AN ANALYSIS OF PROCESSES AND STRATEGIES USED BY QUALIFIED NURSES IN ASSESSING THE MENTAL CAPACITY OF ACUTELY AND CRITICALLY ILL HOSPITALISED ADULT PATIENTS

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TABLE OF CONTENTS

APPENDICIES ....

LIST OF FIGURES ....

LIST OF TABLES ....

Abstract

Introduction: Mental capacity is the ability to understand, reason, and exercise choice by making informed decisions. Acute and/or critical illness may impact upon the decision making abilities of hospitalised adult patients. Assessment of patients for reduced, fluctuating or absent capacity gives the healthcare team the legal authority to assess best interests and to make treatment decisions without consent under this justification. Qualified nurses are the ever-present professional group in acute and critical care settings. They may initiate assessments of mental capacity which may be influential in the ways that the decision making of patients is facilitated or substituted. There are, however, few studies that focus on processes employed by them in this area in fast-moving clinical settings, although it is recognised that physical illness may have a significant impact upon capacity status.

Aim: To explore processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill hospitalised adult patients.

Methods: A qualitative grounded theory approach was used, informed by the methodological pathway of Corbin and Strauss (2008), to explore assessment processes used by 13 registered nurses employed in acute and critical care environments in a district general hospital in South Wales. Data were collected through a series of digitally recorded, semi-structured interviews which were transcribed verbatim. Data were analysed leading to a central category

Findings/Discussion: Informal, intuitive, nurse-led processes were used to assess the mental capacity of patients which resulted in an articulation of "something not quite right" and which combined processes for the assessment of the physiological and mental capacity status of patients. A dynamic, holistic approach was evident which recognised the need to support the rights, dignity and autonomy of patients. This suggested the assessment of mental capacity was not a lone process but one that contributed to a cyclical process in which multi-professional assessment was necessary and ongoing, and in which qualified nurses had a co-ordinating role. This led to the development of the theory, Nurse Managed Patient Focused Assessment and Care.

Conclusion: This study has provided an insight into nurse-led assessment processes that appear to be hidden due to their informal and instinctive nature. Processes appear to be holistic, patient-centred and dynamic. The developed theory, Nurse Managed Patient Focused Assessment and Care, provides a framework to explain processes and strategies used by qualified nurses in assessing mental capacity of, and caring for, adult patients with acute and/or critical illness. This framework may inform clinical practice in this area and can serve as a basis of an assessment tool. It may also inform programmes of education for nurses in the need to enhance critical analysis of what has been identified as a fundamental role of the qualified nurse.

Chapter: 1 Introduction

1.1 Introducing the Study

Mental capacity is at the centre of the concept of autonomy and the right of self-determination. It is the ability to use cognitive processes to understand and reason and to also exercise choice by making decisions. It enables freedom of expression that supports the notion of being an individual. Rights and freedoms are dependent on having the capacity to represent self and the ability to use information to inform decision making processes. Capacity is therefore central to the law on consent (Richardson 2010). For an adult, a person over sixteen years, the law normally will not recognise consent to or refusal of healthcare treatment unless it is made with capacity (Jones 2014). Capacity therefore performs a crucial role in setting the threshold for the legal protection of the decisions of a person and of the right to make decisions.

Acutely or critically ill adult patients needing hospital-based healthcare interventions may be required to make decisions that range from routine to potentially life-saving or life-changing. Therefore having sufficient understanding and decision-making abilities are essential, as is the ability to demonstrate these to a healthcare team. The expression and articulation of capacity has its challenges. Many factors may impact upon a person being able to provide healthcare practitioners with evidence of capacity. These may include being suddenly admitted to hospital in an ill and frightened state, feeling a sense of panic and loss of control, being disorientated or confused, experiencing pain and discomfort or suffering from the effects of medication (Brazier and Cave 2011). In addition, the quality and efficacy of assessment processes will depend on the skills of the individual practitioner. If the capacity of a person is called into question, the outcome of an assessment is of profound importance, both clinically and legally. Assessing and concluding that a patient is without capacity may result in loss of fundamental rights, freedoms and autonomy and will take decision making powers away from a patient (O’Keefe 2008, Emmett et al 2013). If the capacity of a person is reduced or absent the healthcare team has the legal authority to assess best interests and provide care and treatment under this justification (Jones 2014).

The researcher in this study is practitioner of acute and critical care and also an academic and educationalist with a particular interest in the field of healthcare law. The need for this study has been realised by many years of personal and professional experience, with continuous interest, participation and immersion in the care and management of adult patients needing acute and critical care and treatment in hospital environments and the application of legal rules and principles to these contexts. Personal and professional value is placed upon the fundamental concepts of kindness, respect and dignity. Professional recognition is given to the significance of accurate and appropriate assessments strategies, with the long held the view as a clinician that assessments must be in-depth and timely to set the scene for effective care and management of ill adult patients with urgent and pressing physical and/or emotional needs. A privileged position has been enjoyed by the researcher of having time, range and depth of experience to critically analyse and reflect upon own practice and that of other professionals regarding assessment, care and intervention strategies and processes which are employed across a range of contexts. The researcher has also been able to reflect upon the ways in which patients are, and should be supported to make their own decisions and the significance of the support of families and carers in this respect. This has fuelled own views and judgements regarding the primacy of effective, accurate and patient-centred assessments. This study therefore represents a culmination of long-held clinical and educational interests.

Acutely and critically ill adult patients are faced with serious, sometimes life threatening illnesses, often the worst experience of their lives, and may be admitted to a range of clinical environments which include emergency departments, medical and surgical assessment units, acute wards, critical care and/or high dependency units. The pace of these can be fast and intense and the needs of the patient are often complex. This, however, should not detract from the provision of effective care and treatment in which the patient is involved. In these situations, it is imperative that the rights and interests of patients are supported by the multi-professional team.

An effective multi-professional team is a unit of quality, with each team player providing a vital clinical service to ensure effective patient outcomes. A starting point in discharging the duty of quality is the concept of patient-centred care, putting the patient at the heart of decision-making processes. This study recognises that patients should be regarded as users of healthcare services and, as such, should be enabled and encouraged to secure the best possible outcomes for themselves in any journey through service use. If patients are not in positions to make their own decisions practitioners need to facilitate best outcomes for them on their behalf. Thus the role of relatives and carers may be significant as they can provide valuable information and support to both the patient and the multi-professional team. Nurses hold a unique position in this multi-professional context. They are the only health care professional group to provide a continuous, twenty four hour clinical service to patients which gives them a unique level of knowledge, exposure and proximity to patients and patient-specific detail. By the very nature of such exposure, qualified nurses may also have closer working relationships with relatives and carers.

Qualified nurses therefore have a key role in making assessments and forming clinical opinions that inform appropriate referrals to other members of the multi-professional team. This means that they often initiate assessments of capacity due to their ever-present status (Traynor et al 2010). The assessment of capacity is a starting point and influential in the ways that qualified nurses involve patients in their care and the results of assessments determine the extent to which the decision making of patients is encouraged and facilitated. Assessment processes that determine capacity are therefore key, not only to establish a legal threshold for care and treatment but also as a basis to facilitate patient involvement, choice and freedom of expression.

Therefore, the ways that qualified nurses assess the mental capacity of acutely and critically ill adult patients across acute and critical care settings in a district general hospital are explored in this study. These settings are chosen due to their complex, challenging and time limited nature in which qualified nurses are required to provide clinically effective care and in which treatment regimes may carry significant risks for the patient when they often feel vulnerable and threatened (Jones and Jones 2007). In these settings, qualified nurses may be confronted by patients with complex health needs and whose condition may rapidly deteriorate. They are required, therefore, to make decisions about the well-being, if not survival, of patients and often with little prior knowledge of the patient. Also, the first time nurses meet patients is often when patients may not have capacity or capacity may be reduced (McGlade et al 2011). Furthermore, many patients may display levels of capacity which may fluctuate which implies that qualified nurses may need to be vigilant regarding assessing the capacity status of patients in their care (Jones 2014).

Added to this is the increasingly sophisticated legal context in which qualified nurses function, informed by the enactment of primary legislation, such as the Human Rights Act 1998 and the Mental Capacity Act 2005. Both focus on the primacy of the rights of a person and both enforce autonomy, self-determination and choice as fundamental concepts. The significance of the Mental Capacity Act, which came into force in 2007, cannot be underestimated. Whilst it does not change existing legal principles it brings existing case law under statutory influence and it provides processes and structures to facilitate the protection of those who lack the necessary mental capacity to make their own decisions (Brazier and Cave 2011, Jones 2014). This legislation has also resulted in providers of healthcare focusing on the significance of the concept of mental capacity, in particular on the implications for the patient if capacity is found to be diminished or absent (Griffiths and Tengnah 2010, Brown et al 2013). In addition, the need to protect the rights and liberties of patients is an increasingly significant and high profile theme. This appears to be gathering pace as a result of recent exposures of failures of providers of healthcare outlined in the report of the public inquiry into the Mid Staffordshire NHS Foundation Trust in April 2013 chaired by Robert Francis QC. More recently, and specific to Wales, are the failings of a Local Health Board in protecting vulnerable groups of service users such as the frail elderly person, those with dementia and those needing palliative care (Andrews and Butler 2014). Themes of upholding human rights and freedoms currently receive closer scrutiny than ever (Emmett et al 2013) at a time when patient demands on acute and critical front-line healthcare services are unprecedented.

The reasons for undertaking this study are therefore rooted in the need to critically evaluate assessment processes that are fundamental in their significance in supporting the decision-making processes of patients. Assessments of capacity are subsequently influential in setting a scene for the ways that the patient is cared for, managed and generally regarded by the multi-professional team and beyond. Clinical and anecdotal evidence indicates that such processes are complex and hence recognition of this complexity is noted and included in the research situation of this study. It was identified that these processes could be explicated by grounded theory methods, resulting in the generation of theory as the product of the research process. It is recognised that nurses do not function in isolation and effective care, treatment and management is the result of a cohesive multi-professional approach. However, this approach is beyond the scope of this study, although the role of the nurse as a part of a larger clinically focused team is recognised.

Also, this is an area of nursing practice in which there is little existing evidence of directly related research. This has provided an added stimulus for investigating this area of practice in the need to explore what qualified nurses working in acute and critical care settings actually do to assess capacity. An initial review of the literature indicates a lack of evidence regarding a focus on the role of qualified nurses and the assessment and decision making processes they employ. There is also little evidence of research having being undertaken to explore specific mechanisms that nurses use in assessing the mental capacity of patients with acute, critical and complex health needs in hospital settings. Evidence in the literature indicates that studies have explored the concept of mental capacity and its assessment across a range of clinical contexts, involving a range of client groups. Few empirical studies have explored the assessment of capacity of acutely ill adults with unstable or life threatening conditions. Furthermore, few have considered the ways in which nurses in acute and/or critical care settings assess the ability of patients to understand and make choices where timeframes for employing healthcare interventions are often crucial. The concept of mental capacity is discussed and the complexity of its definition is recognised (Patchet et al 2007, Steis and Flick 2008, Lamont et al 2013). The common law test of capacity is also a well established concept since the enactment of the Mental Capacity Act 2005. This requires the assessment of understanding, retention of information and ability to use information to make and communicate decisions (Jones 2014). Pre-dating this Act, assessment tools and interview guides for evaluating capacity have been in existence for some time, have been utilised by clinicians and are comprehensively reported. These mainly originate from the USA and focus on the patient with acute confusion, the elderly and those with mental health problems (Gunn et al 1999, Moye et al 2006, Okai et al 2007, Brown et al 2013).

A number of studies have noted that physical illness has a significant impact upon capacity and ability to make decisions. These have explored a lack of capacity in groups of patients with stable or chronic medical or surgical conditions (Appelbaum and Grisso 1997, Smithline et al 1999, Moser et al 2002, Casarett et al 2003, Raymont et al 2004, Palmer et al 2005, Appelbaum 2007, Owen 2009, Burton et al 2012). Impairment of capacity in groups such as acutely ill patients has been less extensively studied, but it is recognised they contribute to a large population in which reduced capacity can be anticipated (Raymont 2004, Jacob et al 2005, Lepping 2011). None of these studies, however, focus upon the role, function and strategies of qualified nurses which indicates there is a gap in the evidence base. This study is in direct response to this, particularly in relation to providing empirical evidence that may help to critically analyse a key and essential area of nursing practice. Facilitating, supporting and protecting the decision making abilities of patients with acute and/or critical illnesses has fundamental significance in contexts of patient-focused, individualised healthcare. Therefore detailed insight into this area of practice is necessary. Also, a detailed understanding of complex processes of assessment and management of patients, whose capacity status is in question may inform the education of qualified nurses and on-going mechanisms for the scrutiny of practice.

1.2 Structure of the Thesis

This chapter has served to introduce this study and to outline justification for it, both personal and in relation to gaps in evidence base. Also, the need to critically analyse a key area of nursing practice has been identified. The remainder of this thesis is structured into chapters.

Chapter 2 provides a justification for, and a review of the literature. This establishes a context for the research and highlights gaps in the evidence to support the need for further empirical research. A critical analysis of the concept of mental capacity and overarching legal frameworks are provided. Also the literature is examined to review established published research regarding processes used to assess mental capacity and the assessment tools available to inform these processes.

Chapter 3 outlines the research aims and approach and also examines the research methodology which underpins this study. The justification for using a qualitative research approach is presented, leading to the decision to use the research methodology of grounded theory informed by the methodological pathway of Corbin and Strauss (2008). The grounded theory methods consistent with this pathway are outlined.

Chapter 4 identifies the setting for this study and outlines research methods used. The recruitment of 13 participants is presented and methods of data collection justified. Processes of data analysis are presented in detail using the coding paradigm of Corbin and Strauss (2008).

Chapter 5 provides a detailed presentation of findings, the themes of which are structured using the categories and subcategories identified as a result of the analysis of data. Themes presented represent and contain processes of assessment and personal, professional, environmental and contextual factors that inform these processes. They also represent the role of the qualified nurse and others in capacity assessment processes and in the continued care and management of acutely and critically ill patients.

Chapter 6 provides a discussion of the findings of this study and the developed grounded theory. This is placed in the context of existing research and conclusions made.

Chapter 7 presents conclusions, outlines the original contribution to knowledge and makes recommendations for future clinical practice. The limitations of this study are explored and a personal reflection concludes this study.

Finally, appendices can be found after the reference list. These contain numerous supplementary materials to which reference is made throughout aspects of this study.

Chapter 2: The Concept of Mental Capacity: Definitions and Assessment

2.1 Introduction

This chapter contains a review of the literature to establish a context for the research and to highlight gaps in the evidence to support the need for further empirical research. A justification for this is provided since it is believed that a review of the literature has some importance, as it enables the reader to identify the perspective of the researcher at the start of a project and provides justification for launching a grounded theory study (Strauss and Corbin 1998).

Early ideas for this study clarified that providing a context is an essential element in a critical analysis of the concept of mental capacity, how this is assessed and by whom, together with the ways in which legal requirements inform definitions of mental capacity and assessment processes.

2.2 Justification for the Literature Review

Before a review of the literature is provided, it is necessary to recognise that generally the place of the literature review in grounded theory research is controversial and often disputed (McGhee et al 2007, Charmaz 2014). As is the case with many approaches to qualitative research, it is argued by some grounded theory researchers that a formal review of the literature should be delayed prior to the start of a grounded theory study to prevent the researcher imposing existing theories or knowledge on the study processes and outcomes (Birks and Mills 2011). Glaser and Strauss (1967) and later Glaser (1998) instruct against reviewing the literature at the start of a study, rather, this should be left until a grounded theory is nearly completed where the results of a literature search can be woven into the theory. In doing this, the researcher will remain free and open to discovery and will not impose pre-conceived ideas on the area of study (Glaser and Strauss 1967, Glaser 1998, Urquhart 2013).

Alternatively, it is acknowledged that no researcher enters into their research field in a blank state (Glaser and Strauss 1967, Corbin and Strauss 2008). Researchers are unlikely to enter the field without depth of knowledge and insight before they decide on a research topic (Charmaz 2014). Also the identification of a credible research area before entry to the field is needed to satisfy the process of ethical approval in an era of evidence based health care (Strauss and Corbin 1998, McCallin 2003a, Clarke 2005). It is therefore necessary to approach the area of study with more than “general wonderment” (Glaser and Strauss 1967), rather an initial literature review can assist with clarity of ideas, and signpost where a study may fit. This, in turn, gives some opportunity to begin a theoretical discussion (Charmaz 2014). As a result, it is increasingly recognised by grounded theorists that lack of familiarity with the literature is unlikely at the start of a study (Cutcliffe 2005, Walls, Parahoo and Fleming 2010, Thornberg 2012).

