quality outcomes. The current system of delivery seems incapable of delivering optimal care irrespective of the rigorous improvement strategies already in place such as

> accreditation. The current system of education, regulation and supporting health care delivery is no longer appropriate and appears to be delivering sub-optimal outcomes.
>
> (Hardcastle, 2000, p. 5)

The findings of the Harcastle (2000) survey reflected the feelings of the participants in the present study, although the term "incapability" did not capture the sense of the participants' comments in the present study. To be incapable suggests a lack of skill or incompetence (Macquarie, 1999, p. 398), and that did not apply to the participants. Rather, in the present study, the participants were *unable to get things right,* largely because of contextual factors and associated conditions described earlier in this study.

There were also concerns about the impact of insufficient nursing staff numbers on standards in aged care in the USA, as stated by a nurse writer:

> Gerontological nursing has long felt the adverse impacts of lax enforcement of good policy. Improper delegation of nursing responsibility has been a problem in institutional long-term care for decades. Delegation has been improper because RN staffing has been insufficient for true supervision, training, and mentoring of licensed practical nurses (LPNs) and nursing assistants (NAs) – a situation made even more difficult by serious understaffing of all levels of direct care nursing personnel.
>
> (Mohler, 2002, p. 7)

Resident care standards

The literature confirmed on-going concerns about the standard of care in residential aged care facilities (both hostels and nursing homes). For example, in the *Two year review of aged care reforms*, Gray (2001) discussed the early achievements of the accreditation process, and questioned the extent to which actual standards were being demonstrated:

> It would seem, then, that the capacity of the [Aged Care Standards and Accreditation] Agency to ensure quality of care lies in its ability to identify formal (recorded) processes and practices that are consistent with the achievement of outcomes, and to source supporting evidence that the processes and practices are implemented. Its relative weakness relates to the link between reports of care and actual care delivered.
>
> (Gray, 2001, p. 92)

The participants in the present study generally believed that they maintained reasonable standards of care themselves, although they were not confident that care standards were maintained by other staff on other shifts. Discrepancies between observed and perceived standards of resident care were found by other writers, including Bartlett (1993) who studied nursing homes in the UK, and Nay (1998) who discussed a study carried out in Australian nursing homes.

It was beyond the scope of this study to explore the work practices and care standards of personal carers, and no literature was found specifically addressing the work of personal carers, apart from Peisah's (1991) study. However, the RN participants in this study did express concerns about the work practices of personal carers when they commented on their inability to effectively supervise them. With five or six personal carers working in sections or wings of the nursing homes, and one RN assigned to the area and already fully occupied with medication administration, treatments, and liaising with doctors and other health professionals, it was virtually impossible for the RN to directly supervise resident care. Therefore, acceptable care standards could not be assured through close supervision because there was no capacity to provide such supervision.

Insufficient time

A study conducted in the US using "grounded dimensional analysis" (Bowers, et al., 2001, p. 485) investigated how working conditions affected long-term care nursing. The methodology was based on the grounded theory method variation developed by Schatzman (cited by Dey, 1999, p. 19).

The findings of the Bowers' study were very similar to those of the present study, and perhaps this should not be surprising because the context was similar. However, there are often thought to be many differences between health and aged care in Australia and the United States, so in that sense the similarities were startling. Bowers, et al. (2001) found that the nurses felt they had too little time to provide good care, and too many interruptions occurred. These were the same conditions that led to the participants in the present study *being unable to get things right*.

The following series of quotations from the Bowers' study could have been written to illustrate the findings of the present study, even though the comments and analysis arose from interview data provided by nurses in nursing homes in the United States. In the following excerpts, categories or concepts that were similar to those that emerged in the present study are underlined for emphasis (emphasis added).

- "Nurses reported that their control over time was often reduced by interruptions including medical emergencies, physician calls, family visits and demands by other staff members or supervisors" (Bowers et al., 2001, p. 486).
- "Nurses' time management strategies fell under the broad categories of keeping up and catching up. The strategies included minimizing time spent doing required tasks, creating new time when behind time, and redefining work responsibilities in order to both keep up and catch up" (Bowers et al., 2001, p. 486).
- "The main strategies for minimizing time spent were to establish and maintain a routine and to manage disruptions by prioritizing (and then reprioritizing) work tasks" (Bowers et al., 2001, p. 486).
- "The narrow focus on task completion, however, meant little time to talk with residents or to respond to requests unrelated to the task at hand" (Bowers et al., 2001, p. 487).
- "Any interruption, by definition, destroyed the routine being used, causing nurses to 'get behind' and pushing them to enlist other strategies" (Bowers et al., 2001, p. 487).
- "One staff nurse described 'missing a few eye drops' in order to complete the administration of medications that she felt were 'more crucial' to the resident's health" (Bowers et al., 2001, p. 487). (A similar omission occurred in the present study, although the RN participant did not feel comfortable with it.)
- "During periods when paperwork – a task with many consequences for the facility, but few for residents or nurses – was emphasised by supervisors, its completion assumed a higher priority than some resident needs" (Bowers et al., 2001, p. 487).
- "Speed narrowed the scope of work to those technical or visible and urgent tasks for which nurses could be held directly accountable. For residents, this meant that

nurses were less likely to perform the surveillance and follow-up work that could prevent small problems from escalating" (Bowers et al., 2001, p. 488).

- "The lack of time often forced nurses to make impossible choices between completing their tasks and providing high quality care" (Bowers et al., 2001, p. 490).
- "The main consequence of lack of time was to revise their definitions of *must do* work and *should do* work. *Must do* work included those things that were rigidly scheduled and for which nurses were held directly accountable…" (Bowers et al., 2001, p. 490).

The strategies used by the nurses in the Bowers et al. (2001) study helped them to complete required tasks, but, as in the present study, there were adverse consequences, in that the American nurses were dissatisfied with the standards of care they were able to achieve. Nurses' "inability to consistently provide quality care to all patients" was also the problem experienced by RNs working in acute care in Western Australian (Williams, 1996).

A recommendation of the Bowers' et al. (2001) study was to increase staff ratios because "[b]y freeing nurses to spend more time with residents, doing so would likely result in improved outcomes for residents – fewer pressure ulcers… and reduced use of psychotropic medications and physical restraints…" (Bowers, et al. 2001, p. 491). It is also likely that reducing the administrative and housekeeping responsibilities of RNs working in nursing homes in Western Australia could result in similarly improved outcomes for residents.

Nursing home managers in the United States had their own problems, and these were also similar to the experiences of the manager participants in the present study. Gelfand (1993) described himself as a "frustrated" nursing home administrator, and went on to state:

> Nursing homes are one of the most regulated, underpaid, poorly regarded and least understood industries in the United States. The public has been led to believe that nursing homes are in business to provide mediocre care in the worst possible conditions and to overcharge for these services. Our own facilities are inspected, re-inspected, criticised and put on display constantly. The federal government, the

> state government and local health officials are all around us, as are the families, board members (in the case of non-profits) and, in some cases, Ombudsmen to handle special complaints. This, of course, doesn't include the need to respond to the Occupational Safety and Health Administration (OSHA), a trade union, or the fire department.
>
> (Gelfand, 1993, p. 54)

Similar feelings of frustration regarding the wide range of regulatory procedures were expressed by the manager participants in the present study. A participant commented that in 1997 in Western Australia, nursing home managers could expect visits from inspectors, auditors, and monitors representing up to 11 different authorities, ranging from Local to Commonwealth Government personnel.

Staffing levels and skills mix

The shortage of qualified nurses and its impact on the quality of aged care services has been widely discussed in literature referred to earlier in this chapter (e.g. McDonald, 2001; Nay & Closs, 1999; Pearson et al., 2002; Senate Community Affairs Reference Committee, 2002). However, the "skills mix" of staff was also an issue for aged care because most of the care staff in nursing homes were unregulated care workers (nursing assistants or personal carers). It was recognised that RNs were concerned about having to supervise unqualified carers, and that they didn't have enough time to provide adequate supervision (Cheek, et al., 2002; Iliffe, 2001; Pearson, et al., 2001; Peisah, 1991).

Aged care accreditation standards required that there should be sufficient qualified nursing staff to meet resident specialised care needs (Aged Care Principles 1997 – Schedule 2, Part 2 of Quality of Care Principles). However, there was ongoing debate over "the nature of nursing care, characterised by skilled intervention, [versus] personal care, which can be provided by any caring person" (Bradley, 1999, p. 59).

The New South Wales Branch of the Australian Nursing Federation (ANF) commissioned a survey of nurses' perceptions about aged care and the aged care sector (McDonald, 2001). The results included a finding that the majority of the respondents considered that they were not able to provide adequate standards of nursing care with the

staffing levels and skills mix that existed at that time (McDonald, 2001). Nay and Closs (1999) also addressed staffing and its relationship to quality of residential aged care services. They cited a number of studies that confirmed the cost effectiveness of employing qualified nurses to provide residential aged care.

The issue of staffing and skills mix goes to the heart of the problem experienced by the RN participants in the present study because those factors contributed to their *being unable to get things right*. Of equal concern was the lack of a coherent role definition for the RNs working in nursing homes in Western Australia. The participants described, and complained about, the non-nursing work that was expected of them, and such duties were the source of most of the interruptions that occurred.

Role definition

Nursing roles in nursing homes are usually defined through position descriptions and duty statements, as required under the aged care accreditation standards (Aged Care Principles 1997 – Schedule 2, Part 1 of Quality of Care Principles). In most nursing homes, the position descriptions describe the clinical role of the RN, and include supervision requirements and individual occupational safety and health responsibilities.

In most of the RN job descriptions that the researcher saw in nursing homes, there was an item that referred to "other duties" to be carried out at the request of the manager. While these "other duties" were not defined, they were understood by the job incumbents to include a range of administrative tasks such as answering the telephone, replacing staff, and monitoring facility security, particularly during evening and night shifts and on weekends.