The need to make an original contribution to knowledge, which is one of the defining features of doctoral research, was one of the reasons for conducting an initial and purposive review of the literature in this study. Using a critical approach to identifying gaps in the existing evidence base can avoid duplication which facilitates the concept of originality (Urquhart 2013). Also, the review was undertaken to provide effective means of being orientated to the field of study and to assist early enhancement of theoretical sensitivity (Urquhart 2010, Birks and Mills 2011). An initial literature review is considered to work well as long as the researcher realises that it is conducted on the understanding that it is the generated theory that will determine the relevance of the literature. The literature is then revisited and extended once the theory has been generated from the data (Urquhart 2013). It was therefore identified that an initial review of the literature would serve as a launch to this study in the need to provide sound rationale and justification for its undertaking. An approach was taken that guiding interests and professional perspectives can provide the researcher with points of departure for development, rather than limiting ideas and directions (Charmaz 2014). It was recognised that implicit in points of departure were insight into area of study, subject expertise, prior knowledge of the main tenets or themes in the literature and the notion that researchers are a sum of all they have experienced (Birks and Mills 2011).

2.3 Literature Review Strategy

The scope of the themes implicit in this study was identified as broad, encompassing legal and clinical components. Therefore numerous sources of literature were used to inform the introduction, literature review, methodology and the discussion in this thesis. Literature were therefore obtained from a variety of sources. These were obtained primarily from computer databases. Searches were conducted of key papers from journals up to July 2015 and review of the reference lists of relevant papers undertaken where appropriate. Searches were conducted regularly to facilitate currency of literature used, the main ones occurring 2009-2010, 2011-2012 and 2014-2015. Literature were selected based on relevance and fit to the context of this study.

2.3.1 Legal Databases

Table 1 outlines the legal databases searched and search terms used. Search terms were related to the aims of this study and were used singularly and in combinations:

Table 1: Legal Databases and Search Terms

Database	Search Terms
Lawtel Westlaw UK LexisLibrary	Mental capacity
	Mental capacity assessment
	Legal test of capacity/diagnostic test
	Mental capacity and acute and/or critical health care
	Hospital based healthcare/medical treatment
	Best interest assessment
	Fluctuating capacity
	Functional approach
	Information giving
	Informed consent
	Prudent patient test
	Substituted judgement
	Autonomy
	Human rights
	Duty of care
	Clinical judgement

The above were used to establish the legal context and frameworks for this study and to begin the process of exploring legal comment on the concept of mental capacity and its assessment. This aspect of the search of the literature was not intended to explore the evidence base regarding the nursing role in assessing capacity status.

Searches of these databases were narrowed using the timeline of 2000 to June 2015. In addition, facilities within each to refine searches were used. These include, limiting to case law, articles indices, legislation, journals, press releases and comment on current awareness issues.

2.3.2 Healthcare Databases

Table 2 outlines the healthcare databases searched and search terms used. Again search terms were related to the aims of this study and were used singularly and in combinations:

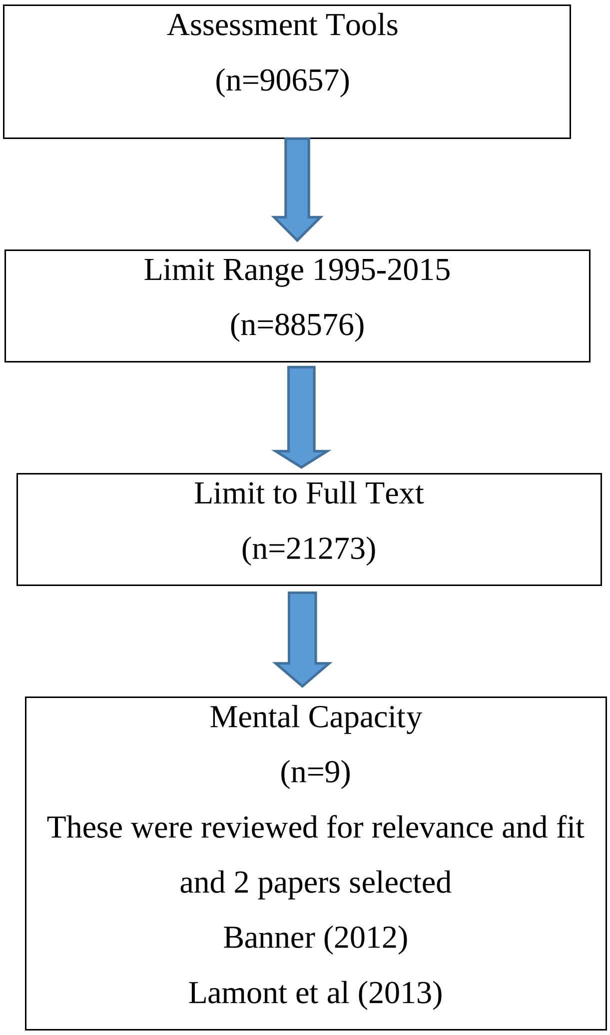
Table 2: Healthcare Databases and Search Terms

Database	Search Terms
CINAHL Plus with full text MEDLINE EMBASE PsycINFO Cochrane Library	Nursing assessment
	Nurse-led assessment
	Nursing diagnosis
	Nurse recognition
	Intuition and gut feelings
	Clinical assessment
	Clinical decision making
	Clinical judgement
	Heuristics
	Assessment tools, early warning systems
	Mental capacity
	Fluctuating capacity
	Assessment of mental capacity
	Delirium
	Confusion
	Best interests
	Informed consent
	Patient choice, patient centred care
	Acute care
	Critical care
	Emergency care
	Human rights and autonomy
	Advocacy
	Dignity

Searches of the above were narrowed using access to full text articles and a timeline starting from 1995. National and international sources were considered. This was implemented to provide a broad view of the scope of existing evidence regarding themes relevant to the aims of this study. Therefore, focus was placed upon methods of assessing mental capacity and published research regarding assessment tools which had been developed and which had been tested. Searches were also conducted of these in emergency, acute and critical care settings.

Due to the breadth of the literature searched and the many combinations of search terms applicable to the aims of this study, a methodical approach was applied which consisted of combinations of search terms. The following serves as an example of search methods used. This relates to the use of CINAHL Plus with full text but a similar approach was used to search other electronic databases,

Figure 1: Literature Search Example



The review revealed a range of literature which indicated that the assessment of mental capacity had been reported and originated primarily from the USA, to a lesser extent the UK. This review also established that a number of assessment tools designed to assess the mental capacity of patients were in use and had been the subject of empirical research. This aspect of the review indicated that assessment tools had been used with some success in mental health clinical settings when used by doctors with patients diagnosed with mental health problems and the elderly patient with dementia. In this context, a number of key authors were identified in the search, therefore author searches were conducted to ensure a thorough approach. For example, these included Appelbaum and Grisso from the USA and Hotopf, Raymont and Owen from the UK.

However, the search of the literature revealed a notable lack of empirical evidence regarding the role and function of qualified nurses in assessing the capacity status of ill patients in acute and critical care settings. Evidence in nursing journals indicates that assessing the mental capacity of patients in hospital and community settings poses challenges for qualified nurses. Also, there is a range of comment that they should uphold standards of assessment of the capacity and best interests of patients as directed by the Mental Capacity Act 2005 and the NMC (2015) as set out in the “Code”. There is no direct evidence of research being undertaken with patients who are acutely or critically ill in hospital settings and the methods of assessment and the care and management interventions which qualified nurses employ to ensure that patients in their care receive effective levels of service. Therefore, the review of the literature indicated a gap in the evidence regarding strategies and processes used by qualified nurses in assessing the capacity status of adult patients with acute and critical illnesses.

2.3.3 Using and Referencing Legal Materials

Throughout this study reference is made to legal materials such as statutes and common law, or case law as it is also known. Cases are named and expressed in a number of ways:

- These include two parties who are named such as, for example, Gillick v West Norfolk and Wisbech Area Health Authority.
- In some cases, two parties who are involved but identities are protected such as B v An NHS Trust, usually due to sensitivities surrounding the circumstance of the case.

- In addition, cases often involve one party only, whose identity is normally protected due to the need to protect the identity of this person. These are expressed as Re, in other words regarding, such as in Re MB.
- Often cases involving one party will include an indication of the main theme of the case in the title, for example, Re T (Refusal of Treatment). This is due the frequent use of letters of the alphabet used to protect identity. Therefore, frequent use of the letter T will result in cases using this letter being differentiated with the main theme of the case identified in brackets.
- A further requirement of legal materials is that square brackets are used if a case has been reported in law journals. A case would therefore be presented as Re MB [1997]. Where cases have not been reported, the normal use of circular brackets applies.
- Full references of cases used in this study are presented in the reference list. Cases are normally reported in law journals and their full reference will indicate the journal in which they are reported. The names of legal journals, however, are never expressed in full, rather abbreviations are used. For example, the case Re MB [1997] 38 BMLR 175 (CA) is used in this study. The journal used for this case was Butterworths Medical Law Reports. This case can therefore be found in the 38th volume of these law reports on page 175. In addition, this case was heard at the Court of Appeal, this is indicated by (CA) as identified in the title of this case
- If a case is regarded as high impact thereby setting significant precedence, it may be reported in a number of legal journals. The case Re MB above is also reported in, for example, The Family Law Reports and The Medical Law Reports.
- Some cases used in this study were accessed from the All England Law Reports. These are abbreviated as All ER. The case of Re C is used and presented in full in the reference list as Re C [1994] 1 All ER 819.
- Two cases used in this study were accessed from the reports of the England and Wales High Court, the name of which is again abbreviated. For example, A NHS Trust v Dr A [2013] EWHC 2442 (COP). COP in this instance is the Court of Protection before which this case was presented.
- Reference is also made to statutes. These are identified by their name with their dates indicating when they were given royal assent. Therefore the Mental Capacity Act is dated 2005, but this came into force in 2007.

2.4 Legal Frameworks for Consent and Mental Capacity

Practitioners of acute and critical care are required to work within legal and professional frameworks and work within the boundaries of the law in countries where they are practicing (NMC 2015). The law establishes the fundamental principle that a person over 16 years is assumed to be mentally capable of making their own decisions (Jones 2014). There are some exceptions to this where the law relating to consent has provision for those under 16 years, who are deemed to have capacity and maturity beyond their years, to be treated and regarded as adults. This is known as “Fraser Competence”, so named after the Judge who presided in the case, Gillick v West Norfolk and Wisbech Health Authority [1986]. If the assumption of being mentally capable is found to be accurate, decision making ability renders the consent of an adult legally valid. To support this, consent must be informed where information is provided in a manner which is accurate and facilitates understanding and choice (Dimond 2015). The clinical reality for qualified nurses in acute and critical care settings is the need to manage a number of dimensions on a continuum of consent, autonomy, capacity and best interests (Price 2011).

For those patients who are mentally capable of making decisions, qualified nurses must ensure that consent is valid and patients are effectively supported to make decisions. Qualified nurses may also be faced with making decisions for those incapable of deciding for themselves for a variety of reasons. They must also establish what interventions can lawfully be employed for patients without a valid consent (Dimond 2015).

The criteria for the legal validity of consent are well established (Jones 2014). To make choices, a person requires information which must not be misrepresented in order to mislead or unduly influence. A person must also have sufficient capacity and ability to understand information and the situation they are in to exercise free will and make decisions for themselves (Dimond 2015). The concept of consent and its validity is a key theme at the heart of health care law. It represents the legal expression of human rights to uphold the principles of autonomy and self-determination (Avery 2013, Herring 2015). This has been reinforced in high profile legal cases where it has been established that an adult who has capacity has an absolute right to choose to consent to healthcare treatment, to refuse it, or to choose other options and alternatives. This right to autonomy exists even if the reasons for a person’s choice are irrational, unwise or unknown. Each individual should be able to exercise their autonomy and their right of self-determination even it this results in their untimely death (Re T (Adult Refusal of Treatment) 1992, ST George's Healthcare NHS Trust v S 1998).

A key factor in a person exercising their autonomy or being supported to do so is that the person must be of sound mind, that the person is mentally capable of making decisions for themselves. UK law presumes capacity, rationality and autonomy in that all adults are capable of giving and refusing consent to care and treatment (Mason and Laurie 2013). With capacity comes the presumption that a person will be able to understand information given to them in order to make choices, including explanations about risks involved in proposed care and treatment regimes (Chester v Afshar 2004, Birch v University College London Hospital NHS Foundation Trust 2008, Heywood et al 2010).

Practitioners of acute care may be confronted with patients who cannot give consent due to the effects of illness or injury, and thus by implication, such consent may not be lawful. Clarification and authority of the legal basis to provide care and treatment for those without capacity was established in a series of common law cases which involved the sterilisation of women with learning disabilities over the age of eighteen years. These established that practitioners can provide care and treatment which is considered to be in the best interests of the patient (Re T 1987, Re X 1987, T v T 1988, F v West Berkshire Health Authority 1989). This principle has been more recently clarified in the Mental Capacity Act 2005 which provides guidance on the assessment of best interests. However, here the principle of therapeutic necessity applies which is defined as treatment which is essential for the patient at a given time to resolve immediate health problems. Whatever is proposed under the justification of therapeutic necessity must not be regarded as inhumane or degrading as defined under Article 3 of the Human Rights Act 1998 (Brazier and Cave 2011).

The Mental Capacity Act 2005 represents a major advance for those who are over sixteen years in striking a balance between respect for individual autonomy and the need to protect those who may be vulnerable (Jones 2014). It has a broad range of scope and influence and provides a framework for addressing a range of decisions that need to be made if it is recognised that a person is not able to make choices and decisions for themselves (Brazier and Cave 2011). Such decisions cover more than healthcare treatment and also include personal and social care issues across any timescale continuum. At the outset, the Mental Capacity Act 2005 needs to be distinguished from the Mental Health Act 2007. The latter is concerned with assessment and treatment for mental health disorders only, allowing compulsory assessment, treatment and detention in places of safety for those who may or may not lack capacity but who pose a risk to themselves or others. There is, however, overlap between both statutes and populations covered. Despite this, both statutes are designed for very different purposes. The Mental Health Act 2007 is primarily concerned with the reduction of risks of self and others as a result of mental disorder, whereas the Mental Capacity Act 2005 is designed to empower people to make decisions for themselves and to protect those who lack capacity (BMA and Law Society 2010, Richardson 2010).

The Mental Capacity Act 2005 has a number of key principles which apply to all actions and decisions taken under its influence both by lay people and professionals of healthcare and the law (Jones 2014). These are:

- A person must be assumed to have capacity unless it is established that capacity is reduced or absent
- A person is not to be treated as unable to make decisions unless all options have been explored and attempted, albeit unsuccessfully, to facilitate that person making a decision
- A person is not to be treated as being unable to make a decision and without capacity simply because they make a decision that may be regarded as foolish or unwise
- All decisions taken and interventions done without the consent of a person must stand scrutiny as being in the best interests of that person
- All decisions and actions taken in the best interests of a person must be achieved in a way that is least restrictive of that person's human rights and freedoms (Jones 2014).

In addition, this legislation provides for a Code of Practice that serves as a point of guidance and direction for professionals who are required to interpret and apply the provisions of the Act (Department of Constitutional Affairs 2007). As a result a broad statutory framework and related structures are provided through which decisions are made on behalf of adults who lack relevant decision-making capacity (Herring 2015).

2.5 Definitions of Capacity

The concept of mental capacity is one that has increased in significance in legal and clinical contexts as a result of the enactment of the Mental Capacity Act 2005. It is strongly linked to decision making abilities and to the notion of best interests, the assessment of which continues to be the benchmark against which lawful treatment of patient lacking capacity is normally judged (Brazier and Cave 2011). Capacity or mental capacity is also a concept that is discussed at length in the literature, much of which pre-dates current statutory and legislative processes. A number of empirical research studies define and conceptualise mental capacity, focussing largely on decision-making abilities regarding the need for medical treatment (Appelbaum and Grisso 1995, Wong et al 1999, Wong et al 2000, Appelbaum 2007, Appelbaum 2007a, Price et al 2014). It is thought that studies such as these have done much to inform and shape contemporary models of law relating to capacity, incapacity and clinical practice as they demonstrate agreement on the focus of decision making ability underpinned by understanding, appreciation and reasoning (Emmett et al 2013).