Pearson et al. (2001) referred to the multiple role responsibilities of RNs in aged care, including them being responsible for housekeeping, security, administration, and receptionist duties. In circumstances where the RN may be the only qualified nurse on duty, and where the residents were more frail and ill than in the past, traditional staffing levels were no longer considered to be adequate (Pearson, et al., 2001).

Cheek, et al. (2002) investigated issues that impacted on the RN providing residential care to older Australians in South Australia, and, in addition to findings that were similar to those of the national inquiries described earlier in this chapter, found particular problems with RN role definition in aged care. As they described it, RNs have to:

> … attend to increasing dependency and acuity of residents, operate as an integral part of the efficient and economic running of a business, document in order to contribute to validating and justifying funding, and create a home environment for the residents.
>
> (Cheek, et al., 2002, p. 38).

Therefore, the role of the RN in aged care continued to be ill-defined, as suggested by Carter and Phillips (1987) because RNs tended to have responsibilities in addition to those documented in job descriptions, and the additional duties tended to be situationally determined. Lillibridge, Axford, and Rowley (2000) studied the scope and boundaries of nursing practice in Melbourne, and found that nurses adjusted their perceptions of professional boundaries according to situational variations, and managed the scope of their practice according to prevailing circumstances. These behaviours are very similar to the *situational positioning* process used by the RN participants in the present study.

The findings of the Melbourne study cited above revealed four categories of strategies used by the nurses to manage the scope of their practice, and one group of strategies related to the nurses' maintenance of a "comfort zone" which served to "perpetuate the status quo and may threaten holistic care" (Lillibridge, et al., 2000, p. 35). Working within their comfort zone tended to lead to task-oriented practice that was stagnant rather than based on contemporary or evidence-based practice (Lillibridge, et al. 2000).

The findings of the present study revealed a similar tendency in the RN participants, in that they often functioned within their comfort zones because of adverse conditions, especially insufficient time. In those circumstances, the participants used *situational positioning* to negotiate their way through the situation, in order to move on to the next task or situation.

Role definition, staffing levels and skills mix, and other contextual conditions were all issues that were identified in the literature as concerns for aged care nursing. These concerns impacted on recruitment and retention of qualified nurses in aged care, and, in the present study contributed to the participants' being *unable to get things right*.

SUMMARY

This chapter explored literature relevant to the theory of *situational positioning* in aged care, which was summarized in the first section of the chapter. *Situational positioning* was compared to several similar models, including Contingency Theory, Situational Leadership, and the five-stage model of skill acquisition applied to nursing by Benner (1984). Other relevant literature was discussed in relation to those theories and to the findings of the present study.

Literature related to decision-making was discussed in the next section of the chapter, including the concept analysis by Matteson and Hawkins (1990). Two relevant studies involving decision-making were then described and interpreted in relation to the findings of the present study.

The final section of the chapter provided a discussion of issues that were related to the core category in the present study, that was, *getting things right*. Beginning with consideration of the two national reviews related to nursing, other surveys and studies that had similar findings to those in the present study were discussed. The final parts of that section drew attention to specific issues of nursing home staff levels, skills mix, and the ill-defined role of the registered nurse in aged care.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

This thesis described the development of the substantive theory of *situational positioning,* which explained how registered nurses (RNs) in Western Australian nursing homes managed the adverse conditions in their work environments. The problem experienced by the study participants was *being unable to get things right* because of adverse contextual, intervening, and causal conditions that prevailed in the aged care sector at the time of the study. Central amongst the adverse conditions that led to the problem experienced by the RN participants were under-resourcing of aged care, which resulted in insufficient qualified nursing staff to meet the complex care needs of residents, and inefficient use of RN time because of their multiple roles in nursing homes. The RN participants were also unable to adequately supervise care-giving by personal carers, mainly because of the high ratio of personal carers to RNs, and were therefore unable to ensure that resident care consistently met the high standards expected by the various stakeholders in the aged care sector.

When the participants were *trying to get things right*, they used *situational positioning* to deal with situations in which variable factors could change quickly and unpredictably. *Situational positioning* was visualised on intersecting, bi-polar continua that depicted the relationship between four categories that emerged from the data, as described in Chapter 5. These categories represented ranges of RN behaviours that occurred in response to situational variables, with the horizontal, or "action" axis of the continua ranging from *yielding* to *confronting* and the vertical or "responding" axis behaviours ranging from *being flexible* to *being rigid*. As situations developed at work, the participants positioned themselves according to their perceptions of situational requirements. Their positioning facilitated *recognising* salient features of the situations to enable *prioritizing* before *moving on* to the next situation.

When situations were complicated by adverse conditions, the participants had to *compromise* and re-prioritize, and this usually involved adopting more *flexible* and *yielding* decision-making so that they could *move on*. Such positioning often resulted in unsatisfactory outcomes for the participants, and sometimes also resulted in sub-standard care for the residents.

The adverse conditions that prevailed in nursing homes at the time of this study impeded nursing practice and the delivery of consistently good standards of care for all residents. *Situational positioning* enabled the participants to *persevere* in their efforts to *try to get things right,* but their capacity to maintain the effort was eroded by the apparently unrelenting nature of the adverse conditions that existed in nursing homes.

CONCLUSIONS

This study illustrated the adverse conditions in which RNs worked in Western Australian nursing homes, and the impediments to their practice. The aged care context was complex and subject to different perceptions and foci of attention by different stakeholders. For example, while residents and their families sought quality care and quality of life at a personal and individual level, service providers sought to efficiently manage service organisations that were subject to many regulations and personnel management issues. Regulatory authorities sought to monitor and ensure compliance with legislation and standards, while special interest groups worked to represent the interests of their constituents by influencing government policy. Another group of stakeholders were the aged care workforce, who provided nursing and personal care and support services, and sought job satisfaction and, in most instances, opportunities to provide good care for frail, older people.

In that range of stakeholders, in a seemingly central position, the RN was the health professional whose role offered the greatest potential capacity to positively influence care standards and the quality of life of residents. However, the data in this study indicated that the RN participants had few opportunities to demonstrate their capacities, assuming that all of the participants actually had the necessary advanced clinical practice skills (e.g. *Competency Standards for the Advanced Gerontological Nurse*, Geriaction,

2000). The adverse conditions in which they worked not only impeded their nursing practice and their ability to meet standards, but may also have masked their skill levels, making identification of individual RN performance deficits difficult.

The RN role in nursing homes was multi-faceted, as recognised in recent reports (Cheek, et al., 2002; Pearson, et al., 2001). The data in the present study suggested that RNs spent a large proportion of their time performing routine tasks and administrative work, and they considered that there was insufficient time for them to provide hands-on nursing care. Their roles were based on the traditional job design of the nursing home RN, which had remained virtually unchanged in Western Australian nursing homes since at least the 1960s (Source B, personal communication, May 2003). The dichotomy of clinician versus administrator meant that the RN participants had to prioritize the way they used their time, and routine procedures such as medication rounds and episodic administrative tasks tended to have higher priority than supervision of resident care given by personal carers. This reduced the participants' opportunities to ensure good care standards.

It was also apparent during the study that the RN participants engaged almost exclusively in technical aspects of nursing care, with "body care" (Lawler, 1991) being provided by enrolled nurses (ENs) and personal carers. They also seemed to have few opportunities to provide anything other than superficial social, emotional, or spiritual support for residents, which was also a finding of Williams' (2003) study with RNs working in the acute health care sector.

The RN role in Western Australian nursing homes at the time of the study was not unlike the "ward sister" role of the 1950s, when the "sister" coordinated nursing care carried out by student nurses, who were themselves organised into a hierarchy according to their seniority (McCoppin & Gardner, 1994; Russell, 1990). The parallel in nursing homes during this study was the hierarchy of nursing and personal care staff, with the ENs' status being similar to senior student nurses of the 1950s, and the personal carers being more or less "junior" depending on their experience and skill.

While the RN job design had remained virtually unchanged since the 1950s, there had been many other changes in the aged care sector by the late 1990s. A significant change was that the nursing home residents' profile in the 1990s was different than it was in the 1960s and 1970s (Gray, 2001), with most of the residents having complex care needs requiring skilled, round-the-clock nursing care. Another change was the introduction of legislated aged care standards and the associated accreditation program, which impacted on the role of the RN in nursing homes by specifying care standards and the expectation of continuous quality improvement in all aspects of residential aged care.

However, while specifying care standards, the accreditation program imposed more administrative tasks on nursing homes. Most of the management staff in the nursing homes represented in the present study were senior nurses, but they spent more of their time performing administrative functions and maintaining documentation for accreditation and funding purposes than coordinating resident care. The *Two Year Review of Aged Care Reforms* (Gray, 2001) also found that accreditation procedures demanded more documentation and resources than had the previous standards monitoring system.

With senior nursing staff often tied up with administrative activities, the actual supervision of resident care fell increasingly to the RNs, but they were even less able to provide appropriate direction and supervision of personal carers because of their own increasing workloads. The findings of the study suggested that it is unlikely that the existing organisational structures could enable continuous improvement of resident care standards; at best, they might maintain the status quo. Essentially, *situational positioning* used by the study participants when *trying to get things right* was a process that involved *compromising* to achieve the best outcomes that were possible in the prevailing circumstances. In that environment, improvements in care standards were likely to be hard won.

Therefore, the main conclusion of this study was that the RN role in nursing homes in Western Australia was ill-defined, and inefficient in terms of best utilisation of nursing time. Actions to address the range of adverse conditions that impacted on effective nursing practice have been proposed in recent literature (Cheek, et al., 2002; Heath, 2002; Pearson, et al., 2002; Nay & Closs, 1999), and it is hoped that these recommendations will be implemented, especially those related to education and documentation requirements. However, redefinition of the RN role may be the most accessible and potentially cost effective strategy to contribute to improvements in quality of care for nursing home residents.