Mental capacity is observed as a complex concept and is a central determinant of an individual's ability to make autonomous decisions (Jones and Jones 2007). Also its assessment has become increasingly important with the move away from the paternalistic role of healthcare professionals towards a greater emphasis on the treatment decisions of a person (Okai et al 2007, McHale 2009). This is consistent with the Mental Capacity Act 2005 which instructs that the focus of assessment is essentially a persons' capacity to understand what is at stake and to act on information provided (Avery 2013). Capacity is the ability to use cognitive processes to understand and identify situations and options, to appreciate the consequences of different options and to make decisions. Involved in this are understanding, appreciation, reasoning and expression of choice (Pachet et al 2007).

To further the definition of the concept of capacity, a differentiation is made between the concepts of capacity and competency. Capacity is used in relation to clinical assessment and determination of a patients decision making abilities by healthcare professionals. In addition it is suggested this should refer to a time and decision-specific ability (Srebnik and Scott 2006, Patchet et al 2007, Banner 2012, Hein et al 2014). By contrast the term competency is identified as referring to the decisions and rulings of courts in legal cases regarding the clinical determination of capacity (Coggan and Miola 2011, Jones 2014a). The terms capacity and competency are used interchangeably in the literature in addition to the notion of sound mind, the latter being a generic label for capacity or competency (Lamont and Chiarella 2013). However, most references to these terms or labels appear to have common elements in that they relate to understanding, appreciation and decision making abilities (Banner 2012). This highlights consistency with the main tenets of the Mental Capacity Act 2005.

To determine capacity or incapacity, a legal test or criteria are applied. These were developed as a result of decisions made in a number of legal cases which pre-date, and have helped shape, the Mental Capacity Act 2005 (Re T (Adult Refusal of Treatment) 1992, Re C 1994, Re MB 1997, B v An NHS Trust 2002). Significant principles arising from these cases relate to the potential for capacity to fluctuate due to a number of factors such as illness, pain, anxiety or the effects of medication. Also of note is that those with significant mental or physical health problems may continue to have unaffected capacity (Re C 1994). Therefore, an assumption of capacity free from bias and judgement would appear to be significant in making assessments of capacity status.

The Mental Capacity Act 2005 uses the term mental disability and the definition of mental capacity contains a two-stage process for establishing if a person has capacity to make their own decisions (Fennell 2012). Firstly it must be established that the person is not able to make decisions if there is an impairment or disturbance in the mind or brain. This is a cognitive-functional test of capacity and specifically includes temporary states of impairment (Pattinson 2013). It is recognised impairment may be caused by a number of factors including the effects of medication, alcohol, altered physiological and psychological states, dementia and brain damage. The terms mind or brain are occasionally used interchangeably in the literature. There are, however, differences between them. The term mind describes thought processes, views and perceptions. The term brain refers to the organ and its complex structures (Davies and Jones 2002, Banner 2012).The second stage of the process relates to an assessment to ascertain if the impairment or disturbance results in an inability to make decisions and to communicate decisions made (Dimond 2008).

The legal test for capacity is further clarified regarding stage two highlighted above. Capacity, lack of capacity and inability to make decisions depends on assessing and establishing that a person is unable to understand information relevant to a decision, to retain information, to use information to make a decision and to communicate the decision made (Mental Capacity Act 2005 Section 3). All four aspects must be satisfied in order for a person to be deemed as having capacity. Where one or more are absent, decisions can be made on behalf of a person providing that the best interests of that person have been assessed and justified (Coggan and Miola 2011). It is recognised that there may be occasions where a person may be able to satisfy one or two of the above stages, such as understand and absorb information, but the effects of a mental disability, for example, may prevent an ability to use that information to make a choice (Re P 2009). If this were the case, the person would be deemed not to have levels of capacity sufficient to make a decision. What therefore must be assessed is essentially capacity to understand what is at stake, to act on information, and at some point, have the ability to communicate a decision either verbally or non-verbally (Donnelly 2009). The four stages of this test appear to be common criteria in the determination of capacity where the ability to make decisions is a central prerequisite (Byatt et al 2006, Dunn et al 2006, Srebnik et al 2006, Pachet et al 2007, Ryan and Callaghan 2010, Lamont et al 2013). Furthermore, four core abilities appear to have common and universal recognition as pre-requisites of capacity, namely, understanding, appreciation, reasoning and ability to choose and are common to both UK and US legal systems (Berg et al 1996, Appelbaum 2010).

2.6 A Functional Approach to Capacity Assessment

The approach taken in the Mental Capacity Act 2005, in relation to the assessment and definition of capacity, is regarded as a functional approach which was recommended by the Law Commission when it reviewed legal provision relating to incapacitated adults in the 1990s (Law Commission 1995). The approach originated from the case Re C [1994] where the patient was detained against his will in a mental health facility for significant mental health problems, but deemed to have sufficient mental capacity to make his own decisions regarding a surgical procedure for a physical health problem. This patient was delusional as a result of acute and serious mental health problems but was assessed to be able to comprehend the risk of death if he refused to undergo the proposed surgical intervention. This case highlighted that the assessment of capacity must be objective and cognisant of the decision making abilities of a person despite existing health issues or diagnoses.

Although a functional approach is the one of choice and enacted in the Mental Capacity Act 2005, it is regarded as the most difficult to implement (Jones 2014). It is also the one that has received the most informed empirical, clinical and legal support to date (Suto et al 2005, Emmett et al 2013, Jones 2014). This approach relates to the ability of a person to make a particular decision at a particular time and not on the ability of the person to make decisions generally (Jones 2014). Embedded in this approach is the principle that capacity cannot be established merely by reference to age, condition, appearance, behaviour, modes and methods of communication (Mental Capacity Act 2005). This implies that the capacity of a person must be assessed and determined at a given time when a decision needs to be made and the assessment process must be objective and informed by the four aspects, or stages, of understanding, retention, decision making and communication abilities. The difficulties in applying this approach are linked to the need to assess the capacity status of a person frequently if is it judged that the physical or psychological condition of the patient is changing or may change at a later date.

A functional approach also allows for temporary loss of capacity or changes in levels of capacity, known commonly as fluctuating capacity. This is a concept that has been recognised as significant in the assessment of the ability to make choices (Re T 1992, Re MB 1997) and of the notion that the graver the consequences of the decision, the greater the ability needed to make decisions (Re MB 1997). This concept has an allowance built into it which recognises that the capacity of a person may vary due to, for example, an illness or trauma where capacity may fluctuate with the trajectory of a disease process or recovery period. Also, this concept recognises that a person may not have sufficient capacity to make complex or major decisions, but may still have enough capacity to make other, less complicated decisions or to express views and opinions regarding the outcome of more complex decisions (Jones 2014). However, the assessment of capacity using a functional approach is time and decision-specific. Legal capacity is assessed and established at a particular point in time in relation to a specific reason or set of circumstances. If appropriate and circumstances allow, it is advised that a decision should be delayed if it is anticipated the capacity of a person may improve sufficiently, enabling that person to be supported to make a decision for themselves (Mental Capacity act 2005). A person may have periods of lucidity with greater ability to make their own decisions at a future date, thus their ability to demonstrate functional capacity will be enhanced (Re T 1992, Re MB 1997, Raymont et al 2004, Church and Watts 2007, Brazier and Cave 2011). It is also recognised that fluctuations in capacity creates the notion of a capacity continuum, with full capacity at one end and total incapacity at the other. A person may be placed at varying points of the continuum as their levels of capacity ebb and flow at any one time (Carroll 2010).

When exposed to patients with a potential for fluctuating capacity, practitioners of acute care may be faced with considerable challenges. The case of Re MB [1997] involved a patient who was deemed temporarily not to have capacity due to a needle phobia. In this case, it was recognised that temporary factors can erode capacity such as:

> *"…confusion, shock, pain or drugs. Fear may also paralyse the will and thus destroy capacity to make decisions"* (Re MB 1997 page 224).

This could apply to the majority of patients requiring acute and/or critical care interventions and practitioners must be cognisant of the transitory nature of the capacity of patients and of the need to factor this into care and treatment decisions. This signposts the challenges inherent in processes of assessing capacity. Practitioners must assess using the pre-defined criteria in the four-stage process outlined in the Mental Capacity Act 2005, focusing upon understanding, retention, reasoning and communication. Also, practitioners must be mindful that this is an ongoing process as the capacity status of patients may change at any time. The physical, emotional and clinical status of patients may also be unpredictable which further implies that practitioners need to be vigilant to the changing needs of patients (Griffiths and Tengnah 2010). This is highlighted by the observation that capacity is a fluctuating commodity and the state of mind of patients is often ambiguous, so much so, that fluctuations in capacity may be the rule rather than the exception (Chiswick 2005). Capacity has also been described as elusive if the emotional or physical status of the patient is unstable (Davies and Jones 2002, Jones et al 2005). Therefore this suggests that many patients in acute and critical hospital settings may lack capacity or may experience fluctuating levels of capacity. It also emphasises the significance of the role of qualified nurses in making accurate and timely assessments of the capacity status of patients in their care. Ultimately, this makes a case and supports the need for research into this area of the role of qualified nurses which may inform practice and also the future education of nurses.

The functional approach to the assessment of capacity is favoured when compared to an outcome approach (Jones 2014). An outcome approach uses the consequences of decision-making processes as the criterion for determining capacity and focuses on the quality of the decisions made. For example, an unwise, foolish or irrational decision may call into question the decision making ability of a person. The rejection of the outcome approach is widely accepted in favour of the functional approach, the latter being regarded as allowing individuals to have maximum decision making powers and is flexible as it allows for changes in the condition of a person (Mastermann-Lister v Brutton & Co 2003, Suto et al 2005, Dunn 2006).

Contrasts can also be made to a status approach applied to capacity assessment in which the capacity of a person can be determined by membership to a specific population, such as those with specific conditions or diagnoses (Grisso and Appelbaum 1998, Jones 2014). This would render large sections of the population as incapacitated, for example, all people with dementia would not be considered to have capacity (Emmett et al 2013). Also, it has been highlighted that not all people with mental health problems or learning disabilities lack the requisite capacity to demonstrate their understanding and ability to make decisions and it is recognised that there are dangers of making pre-determined assumptions regarding people with learning disabilities, or those with existing diagnoses such as having physical or mental health problems (Gunn et al 1999, Hotopf et al 2008, Griffiths 2015). A status approach is therefore rejected as it is not consistent with the underpinning philosophy of the Mental Capacity Act 2005 in that people should be supported and enabled to make their own decisions (Law Commission 1995). Also, a status approach would not take into consideration the need to be cognisant of the notion of fluctuating capacity, together with the need to assess a person at the time a specific decision needed to be made (Raymont et al 2004, Church and Watts 2007, Samsi et al 2011). As a result, a functional approach is regarded as facilitating greater flexibility and allows opportunities for those who are assessing to take diagnoses, circumstances and timeframes into consideration in an attempt to be accurate in assessment processes (Jones 2014).

An advantage of a functional approach can also be a challenge in its application. At the centre of this approach is the notion that a person needs to have the necessary understanding to make a decision, yet the decision made may appear to be unwise, foolish or eccentric. The case of Re C [1994] highlights that mental illness and bizarre beliefs or behaviour do not necessarily result in a conclusion of lack of capacity. Again, in the case of NHS Trust v T (Adult Patient: Refusal of Medical Treatment) [2004], it was established that irrational decisions should not be equated with lack of capacity. Furthermore, legal recognition has been given to the dangers of assessing lack of capacity if foolish decisions are made (CC v KK 2012) and to practitioners confusing their professional drive to protect patients against such decisions by failing to assess capacity objectively (A NHS Trust v Dr A 2013). Hence the challenge in the application of this approach. It would appear to be difficult to assess the ability of a patient to understand relevant information if entrenched beliefs or opinions are expressed and if this resulted in decision making abilities being hidden. Also, a patient may hold and express strong religious beliefs or articulate personal philosophies related to cultural norms and display outward behaviours associated with cultural nuances. These may impact upon the decisions made by patients and may appear alien to practitioners who may interpret these as irrational and illogical. Furthermore, practitioners may encounter patients who do not want to make decisions and refuse to receive information to do so. The difficulties encountered by practitioners who may be confronted with patients who are not co-operative in this respect was considered in the case Re P [2014]. Here, recognition was given to the possibility of concluding that such patients lacked capacity as they may not understand information relevant to making a decision if they refuse to engage with it. They may therefore be assessed as not meeting the legal criteria against which capacity is assessed. However, if a patient does not want to receive information and refuses to make decisions, this may be regarded as unwise, foolish or irrational. Subsequently this may place practitioners in a difficult position if the patient is assessed as having capacity as there would be no legal basis for the assessment of best interests and no legal justification for making decisions on behalf of such a patient (Jones 2014).

Furthermore, if an acutely and/or critically ill patient is physically compromised and does not appear to be expressing logical thought, this would appear to pose difficulties for the practitioner. For example, if a motorcyclist is faced with the possibility of an amputation of lower limb as a result of injuries sustained in a serious road traffic accident and refuses to give consent, it could be anticipated that practitioners would assess that the patient does not have the required capacity due to the traumatic nature of the situation. The professional priority in this instance may be in favour of preserving life (Jones and Jones 2007). Also, when practitioners disagree with the decision of a patient, there may be some temptation to assess that the patient lacks capacity in the justification of providing care and treatment which the patient has refused and does not want. The case of B v An NHS Trust [2002] illustrates such a challenge and the dangers of an incorrect or unethical assessment of capacity:

> *"It is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence"* (B v An NHS Trust 2002 at para 100).

It would appear that a reality for practitioners is that the outcome of the decision of a patient may have an influence upon the assessment of capacity, particularly with acutely or critically ill patients. There may be a professional drive on the part of practitioners for the preservation of the life of a patient which may strongly impact upon conclusions about the capacity status of patients (Mita et al 2009, Odell 2015).

2.7 Assessment of Capacity Processes

In order to determine the capacity status of a person, an assessment process of some kind must be employed. Published evidence suggests the process of assessing capacity is complex, multi-dimensional and challenging but broad consensus appears to reflect themes of understanding, appreciation, reasoning and ability to express choices (Grisso and Appelbaum 1995, Grisso and Appelbaum 1995a, Grisso and Appelbaum 1998, Warner et al 2008, Banner 2012). These are recurring themes which appear to have universal acceptance and recognition. It is suggested that there are five key principles that form ethical and theoretical underpinnings of a sound approach to the assessment of capacity. These are:

1. Capacity assessment is performed as a last resort as the presumption is in favour of capacity
2. Capacity assessment for complex cases is a multi-professional process
3. Capacity assessment is domain specific and/or decision-making specific
4. Capacity assessment is multi-factoral and includes assessment of psychological, cognitive, functional and medical factors as a well as assessment of the persons' decision-making abilities
5. Capacity assessment takes into account a person's culture, beliefs, values and preferences (Pachet et al 2007).

The above approach has resonance with the philosophies and underlying principles of the Mental Capacity Act 2005 and highlights the complex nature of the process and the challenging implications for those who are required to assess. There is also the recognition that the balance between preserving autonomy and facilitating the treatment and care of patients in their best interests is difficult to achieve (Banner 2012, A NHS Trust v Dr A 2013). The assessment of capacity status is central to the efficacy of "getting it right" for patients. Processes used to assess capacity are influenced by the presentation and condition of patients and the environment in which care and treatment is provided. There is recognition that the cognitive abilities of patients may be impaired by significant symptoms related to physical illness and the effects of medication (Dunn et al 2006). Also, it is recognised that capacity may be reduced by certain mental health conditions such as dementia and/or situational factors such as the complexity of information disclosed and the manner of its disclosure. This is fundamental to the recognition that different settings and the seriousness of situations may demand different levels of functional ability and the context may have a direct influence upon the reactions of patients and their abilities to demonstrate their mental capacity (Dunn et al 2006, Appelbaum 2007a, Brown et al 2013).

There is much to suggest that patients with significant cognitive impairment do not have capacity and that a high proportion of these do not have sufficient capacity to make decisions (Smithline et al 1999, Raymont et al 2004, Jacob et al 2005, Fassassi et al 2009, Burton et al 2012). These studies link impaired capacity and decision making abilities with increasing age and illness and this association is amplified by lowered educational levels and physical illness (Fassassi 2009). It is also recognised that patients whose capacity is impaired are commonly found in medical and surgical hospital in-patient units and less frequently in out-patient clinics (Lepping 2011). This appears to signal that being physically ill and admitted to in-patient units can impact upon capacity status. Furthermore, it is observed that between 3% and 25% of requests for mental health consultations in general hospital settings involve questions about the capacity of patients in making treatment related decisions (Applelbaum 2007a, Brown et al 2013). Again, this appears to highlight the impact of illness on capacity status.

A longitudinal study by Raymont et al (2004) confirms that physical illness has a significant impact upon capacity and ability to make decisions. Starting assumptions of this study were that patients with acute medical illnesses were likely to have impaired capacity in situations when treatment decisions may need to be made quickly. This study observed that approximately 40% of acutely ill medical patients in 2 general medical wards in a general hospital in London had significant difficulties in making complex treatment decisions when assessed by doctors. Over an 18 month period 302 acute medical inpatients were randomly recruited to assess their capacity with the use of an assessment tool using semi-structured interviews and by clinical interview. Of the 302 patients recruited to this study, 143 were not interviewed due to a number of reasons, namely unconsciousness (n=14), unable to express choices due to communication difficulties (n=19), severe cognitive impairment (n=39), could not communicate sufficiently in English (n=16) and refused to participate (n=55). 159 patients were therefore interviewed. Of this sample 107 (67%) had more than one medical diagnosis with the most common identified as cardiovascular (n=71 or 45%), respiratory (n=50 or 31%) and infections (n=32 or 20%). It was identified that patients with more than one diagnosis, those with infections and those with neurological disorders were more likely to lack capacity, as were those with new diagnoses. However, the above sample consisted of elderly patients and those who were admitted for longer periods of time. This therefore appears to have biased the sample towards those with more complex medical illnesses and those needing more in-depth healthcare interventions as a result. The results of this study demonstrate a correlation between acute illness and impaired capacity and consequently decision making abilities. Despite the bias of the sample and the age of patients included in this study, these findings may be regarded as significant and applicable to present day hospital settings as elderly patients, many with complex health needs, continue to form a large proportion of populations admitted to acute medical wards.

The effects of illness on the capacity status of hospitalised patients with acute medical health problems has been highlighted in a more recent publication which reported on the results of an audit across a then NHS Trust in North Wales (Lepping 2010). A survey was undertaken of 688 in-patients in a one week period. Senior nurses were asked to identify the numbers of patients who would not be able to give their consent to various procedures during the week of audit. They were also asked to identify the numbers of patients who did not have the mental capacity to make basic and complex decisions. Senior nurses judged that 21% of patients who were medical in-patients lacked capacity, followed by 20% of patients who were diagnosed with mental health problems. Mental capacity was judged not to be a significant problem in surgical in-patients (6%). The limitations of this audit are considerable in that no indications are given of the ways in which senior nurses formed opinions of the capacity status of patients, who actually assessed this or whether senior nurses simply estimated based on evidence from ward based staff. The results are therefore reliant on the report of senior nurses. Despite this, the results appear to suggest that patients with medical diagnoses and receiving treatment as in-patients may have reduced mental capacity. This is consistent with previous research.

This correlation has been established in other studies in the recognition that different types of physical illness and/or treatment may compromise decision making abilities (Appelbaum and Grisso 1997, Moser et al 2002, Casarett et al 2003, Palmer et al 2005, White-Bateman et al 2007). Capacity may therefore be reduced or absent. A cerebro-vascular accident can affect capacity to make decisions depending on the location and size of the affected area of the brain

(White-Bateman et al 2007). In the absence of accompanying cognitive impairment, medical conditions such as angina (Appelbaum and Grisso 1997), myocardial infarction (Smithline et al 1999), diabetes mellitus (Palmer et al 2005), human immunodeficiency virus (Moser et al 2002) and cancer (Casarett et al 2003) can also impact upon the ability of patients to make their own decisions. It is also recognised that some patients with acute physical illness may have difficulty in processing information necessary to give an informed consent due to a number of factors, such as pain, fear, hypoxia or the effects of medication (Smithline et al 1999). These factors may not result in a complete lack of capacity, but rather capacity is diminished or is not sufficient at a given time to enable the patients to make significant decisions. Here the concept of fluctuating capacity is highlighted, as the patient may be distracted or not able to process information due to the effects of, for example, pain and/or anxiety. The timescales within which capacity is assessed would therefore appear to be significant, as levels of capacity may improve with sound pain management regimes or with effective interventions to relieve anxiety. This is consistent with the principles of the Mental Capacity Act 2005 which directs that treatment decisions should be delayed if it is considered appropriate to wait until the capacity of a patient improves or returns (Jones 2014).

Adding to the complexity of what is suggested above, it is noted that a substantial proportion of patients with difficulties in making decisions place their trust in doctors and passively acquiesce to care and treatment plans (Kothari 2003, Raymont et al 2004, Okai et al 2007). If a patient is prepared to accept treatment, the issue of capacity may not arise as a doctor presumes it is present. A qualitative, cross sectional study by Hotopf et al (2008) in two large Mental Health Trusts in London explored how consultant psychiatrists (n=189) conceptualised mental capacity and the extent to which they thought a change in the law with the introduction of the Mental Capacity Act 2005 would impact on the use of electro-convulsive therapy (ECT) for involuntary patients lacking in mental capacity. This was a qualitative study using focus groups and semi-structured interviews and used the recall of consultant psychiatrists to explore their practice. This study did not observe the practice of participants directly and the authors recognise this as a limitation. However, this study found that psychiatrists failed to recognise a lack of capacity in patients who were compliant with treatment regimes and who accepted, and agreed to these without question. In the situation of needing to give a patient ECT, consultants were more likely to administer this regardless of the results of capacity assessments. The complexities of the clinical setting and the diagnoses of patients were the reasons identified for this with the best interests of the patients appearing to dominate the justification of administering this treatment. Here it could be argued that there is little to differentiate between attending to the best interests of a patient and a paternalistic approach. The authors of this study did not explore how participants assessed the best interests of patients, but findings indicate an apparent misunderstanding in definitions of what constituted bests interests. The Mental Capacity Act 2005 directs that best interests are derived from what can be ascertained about the past and present wishes and values of patients. In this study by Hotopf et al (2008) participants regarded best interests as:

> *"Treatment needed to bring about the best clinical outcome"* (Hotopf et al 2008 page 324).

These findings appear similar to those of a qualitative study, using focus group discussions informed by critical incident technique, exploring the ways in which qualified nurses (n=50) on general medical wards obtained consent prior to carrying out generic nursing care in two teaching hospitals in the UK (Aveyard 2005). Findings in this instance indicate that some qualified nurses reported reluctance in allowing patients to refuse care which was considered to be in the best interests of those patients, in particular if this care was considered to be clinically essential. This suggests paternalism on the part of qualified nurses. However, this study pre-dates the Mental Capacity Act coming into force in 2007, by which time many qualified nurses had undergone some kind of education and training to inform them of the requirements of this legislation. This, therefore, raises some questions regarding the applicability of the conclusions of this study.

Both studies by Hotopf et al (2008) and Aveyard (2005) have some resonance with a recent legal case where it was established that practitioners involved in treating and helping a patient may be more compelled to choose an outcome which is more protective of that patient and fail to assess capacity in a detached and objective manner (A NHS Trust v Dr A 2014). This may be regarded as having some application to acute and critical care settings, with the priority for assessing and treating patients in time limited situations in the justification of securing the best clinical outcome. This may lead to superficial or no objective assessment of capacity status.

The observation that practitioners may equate refusal of treatment with incapacity and acceptance of treatment with a presumption of capacity (Okai et al 2007, Lamont and Chiarella 2013) has echoes to B v An NHS Trust [2002] where a court found that a healthcare team assessed a lack of capacity in a patient who disagreed with them. The court warned of a danger of benevolent paternalism, doing what is considered to be the best for a patient without actually assessing best interests, and the supposed tendency for practitioners to view responses such as anger or decisions at odds to those of the healthcare team as evidence of incapacity. Added to this is the suggestion that capacity assessments are often triggered by disagreements between patients and their families and practitioners (O'Keefe 2008). This would appear to imply that patients who appear un-cooperative may be assessed as without sufficient insight or capacity to make choices and to refuse treatment (Nicholson el al 2008, Emmet et al 2013). A conclusion may therefore be drawn that a co-operative, passive, unquestioning patient may commonly be assumed to have capacity.

Alternatively, it is also observed that even when hospitalised patients decline treatment, impaired decision making abilities of patients are often undetected by doctors (Lamont and Chiarella 2013). Capacity assessments can be informal and superficial in nature and as a result, doctors miss and fail to recognise key symptoms of disorientation and confusion due to the superficial nature of the assessments which are conducted. The ability of patients to understand the situation in which they find themselves and to make decisions is not assessed in sufficient depth to arrive at a meaningful conclusion. This is exacerbated by the complex and fluctuating nature of capacity and by the challenges which acute and critical clinical environments pose to both patients and practitioners (Lamont and Chiarella 2013). This further implies that practitioners need time with patients in order to assess patients and to pick up on the nuances relating to impaired understanding and decision making abilities. Due to the nature of nursing and the proximity of qualified nurses to patients on a twenty four hour basis, there is recognition that nurses are in strategic positions to assess subtle and obvious changes in the capacity of patients at an early stage. Nurses also have more exposure to relatives and carers and therefore are able to gather information related to the context and background of patients (Schuurmans et al 2001, Devlin et al 2008, Steis and Fick 2008).

A recent ethnographic study by Emmet et al (2013) explored methods of assessing the mental capacity of patients with dementia admitted to acute hospital wards. Three wards in two district general hospitals were used in the North of England. Qualitative interviews were conducted with 29 patients and a broad range of healthcare staff (n=35). The latter included senior and junior doctors, senior and junior nursing staff both qualified and unqualified, and other staff from professional groups allied to healthcare. Focus groups were also conducted with a range of healthcare staff (n=22) which again included nurses. Unfortunately, the results in this study were not presented to reflect differences between the professional groups represented but were presented together. Multi-professional team members were observed to adopt both informal and formal assessment processes for capacity assessment. Both were used concurrently and interchangeably and these appeared not to be two separate processes. Practitioners indicated that formal processes were used at some points in time, usually for patient situations which were considered to be complex and involving the need to organise and manage ongoing health and social care needs. Informal processes were described as occurring over a period of time, at the same time gathering information from a variety of sources which were then included in the overall assessment of capacity process. The authors of this study assert that informal assessments of capacity were made routinely using a variety of subjective clinical judgements. These did not always result in compliance with appropriate legal standards, although the best interests of the patients were normally served in that assessments were conducted about the wishes of patients. Assessment practices were considered to be largely idiosyncratic in their approach. Professionals used their own clinical judgement to determine which information they considered significant or relevant to making decisions about the capacity of patients, such as levels of understanding and retention of patients, levels of general awareness and whether they had given reasonable responses. Clinical judgement was occasionally informed by intuitive responses regarding the presentation of patients which resulted in more in-depth exploration about the capacity status of patients. Informal, working clinical judgements were also informed by the input of family and friends. Whilst these sometimes resulted in accurate assessments of capacity, they also resulted in subjective and unpredictable outcomes. Practitioners were left to determine which information they considered relevant to their decisions regarding the capacity status of patients and the amount of information given to patients to determine capacity status (Emmett et al 2013).

The Mental Capacity Act Code of Practice (2007) directs that the person who is required to assess an individual's capacity is the person who sets out to act on behalf of the person with diminished capacity. In acute care and/or critical care settings this would place the qualified nurse at the centre of the assessment process which is consistent with the recommendations of the Mental Capacity Act 2005 as there are no requirements for any particular professional to be involved in the assessment of capacity (Jones 2014). This would also suggest that relatives, carers or independent advocates may also be involved in such assessments. Law and policy place evidentiary demands on practitioners when assessing capacity, regardless of processes that they may adopt and use (Herring 2015). If incapacity is assessed, it must be established on the balance of probability before interventions in the best interests of patients are undertaken. This, combined with the statutory presumption of capacity and its association with individual autonomy, may render professionals reluctant to query capacity even when they identify that a patient may have difficulty in making decisions (Griffiths and Tengnah 2014). Consequently, this may lead to a reluctance of some professionals to make capacity assessments at all (Keywood 2010). This is compounded by the argument that the law creates too sharp a boundary between those who possess capacity and those who do not. This does not assist practitioners to assess and manage patients who are at the margins of having decision-making abilities (Herring 2009, Humphreys et al 2014). The patients at these margins pose challenges to practitioners in that capacity assessments are difficult and evidence suggests that such difficult assessments are often subjective and idiosyncratic, where outcomes are often inconsistent and unpredictable (Knapp 2002). It is asserted that capacity is regarded rarely as either/or, namely with or without capacity, but is often regarded as being at the margins and seen as moving between the continuum of with or without capacity (Olumuyiwa et al 2007, Herring 2010). Given that information giving is central to any assessment process related to the understanding of a patient, practitioners must satisfy themselves that a patient has understood information and that the patient has the ability make decisions (Coggan and Miola 2011). The reality for practitioners on a day-to-day basis is that they are left to determine the amount of information given to patients and the manner in which they give it. This can have an important influence on the outcome of assessment processes and can result in subjective and inconsistent outcomes (Emmett et al 2013).

2.8 Assessment tools

Given the complexity of the situation presented above and the focus on the concept of mental capacity since the enactment of the Mental Capacity Act 2005, there is an increased recognition of the challenges faced by practitioners in the need to assess capacity. This has resulted in a rise in the number of referrals for psychiatric evaluation of patients in general hospital settings, regarding patient abilities to make decisions to consent to treatment (Kornfeld et al 2009) and in the number of assessments of patients in mental health settings (Brown et al 2013). This normally results in formal assessments of capacity being conducted by appropriately qualified practitioners using pre-defined assessment tools.

The development of assessment tools and interview guides for assessing and evaluating capacity is reported in the literature with an emphasis placed upon the principle that tools compliment and inform clinical judgement, not replace it (Gunn et al 1999, Moye et al 2006, Okai et al 2007, Lamont et al 2013). Many authors comment on the need to adopt a structured, systematic approach to assessment using pre-determined, well defined criteria (Appelbaum 2007a, Church and Watts 2007, Burton et al 2012). A variety of assessment tools exist. These range from research-based instruments using patient centred clinical vignettes to those designed for actual application by clinicians. Most consist of structured or semi-structured interview format (Hein et al 2014).

A number of authors indicate that the capacity of patients can be assessed utilising pre-defined tools and those with limited capacity or without capacity can be identified (Grisso et al 1997, Smithline et al 1999, Raymont 2002, Appelbaum 2007a, Okai et al 2007). Research studies measuring the reliability of yes/no capacity assessments using semi-structured interviews, report substantial inter-rater reliability (Wong et al 2000, Vollman et al 2003, Cairns et al 2005, Owen et al 2007, Moye et al 2008). These studies suggest that when a consistent approach is taken to assessment, yes/no assessments can be made with a high degree of consistency and therefore can be regarded as valid. However, levels of consistency are apparent when research clinicians use pre-defined assessment tools. When administered by other clinicians inter-rater reliability is slight. This questions the reliability and validity of pre-defined assessment tools in an absolute sense (Owen et al 2007, Hein et al 2014).

Inconsistencies are reported in the use of tools regarding the exact nature of what is being measured. There appears to be consensus on what constitutes an assessment of understanding, but the concepts of appreciation and reasoning are more elusive to assess and tools generally do not provide operating definitions (Dunn et al 2006, Moye et al 2006, Hein et al 2014). Appreciation is regarded as an abstract construct, and one which is difficult to capture in an assessment tool (Moye and Mason 2007, Series 2015). Also, there is evidence to suggest that there are inconsistencies in capacity assessment conclusions where clinical judgement and pre-defined assessment tools are used. A number of studies indicate that patients can be assessed as having capacity when clinicians use their own clinical judgement, but the same patients can be assessed as being incapacitated when pre-defined assessment tools are utilised (Raymont et al 2004, Vellinga et al 2004, Dunn et al 2006, Hein et al 2014). Explanations of this relate to existing pre-defined assessment tools being research tools lacking in practical application and are frequently burdensome and not clinically useful. It is suggested that assessing capacity can be done at the bedside, be this in hospital or community settings, without structured assessment tools. This occurs because clinicians are usually able to identify patients who are at risk of reduced or absent capacity and assess capacity status using clinical judgement (Burton et al 2012).