LIMITATIONS

One of the limitations of this study includes the potential for generalisation related to the methodology, which was designed to explore problem-solving and decision-making by RNs in Western Australian nursing homes. The theory of *situational positioning* is substantive, in that it applies to the particular context from which the data were derived, that is, nursing homes in Western Australia. It is also recognised that the findings of the study emerged during a period of significant change in the aged care sector in Australia, and this may have impacted on the experience and perceptions of the participants. In traditional terms, it could therefore be suggested that the findings of the study are not generalizable to other nursing populations. However, Morse (1999) argued that qualitative research findings may be generalizable when considering application of the theory to contexts in which the conditions and problems are similar.

There were many similarities between the findings of this study and the reported findings of other studies, carried out both in Australia and overseas (Bartlett, 1993; Bowers, et al., 2001; Cheek, et al., 2002; Irurita & Williams, 2001; Nay, 1998; O'Connell, 1997, 1998; Pearson, et al., 2001; Pearson, et al., 2002; Williams, 1996). There was a common thread that ran through those studies and the present study, and that was the importance of favourable contextual conditions to enable RNs to provide consistently high standards of nursing care. Unfavourable or adverse conditions, such as insufficient qualified nursing staff and insufficient time to provide the care needs of

residents, patients, or clients according to expected standards, often resulted in sub-standard care.

The theory of *situational positioning* meets the criteria of fit and relevance, and it is comprehensive and complete, and therefore it may be applied to similar scenarios identified in the wider population of aged care nurses. At the same time further studies in aged care and other nursing contexts may find both similarities and differences in the responses of nurses to adverse working conditions to those found in this study.

Another potential limitation of this study was related to the six-year time span over which the interviews were conducted, as described on pages 38 and 39 in Chapter 2. However, this limitation was overcome by careful review of transcripts and data analysis after each period of more than four months between interviews, so that each new interview was approached with a current appreciation of previous interviews and progress in the constant comparative approach to data analysis. The longest gap between interviews was in 1998, following the emergence of categories related to the impact of the adverse decision-making environment. As described in the "Theoretical sampling" section of Chapter 2 (page 34), a director of nursing was purposefully selected to be interviewed to explore issues that had arisen from the data, and that interview provoked considerable reflection over several months. The fact that the way the participants managed situations in nursing homes did not change over the six-year time span demonstrated that the decision-making processes they used were stable over time and in changing conditions.

IMPLICATIONS

The implications of the study will be addressed under four headings: management of quality nursing care of residents, RN role definition, continuing nursing education in aged care, and on-going research.

Managing quality nursing care of older people in nursing homes

The findings of the study indicated that there were variations in care standards in Western Australian nursing homes. Most of the time, the RN participants considered that the care they provided was of an acceptable standard for most residents, and occasionally it may have been excellent for individual residents, but sometimes it was also sub-standard for some or most of the residents, depending on the circumstances. The participants were aware of the need for improvement, especially in relation to continuity of care for residents.

Holistic care-giving was not evident in this study because of the fragmented and task-oriented approaches to nursing and personal care, which resulted from the way that care provision and staffing were structured. This meant that the provision of consistently high standards of care for all of the residents in a given nursing home could not be assured, and sometimes even minimal care standards were compromised.

The Senate Community Affairs Reference Committee report (2002, p. 158) on the *Inquiry into Nursing* stated that "evidence indicated that delivery of quality aged care is under threat." The Committee attributed the threat to the loss of qualified nurses from aged care and their replacement with unqualified staff, which "results in staff with skills mix which is at best variable, and in some instances not up to standard" (p. 158). In the present study, other factors also contributed to care standards being compromised, including the ill-defined RN role and excessive documentation requirements.

In this study, there was evidence of frequent compromises of standards and reduced expectations of what could be achieved in circumstances where adverse conditions existed. Gray (2001) recognised that the aged care accreditation program did not objectively measure care and health outcomes, although assessors made inferences and judgements based on their observations and interpretation of documentary evidence. It has also been suggested that some facilities may have been unable to sustain the improvements made for their accreditation assessment visit (Pearson, et al., 2002).

Situational positioning, the process used by the participants when *trying to get things right,* involved *compromising* and *repositioning*. This enabled the RNs to return to their comfort zones, a phenomenon described by Lillibridge, et al., (2000), rather than to create an environment in which they could improve care standards in subsequent, similar situations. However, potential capacity for sustained improvement in care outcomes existed in the skills and dedication of the RNs, although changes would be required in a number of conditions to enable that potential to be realised.

It was evident during this study that personal carers were the backbone of the aged care workforce, and that their skills and attitudes to aged care were essential to the assurance of consistently good care standards. Given that it is unlikely that the shortage of RNs will be reversed, even in the medium-term (Senate Community Affairs References Committee, 2002), investment in personal carer knowledge and skills development would probably have beneficial outcomes for residents. With appropriate training such as Certificate III and IV courses in Aged Care Work, personal carers could be encouraged to accept more responsibility for their own work practices and on-going skills development. In some organisations in Western Australia, achievement of Certificate III in Aged Care Work was made a pre-requisite for employment of personal carers, and the number of such courses that were available increased significantly after 1998.

Aged care service providers may need to consider creation of a career pathway for personal carers. This notion would see Level 1 personal carers having completed, or be working towards, a Certificate III in Aged Care Work. Promotion to Level 2, or Team Leader, could be a goal for those experienced carers who are working towards, or have completed a Certificate IV in Aged Care Work, and their role would include working with less skilled personal carers and provide direct supervision and on-the-job coaching. A Level 3 role as Unit Manager could then create opportunities for older personal carers, who are no longer able to manage the hard physical workload, to carry out coordination and routine unit management duties. With employer support, Team Leaders could undertake management studies such as an Associate Diploma, to prepare them for the

Unit Manager role. Apart from providing a career pathway for personal carers, such a project could also enable transfer of non-nursing duties away from RNs, which is so necessary in light of the findings of this study.

The findings of this study challenge the optimistic view that regulation of nursing home standards through accreditation and other controls can achieve sustained improvements in quality of care for all residents. Other strategies are necessary to address the range of factors that impact on the delivery of consistently good standards of care, such as those suggested in this chapter. Further, the recommendations of recent reviews and reports, discussed in Chapter 6, should be implemented (Cheek, et al., 2002; Pearson, et al., 2001; Pearson, et al., 2002).

RN role definition in the aged care context

The study reinforced the need for review of the RN role as identified by Cheek, et al., (2002), Heath (2002), and Pearson, et al., (2002). The consequences of the ill-defined RN role and out-dated job design, together with the contextual and intervening conditions that applied in the present study, meant that the RN participants were often *unable to get things right*:

1. Resident care was fragmented because of traditional rostering styles, the mainly part-time RN workforce, and the need to use agency RNs to cover vacant shifts.
2. The predominance of unqualified care staff made it difficult for RNs to effectively supervise their work practices, and there was virtually no time available in the RNs' schedule to provide on-the-job training.
3. RNs tended to be task oriented, focusing mainly on medication administration, technical care (wound care, etc.), and documentation. Frequent interruptions meant that they had few opportunities to carry out comprehensive assessments of residents' needs, and to develop individualised, goal-oriented care plans.

The RN participants in this study spent the bulk of their time undertaking routine technical nursing procedures and administrative tasks, with approximately 50 per cent of each shift being taken up with medication administration. Therefore, any strategies that

reduced medication administration time would be likely to release the RNs to carry out more professional nursing such as resident assessments and care planning. One aged care organisation in Western Australia has experimented with a different approach to medication delivery, including administration of medications by personal carers using multi-dose blister packs, with supervision and monitoring by RNs (Source F, personal communication, April, 2003). Interim evaluation of the project was positive, and that result encourages further examination of the RN role and responsibilities.

Senior RNs who had the most experience in nursing and aged care spent most of their time carrying out routine administrative tasks and tasks associated with accreditation and funding procedures. The nurse manager participants were aware of the extent to which their roles had changed, and that they had few opportunities to observe direct care, except when asked to assist with a resident health crisis. They felt that they needed to rely on the RNs to be their eyes and ears, but were also aware that the RNs were fully engaged with their own responsibilities. It was clear that the nursing skills of RNs at all levels were being under-utilised and, as a result, there was a tendency for RNs to rely on information provided by personal carers to plan and evaluate resident care.

There is a potential for nurse managers to be released to manage nursing and personal care if routine administrative tasks were to be delegated to non-nursing support staff. In some organisations, most of the human resource management tasks were carried out by support staff, although the time thus made available to the nurse managers then tended to be taken up by documentation of continuous improvement activities to maintain their accreditation status (Source C, personal communication, April, 2003).

It was acknowledged that the global shortage of RNs would continue to have an impact for the foreseeable future (Senate Community Affairs References Committee, 2002), and therefore, it is likely that the critical shortage of RNs in aged care will continue. Therefore, consideration should be given to reviewing the RN role in aged care, and to exploring models other than the "case-load", or individual client-focus model that dominates other health care professional approaches to care. For example, a

collaborative team approach (Hart, Mungomery & Bull, 1995) may be a more appropriate model for residential aged care. The key aspect of the collaborative team approach is planned peer consultation between RNs to plan and coordinate nursing care (Hart, et al., 1995).