More recently, this is highlighted in an integrative review of capacity assessment instruments and tools to aid assessment of the capacity of patients to consent to treatment in general hospital settings (Lamont et al 2013). Primary studies of assessment tools published in English in peer reviewed journals between January 2005 and December 2010 were included in this review and 19 tools were found which assess capacity. All tools reviewed used either structured or semi-structured interviews and/or hypothetical patient-focused vignettes. All tools broadly assessed the domains of understanding, appreciation, reasoning and communication abilities and all had time implications regarding the need to administer each tool. This is reported to range from 10 to 90 minutes depending on the tool employed. For this reason the application of comprehensive tools can be problematic in acute and critical care settings due to the requirements of time involved when clinical imperatives dictate rapid decision making in urgent and acute situations. This review found that only a small number of assessment tools were found to be both reliable and valid and also established that most pre-defined assessment tools demonstrate good inter-rater reliability in research settings amongst researchers but inter-rater reliability amongst clinical teams using the same tools is inadequate (Lamont et al 2013). The reasons for this were identified as a difference in the definitions and descriptions of capacity between assessment tools and a conclusion made that there is no accepted criterion validity standard for capacity. Furthermore, the performance of clinicians may be influenced by the severity of the condition of patients and the interpretation of symptoms that they display. Clinicians also use clinical judgement in the need to secure clinically effective outcomes for a patient whilst researchers are focused on the research study and are therefore at a different starting point, both practically and philosophically to capacity assessment (Lamont et al 2013).

The most frequently used tool is reported to be the MacAuthor Competence Assessment Tool for Treatment (MacCAT-T) which has been tested mainly with patients with dementia, schizophrenia and other mental health problems (Raymont 2002, Owen et al 2007, Owen et al 2008, Lamont et al 2013). This specifically focuses on four broad domains of abilities, namely, understanding, appreciation, reasoning, expressing a choice, and has acquired pedigree in legal rulings (Kennedy and Grubb 2000). The test involved in this tool takes at least 20 minutes to administer, and it is considered to have value when the assessment is especially difficult or when a case is likely to be resolved in court. (Appelbaum 2007a). The MacCAT-T allows for detection of inadequacies of any of the four domains above but it should always be used to make a judgement of capacity in conjunction with a clinical assessment. This tool also does not generate a categorical result, such as, has capacity or does not have capacity, but it is advised that it is used alongside clinical interviews in order to make such a judgement. It is suggested that experienced doctors, when using the above tool, are able to make reasonably confident judgements in a clinical population with diverse medical conditions (Raymont et al 2007). However, this tool places more emphasis on appreciation than does the Mental Capacity Act 2005 and the wide range of interpretations that can be allocated to the concept of appreciation can complicate assessment processes for the practitioner (Hotopf 2005).

A study by Cairns et al (2005) shows that two doctors can reliably agree about capacity and ability to decide about treatment in the early stages of admission to a psychiatric hospital using a combination of the MacCAT-T and clinical interview. Methods in this study involved patients being recruited over a nine month period in South London (n=112), and interviewed soon after admission to hospital and a judgement of capacity made guided by MacCAT-T. Demographic and clinical information were collected from interview and case notes. After each interview, assessments of understanding, appreciation, reasoning and expression of choice were made and a judgement made about the capacity of patients. This study found that 43.8% (n=49) of patients lack sufficient capacity to make decisions. The main use of the MacCAT-T in this context was to ensure that a full range of necessary abilities was considered when making a capacity judgement. This study showed that in combination with a clinical interview, this tool allows a rigorous and reliable assessment of mental capacity (Cairns et al 2005). As a result, the MacCAT-T is reported to offer the best choice for measuring capacity to consent to treatment and is the most widely tested in a variety of populations (Dunn et al 2006, Lamont et al 2013).

Despite the above, the 20 minutes needed to apply the MacCAT-T assessment tool may be prohibitive in acute and critical care settings and may not be suited to the needs of the acutely and/or critically ill adult patients. Comprehensive assessments take time and are often difficult in these settings due to the clinical imperatives to assess and treat patients with urgent and pressing health needs. Also in these settings, and in very short timescales, the assessment of understanding and retention make take priority over appreciation and reasoning depending on the severity of the condition of patients. An alternative approach is suggested with the use of mnemonics with attached scoring systems (Chow et al 2010). These may provide aide memoirs for practitioners in acute and urgent clinical settings and also facilitate a structured numerical result with the application of scoring systems. An example of this is the use of the mnemonic CURVES, Choose and Communicate, Understand, Reason, Value, Emergency, Surrogate. Each of these focus on key areas which are applicable to emergency contexts. It is observed that this test is straightforward to use and apply and is proposed as an effective way of approaching, evaluating and documenting decision-making capacity in emergency and acute clinical settings (Chow et al 2010). An approach such as this therefore may appear to have some application for use by qualified nurses if an aide memoir was appropriate. However, assessment tools using scoring systems are in widespread use across acute and critical care settings for the assessment of the physiological status of patients. To date, there is minimal evidence that these have made significant improvements in the ways in which patients are assessed in this respect. Reasons for this are not entirely clear (Fullerton et al 2012) although it is generally regarded that a numerical value may not be recognised across different professional groups, thus limiting the effectiveness of a tool (Mohammed et al 2009, Odell 2015). Consequently, a scoring system generating a numerical value by which to assess capacity status of patients may also have a limited effect.

One of the most often referred to and used assessment tools is the Mini Mental State Examination (MMSE) (Folstein et al 1975). This was originally developed to assess the cognitive abilities of mental health patients but is now used extensively across many specialised and generic clinical settings (Aird and McIntosh 2004, Kahle-Wrobleski et al 2007). This tool measures orientation, attention, registration, calculation, recall, ability to follow a three-part command and use of language. Open-ended questions are used which takes approximately ten minutes to carry out, the purpose of which are to test recall, orientation and the ability to carry out basic commands. This is considered to be a simple tool to use and creates a useful baseline assessment that can serve as a starting point for more in-depth assessments of capacity (Wellens et al 2013).

The MMSE, however, is not without its criticism. A cross sectional study by Fassassi et al (2009) in Switzerland used semi-structured interviews using patient vignettes and clinical interviews to explore the application and efficacy of the MMSE when used by psychiatrists for patients (n=157) admitted to medical wards in a university hospital. It was observed that scores identified by this tool were inaccurate in determining capacity. In this study 67% (n=24) of patients assessed as being cognitively impaired when the MMSE was used were later assessed as having capacity to make decisions and to consent to treatment by senior psychiatrists. Other studies have concluded that the MMSE has some uses but levels of education of patients, their age and the environment in which the test is conducted can impact upon results and therefore conclusions of a practitioner (Kahle-Wrobleski et al 2007, Haubois et al 2013). For this reason advice is given that this tool should be used in conjunction with other observations and assessments, both informal and formal (Aird and McIntosh 2004).

Capacity is a dynamic concept which can range across a continuum and must therefore be assessed on a continuous basis (Griffiths 2014). As a result, a strictly formulaic approach to assessment is unlikely to capture specific individual nuances and depth of detail. Pre-defined assessment tools should therefore support practitioners in the exercise of their clinical judgement, not replace individual judgement (Moye and Mason 2007). It is also recognised that assessment tools may have limited value as stand-alone assessment measures (Lamont et al 2013).

2.9 Conclusion

In this chapter the legal framework for the concept of mental capacity has been explored. Also, an analysis of published research relating to the assessment of mental capacity using pre-defined assessment tools has been presented. Of note is the lack of directly related evidence regarding the assessment of capacity of acutely and critically ill patients in district hospital settings, yet it is recognised that these may be patients whose capacity may be compromised due to the nature of their illnesses and/or the effects of hospitalisation. As qualified nurses are the ever-present professional group in these clinical settings, their role in the assessment of the capacity status of patients would appear significant, especially so as they are required to make referrals to the multi-professional team in the need to manage this aspect of the care of patients. No studies were found which specifically explored what qualified nurses actually do to assess the capacity status of patients in their care and their wider role in the multi-professional team in this respect. This therefore indicates a gap in the current evidence base regarding a key area of nursing practice, at a time when there is increasing focus on the need to uphold the rights and support the autonomy of hospitalised patients. The concept of mental capacity and the need to assess this with objectivity and accuracy is also under scrutiny in legal contexts which are becoming more sophisticated where supporting patients to make their own decisions is paramount.

This study was therefore in direct response to this in the need to provide empirical evidence. The actions, judgments and care and management interventions employed by qualified nurses would appear to be fundamental as a starting point in processes to care for and support acutely and critically ill patients. Furthermore, a greater understanding in this area may assist to inform directions of future practice and education of qualified nurses.

Chapter 3: Methodology

3.1 Introduction

Chapter 2 established a starting point for the setting and context of the research. The concept of mental capacity and its definitions were explored and the background to assessment processes was established. Also the need for further research and exploration were identified. This chapter examines the methodological approach underpinning a critical analysis of the processes and strategies used by qualified nurses to assess the mental capacity of acutely and critically ill adult patients in district hospital settings.

3.2 The Aims of the Research

This study sets out to critically analyse the ways in which qualified nurses assess the mental capacity of acutely and critically ill adult patients in acute and critical care settings. The initial review of the literature identified a number of significant themes. Capacity assessment is complex, dependant on the physical condition and abilities of patients and also on the skills of the clinician conducting the assessment. The law directs it is situation and context-specific and assessment processes may be influenced by application of knowledge and judgement using pre-defined tools and instruments. Notably there is little evidence regarding the ways that qualified nurses assess the capacity of acutely and/or critically ill adult patients and their role in assessment processes. The aims of this study were therefore to explore:

- Processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult patients in district general hospitalised settings.
- Factors influencing opinions and judgement and how these inform methods and processes of assessment.
- Relationships and interactions with members of multi-professional teams and impact upon assessment and decision-making processes.
- How an in-depth insight into assessment and decision making processes may help to inform the practice of acute and critical care and the education of qualified nurses.

3.3 Research Approach

It was identified that the context for this research involved complex processes, at the heart of which are ill, often distressed and vulnerable patients who are dependent upon qualified nurses for healthcare interventions. Recognition was given to the potential for critical exploration of factors that influence these processes in which professional and clinical judgement and multi-professional relationships would dominate. Therefore, selecting an appropriate research approach was important, as was the appropriateness of the research design in meeting the aims of this study (Cohen et al 2011). Cognisance was given to an awareness that this study would be shaped by guiding principles associated with experiences and views, both personal and professional (Jeon 2004). Quantitative and qualitative approaches were explored to select the most appropriate to meet the aims of this study.

3.3.1 Qualitative and Quantitative Research Approaches

The quantitative approach comes from the philosophical paradigm in which human phenomena are viewed as being suitable for objective study, in particular in relation to measurement (Parahoo 2014). It has roots in positivism with an emphasis on tested and systematic experience rather than on undisciplined speculation. Positivists believe that scientific method used in the natural sciences should be appropriate for the study of social phenomena. Equally, they believe that it is possible to deduce laws to explain human and social phenomena in the same way as there are laws in the natural sciences. These laws predict the probability of an event happening, the higher the degree of certainty the more scientific the knowledge on which the prediction is based (Mills and Birks 2014). A deductive process is employed, cause and effect relationships are established and theory is a starting point for formulating hypotheses which will be tested in research (Boeije 2010, Silverman 2013). The main purpose of quantitative research is to measure concepts and variables objectively and to examine the relationship between them using numerical and statistical procedures. The quantitative researcher is defined as someone who organises research in terms of quantifiable variables and who establishes connections between variables by the use of statistical and mathematical techniques (Parahoo 2014).

Quantitative methods have been utilised extensively in healthcare settings for certain types of research and are generally regarded as preferential in that they use techniques that can be applied with rigour. In this respect, randomised control trials are regarded as the gold standard, they are favoured due to their emphases on evaluating effectiveness (Dingwall et al 1998). However, attitudes to research in these settings are changing and there is now greater recognition that qualitative approaches have a place in health care in particular by nurses in the need to conduct research in nursing contexts (Mays and Pope 2000, Polit and Beck 2014). So much so, that it is suggested that qualitative research is favoured in nursing as it emphasises a person-centred and holistic approach (Holloway and Fulbrook 2001, Walker 2005, Parahoo 2014).

Qualitative research is a broad term for a number of diverse approaches which seek to understand human experience, perceptions, motivations, intentions and behaviour. They are based on the belief that interpretation is central to the understanding of social phenomena and are a means to understand perceptions and actions of participants (Silverman 2013). The main features of qualitative approaches are that they are inductive, interactive, and holistic and carried out by flexible and reflexive methods of data collection and analysis (Parahoo 2014). In this approach, inductive thinking is paramount which means that social phenomena are explored in order to find empirical patterns that can function as the beginning of a theory (Boeije 2010). The exploration is to discover perceptions and behaviour from participants own perspectives, in their own words and in the context in which they live and function. Such approaches are suited to research where little is known or understood and where there are new areas to explore (Koch 2006).

The choice of research method, either quantitative or qualitative, will depend on the ways that the researcher views the research question and the frameworks which can be employed to the research design, measurement, analysis and conclusions (Koch 2006). Also, the fundamental consideration in making a decision about a method is to identify an approach which is most suited to generate knowledge to meet the aims of the research (Bryman 2008). It was anticipated the focus of this research would be embedded in relationships, perceptions, social and clinical processes and in individual and team actions. As there is a lack of existing relevant research regarding the assessment of the mental capacity of adult patients by qualified nurses in acute and critical care settings, it was identified that emphasis may be placed upon descriptions of actions, use of process, language, professional interpretations and feelings rather than on the use of numbers, statistical criteria and quantification to determine whether results support a hypothesis. The researcher of this study is a practitioner of acute care of many years, and understands the challenges, layers of complexities and nuances of providing care and treatment across a range of clinical contexts. Therefore, the need for a flexible and inductive research approach was recognised. This is defined in the following:

> *"The purpose of qualitative research is to describe and understand social phenomena in terms of the meaning people bring to them. The research questions are studied through flexible methods enabling contact with the people involved to an extent that is necessary to grasp what is going on in the field. The methods produce rich, descriptive data that need to be interpreted through the identification of coding of themes and categories leading to findings that can contribute to theoretical knowledge and practical use"* (Boejie 2010 page 11).

This quotation appears to identify three main elements, looking for meaning, using flexible research methods enabling contact with those in the field and providing qualitative findings. A conclusion was therefore made that a qualitative approach was suited to this study which would be best conducted using qualitative methods.

3.3.2 Choosing a Qualitative Research Approach

There are a number of approaches to qualitative research, each contain nuances, traditions and specific processes which results in a diversity of qualitative research practices (Silverman 2013). Some approaches are concerned with the use of language and communication processes, for example, conversation analysis and discourse analysis. Others are interested in understanding the ways in which people give meaning to their lives by interpreting their thoughts, experiences actions and expressions. Included in these approaches are ethnography, phenomenology and grounded theory, the three most common types of qualitative research (Boejie 2010) particularly in healthcare. Each of these three approaches are common in nursing research and each are diverse in their focus and processes, the analysis of each being geared towards the interpretation of human experiences and behaviour (Boejie 2010, Mills and Birks 2014).

The aims of this study suggested there were a number of qualitative approaches that required exploration in the need to select the most appropriate. A research approach was required that would allow exploration of complex assessment processes and the judgements, interactions and interventions of qualified nurses working in time limited and challenging clinical environments. Critical evaluation of these processes were anticipated, as were explorations of information and situations which may impact upon nursing actions, judgements, interactions and eventual outcomes for the patient. This resulted in the approaches of ethnography, phenomenology and grounded theory being considered.