One of the findings of this study was that it was important for RNs to get to know the residents and other stakeholders in the aged care environment, and *knowing* was an intervening condition for *recognising* salient features of situations. Participants commented on the benefits of consulting with other RNs, and discussing resident care problems, and this was reasonably easy when there were several RNs working on the same shift. However, it was more difficult for participants who worked in small facilities, or only on evening or night shifts because in most nursing homes the time allowed for discussion of residents' needs was very limited, with very little time for hand-over between shifts (Savy, 1997). There was anecdotal evidence that RNs did not read care plans, partly because they did not have time, and also because care plans tended to focus on the Resident Classification Scale (RCS), and to consist of many pages of closely-written text. Therefore, RNs tended to work in relative isolation, and to inadvertently exacerbate the discontinuity of care caused by rostering arrangements.

Alternative models of organising nursing work have been explored over the years, including patient allocation, team nursing, and primary nursing. Resident allocation approaches were tried informally in one organisation, but did not succeed (Source C, personal communication, Aug. 2002) because, with the predominantly part-time RN workforce working preferred or set shifts, the few full-time RNs tended to be allocated a more residents than they could manage. Alternative models, such as a collaborative team approach involving peer consultation, would require allocation of time for care conferences and planning. Hart, et al., (1995, p. 393) suggested that such an approach would promote "collegial practice".

Continuing nursing education in aged care

Many of the reviews and studies regarding nursing and aged care that were published in the 10 years to 2002 recommended improvements in aged care staff education. The accreditation standards introduced in 1997 mandated staff education and training in all residential aged care facilities, so it may be argued that the resulting education programs would contribute to improved standards. However, the brief, ad-hoc education sessions that were commonly offered in many nursing homes during the period of this study had little potential to promote the development of effective problem-solving skills in RNs. Participants in this study said that RNs working in aged care at that time did not have the opportunity, motivation, or available money to attend more formal, structured education.

The original question that led to this study related to why some RNs found written application of nursing process difficult to do. This question was partly answered by the findings of the study that contextual and other conditions impeded the application of formal problem-solving skills. However, those impediments dominated the data, and perhaps masked other factors, such as whether the RNs who had not learned nursing process during their general nurse training had actual knowledge and skills deficits, or had retained a task-oriented approach to nursing work.

Therefore, it was difficult to assess the actual abilities of RNs in relation to problem-solving and application of nursing process principles because adverse contextual conditions tended to mask their performance in these areas. For example, the documentation required to substantiate the RCS was set in a nursing process framework, and participants commented that the nursing process had unfortunately become inextricably linked to voluminous, difficult-to-write, and not-very-useful care plans. Oral transmission of information about residents conveyed some problem-solving information, although it was sometimes superficial and focused on short-term outcomes (e.g. to heal a minor wound).

It seems apparent that the nursing process model that was the recommended framework for documentation in residential aged care was inappropriate, and constituted a

constraint to effective nursing practice, as suggested by Henderson (1982), and also found by O'Connell (1997, 1998). No challenges to the recommended framework for nursing documentation in aged care were found in the literature, perhaps because there were no alternative documentation models with sufficient structure and rigour to enable validation of data to confirm funding claims.

Recent reports recommended a review of the documentation requirements in nursing homes (Cheek, et al., 2002; Heath, 2002; Pearson, et al., 2001; Pearson, et al., 2002), and a review was commissioned by the Commonwealth Department of Health and finalised in early 2003 (Aged Care Evaluation and Management Advisors, 2003). Concerns that the validation of funding was linked to resident care documentation was acknowledged by the Minister for Ageing, when he said: "In launching the review I made it clear that we needed to uncouple the relationship between funding and care plans so that care staff could concentrate on what they are trained for - providing the best possible care" (Commonwealth Department of Health & Ageing, 2003b).

The report confirmed the validity of industry concerns about the RCS funding tool, and recommended either a revised funding model based on the existing RCS, or implementation of a new system (Aged Care Evaluation and Management Advisors, 2003). Some recommendations were referred back to the Industry Liaison Group, and other action was deferred to wait on the completion of the Review of Pricing Arrangements in Residential Aged Care (Commonwealth Department of Health & Ageing, 2003b).

Until there has been some decisions about the revised funding tool, it will be difficult to anticipate the education needs of RNs in nursing homes, although more ad-hoc short courses are unlikely to contribute to the development of problem-solving competencies. There were some variances in the apparent competencies of the RNs who participated in this study. For example, some seemed to be very comfortable with nursing process terminology and their comments illustrated application of the principles. However, others seemed to have difficulty with the concepts, and were more comfortable talking

about practical aspects of their work, although this was not necessarily indicative of knowledge or skills deficits (Bowers, et al., 2001).

Recommendations for improvements in education programs for all levels of aged care workers (Pearson, et al., 2002) have cost implications for aged care service providers, and funding did not include provision for staff education during the time of this study. There was anecdotal evidence that many aged care service providers and managers regarded staff education, or support for self-education by staff, as an expense that was not likely to be balanced by a return on the investment because of staff turnover. Therefore, there was a tendency to provide as much on-site education as was necessary to demonstrate compliance with the accreditation standards, although there were notable exceptions to this position. Provision of study leave, payment of higher education fees, and other formal education support strategies for RNs were very rare in the aged care sector in Western Australia at the time of the present study.

Moyle (1996) and Ryan (1989) identified a number of reasons, apart from cost, why RNs did not attend education sessions provided by their employers, either at work or off-site, including family needs and other commitments. During the present study, some RNs attended as much inservice education as they could, and said they received benefit from it. However, the conditions in which the education was provided were less than ideal, and learning outcomes tended to be pitched at knowledge and comprehension levels of learning hierarchies (Bloom and Krathwohl, cited in Guinée, 1978). Application of what the RNs had learned also tended to be difficult because organisational structures, procedures, and practices did not often change to support implementation of their new knowledge or skills.

Ongoing research

The findings of this study provide opportunities to further develop the theory of *situational positioning,* and also to further research RN role and staffing models used in the aged care sector. Collaboration between aged care service providers and university

research centres began some years ago, and so the framework for research and demonstration projects already exists in several Australian States.

A key issue in research in aged care is access to funding (Pearson, et al., 2002). Sources of funding for private sector aged care organisations are limited, funding for projects in aged care tends to be targeted to current agendas, and few aged care services providers (managers or nurses) can allocate the time to writing speculative applications for funding grants.

Consideration should be given to investigating the RN role in the residential aged care sector. For example, RN job specifications and responsibilities should be examined in relation to the care needs of future nursing home residents. The *Competency Standards for the Advanced Gerontological Nurse* (Geriaction, 2000, p. 1) were developed to "reflect the current practices of registered nurses working in the field of gerontological nursing at advanced practice level". These competency standards provide clear descriptions of the advanced clinical role of the RN in aged care settings.

However, aspects of the current RN role that have been taken for granted, and are not described, are the routine administrative and housekeeping duties that impacted so significantly on the participants in this study. Alternative approaches to addressing these tasks could be explored, including developing support roles for experienced and appropriately qualified non-nursing staff.

A second area of nursing practice that warrants investigation is the management of resident medications. The high risk for errors that existed in the adverse environment in which medications were administered in nursing homes was recognised during the 1990s (Baker, 1999; Owens, 1996). Further investigation of ways to improve the quality use of medicines (QUM) in aged care would provide benefits for nursing home residents and for the nurses who administer their medications. Guidelines for a QUM approach to medication management in residential aged care were published by the Australian Pharmaceutical Advisory Council (2002). Together with other strategies,

implementation of these guidelines could help RNs to overcome some of the difficulties they experienced with medication administration.

The third area of research suggested by the findings of the study and related literature was the use of clinical indicators to measure effective nursing practice in aged care. This could help RNs to choose appropriate care strategies, and to prioritize their time more effectively. For example, in an informal project, resident falls were identified as a clinical indicator, and strategies to prevent falls were developed and implemented (Source C, personal communication, Mar. 2002). Other clinical indicators were identified, and some of these were included in a quality improvement program introduced to the aged care industry in 2002 (Midson, 2002). Nursing homes that collect this data have opportunities to collaborate in a range of projects to apply evidence-based practice in aged care.

Finally, the theory of *situational positioning* could be further developed and refined to provide more insight into the problem-solving and decision-making strategies that RNs actually use under more favourable conditions. This could lead to the identification of strategies that RNs could use to focus on the nursing aspects of situations and reduce the impact of the adverse decision-making environment on their practice.

RECOMMENDATIONS

Based on the findings, the recommendations of the study are as follows:

1. There is a need to re-design the RN role as it is applied in nursing homes, to free RNs from administrative and house-keeping duties so that they can focus on clinical nursing work and supervision of personal carers.
2. A mechanism to assess the abilities of RNs to apply problem-solving skills could be developed. If the mechanism was reasonably portable and user-friendly, it could be used by nurse managers in nursing homes, and the results then used to target the specific learning deficits of their RN employees.
3. More collaboration with university schools of nursing should be investigated in order to provide relevant education for RNs working in residential aged care, to assist

them to develop clinical skills that would facilitate effective problem-solving and care planning. If the education was packaged in such a way that it could be delivered in nursing homes by trained facilitators there would be a greater likelihood of RN participation in the education programs.

4. Industry associations should be encouraged to lobby for staff education and training to be included in aged care funding, so that it will no longer be seen to be an unrecoverable expense.
5. The costs of employing non-nursing support staff to perform clerical/receptionist duties after office hours should be examined to explore the feasibility of appointing staff to such duties. This would reduce interruptions of RN practice.
6. Strategies to more efficiently use nursing time should be considered, including:
    6.1 Implementation of quality use of medicines programs and new medication delivery systems to increase the safety of medication management in residential aged care and reduce RN time involved in medication administration.
    6.2 Development of standardized care plans for routine personal care procedures to reduce the time spent by RNs in hand-writing individual care plans that address residents' activities of daily living (ADLs).
7. Strategies that may reduce the impact of the RN shortage in aged care should be considered. For example, in situations where there are insufficient RNs to cover night shift rosters, organisations and staffing agencies could be invited to provide locum RNs to visit residents experiencing nursing and health problems overnight, to provide assessment, advice and referral to acute health services if necessary.
8. Finally, it is recommended that further research be carried out to explore various aspects of *situational positioning*, including:
    8.1 Examination of the contingencies that lead RNs to adopt or vary their positions on the continua;
    8.2 Identification of strategies that facilitate effective RN management of situations and minimise the need for them to compromise care standards, and
    8.3 Investigate the impact of *situational positioning* on residents and their families.

CONCLUDING STATEMENT

Situational positioning was a process used by RNs in Western Australian nursing homes when they were *trying to get things right.* However, the adverse conditions that existed in the aged care sector at the time of the study still led to occasions when the participants were *unable to get things right*, and this impacted negatively on care standards.

The conclusions of the study were mainly related to the consequences of the ill-defined RN role in aged care, in that RN skills were often under-utilised and there was inefficient use of nursing time. The consequences were that care standards were compromised, the RN participants were often dissatisfied with their own performance, and some experienced low self-esteem as a result. Modifications in the working environment of aged care RNs to reduce the impact of the adverse conditions and increase the opportunities for *getting things right* were presented as recommendations.

REFERENCES

ABC Radio National, (1996). *Background briefing: Public patients, private profit*. Broadcast on Sunday, 20 Oct 1996. Australian Broadcasting Commission.

Aged Care Act 1997. No. 112. Parliament of Australia.

Aged Care Evaluation and Management Advisors. (2003). *Resident Classification Scale review.* Aged and Community Care Service Development and Evaluation Reports, No. 43. Canberra: Department of Health and Ageing.

Aged Care Principles (made under subsection 96-1(1) of the *Aged Care Act 1997*) as amended to 01 July 2001.

Alfaro-LeFevre, R. (1994). *Applying the nursing process: A step-by-step guide* (3rd ed.). Philadelphia: J. B. Lippincott Company.

August-Brady, M. (2000). Flexibility: A concept analysis. *Nursing Forum, 35*(1), 5-13.

Australian Bureau of Statistics, (2000). *Australia now: A statistical profile*. Commonwealth of Australia. <http://www.abs.gov.au/websitedbs> [Accessed 30 Jan. 2000].

Australian Institute of Health and Welfare. (1999a). *Nursing labour force 1998.* (AIHW cat. no. HWL 14.) Canberra.

Australian Institute of Health and Welfare. (1999b). *Older Australia at a glance* (2nd ed.). Canberra: AIHW and Commonwealth Department of Health and Aged Care.

Australian Institute of Health and Welfare. (2000). *Residential aged care facilities in Australia 1998-99: A statistical overview.* (AIHW cat. no. AGE 16) Canberra: AIHW (Aged Care Statistics Series).

Australian Law Reform Commission. (1995). *The coming of age: new aged care legislation for the Commonwealth.* Review of legislation administered by Department of Human Services and Health. ALRC Report No. 72. Commonwealth of Australia.

Australian Nursing Council. (1998). *ANCI national competency standards for the registered nurse.* Dickson, ACT: Australian Nursing Council.

Australian Pharmaceutical Advisory Council. (2002). *Guidelines for medication management in residential aged care facilities* (3rd ed.). Canberra: Commonwealth Department of Health and Ageing.

Babchuk, W. A. (1996). *Glaser or Strauss?: Grounded theory and adult education.* Paper presented at the Midwest Research-to-Practice conference, Michigan State University. <http://www.anrecs.msu.edu/research/gradpr96.htm> [Accessed 13 June 2001].

Backman, K., & Kyngäs, H. A. (1999). Challenges of the grounded theory approach to a novice researcher. *Nursing and Health Sciences, 1*, 147-153.

Bailey, J. T., &. Claus, K.E. (1975). *Decision making in nursing: Tools for change.* St Louis: C.V.Mosby.

Baker, H. (1999). Medication errors: Where does the fault lie? In S. Hunt & R. Parkes (Eds.), *Nursing and the quality use of medicines* (pp. 73-85). St Leonards, NSW: Allen & Unwin.

Bartlett, H. (1993). *Nursing homes for elderly people: Questions of quality and policy.* Chur, Switzerland: Harwood Academic Publishers.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, Calif.: Addison-Wesley.

Benner, P., & Tanner, C. (1987). Clinical judgement: How expert nurses use intuition. *American Journal of Nursing, 87*(1), 23-31.

Benner, P., & Wrubel, J. (1982). Skilled clinical knowledge: The value of perceptual awareness. *Nurse Educator, 7*, 11-17.

Bevan, C., & Jeeawody, B. (1998). *Successful ageing: Perspectives on health and social construction.* Sydney: C.V.Mosby.

Blegen, M. A., Goode, C., Johnson, M., Maas, M., Chen, L., & Moorhead, S. (1993). Preferences for decision-making autonomy. *Image: The Journal of Nursing Scholarship, 24*(4), 339-344.

Bolton, G. C., & Joske, P. (1982). *History of Royal Perth Hospital*. Perth: Royal Perth Hospital.

Bowers, B. J., Lauring, C., & Jacobson, N. (2001). How nurses manage time and work in long-term care. *Journal of Advanced Nursing, 33*(4), 484-491.

Bowles, J., & Fleming, R. (1994). The prosthetic environment in dementia care. In *Dementia: A positive view. A collection of articles by health professionals and carers.* Canberra: Department of Veterans' Affairs.

Bradley, C. (1999). Doing more with less in nursing work: A review of the literature. *Contemporary Nurse, 8*(3), 57-64.

Braithwaite, J., Makkai, T., Braithwaite, V., Gibson, D., & Ermann, D. (1990). *The contribution of the standards monitoring process to the quality of nursing home life: A preliminary report.* Canberra: Department of Community Services and Health.

Braithwaite, J., Makkai, T., Braithwaite, V., & Gibson, D. (1992). *Raising the standard: Resident centred nursing home regulation in Australia.* Canberra: Department of Health, Housing and Community Services.

Brickhouse, N. (1992). Ethics in field-based research: Ethical principles and relational considerations. *Science Education, 76*(1), 93-103.

Buckingham, C. D., & Adams, A. (2000a). Classifying clinical decision making: A unifying approach. *Journal of Advanced Nursing, 32*(4), 981-989.

Buckingham, C. D., & Adams, A. (2000b). Classifying clinical decision making: Interpreting nursing intuition, heuristics and medical diagnosis. *Journal of Advanced Nursing, 32*(4), 990-998.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*, 13-23.

Carter, M. P., & Phillips, C. (1987). What's wrong with working in a nursing home? An analysis of nurses' comments. *The Australian Nurses Journal, 16*(11), 49-62.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed. pp. 509-535). Thousand Oaks: Sage Publications, Inc.

Cheek, J., Ballantyne, A., Jones, J., Roder-Allen, G., & Kitto, S. (2002). *Ensuring Excellence: An investigation of the issues that impact on the registered nurse providing residential care to older Australians*. Adelaide: University of South Australia, Centre for Research into Nursing and Health Care, and Aged Care & Housing Group Inc.

Child, J. (1995). Organizational structure, environment and performance: The role of strategic choice. In L. Donaldson (Ed.) *Contingency theory* (pp. 399-420). Aldershot: Dartmouth.

Clare, J., De Bellis, A., & Jarrett, D. (1997). Planning aged care in Australia: A review and critique of the reforms 1975-96. *Collegian, 4*(1), 22-29.

Commonwealth Department of Health and Ageing. (2003a). *Submission to the House of Representatives Standing Committee on Ageing*. Canberra: Commonwealth of Australia.

Commonwealth Department of Health and Ageing. (2003b). *Resident Classification Scale review response*. March 2003. Canberra: Commonwealth of Australia.

Commonwealth Department of Health and Aged Care. (2000). *Report on the Operation of the Aged Care Act 1997: 1 July 1999 to 30 June 2000.* Canberra.

Conrick, M. (1998). Clinical decision making: Issues in teaching. *The Australian Electronic Journal of Nursing Education, 2*(1).

Corcoran, D. W. J. (1971). *Pattern recognition.* Harmondsworth, Middlesex: Penguin Books Ltd.

Courtney, M., & Price, G. (1999). Funding and policy in residential care. In R. Nay & S. Garrett (Eds.), *Nursing older people: issues and innovations* (pp. 18-39). Sydney: MacLennan & Petty.

Davis, J. A. (1994). *Older Australians: A positive view of ageing.* Sydney: Harcourt Brace & Company.

dela Cruz, F. A. (1994). Clinical decision-making styles of Home Healthcare nurses. *Image: The Journal of Nursing Scholarship, 26*(3), 222-226.

Denzin, N. K., & Lincoln, Y.S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 1-28). Thousand Oaks: Sage Publications, Inc.

Department of Community Services, (1986). *Nursing Homes and Hostels review (Rees Report)*. Canberra: AGPS.

Dewey, J. (1933). *How we think.* Boston: Heath.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry.* San Diego: Academic Press.

Donaldson, L. (Ed.). (1995). *Contingency theory.* Aldershot: Dartmouth Publishing Company.

Dreyfus, H. L., & Dreyfus, S. E. (1996). The relationship of theory and practice in the acquisition of skill. In P. Benner, C. A. Tanner, & C. A. Chesla, (Eds.). *Expertise in nursing practice: Caring, clinical judgement and ethics* (pp. 29-47). New York: Springer Publishing Company.

Fiedler, F. E., & Chemers, M. M. (1974). *Leadership and effective management*. Glenview, Illinois: Scott, Foresman and Company.

Fine, M., & Stevens, J. (1998). Innovation on the margins: Aged care policies. In C. J. Bevan, B. (Ed.), *Successful ageing.* Sydney: Mosby.

Fleming, M. H. (1991). The therapist with the three-track mind. *The American Journal of Occupational Therapy, 45*, 1007-1014.