3.3.3 Ethnography

Ethnography is an approach relying on the collection of data in the natural environment. Researchers using this method are interested in how the behaviour of individuals is influenced by the culture in which they live. Ethnographers therefore believe that behaviour can only be understood if examined in the setting in which it occurs (Parahoo 2014). An ethnographic approach recognises that people can influence and be influenced by the groups to which they belong and they have shared meanings, perceptions, language and values. This approach is not about individuals but how they interact in groups (Prus 1996). The aim of the ethnographer is to learn from members of the cultural group and to understand the world as they see it. The researcher examines learned patterns of behaviour, customs and ways of life and strives for intimate familiarity with the lived experience of those they study (Prus 1996, Bowling 2002). The main methods of data collection using this approach are interviews and participant observation (Prus 1996).

An ethnographic approach originates, and has its roots in social and cultural anthropology, where early anthropologists lived with tribal communities, often for long periods of time, and immersed themselves in tribal customs, practices and modes of behaviour (Silverman 2013). In healthcare settings, ethnographers may find themselves in hospital wards or departments, spending significant time with populations being studied in order to view the world from the perspectives of that population (Parahoo 2014).

A number of disadvantages were identified if an ethnographic approach was pursued. Participants may be recruited to this study of differing levels of experience and seniority and from a number of clinical settings across a district general hospital. These may include wards and specialised departments and units. This led to an acknowledgement that it would be unlikely that participants would represent a common culture and or a homogenous group. It was further recognised that participants may not be influenced by the experiences and shared meanings of each other, due to them not being co-workers in a team and due to them representing diverse clinical backgrounds. In addition, fieldwork is regarded the cornerstone of an ethnographic approach and involves the participation of a researcher in a setting for an extended period of time (Mills and Birks 2014). Furthermore, fieldwork may be conceptualised as deep immersion in a setting. (Dutta 2014). This implies significant amounts of time needed to become immersed in the lives and culture of participants. The diverse nature of the clinical settings in which data collection would occur in this study and the anticipated lack of common culture of participants suggested that an ethnographic approach was not suitable. Also many of these settings may be intense, front-line services where the continued presence of a researcher may be interpreted as intrusive at a critical and distressing time for patients and families. As a result, conclusion was made that a true ethnographic approach was not appropriate for this study.

3.3.4 Phenomenology

Phenomenology, a philosophy that was adapted as a research approach, was developed by the German philosopher Husserl to investigate consciousness as experienced by those being studied (Parahoo 2014). This approach focuses on individual interpretation of experiences and the expression of these. The underlying philosophy of phenomenology is that only those who experience phenomena are capable of communicating them. It is therefore concerned with the lived experience of those being studied and to reveal the object or phenomena to which meaning is being attached. One of the main features of Husserlian phenomenology is the notion of bracketing which is suspension of the researchers pre-conceived ideas, prejudices and beliefs so that they do not interfere with or influence the description of the experiences of those being studied. Bracketing therefore enables phenomena to be revealed in their truest form (Usher and Jackson 2014).

Phenomenology is also concerned with exploring the different ways that people understand their world and their relationships with others and their environment (Usher and Jackson 2014). It is, for this reason, especially suited to the study of peoples' experience of illness and the care they receive and practitioners can be provided with insights into the experiences of patients from their unique perspectives (Wimpenny and Gass 2000, Mills and Birks 2014).

A development in phenomenological research is the adoption of a Heideggerian hermeneutical approach to the study of nursing phenomena (Parahoo 2014). Heidegger, a protégé of Husserl, did not believe that getting to know and describing the experience of individuals was enough. He stressed the importance of knowing how respondents come to experience phenomena in the way they do and strove to discover how personal history, such as education and social class, past events and psychological make-up can influence the ways in which individuals experience phenomena. The focus is therefore upon the background of the individual and on the conditions in which understanding takes place (Wimpenny and Gass 2000). A feature of this approach is the interpretation of the lived experience and a recognition that bracketing is not possible or desirable as the researcher actively co-creates data with participants (Usher and Jackson 2014).

A phenomenological approach is regarded as a dominant means of knowledge development in nursing (Dowling 2006). However the focus on lived experience suggested it was not appropriate for this study. Phenomenologists seek to understand what experiences of the world are like and experience is examined as it actually occurs (Smith et al 2009). It was anticipated that participants in this study may refer to, and focus upon, prior knowledge and experience when discussing assessments of the mental capacity status of patients. Therefore process, strategies and interventions may be articulated which would not focus on lived experience as it actually occurred. Also, phenomenology aims to explore the different ways in which people experience and describe and understand their world. The aims of this study were in response to addressing gaps in empirical evidence regarding assessment and decision making processes employed by qualified nurses when assessments of capacity were indicated. Therefore, a methodology which would allow for exploration of clinical processes of assessment was indicated. A decision was made that a phenomenological approach was not suitable for this study.

3.3.5 Grounded Theory

Grounded theory is an interpretative research methodology that is useful to generate research based knowledge about the behaviour patterns that shape social processes as people interact together in groups (McCallin 2003). Grounded theory is based on the belief that as individuals within groups define situations with self and others, common patterns of behaviour emerge (Glaser 1998). For this reason, grounded theory is widely used by social scientists and is also considered applicable for nurse researchers providing comprehensive and complex care for adults in many health care settings (Gelling 2002, McCallin 2003). It aims to study the social and psychological processes which people experience in order to make sense of their surroundings (Thompson et al 2006). It differs from other approaches to research in that it serves to explain phenomena being studied (Birks and Mills 2011). One of the main strengths of grounded theory is that it explains what is actually happening in practical life at a particular time, rather than describing what should be going on (McCallin 2003). Grounded theory methods consist of systematic, flexible guidelines for collecting and analysing qualitative data to construct theories grounded in the data themselves. The analysis of data generates the construction of concepts, codes and categories which lead to generation of theory. The guidelines offer a set of general principles rather than formulaic rules, with an emphasis on principles and practices rather than prescriptions and packages (Charmaz 2014). Theory is the product of an investigative process and is the hallmark of grounded theory research. The method is all about theory and its creators defined it as the discovery of theory from data, emphasising that theory produced is grounded in the data (Glaser and Strauss 1967, Birks and Mills 2011, Urquhart 2013).

The history of grounded theory is rooted in early American sociology and anthropology. Both sociologists and anthropologists traditionally worked in the field and collected their data there in an attempt to understand, describe and explore how people construct and make meaning to their lives (Bogdon and Knopp-Biklen 2006). Grounded theory emerged from the successful collaboration of Barney G. Glaser and Anselm Strauss whilst studying death and dying in hospitals. They utilised specific data analysis techniques and produced theoretical analyses of the temporal order of dying (Glaser and Strauss 1965). The epistemological assumptions of grounded theory are derived from symbolic interactionism which explores the processes of interaction between people's social rules and behaviours. Interaction is symbolic because these processes use symbols, words, interpretations and language (Denzin and Lincoln 2000). Symbolic interactionism also assumes that people can and do think about their actions rather than respond mechanically to stimuli (Charmaz 2014).

Grounded theory is indicated when little is known about the prospective area of study, a desired outcome is the generation of theory with explanatory power and an inherent process is embedded into the research situation which is likely to be explicated by grounded theory methods (Birks and Mills 2011). A grounded theory method is regarded as a research design in which the researcher generates a general theory of a process shaped by the views of participants (O'Neil et al 2007).

The focus on process of a grounded theory approach appeared appropriate to meet the aims of this study, to explore methods and processes used by qualified nurses in assessing capacity status of adult patients in acute and critical care settings. The initial review of the literature indicated there is little or no directly related relevant research in this area, thus highlighting a gap in the evidence. As a result, a grounded theory approach appeared to be appropriate as it is indicated when little is known about the area of study (Urquhart 2013). It was anticipated that many of the processes utilised may be linked to, and influenced by, relationships that qualified nurses develop with patients, their relatives and/or carers and colleagues from the multi-professional team. Therefore, an approach rooted in sociology appeared appropriate as was an approach which facilitated exploration into psycho-social processes. It was further anticipated that, in the assessment of patients, qualified nurses utilise clinical and professional judgement and the ways in which they did this were central to the aims of this study. These assessment processes may contain layers of complexity and prior experience of the researcher as a practitioner of acute care and as an academic of long standing, led to an acknowledgement that qualified nurses may experience some difficulty in articulating the nuances and depth of processes they employ. Also, it was predicted that qualified nurses may not appreciate the intricate nature of their day-to-day activities and responsibilities in the assessment of patents. Grounded theory is regarded as an excellent tool for understanding invisible things and can be used to reveal the invisible work involved in many kinds of tasks (Star 2007). This was recognised as significant due to predicted difficulty that qualified nurses may encounter in articulating judgements and actions and also lack of appreciation regarding complexity and depth of processes employed when caring for acutely and/or critically ill patients whose mental capacity status was in question.

The flexibility inherent in a grounded theory was also considered appropriate for this study. This approach gives more flexibility and focus than any other method and quickens the speed of gaining clear focus on what is happening in data (Charmaz 2014). This approach facilitates following pathways of data collection and analysis until data saturation occurs. At the start of the research process, the researcher begins to review, critically analyse and compare data as it is gathered. Such data can only be gathered in the field, and the most common way of data collection is by interviews (Robson 2002, Glaser 2004). So much so, that interviews are regarded as the principal mechanism for gathering data (Birks and Mills 2011). As data collection and analysis progress, the researcher can repeatedly return to the field until data saturation occurs. This is a point when gathering fresh data does not reveal new concepts, insights properties or categories (Birks and Mills 2011). It was anticipated this study would provide an in-depth view of the complexity of the actions of qualified nurses when assessing mental capacity which may necessitate the need to make difficult and challenging clinical decisions. It was therefore identified that the flexibility of a grounded theory approach would provide processes to pursue themes that emerged until data saturation occurred. This method is designed to encourage researchers' persistent interaction with their data, while remaining involved with their emerging analyses. This method also builds checks into the analytical process and leads researchers to examine all possible theoretical explanations for their findings by using an iterative process of moving between data and emerging analysis. This makes data more focused and the analysis more theoretical (Bryant and Charmaz 2010). Additionally, grounded theories, because they are created from the data, are likely to offer insight, enhance understanding and provide a meaningful guide to action (Strauss and Corbin 1998, Glaser 2004). One of the aims of this study set out to explore how in-depth insights onto assessment and decision processes, employed by qualified nurses, may inform the practice of acute and critical care and the education of nurses. It was anticipated therefore that the creation of a grounded theory may provide a meaningful guide to action in the context of care and/or education.

There are considered to be a number of versions of grounded theory methods which are also referred to as a “family” of methods (Bryant and Charmaz 2007 page 11). Hence it was identified that there was a need to conduct a critical analysis of the main schools of thought to inform the selection of the most appropriate methodological pathway to pursue for this study.

3.4 Analysis and Evolution of Grounded Theory

As previously indicated, grounded theory methodology emerged from the sociologists Barney G Glaser and Anselm L Strauss’ successful collaboration during their studies of dying patients in hospitals in the USA in the 1960s. As they constructed their analyses of dying, they developed systematic, methodological strategies that social scientists could adopt for studying other topics. Glaser and Strauss’ book “The Discovery of Grounded Theory” (1967) first articulated these strategies and advocated developing theories from research grounded in data, rather than deducing testable hypotheses from existing theories. “The Discovery of Grounded Theory” challenged the predominant modes of theorising current in sociology at the time and set up grounded theory as an alternative approach (Dey 2008). For this reason, this work is also regarded as a revolutionary book in revolutionary times (Urqhuart 2013). The work was directed against a long tradition of quantitative research in sociology where the beliefs of sociologists in logic, a unitary method, objectivity and truth legitimised reducing qualities of human experience to quantifiable variables (Charmaz 2014). With the publications of their work, Glaser and Strauss saw the need to relate theory more closely to evidence through a flexible research process in which the constant interplay of data collection and analysis provided a sound base for generating theory. One of their main aims was to set out a logical framework for the conduct for this type of approach (Dey 2008). A related ambition was to provide a strong rationale for the adoption and use of qualitative methods of enquiry (Strauss and Corbin 1998). Defining components of grounded theory practice were identified as:

- Simultaneous involvement in data collection and analysis
- Constructing analytic codes and categories from data, not from preconceived logically deduced hypothesis
- Using the constant comparative method, making comparisons during each stage of the analysis
- Advancing theory development during each step of data collection and analysis
- Memo-writing to elaborate categories, specify their properties, define relationships and identify gaps
- Sampling aimed at theory construction (Charmaz 2014).

Since the 1960s grounded theory has developed and evolved. There is a trend in the literature to recognise Glaser and Strauss as the first generation of grounded theorists (Birks and Mills 2011). Those who have used and developed the original methods have since become known as the second generation (Morse et al 2009). As a result it is identified that, “there are a family of methods claiming the grounded theory mantle” (Bryant and Charmaz 2007 page 11). This implies that each iteration by a second generation theorist has resulted in specific ideas and interpretations regarding the application of the method. Whilst not all approaches have absolutely common elements, they have similarities, hence the analogy of family as all approaches have resemblances and similarities (Bryant and Charmaz 2007).

One of the major criticisms of the first generation of grounded theorists is that they did not write about grounded theory as a methodological and methods package, rather they wrote about strategies and techniques that could be used. No elaborate procedures were given in the “Discovery of Grounded Theory” by Glaser and Strauss in 1967, instead there was a focus on theory, the nature of this and ways of its development (Birks and Mills 2011, Urquhart 2013). However, in 1978 Glaser published “Theoretical Sensitivity” which introduced several key concepts. These focused on the role of literature and induction, the need to be theoretically sensitive was explained as the need to understand theories and the ways these could be constructed without imposing pre-conceived concepts on emergent theory. This work also introduced the notion of coding families to assist with relating concepts to data.

Since the above publication in 1978, Glaser and Strauss have taken different directions. Glaser has remained consistent with his definition that grounded theory is a method of discovery where categories emerge from data and has never really entered the conversation about grounded theory methodology. Rather, he has focused on grounded theory method and what constitutes a grounded theory itself (Birks and Mills 2011). In 1990, Anselm Strauss and Juliet Corbin published "Basics of Qualitative Research". This text is regarded as offering a grounded theory methods manual, which has also been termed a "cook book approach", in which the authors discuss ingredients, procedures and outcomes in detail with clear instructions regarding the methods (Bryant and Charmaz 2007 page 12). As a result, this text has been regarded as a "how to manual" of grounded theory (Urquhart 2013 page 19). Glaser requested this publication be withdrawn and when it was not, he published a rebuttal in 1992 entitled, "Basics of Grounded Theory Analysis: Emergence vs Forcing". This resulted in differences of opinion between Glaser and Strauss and Corbin and much has been made of this in the literature which has generated debate amongst scholars (Birks and Mills 2011). In the original statement of grounded theory method, readers were invited to use grounded theory strategies flexibly in their own way (Glaser and Strauss 1967). However, there are a number of key differences between the approaches of the original founders which, in turn, has resulted in different approaches and ideas about the essential properties and features of grounded theory method (Hood 2007).

One of the most significant difference between Glaser and Strauss (later Strauss and Corbin) is the debate regarding whether theory should be emergent or forced (Schreiber and Stern 2001). The method of discovery defended by Glaser treated categories as emergent from data along with eventual theory. He felt that Strauss and Corbin's book in 1990 was far too restrictive in the way that it presented grounded theory and that emerging concepts would be forced. Strauss and Corbin introduced a new coding paradigm and suggested breaking down the coding process to prescriptive steps, named, open, axial and selective coding and coding for process. They also suggested that the paradigm was mandatory which was regarded as completely in opposition to the guiding tenets of grounded theory method of the day (Urquhart 2013). Glaser objected to the coding paradigm which was designed to provide ready-made tools to assist with the conceptualisation process. To force data through one paradigm ignored the emergent nature of theory (Glaser 1992). However in 1998 Strauss and Corbin modified their advice with the statement:

> *"….The paradigm is nothing more than a perspective taken towards data, another analytic stance that helps to systematically gather and order data in such a way that structure and process are integrated"* (Strauss and Corbin 1998 page 128).

This was further modified in 2008 where the role of the paradigm was weakened in favour of emphasising a broader set of tools which they called context, process and theoretical integration. The paradigm is only one of a number of analytic strategies and was identified as, "only a tool and not a set of directives" (Corbin and Strauss 2008 page 90). This work emphasised that researchers must choose a variety of tools which make use of procedures that best suit them and their research aims.