Fogg, S. (1999). Consumer perspectives. In I. Stein (Ed.), *Aged care: A contemporary view.* Deakin, ACT: Royal College of Nursing Australia.

Follett, M. P. (1982). Decision making. In D.A.Gillies (Ed.), *Nursing management: A systems approach.* Philadelphia: W.B.Saunders Company.

Freke, T. (Ed.). (1999). *Lao Tzu's Tao Te Ching*. London: Judy Piatkus (Publishers) Ltd.

Fruedenberger, H. J., & North, G. (1982). *Situational anxiety*. Garden City, NY: Anchor Press.

Gahan, C., & Hannibal, M. (1998). *Doing qualitative research using QSR NUD*IST*. London: Sage Publications.

Gelfand, L. (1993). Frustrations of a nursing home administrator in the 1990s. In J. A. Toner, Tepper, L.M., & Greenfield, B. (Ed.), *Long-term care: Management, scope and practical issues* (pp. 54-59). Philadelphia: The Charles Press.

Geriaction, Inc. (2000). *Competency standards for the advanced gerontological nurse*. Chatswood, NSW: Geriaction, Inc.

Giles Report – see Senate Select Committee on Private Hospitals and Nursing Homes.

Glaser, B. G. (1978). *Theoretical sensitivity.* Mill Valley CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence Vs forcing.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A.L. (1965). *Awareness of dying*. Chicago: Aldine Publishing Company.

Glaser, B. G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* London: Weidenfeld and Nicolson.

Gray, L. (2001). *Two year review of aged care reforms.* Canberra: Department of Health and Aged Care.

Gregory, R. (1991). *Aged care reform strategy mid term review 1990-91.* Canberra: Department of Health, Housing and Community Services.

Gregory, R. (1994). *Review of the structure of nursing home funding arrangements, Stage 2, Aged and Community Care Service Development and Evaluation Report No. 12.* AGPS, Canberra: Department of Health, Housing, Local Government and Community Services - Aged and Community Care Division.

Guba, E. G., & Lincoln, Y.S. (1978). *Toward a methodology of naturalistic inquiry in educational evaluation.* Los Angeles: University of California.

Guinée, K. K. (1978). *Teaching and learning in nursing.* New York: Macmillan Publishing Co., Inc.

Haig, B. D. (1995). Grounded theory as scientific method. *Philosophy of Education, Yearbook 1995*.

Hall, M. M. (1999). Breaking the silence: Marginalisation of registered nurses employed in nursing homes. *Contemporary Nurse, 8*(1), 232-237.

Hall, W. A., & Callery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflectivity and rationality. *Qualitiative Health Research, 11*(2), 257-272.

Hardcastle, H. (2000). *Aged care review report*. Perth: Nurses Board of Western Australia.

Hart, G., Mungomery, L., & Bull, R. (1995). *Peer consultation: A strategy to support collegial practice.* In G. Gray & R. Pratt (Eds.). *Issues in Australian nursing 4* (pp. 391-405). Melbourne: Churchill Livingstone.

Health Workforce Branch (1996). *Registered and enrolled nurse labour force survey*. Health Department of Western Australia.

Heath, P. (2002). *National review of nursing education 2002: Our duty of care.* AusInfo: Commonwealth of Australia.

Heinrich, J. (1999). The changing face of aged care in Australia. *National Healthcare Journal, 9*(4), 26 - 27.

Henderson, V. (1982). Nursing process - is the title right? *Journal of Advanced Nursing, 7*, 103-109.

Hersey, P., Blanchard, K.H., & Johnson, D.E. (1996). *Management of organizational behaviour* (7th ed.). Upper Saddle River, NJ.: Prentice Hall.

Hersey, P., & Duldt, B. W. (1989). *Situational leadership in nursing.* Norwalk, Conn.: Appleton & Lange.

Hershey, J. C., & Baron, J. (1987). Clinical reasoning and cognitive processes. *Medical Decision Making, 7*(4), 203-211.

Hickey, G. (1997). The use of literature in grounded theory. *NT Research, 2*(5), 371-378.

Hobbs, V. (1980). *But westward look: Nursing in Western Australia 1829 - 1979.* Perth: University of Western Australia Press.

Holle, M. L., & Blatchley, M.E. (1987). *Introduction to leadership and management in nursing* (2nd ed.). Boston: Jones and Bartlett.

Horner, B. (2002). Where have all the aged care nurses gone? *Geriaction, 20*(3), 9 - 13.

Hospitals and Health Services Act 1927. Government of Western Australia.

House of Representatives Standing Committee on Expenditure (McLeay Report) (1982). *In a home or at home: accommodation and home care for the aged.* Canberra: The Parliament of the Commonwealth of Australia.

Howe, A. L. (1990). Nursing home care policy: From laissez faire to restructuring. In H. Kendig & J. McCallum (Eds.). *Grey policy: Australian policies for an ageing society* (pp. 150-169). Sydney: Allen & Unwin.

Hutchinson, S. (1986). Grounded theory: The method. In P. L. Munhall & C. J. Oiler (Eds.), *Nursing research: A qualitative perspective.* Norwalk, CT: Appleton-Century-Crofts.

Iliffe, J. (2001). What happened to Florence Nightingale? *National Healthcare Journal,* (November), 52 - 53.

Ireland, J. (1999). Productivity Commission challenge. *National Healthcare Journal, 9*(4), 13.

Irurita, V. (1996). *A pathway to understanding: Application of grounded theory method.* Paper presented at the Flagship in Nursing Research Seminar, Western Sydney Area Health Service/University of Western Sydney.

Irurita, V., & Williams, A.M. (2001). Balancing and compromising: nurses and patients preserving integrity of self and each other. *International Journal of Nursing Studies, 38*, 579-589.

Jenks, J. M. (1993). The pattern of personal knowing in nurse clinical decision making. *Journal of Nursing Education, 32*(9), 399-405.

Jorm, A. F., & Henderson, A.S. (1993). *The problem of dementia in Australia.* Canberra: Department of Health, Housing and Community Services - Aged and Community Care Division.

Keenan, M. J., Hurst, J. B., Dennis, R. S., & Frey, G. (1990). Situational leadership for collaboration in health care settings. *Health Care Supervisor, 8*(3): 19-25.

Kelle, U. (1997). Theory building in qualitative research and computer programs for management of textual data. *Sociological Research Online, 2*(2).

Kendig, H. L., & McCallum, J. (1986). *Greying Australia: Future impacts of population ageing.* Canberra, AGPS: The Migration Committee, National Population Council.

Kendig, H. L., & McCallum, J. (Eds.). (1990). *Grey policy: Australian policies for an ageing society.* Sydney: Allen & Unwin.

Kovach, C. R., & Arnold, E.A. (1996). Coping with conflicting agendas: The bathing experience of cognitively impaired older adults. *Scholarly Inquiry for Nursing Practice: An International Journal, 10*(1), 23-36.

Kramer, M. (1974). *Reality shock: Why nurses leave nursing.* St Louis, MO: C.V.Mosby.

Krull, D. S., & Dill, J.C. (1996). On thinking first and responding fast: Flexibility in social inference processes. *Personality and Social Psychology Bulletin, 22*(9), 949-959.

Lancaster, W., & Beare, P. (1982). Decision making in nursing practice. In J. L. Lancaster, W. (Ed.), *Concepts for advances nursing practice: The nurse as a change agent.* St Louis, MO: C.V.Mosby.

Lawler, J. (1991). *Behind the screens: Nursing, somology, and the problem of he body.* Melbourne: Churchill Livingstone.

Leininger, M. M. (1985). *Qualitative research methods in nursing*. Philadelphia: W.B.Saunders Company.

Lewis, J., & Boldy, D. (2001). Decision-making and the health service manager. In M. G. Harris (Ed.). *Managing health services: Concepts and practice* (pp. 169-194). Sydney, MacLennan & Petty.

Lillibridge, J., Axford, R., & Rowley, G. (2000). The contribution of nurses' perceptions and actions in defining scope and stabilizing professional boundaries of nursing practice. *Collegian, 7*(4), 35-39.

Lincoln, N. K., &. Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (2nd ed. pp. 163-188). Thousand Oaks: Sage Publications, Inc.

Longenecker, J. G. & Pringle, C. D. (1978). The illusion of contingency theory and general theory. *Academy of Management Review, 3*(3), 679-683.

Luthans, F. & Stewart, T. I. (1977). A general contingency theory of management. *Academy of Management Review, 2*, 181-195.

Luthans, F. & Stewart, T. I. (1978). The reality or illusion of a general contingency theory of management: A response to the Longenecker and Pringle critique. *Academy of Management Review, 3*(3), 683-687.

MacDonald, M. (2001). Finding a critical perspective in Grounded Theory. In R. S. Schreiber, & P.N. Stern. (Eds.). *Using grounded theory in nursing* (pp. 113-157). New York: Springer Publishing Company.

MacDonald, M. & Schreiber, R. S. (2001). Constructing and deconstructing: Grounded theory in a postmodern world. In R. S. Schreiber, & P.N. Stern. (Eds.), *Using grounded theory in nursing* (pp. 35-53). New York: Springer Publishing Company.

Mace, N. L. (1990). The management of problem behaviors. In N. L. Mace (Ed.) *Dementia care: Patient, family, and community* (pp. 74-112). Baltimore: The Johns Hopkins University Press.

Macquarie essential dictionary (1999). Sydney: Macquarie University.

Macri, S. (1993). *Resident Classification Instrument documentation consultation report.* Canberra: Commonwealth Department of health, Housing, Local government and Community Services.

Mannix, J. (1999). Political context. In I. Stein (Ed.), *Aged care: A contemporary view* (pp. 1-14). Deakin, ACT: Royal College of Nursing Australia.

Marriner, A. (1977). The decision making process. *Supervisor Nurse, 8*(2), 58-67.

Matteson, P., & Hawkins, J. W. (1990). Concept analysis of decision making. *Nursing Forum, 25*(2): 4-10.

McLeay Report – See House of Representatives Standing Committee on Expenditure.

McCoppin, B. G., & Gardner, H. (1994). *Tradition and reality: nursing and politics in Australia*. Melbourne: Churchill Livingstone.

McDonald, T. A. (2001). *What do nurses thing about aged care?* A report on nurse perceptions about the aged care sector. Camperdown, NSW: NSW Nurses' Association.

Mee, C. L., & Robinson, E. (2003). What's different about this nursing shortage? *Nursing 2003,* 33(1), 51-55.

Merriam-Webster On-Line. (2002). <http://m-w.com/cgi-bin/dictionary> [Accessed 16 Dec. 2002].

Midson, S. (2002). *Moving ON audits.* Brisbane: Stephen Midson and Associates Pty Ltd.

Mills, D. I., & Sauter, M.K. (1986). Ida Jean Orlando (Pelletier): Disciplined professional response theory. In A. Marriner (Ed.), *Nursing theorists and their work* (pp. 205-216). St Louis: The C.V. Mosby Company.

Mohler, M. M. (2001). Big public policy issues face gerontological nursing. *Journal of Gerontological Nursing, 27*(12): 7-11.

Morse, J. M. (1986). Quantitative and qualitative research: Issues in sampling. In P.L.Chinn (Ed.), *Nursing research methodology: Issues and implementation* (pp. 181-193). Rockville MD: Aspen Publications.

Morse, J. M. (1989). Strategies for sampling. In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 117-131). Rockville, MD: Aspen Publishers.

Morse, J. M. (1999). Qualitative generalizability. *Qualitative Health Research, 9*(1), 5-6.

Morse, J. M. (2000). Determining sample size. *Qualitative Health Research, 10*(1), 3-5.

Morse, J. M., & Richards, L. (2002). *Readme first for a user's guide to qualitative methods.* Thousand Oaks: Sage Publications.

Moyle, W. (1996). Strategies to overcome the educational challenges in aged care. *Geriaction, 14*(3), 14-18.

Munhall, P. L., & Oiler, C.J. (1986). *Nursing research: A qualitative perspective.* Norwalk, Conn.: Appleton-Century-Crofts.

National Aged Care Alliance, (2001). *About NACA*. <http:/www.naca.asn.au /about.html> [Accessed 30 April 2003].

National Nursing Workforce Forum. (2000). *Rethinking nursing.* Canberra: Commonwealth Department of Health and Aged Care.

Nursing Development Conference Group. (1973). *Concept formalization in nursing: Process and product.* Boston: Little, Brown and Company.

Nay, R. (1998). Contradictions between perceptions and practices of caring in long-term care of elderly people. *Journal of Clinical Nursing, 7*(5), 401 - 408.

Nay, R. & Closs, B. (1998). Recruitment and retention of qualified nursing staff in long term care of older people: Interim report. Gerontic Nursing Professorial Unit, La Trobe University: Melbourne.

Nay, R., & Closs, B. (1999). Staffing and quality in non-acute facilities. In R. Nay & S. Garrett (Eds.), *Nursing older people: issues and innovations* (pp 172-190). Sydney: MacLennan & Petty.

National Health Act 1953. Parliament of Australia.

Nurses Board of Western Australia. (1991). *Competencies for Division 2*. Perth: Nurses Board of Western Australia.

O'Connell, B. (1996). Ways of knowing in nursing. In J. Greenwood (Ed.), *Nursing theory in Australia: development and application* (pp. 31-48). Sydney: Harper Educational.

O'Connell, B. (1998). The clinical application of the nursing process in selected acute care settings: A professional mirage. *Australian Journal of Advanced Nursing, 15*(4), 22-31.

O'Neill, E. S. (1995). Heuristics reasoning in diagnostic judgements. *Journal of Professional Nursing, 11*(4), 239-245.

Orb, A., Eisenhauer, L., & Wynaden, D. (2000). Ethics in qualitative research. *Journal of Nursing Scholarship, 33*(1), 93-96.

Ory, M. G., Abeles, R.P., & Lipman, P.D. (1992). *Ageing, health, and behaviour.* Newbury Park: Sage Publications.

Owens, J. (1997). Safe use of medicines. In I. Stein (Ed.). *Quality use of medicines in nursing practice* (pp. 1-15). Professional Development Series No. 6. Deakin, ACT: Royal College of Nursing, Australia.

Parkes, M. (1997). *Transitions through time: The Thirty First Patricia Chomley Oration*: Royal College of Nursing, Australia.

Pearson, A., Nay, R, Koch, S., Ward, C., Andrews, C., & Tucker, A. (2001). *Australian aged care nursing: A critical review of education, training, recruitment and retention in residential and community settings.* Canberra: National Review of Nursing Education <http.dest.gov.au/highered/nursing/pubs/aust_aged_care/5.htm> [Accessed 06 Jan 2002].

Pearson, A., Nay, R., Koch, S., & Rosewarne, R. (2002). *Recruitment and retention of nurses in residential aged care: Final report.* Canberra: Commonwealth Department of Health and Ageing.

Peden-McAlpine, C. (2000). Earling recognition of patient problems: A hermeneutic journing into understanding expert thinking in nursing. *Scholarly Inquiry for Nursing Practice: An International Journal, 14*(3), 191-225.

Peden-McAlpine, C., & Clarke, N. (2002). Early recognition of client status change: The importance of time. *Dimensions of Critical Care Nursing, 21*(4), 144+. <http://80-proquest.umi.com.dbgw.lis.curtin.edu.au/pqdlink> [Accessed 11 Dec 2002]

Peisah, C. (1991). Caring for the insitutionalized elderly: How easy is it? *Australian Journal of Public Health, 15*(1), 37 - 42.

Percival, E. (1999). Quality care and continuing education. In R. Nay & S. Garrett (Eds.). *Nursing older people: Issues and innovations* (pp. 321-337). Sydney: MacLennan & Petty.

Piper, J. R. (1994). "Situational constitutionalism" and presidential power: The rise and fall of the liberal model of presidential government. *Presidential Studies Quarterly, 24*(3): 577+ <http://80-proquest.umi.com.dbgw.lis.curtin.edu.au/pqdlink> [Accessed 11 Dec 2002].

Podger, A. & Hagan, P. (1999). *Reforming the Australian health care system: The role of government.* (Occasional Papers: New Series No. 1.). Canberra: Commonwealth Department of Health and Aged Care.

Pratt, R. (1996). Considerations of context: The crucial moderator. In J. Greenwood (Ed.), *Nursing theory in Australia: Development and application.* Sydney: Harper Educational.

Price, G., & Taylor, G. (1998). Change, challenges, choices, confusion, chocolates & chakras. *Geriaction, 16*(4), 5 - 9.

Productivity Commission. (1999). *Nursing home subsidies,* Inquiry Report. Canberra: AusInfo.

Pursey, A., & Luker, K. (1995). Attitudes and stereotypes: Nurses' work with older people. *Journal of Advanced Nursing, 22*, 547-555.

Qualitative Solutions and Research (QSR) Pty Ltd. (1997). QSR NUD*IST 4. La Trobe University, Vic: QSR.

Quinn, M. (2000). Fallout from Riverside. *National Healthcare Journal* (May), 15 - 16.

Radwin, L. E. (1995). Knowing the patient: a process model for individualized interventions. *Nursing Research, 44*(6), 364-370.

Rees Report – See Department of Community Services.

Reif, L., & Estes, C. L. (1982). Long-term care: New opportunities for professional nursing. In L. H. Aiken & S. R. Gortner (Eds.). *Nursing in the 1980s: Crises, opportunities, challenges* (pp. 147-194). Philadelphia: J. B. Lippincott Company.

Rew, L. (1987). Nursing intuition. *Nursing 87, 17*(7), 43-45.

Rhys-Hearn, C. (1986). *Quality, staffing and dependency: Non-government nursing homes.* Canberra: AGPS.

Roberts, V. Z. (1994). The organization of work: Contributions from open systems theory. In A. Obholzer & V. Z. Roberts (Eds.). *The unconscious at work: Individual and organizational stress in the human services* (pp. 28-38). London: Routledge.

Robley, L. R. (1995). The ethics of qualitative nursing research. *Journal of Professional Nursing, 11*(1), 45-48.

Robrecht, L. C. (1995). Grounded theory: Evolving methods. *Qualitative Health Research, 5*(2), 169-177.

Ronalds, C. (1989). *Residents rights in nursing homes and hostels: Final report.* Canberra: Australian Government Publishing Service.

Russell, L. (1990). *From Nightingale to now: Nurse education in Australia*. Sydney: W. B. Saunders/Bailliér Tindall.

Ryan, P. (1989). Continuing education in nursing: Current status and future prospects. In G. Gray & R. Pratt (Eds.). *Issues in Australian nursing 2* (pp. 361-377). Melbourne: Churchill Livingstone.

Savy, P. (1997). Accounting for care: Documenting residential aged care nursing. In J. Richmond (Ed.). *Nursing documentation: Writing what we do* (pp. 7-17). Melbourne: Ausmed Publications.

Sax, S. (1993). *Ageing and public policy in Australia.* Sydney: Allen & Unwin.

Schell, R. A., & Cervero, R.M. (1993). Clinical reasoning in Occupational Therapy: An integrative review. *The American Journal of Occupational Therapy, 47*, 605-610.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action.* New York: Basic Books, Inc.

Schreiber, R. S., & Stern, P.N. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber & P.N. Stern (Eds.). *Using grounded theory in nursing.* (pp. 55-83). New York: Springer Publishing Company.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics and social constructionism. In N. K. Denzin & Y.S. Lincoln (Eds.). *Handbook of qualitative research* (2nd ed. pp. 189-213). Thousand Oaks: Sage Publications, Inc.