Glaser (1992) contends that Strauss and Corbin's procedures force data and subsequent analysis into pre-conceived categories and thus contradict the fundamental tenets of grounded theory. Glaser was concerned with allowing theory to emerge and considered that this may not occur if theory was forced and influenced by pre-conceived ideas and processes. Glaser regarded the coding paradigm of Strauss and Corbin as the imposition of "pet theories" on data, rather than letting theory emerge through the analysis. As this paradigm seems to impose a conceptual framework in advance of data analysis, it does not appear to sit easily with the inductive emphasis in grounded theory (Dey 2008). Glaser (2001) wrote at length of the difficulties that arise when a researcher attempts to bring pre-conceived ideas to a new study and subsequently forces these on data. The alternative, which is to approach without a formed idea, can feel insecure. Yet if a researcher has confidence in self and the method, approaching a study from a position of unknowing gives life to a concept of idea (Cutcilffe 2005). However, Glaser (2001) admits that not knowing in the initial stages can lead to anxiety and confusion. He suggests that the answer resides in the grounded theory method, staying open and allowing the theory to emerge. By trusting data, engaging in further comparison, allowing creativity to be engaged, and facilitating the application of tacit knowledge, the real value of grounded theory is actualised (Cutcliffe 2003).

A Straussian approach to the grounded theory method recognises the researcher creates data and analysis through interaction with the viewed and is considered more embedded in a constructivist paradigm than the approach of Glaser (Charmaz 2000, Mills et al 2006). Strauss and Corbin demonstrated shift in how they viewed their interaction with participants and they considered the interplay between researcher and those being studied would result in some degree of "reciprocal shaping" (Mills et al 2006). The term interplay in this instance is defined as a researcher actively reacting to working with data (Strauss and Corbin 1998). This acknowledges the co-construction of meaning between researcher and participant which is implicit in the interview process. Clearly Strauss and Corbin’s evolved grounded theory has some constructivist intent (Mills et al 2006). Engaging in a constructivist enquiry requires a transformation of the participant/researcher relationship and for the researcher to prioritise and analyse the interaction that occurs between the two. During the process of narrative interaction the researcher and participant give and take from each other, the complexity of the area of interest being explored becomes apparent and therefore gains density as the conversation about meaning ensues. The interview becomes the site for the construction of knowledge and the researcher and participant produce this knowledge together (Hand 2003). In the construction of such knowledge, the information generated needs to reveal depth, feeling and reflexive thought. A constructionist intent is further developed by Charmaz (2014) who asserts that neither data nor theories are discovered. Rather, the researcher is part of the world being studied and the data collected. Grounded theories are therefore constructed through past and present involvements and interactions with people. Any theoretical conclusions are interpretive portrayal of the studied world, not an exact picture of it.

A further area of difference, or issue of evolution of method between Glaser and Strauss, is the point at which the literature should be consulted. This has been discussed in Chapter 2 of this thesis, in introducing the initial literature review. As indicated, the place of the literature review in a grounded theory method is controversial (McGhee et al 2007) and is one of the most misunderstood and contentious aspects of this research approach (Birks and Mills 2011, Charmaz 2014). Despite the divergent views of Glaser and Strauss regarding the timing of a literature review, the reality would appear to suggest that there are no significant differences between their positions. Neither promotes a thorough review of the literature at the start of the study and both acknowledge that a researcher will enter into a study with broad ranging knowledge about the proposed area of study (Birks and Mills 2011). It is suggested that Glaser and Strauss overstated their original position in regarding the researcher as a tabula rasa, in other words a blank sheet, with an insistence by Glaser that a researcher must remain uncontaminated by extant literature (Charmaz 2014). However, there is increasing rejection of this stance and recognition that lack of familiarity with the literature is untenable (Walls et al 2010, Thornberg 2012). Furthermore there is an assertion that grounded theory should be informed by existing literature (Thornberg 2012). This is particularly significant in modern, rigorous healthcare research at doctoral level. Here, originality is essential and ethically important and demonstrating originality will require knowledge and appreciation of what relevant evidence already exists. Furthermore, anticipating ethical implications of a study will require premeditation on the part of the researcher to anticipate and signal the nature of these and ways against which they can be mitigated.

Over the years, much has been made of the differences between Glaser and Strauss following the collaboration of Strauss with Corbin and about the merits of each of their work. However, there is much to learn from both approaches (Birks and Mills 2011). There is the consideration that neither Glaser or Strauss departed from their initial understanding of grounded theory but their differences became evident in their subsequent publications as they moved to more independent writing in which their individual views became more apparent (Jeon 2004). Also, the approaches of Glaser or Strauss cannot be regarded as entirely separate and different because both Glaser and Strauss claim that their evolution of grounded theory methods in subsequent publications is similar to the original (Glaser 1992, Strauss and Corbin 1998). In their original statement of grounded theory method, Glaser and Strauss (1967) invited their readers to use grounded theory strategies flexibly in their own way (Charmaz 2014). This is continued by the later works of Corbin and Strauss (2008) who emphasise that researchers must choose from a variety of analytical tools and make use of procedures that best suit the aims of their research. Ultimately, the researcher must choose carefully, giving cognisance to research aims and consideration given to the applicability and feasibility of the method in the context of the research (Jeon 2004, Urquhart 2013).

3.5 Grounded Theory Approach

In choosing the grounded theory approach best suited to this study, the identification of research area prior to the start of the study suggested movement towards the approach taken by Strauss and Corbin. Originally it was proposed that the research area must emerge through the application of essential grounded theory methods (Glaser and Strauss 1967). Strauss and Corbin (1998), and later Corbin and Strauss (2008), have taken a much more pragmatic view in that the research aims should be narrow and function to establish boundaries to the research (Strauss and Corbin 1998). This position is much more relevant to current governance requirements for those engaging with processes to commence research projects, as there is a need to demonstrate a focused research topic and the production of a formal research proposal is mandatory. However, establishing a mid-point between both of these approaches is possible in that keeping an identified area of study sufficiently broad will allow for flexible and dynamic nature of research methods to be employed (Birks and Mils 2011).

Also the Straussian view that humans are active agents in their lives and in their worlds, rather than passive recipients of larger social forces, was considered appropriate for this study. He assumed that process not structure was fundamental to human existence and human beings created structures through engaging in processes. For Strauss, subjective and social meanings relied on use of language and emerged through action. Strauss brought notions of human agency, emergent processes, social and subjective meanings, problem-solving practices and the open-ended study of action to grounded theory (Charmaz 2014). As previously indicated, it was anticipated that complex processes were central to the context of this study, for this reason the pragmatist approach of Strauss was considered suited to the aims of this research.

In addition, recognition was given to the advantages of using the coding paradigm of Corbin and Strauss (2008) which is referred to as an organisational scheme or tool which can be used by the researcher to obtain an understanding of circumstances surrounding events. It is intended to assist in the systematic organisation of data so that structure and process are integrated, thus analyses of contextual factors facilitate relationships between context and process.

Depth of insight into the context of this study led to the anticipation that responses of participants may reflect the complex nature of the care and management of acutely and/or critically ill adults in time pressurised settings, in particular, those processes and interventions employed to assess mental capacity. The coding paradigm of Corbin and Strauss (2008) was considered therefore a valuable and structured tool to facilitate depth of analysis and to realise the aims of this study leading to the development of a grounded theory.

The above paradigm and coding processes, however, are not without their criticism. There are claims that these are complex and may distract the researcher from what data are telling them and result in analyses which are not informed by data. Techniques involved in these processes make it difficult to identify the properties of categories and simultaneously determine how these relate to other categories (Urquhart 2013). In addition, the coding framework may limit the vision of the researcher if simple, flexible guidelines are preferred. However, it is also recognised that this framework, albeit complex, will assist the researcher for whom pre-set structures are preferred or for the nascent researcher (Charmaz 2014). Here it was identified that the aims of this study would be met by the application of the paradigm and coding processes of Corbin and Strauss (2008), using its systematic and precise stages and its clear and explicit framework. Understanding of circumstances that surround events was considered necessary to meet the aims of this study, as was the need to use methods which would facilitate in-depth analyses of relationships between context, actions and consequences.

A conclusion was made that this study would be informed by the methodological pathway of Corbin and Strauss (2008). Therefore, grounded theory methods were used which are consistent with this pathway. Throughout this study, the terms concepts, codes and categories are used as labels for conceptual terminology that are universal to all grounded theorists (Birks and Mills 2011). In this study the term concept is used to label significant phrases, terms and descriptions which were initially identified in data. The term code is used to label open codes and the term category to label groups developed from open codes. Axial coding processes are used to analyse categories and their dimensions.

For purposes of clarity, grounded theory methods consistent with the methodological pathway of Corbin and Strauss (2008) are outlined in the following sections.

3.5.1 Coding

In grounded theory data are conceptualised and coded. Coding involves naming segments of data with a label that simultaneously categorises, summarises and accounts for each piece of data. In grounded theory methods, coding is more than a beginning in that it provides structure for an analytic frame upon which the researcher can build the emerging analysis. It is the pivotal link between collecting data and an emerging theory (Charmaz 2014). Coded data, in turn, form properties that structure categories which are compared and a number of core categories emerge which form eventual theory (Strauss, Corbin 1998). Open, axial and selective coding are the coding processes advocated by Strauss and Corbin (1998) and later Corbin and Strauss (2008).

3.5.2 Open Coding

Open coding is in close relationship to data, is provisional, comparative and grounded in data. This process involves uncovering, naming and developing concepts where data are examined to expose thoughts, ideas and meanings (Strauss and Corbin 1998). During open coding, data are broken down into discrete parts, closely examined and compared for similarities and differences. Events, actions and interactions which are found to be conceptually similar in nature or related in meaning are grouped into categories. Open coding, therefore, encourages a thematic approach since it forces the researcher to break up the text into pieces, to compare them and to assign them to groups that address the same theme (Boeije 2010). In grounded theory analysis, open coding is the first step in this process and is the link between collecting data and developing an emerging theory to explain data (Birks and Mills 2011, Charmaz 2014). Corbin and Strauss (2008) advise that coding should begin soon after the initial collection of data, as the first data serve as a foundation for further data collection and analysis. First data are significant as they are then used as a "springboard for analysis" (Corbin and Strauss 2008 page 163).

A detailed form of open coding is recommended which is designed to break open data to consider all possible meanings (Corbin and Strauss 2008). This is referred to as the process of microanalysis where the researcher applies analytic tools and mental strategies to the analysis of data. Microanalysis is normally used in the beginning of analytical processes of a study and is considered to be a valuable tool to examine each piece of data. This process is highly valued as it enables the researcher to think differently about things and is compared to "using a high powered microscope" to examine data (Corbin and Strauss 2008 page 59). This will in turn assist in getting the researcher deeper into data and to generate ideas.

Analytical tools suggested by Corbin and Strauss (2008) consist of asking questions of the text, thinking about meanings of words and language, and making constant comparisons with data obtained, including language, emotions, words, phrases. These are regarded as the mainstay of analysis using a qualitative method. Questions are therefore posed regarding what is happening in data and provisional answers are developed in making constant comparisons and to "think outside of the box" (Corbin and Strauss 2008 page 69).

Constant comparisons are made regarding what is happening in data which is assisted by using a questioning approach. It is recognised that constant comparative analysis is a key aspect of grounded theory analysis, as it enables a researcher to differentiate categories and themes and to identify properties and dimensions specific to categories and themes (Corbin and Strauss 2008, Urquhart 2013). Ultimately, this is an iterative analytical method that enables the researcher to generate data which results in high-level categories that are rich in meaning and which eventually contribute to the advancement of theory (Birks and Mills 2011). Furthermore, making theoretical comparisons will assist the researcher to examine levels of properties and dimensions which, in turn, will assist in achieving an understanding of what is happening in data (Corbin and Strauss 2008).

3.5.3 Use of Memos

Essential to the process of coding is the need to write memos which constitute a crucial method in grounded theory, as it prompts the researcher to analyse data and codes from an early point in the research process. Memos record and catch the thoughts of the researcher, capture comparisons and "crystallise" questions and directions for the researcher to take (Charmaz 2014). Creating memos provides the researcher with opportunities to interrogate data and to begin processes for developing abstract concepts necessary for the construction of theory (Corbin and Strauss 2008). Memoing enables the researcher to articulate, explore and question interpretations gained from data thus enhancing theoretical sensitivity in the need to answer questions about what is happening in data (Birks et al 2008).

3.5.4 Category Development

Categories are defined as groups of related codes and are a stage in the process of direction of analysis of a study (Holloway 2008). The initial coding process determines open codes which are normally too numerous for the researcher to use as a basis for in-depth analysis. Therefore by finding common ground between open codes, the researcher is able to group these together to produce manageable units to facilitate the next level of analysis. Categories also have analytic power because they have the potential to explain and predict (Strauss and Corbin 1998). Strauss and Corbin (1998) state:

> *"Once a category is identified, it becomes easier to remember it, to think about it, and (most important) to develop it in terms of properties and dimensions, and further differentiate it by breaking it down into its subcategories, that is, by explaining the when, where, why, how and so on of a category that are likely to exist"* (Strauss and Corbin 1998 page 114).

Strauss and Corbin (1998) also suggest researchers name categories from the pool of concepts already discovered in data. In addition, they suggest that broad, comprehensive and abstract labels can serve as headings for concepts that share similar themes and characteristics. Names for categories can also be sourced from open codes which have been identified from data.

3.5.5 Axial Coding

An essential characteristic of grounded theory involves coding processes which become increasingly elaborate as the researcher synthesises and analyses large amounts of data leading to theory development (Charmaz 2014, Gibson and Hartman 2014). Intermediate coding processes are referred to as selective coding by Glaser (1978) defined as the stage where coding is limited to categrgories which relate to a core category. Charmaz (2014) uses the label focussed coding, a process by which initial codes are assessed, comparing them with data and identifying codes which have the greatest analytical power. Strauss and Corbin (1998) present axial coding as an intermediate stage of coding process which is defined as:

> *"The process of relating categories to their subcategories, termed axial because coding occurs around the axis of a category, linking categories at the level of properties and dimensions"* (Strauss and Corbin 1998 page 123).

In 1987, Strauss viewed axial coding as building "a dense texture of relationships" around the axis of a category (Strauss 1987 page 64). Thus, axial coding facilitates the development of categories by organising large amounts of data and reorganising them after processes of open coding (Charmaz 2014). Strauss and Corbin (1998) describe this as data being fractured during open coding (Strauss and Corbin 1998). Putting data back together in new ways implies that patterns and relationships between developing categories will occur. Grounded theory categories are multi-dimensional and may consist of a number of sub categories that together explain a broader concept. A category, therefore, stands for something, called a phenomenon, a problem, issue or event which is defined as being significant to participants and which has the ability to explain what is going on (Strauss and Corbin 1998). A subcategory is also a category, but rather than standing for the phenomenon, subcategories answer questions about the phenomenon (Strauss and Corbin 1998).

During axial coding processes the researcher uncovers relationships between categories by adopting a questioning approach and, in doing so, is able to "conceptualise a phenomenon" (Strauss and Corbin 1998 page 127). Put simply, asking questions of who, when, where, why and how and with what consequences, researchers are able to relate structure with process. Structure or conditions sets the stage, namely create the conditions and circumstances relating to a phenomenon and process relates to actions and interactions, again relating to a phenomenon. Consequences are the result of actions and interactions where the researcher asks questions regarding what happens because of actions and interactions (Charmaz 2014).

However, the relationships between categories can be subtle and for this reason Strauss and Corbin (1998) and later Corbin and Strauss (2008) provide what they call a paradigm which they refer to as an organisational scheme. This is intended to assist in the systematic organisation of data, so that structure and process are integrated. The paradigm consists of the following components:

- Conditions – the structure or set of circumstances in which a problem or event is embedded
- Actions, interactions and emotions – these are responses made to situations, events, problems
- Consequences – the outcomes of actions, interactions or emotional responses to events or problems. (Corbin and Strauss 2008).

The paradigm is intended to be a tool and not a set of directives, one that can be used by the researcher to obtain an understanding of circumstances that surround events. The researcher is advised not be to too "overly concerned" about identifying conditions, actions or consequences as this can "rigidify" process for analysis (Corbin and Strauss 2008 page 90). In 1998, Strauss and Corbin advised that to apply the components of the paradigm in a rigid manner will prevent from:

> *"…capturing the dynamic flow of events and the complex nature of relationships that, in the end, make explanations of phenomena interesting, plausible and complete"* (Strauss and Corbin 1998 page 129).