Scott, B. (2000). A balancing act: Nursing in residential aged care. *Collegian, 7*(2), (Supplement).

Sellers, H. (2000). Costing nursing care. *National Healthcare Journal* (May), 17.

Senate Community Affairs References Committee. (2002*). The patient profession: Time for action.* Report on the Inquiry into Nursing. Canberra: Commonwealth of Australia.

Senate Select Committee on Private Hospitals and Nursing Homes. (1985). *Private nursing homes in Australia: Their conduct, administration and ownership (Giles Report).* Canberra: Australian Government Publishing Service.

Shetty, Y. K., & Carlisle, H. M. (1972). A contingency model of organization design. *California Management Review, 15*(1), 38 - 45.

Simon, H. A. (1993). Decision making: Rational, nonrational and irrational. *Educational Administration Quarterly, 29*(3), 392-411.

Spetz, J. (2001). *The nursing crisis in California: Where to we go from here? Testimony prepared for the Assembly Health Committee.* Center for California Health Workforce Studies.

Speziali, H. S., & Carpenter, D.R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.

Staunton, P., & Whyburn, B. (1993). *Nursing and the law* (4th ed.). Sydney: W. B. Saunders.

Stein, H. F. (1991). The role of some biomedical parameters in clinical decision making; an ethnographic approach. *Qualitative Health Research, 1*(1), 6-26.

Stein, I. (1999). *Aged care: A contemporary view.* Deakin, ACT: Royal College of Nursing, Australia.

Stein, I., Jackson, D., & Mannix, J. (1999). Safe housing and health. In I. Stein (Ed.), *Aged care: A contemporary view*. Deakin, ACT: Royal College of Nursing, Australia.

Stein, I. (2002). Why stay in aged care? *Geriaction, 20*(3), 5 - 8.

Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. *Image: The Journal of Nursing Scholarship, 12*(1), 20 - 23.

Stern, P. N. (1985). Using grounded theory method in nursing research. In M. M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 149-160). Philadelphia: W. B. Saunders.

Stern, P. N. & Covan, E.K. (2001). Early grounded theory: Its processes and products. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 17-34). New York: Springer Publishing Company.

Stevens, J. (1999). Ageism and economic fundamentalism. In R. Nay. & S. Garrett (Eds). *Nursing older people: Issues and innovations* (pp. 151-171). Sydney: MacLennan & Petty.

Stevens, J., & Herbert, J. (1997). *Ageism and nursing practice in Australia.* (Discussion Paper No. 3). Deakin, ACT: Royal College of Nursing, Australia.

Strauss, A. (1987). *Qualitative analysis for social scientists.* Cambridge: Cambridge University Press.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Oaks: Sage Publications.

Sweeney, N. M. (1994). A concept analysis of personal knowledge: Application to nursing education. *Journal of Advanced Nursing, 20*, 917-924.

Tanner, C. A., Benner, P., Chesla, C., & Gordon, D.R. (1993). The phenomenology of knowing the patient. *Image: The Journal of Nursing Scholarship, 25*(4), 273-280.

Tarter, C. J., & Hoy, W. K. (1998). Toward a contingency theory of decision making. *Journal of Educational Administration, 36*(3), 212 - 228.

Thompson, C. (1999). Qualitative research into nurse decision making: Factors for consideration in theoretical sampling. *Qualitative Health Research, 9*(6), 815-828.

Vesk, K. (2002). Past tense, future perfect? The path of aged care reform. *National Healthcare Journal* (February), 16-17.

Vladeck, B. C. (1996). The past, present, and future of nursing home quality. *JAMA (Journal of the American Medical Association), 275*(6): 425.

Voss, J. F., & Post, T.A. (1988). On the solving of ill-structure problems. In M. T. H. Chi, R. Glaser, & M.J. Farr (Eds.), *The nature of expertise* (pp. 261-285). Hillsdale, NJ: Larence Erlbaum.

Welk, D. S. (2002). Designing clinical examples to promote pattern recognition: Nursing education-based research and practical application. *Journal of Nursing Education,* 41(2), 53-65

Williams, A. M. (1996). *The delivery of quality nursing care: A grounded theory study of the nurse's perspective.* Unpublished Masters thesis, Curtin University of Technology, Perth.

Williams, A. M. (2003). *Contribution of therapeutic interpersonal interactions to the comfort of hospitalised patients. A grounded theory study of the patient's perspective.* Unpublished PhD thesis, Curtin University of Technology, Perth.

Willis, E., & Morrow, L. (1995). Nurses and women: Fallen angels of deinstitutionalisation. In G. Gray & R. Pratt (Eds.). *Issues in Australian nursing 4* (pp. 159-175). Melbourne: Churchill Livingstone.

Wilson, H. S., & Hutchinson, S. A. (1996). Methodological mistakes in grounded theory. *Nursing Research, 45*(2), 122-124.

Wiltshire, J. (1995). Telling a story, writing a narrative: terminology in health care. *Nursing Enquiry, 2*, 75-82.

Wimpenney, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory: Is there a difference? *Journal of Advanced Nursing, 31*(6), 1485-1492.

Woolley, N. (1990). Nursing diagnosis: Exploring the factors which may influence the reasoning process. *Journal of Advanced Nursing, 15*, 110-117.

Wurzbach, M. E. (1991). Judgement under conditions of uncertainty. *Nursing Forum, 26*(3), 27-34.

20 Feb 2000

CURTIN UNIVERSITY SCHOOL OF NURSING

INFORMATION SHEET

How RNs manage the decision-making environment in aged care.

Dear Registered Nurse

My name is Beverley Scott and I am a Doctoral student at Curtin University. The purpose of my study is to explore decision-making in residential aged care, with particular reference to how the complex environment influences the decision-making process. I will be interviewing 25 - 30 RNs working in Western Australian nursing homes.

I would like to invite you to participate in the study. Your participation is voluntary and your can withdraw at any time without penalty. Participation will involve a face-to-face, tape-recorded interview of about 45 minutes, to be conducted in a place and at a time suitable to both of us. During the interview you may decline to answer any question and you may ask me to turn off the tape recorder at any time.

I may also contact you again to follow-up specific points or to clarify meanings. The follow-up contacts may be face-to-face or by telephone, depending on circumstances. The interviews will be audio- taped and transcribed. On completion of the study the tapes will be erased and the transcripts will be kept for five years in a locked cabinet.

All information obtained during the interview will be kept confidential and a code number will be assigned to each interview. Identifying information about staff, residents or the nursing home will not be transcribed and your name will be known only to me.

I have attached a Consent Form. If you agree to be a part of this study, I would appreciate it if you could sign the form, and give it back to me when we meet for the interview.

I would be happy to answer any other questions about the study. I can be contacted by telephone on (08) 9483 6999, Pager No. 603395. Also, if you would like to speak with my Thesis Supervisor, she is Dr Vera Irurita of Curtin Unversity and you can contact her on (9266 2191 - direct line).

Thanking you in anticipation

Yours sincerely

Beverley Scott RN

Encl.

CONSENT FORM

TITLE: HOW REGISTERED NURSES MANAGE THE DECISION-MAKING ENVIRONMENT IN RESIDENTIAL AGED CARE

I ..... have read the Information Sheet and am willing to participate in the above study. I understand that the initial interview will last between 30 and 45 minutes, and I am also willing to discuss or clarify aspects of the interview when it has been transcribed and analysed (in person or by telephone).

I understand that interviews will be tape recorded unless we mutually agree that the recorder will not be used for parts of the discussion. I may decline to answer particular questions and ask for the tape recorder to be turned off during the interview or to withdraw from the study if I so wish.

All information will be held in confidence and any identifying information about me, my co-workers, my place of work and the residents will not be transcribed. I understand that I can check the audiotape and transcription together if I wish. Audiotapes will be fully erased at the end of the study.

I am assured that all information will be securely held in the home office of the researcher.

Signature of Participant Signature of Researcher

Date: Date:

Appendix C

(Date)

PO Box 77
PALMYRA WA 6157

Director of Nursing
(address)

Dear

Re: Study of nursing decision-making in aged care

I am a Doctoral student at Curtin University School of Nursing and my thesis will explore decision-making in aged care facilities in Western Australia. The purpose of the study is to investigate the interaction of factors that surround decision-making by registered nurses, and to explore their interpretations and perspectives regarding decision-making. If you would like to read the study proposal, I would be happy to lend you a copy.

I am writing to you to ask permission conduct interviews with one or two Registered Nurses who are working in your facility. I will invite the RN(s), whom I have selected, to participate in the study. Participation will involve face-to-face interviewing, to be conducted in a place and at a time suitable to all parties. The interviews will be audio-taped and transcribed. I have attached, for information, a copy of the "Consent form" which will be given to participating RNs.

All information obtained during the interviews or while I am in your nursing home will be held in confidence. I will keep my role as researcher separate from any other role I may have in relation to your organisation (e.g. nurse educator). Identifying information about staff, residents and the facility will not be transcribed, and all information will be locked in a filing cabinet in my home office. Audio-tapes will be erased on completion of the study, and interview transcripts will be destroyed after five years.

In the final report code numbers will be used instead of RN participant names, and I will withhold any information that might result in participants or your facility being

identified by the reader. I would be happy to answer any other questions about the study or methodology. I can be contacted via Telepager on (08) 9483 6999, Pager No. 603395. Also, if you would like to speak with my Thesis Supervisor, she is Dr Vera Irurita of Curtin Unversity's School of Nursing, and you can contact her on (08) 9266 2191 (direct line).

Thanking you in anticipation

Yours sincerely

Beverley M Scott RN, FRCNA.

Encl.