Axial coding processes, however, are not without their criticism. There are claims that these processes are complex and may distract the researcher from what data are telling them and therefore analyses. The techniques involved in these processes make it difficult to identify the properties of a category and simultaneously determine how this relates to other categories (Urquhart 2013). In addition, the framework which axial coding provides may limit the vision of the researcher if simple, flexible guidelines are preferred. However, it is also recognised that this framework, albeit complex, will assist the researcher for whom pre-set structures are preferred or for the nascent researcher (Charmaz 2014). The methods used in this study are informed by the approach of Strauss and Corbin. Therefore, processes of axial coding were identified as essential in enhancing levels of analysis in that they may be used to obtain an understanding of the circumstances that surrounded events, thus enriching analyses (Corbin and Strauss 2008).

3.5.6 Selective Coding: Identifying a Central Category

A central category is selected when connections between categories and their subcategories can be identified (Birks and Mills 2011). Also, the first step in theoretical integration is deciding on a central category which should represent the main theme of the research. This should be the concept that all other concepts relate to. A central category is defined as:

> *"The category that appears to have the greatest explanatory relevance and higher potential for linking all of the other categories together" (*Corbin and Strauss 2008 page 104).

A central category has the power to explain what is at the centre of a research study. This may evolve out of existing categories, or, if a researcher decides that existing categories do not tell all of the story of the research, another more abstract term or phrase is needed, a conceptual idea under which all the other categories can be subsumed (Corbin and Strauss 2008). In identifying a central category, the researcher must be aware of the following:

- It must be abstract and all other categories must relate to it
- It must appear frequently in the data, there must be indicators pointing to it
- It must be logical and consistent with the data
- It should grow in depth and explanatory power as each of the other categories is related to it through statements of relationship. (Corbin and Strauss 2008).

A central category is selected when the researcher can identify connections between a frequently occurring variable and all other categories, subcategories and their properties and dimensions (Birks and Mills 2011). However, the researcher may experience difficulty in moving beyond levels of description needed to develop theory. This can be attributed to failure to keep detailed, reflective memos which may lead to poor understanding of the analytic story behind data. Also, there are challenges in differentiating the meanings of description and theory. Description describes something at observational and factual levels (Corbin and Strauss 2008). Theory, however, has explanatory power and gives the researcher depth of answers to questions and offers accounts for what happens in data (Charmaz 2014).

3.5.7 Constant Comparative Analysis

Glaser and Strauss (1967) described systematic procedures which they called the constant comparative method used during the collection and analysis of data. New data are constantly compared to old or previous data which, in turn, informs further collection and further development of the analyses of data. It is now recognised that constant comparative analysis is a key aspect of grounded theory analysis as it enables a researcher to differentiate categories and themes and to identify properties and dimensions specific to these (Corbin and Strauss 2008, Urquhart 2013). This method is also considered to facilitate the definition of analytical properties of categories and to encourage the researcher to begin to deal with such properties with rigorous scrutiny (Charmaz 2014). Ultimately, this is an iterative analytical method that enables the researcher to generate data which results in high-level categories that are rich in meaning and which eventually contribute to the advancement of theory (Birks and Mills 2011). Furthermore, making theoretical comparisons will assist the researcher to examine levels of properties and dimensions which, in turn, will assist in achieving an understanding of what is happening in data (Corbin and Strauss 2008). By constantly comparing data, the researcher is able to find a focus for the research as data becomes clearer. The evolving theory that emerges from constant comparisons informs the researcher where to obtain further data. This is known as theoretical sampling.

3.5.8 Theoretical Sampling

Theoretical sampling is defined as a method of data collection based on concepts and themes derived from data. It is responsive to data and is an open and flexible approach. Concepts are derived from data analysis and questions about concepts:

> *"…drive the next round of data collection. The research approach feeds on itself"* (Corbin and Strauss 2008 page 144).

The logic of theoretical sampling distinguishes grounded theory from other types of qualitative approaches. It provides systematic checks and refinement into analyses and is conducted to develop properties of categories until no new properties emerge. Categories are therefore saturated with data. The process of theoretical sampling is continued until no new properties emerge and the researcher is confident that the saturation of categories has been achieved. Conducting theoretical sampling can keep the researcher from becoming entrenched in unfocused analyses (Charmaz 2014).

3.6 Conclusion

This chapter has identified the research aims and discussed appropriate research approaches which were considered for this study. The justification for choosing a grounded theory methodology informed by the methodological pathways of Corbin and Strauss (2008) has been presented as the approach which is best suited to meet the aims of this study and to generate a theory to explain and explore the processes and strategies used by qualified nurses across acute and critical care settings to assess the mental capacity of acutely ill hospitalised adult patients.

Chapter 4: Research Methods

4.1 Introduction

In Chapter 3 the justification for selecting a grounded theory approach informed by the methodological pathway of Corbin and Strauss (2008) was presented. This chapter provides a detailed account of the research methods used to conduct this study. Processes of recruiting participants are discussed, along with gaining informed consent and securing confidentiality and anonymity. Also justification for, and selection of, the method of data collection are presented. This leads into processes used for the analysis of data and to the identification of a central category. Throughout this chapter reference is made to appendices which contain supplementary information. These add clarity and detail to aspects of the discussion.

4.2 The Setting for the Study

This study is set within a large University Health Board in South Wales UK, providing a range of healthcare services to a densely populated urban and semi-rural geographical area. Permission for this study was granted by this Health Board which has two district general hospitals within its boundaries both meeting the needs of populations of similar profiles. These range from areas of significant social and economic deprivation to more affluent suburban areas. The invitation of the Health Board extended to using both hospitals as qualified nursing staff sometimes moved between the two depending on staffing levels.

A decision was made to use one hospital only, as both serviced populations with similar profiles and both housed similar acute and critical care services. The hospital at the northern edge of the Health Board was preferred and chosen due to the implications of its geographical location. This is more isolated from other district general hospitals in neighbouring Health Boards which results in the provision of comprehensive emergency, acute and critical services thus providing a good and appropriate range of clinical areas from which participants could be recruited. Also, discussions on-going at the time regarding the redesign of urgent, acute and critical services across the Health Board indicated the enhancement of these services in this hospital. Similar services in the other district general hospital would be down-graded as a result. The specific settings for this study were therefore acute and critical clinical environments, providing a full range of emergency, intensive and acute care services across specialised departments, units and wards. Here it was anticipated that there would be sufficient levels of qualified nurses working in appropriate clinical areas and caring for patients with interest to serve the aims of this study.

4.3 The Research Sample and Recruitment

Fundamental to grounded theory design is the process of concurrent data generation or collection and analysis. To achieve this, the researcher collects data with an initial purposive sample (Neil 2006). These data inform initial analyses that lead onto processes of theoretical sampling which guide further selection of participants (Birks and Mills 2011). Participants are therefore taken from the population where the phenomena in question can be found (Glaser and Strauss 1967) and should be able to inform the purpose of the study and assist in meeting the aims of the study. Participants must therefore be experts in the experience or phenomena under investigation, they must be willing to participate, and they must be reflective and able to speak articulately about their experiences (Morse 2007).

Consequently, the target group for the initial purposive sample of participants for this study were qualified nurses:

- With a minimum of three years post-registration experience of working with acutely or critically ill adult patients requiring acute and/or critical care.
- Who were employed in acute and/or critical clinical environments across a district general hospital.

It was recognised that experienced practitioners were needed, those who were in positions to make key decisions about patients on their own volition, and those who would be able to articulate their experiences. Also, it was decided that, in the need to meet the aims of this study, inclusion criteria were set that participants would need to be involved in the direct delivery of patient care on a day-to-day basis, thus in positions to discuss depth of patient specific detail and current clinical procedures, processes and their related nuances. At the time of designing this study, a significant number of newly qualified nurses were employed across acute and critical care environments. A decision was made not to target these due to their inexperience and also these areas used systems of new staff induction which involved rotation around different clinical settings to gain experience. Furthermore, a decision was made not to include senior nursing staff who were employed at Agenda for Change Bands 8a and 8b. Whilst there were a number of these employed across relevant clinical environments, many of whom provided direct patient care, this was not a substantive part of their role and they were not involved in day-to-day nursing care and management of patients.

Qualified nurses ranging from Agenda for Change Bands 5 to 7 were therefore targeted due to their clinical proximity to acutely and/or critically ill patients. The need to recruit participants with varying degrees of experience and seniority within Bands 5 to 7 was identified as this would give opportunities to obtain rich and varied data which would lead into and assist later processes of theoretical sampling.

One district general hospital was used for this study due to the comprehensive range of appropriate clinical services offered. The initial sample of participants were recruited from this. The Health Board is the result of a merger of two former NHS Trusts, both having one district general hospital. As both former NHS Trusts operated as distinct organisations, both hospitals adopted different practices and procedures in the care and management of acutely and critically ill adult patients. At the time of recruitment to this study, processes were ongoing to harmonise practices across the two hospital sites by the Health Board. Therefore it was considered appropriate to focus on one hospital site for the initial sample which constituted a further reason for choosing one hospital. It was anticipated this would avoid confusion regarding different types of documentation used, different referral mechanisms, different systems for managing experienced staff exercising their accountability and different methods of patient admission, assessment and flow from emergency departments and primary care settings to wards and specialised unit environments.

It was recognised that recruiting an initial purposive sample for this study, across a range of diverse acute and critical care environments contained in a large hospital was a challenge. Large numbers of qualified nurses with the required amount of clinical experience and employed at Bands 5 to 7 would be found in these areas, therefore a decision was made to seek the assistance of Senior Nurses across acute and critical care environments. This was considered a viable starting point to a purposive recruitment process and appropriate to recruit participants who had made decisions to participate without an initial approach from the researcher. A meeting was organised with both the Executive Nurse and Assistant Director of Nursing, Acute and Critical Care, for the Health Board to present and discuss this study. Subsequently approval was secured to approach senior staff across acute clinical environments to assist in the recruitment process. This recognised there is a formal path to be followed when beginning the process of conducting research in a large and complex organisation (Boeije 2010). In addition, an invitation to a senior nurse meeting to outline and discuss this study resulted in collective agreement to approach senior staff across acute and critical care services to assist with recruitment.

Consequently, Senior Nurse Managers and Ward/Departmental Managers were contacted across acute and critical clinical areas of the hospital and asked to distribute recruitment packs to qualified nurses with a minimum of three years experience of working with acutely and/or critically ill adult patients. A letter of explanation was provided for this purpose (Appendix 1). Recruitment packs for participants contained a Research Ethics Committee approved letter of invitation (Appendix 2), participant information sheet (Appendix 3) and participant consent form (Appendix 4).

A total of 80 recruitment packs were distributed across acute and critical care settings by six Band 7 Ward Managers and three Band 8a Senior Nurses. These were identified in advance by the Assistant Director of Nursing, Acute and Critical Care, for the Health Board as staff who could be approached to assist in recruiting to this study. Please see Table 3 for specific detail regarding the clinical areas targeted.

Table 3: Recruitment

Clinical Setting	Number of Recruitment Packs Distributed	Number of Participants
Acute General Surgical Ward	10	1
Acute Surgical Speciality Ward	10	1
Emergency Department Medical Assessment Unit	10	2
Acute Medical Ward Neurology/CVA Unit	10	2
Acute Medical Ward Endocrinology	10	1
Acute Integrated Medical Ward	10	1
Acute Integrated Medical Ward	10	1
CCU	05	4
ITU	05	1

An initial sample, (n=14), of qualified nurses volunteered to participate in this study between March 2011 and April 2011. This represented a 17.5% response rate. All met the inclusion criteria for length of experience, Agenda for Change profile, and clinical environment in which they were employed. The following were observed:

- The settings in which they worked appeared representative of the acute and critical clinical services offered by the Health Board
- A mixture of wards and specialist departments were represented
- A range of roles and levels of seniority were represented
- The majority were experienced in terms of years they had been qualified

Consequently all 14 respondents were potentially eligible for interview as an initial sample. Participant demographics are outlined in Table 4.

Table 4: Profile of Participants

Gender	Role Title	Clinical Speciality	Agenda for Change Profile	Number of Years Qualified	Unique ID Code
Female	Advanced Nurse Practitioner	Cardiology, A/E	Band 7	25	F03
Male	Ward Manager	General Surgery	Band 7	16	M02
Female	Ward Manager	Surgical Speciality	Band 7	24	F01
Female	Stroke Co-ordinator	Acute/Integrated Medicine	Band 6	33	F10
Female	Deputy Ward Manager	Acute Medicine Endocrinology	Band 6	20	F05
Female	Deputy Ward Manager	Acute Medicine Neurology	Band 6	27	F06
Female	Deputy Manager	CCU	Band 6	25	F12
Female	Senior Staff Nurse	CCU	Band 6	20	F08
Female	Staff Nurse	MAU/ITU	Band 5	3	F04
Female	Staff Nurse	A/E	Band 5	5 (not interviewed)	
Female	Staff Nurse	CCU	Band 5	12	F07
Female	Staff Nurse	CCU	Band 5	6	F13
Female	Staff Nurse	Acute Medicine	Band 5	13	F11
Female	Staff Nurse	Acute Medicine	Band 5	3	F09

As data were collected, it was identified that data saturation was potentially achieved after the interview with Participant F10. Discussion with the supervision team for this study resulted in agreement to interview three other participants to establish and be certain of actual data saturation. Data saturation was achieved after the interview with participant F13, therefore the fourteenth participant was not interviewed and it was established that no further participants were recruited to this study.

4.4 Data collection

4.4.1 Study Design

Grounded theory methods informed by the methodological pathway of Corbin and Strauss (2008) were used in this study. To explore strategies and processes used by qualified nurses to assess the mental capacity of adult patients, data were collected from thirteen participants using face-to-face semi-structured interviews. These were conducted during the period of June 2011 to October 2012 and organised in two phases. The first phase consisted of interviews with participants F01 to F04 which were completed during the period June 2011 to November 2011, after which initial codes were identified. This was used as an exploratory starting point regarding what would be discovered from participants in the need to generate data. This phase revealed depth of data which was subsequently used in processes of analyses and included in study findings. The second phase consisted of interviews with participants F05 to F13 which were completed by October 2012. At this point, it was identified that data saturation had occurred. All interviews were audio-recorded and transcribed

4.4.2 Choosing a Method of Data Collection

The value of interviews in grounded theory is recognised and they are regarded as a principal mechanism for gathering data (Birks and Mills 2011). It is also recognised there are limitations in their use as participants simply recount experiences which may not actually provide the researcher with accuracy of what occurs in reality (Mills and Birks 2014). The benefits of using interviews were considered to outweigh the advantages for this study. Interviews were chosen because they were considered to be a valuable way of collecting data in which the interviewer is required to take more direct control of data collection and analysis which gives more analytic control over material (Myers 2008). Interviewing also provides an open-ended, in-depth exploration of the research area about which the interviewee has substantial experience (Charmaz 2014). An opportunity for in-depth exploration and analysis for this study was favoured due to the anticipated complexity of assessment processes to which participants may allude. The initial literature review highlighted a lack of specific empirical evidence regarding capacity assessment processes used by qualified nurses. This indicated a need for a method of data collection that would enable participants to articulate assessment and intervention processes they employed. It was anticipated that there may be a need for a reflective element in the ways participants discussed what they did to assess capacity status of patients in their care, therefore using interviews as a vehicle of data collection would facilitate this.

Furthermore, it was considered that semi-structured interviews would be appropriate. These are considered useful when the researcher seeks true understanding of what is happening in the area of research (Boeije 2010). These allow the researcher to plan the interview beforehand, at the same time allowing for flexibility in the need to follow paths of discussion that may emerge during an interview. Semi-structured interviews enable the researcher be the co-ordinator of the interview and ensuing open discussion with the aim of generating material for the developing theory (Corbin and Strauss 2008). Interview questions also serve as an aide memoire and allow the researcher to collect data in a flexible manner (Gubrium and Holstein 2001). To facilitate rich and potentially reflective discussion, it was decided that interview questions would be open-ended which would allow emergent themes to be developed and pursued as participants explored the capacity assessment processes they used and their subsequent interventions. Also, the decision to conduct interviews face-to-face was made as it was recognised that there was a need to be attuned to what each participant was saying and the manner in which it was said in the need to be theoretically sensitive (Birks and Mills 2011). It was identified that being able to pick up on subtle, non-verbal cues that may be apparent during interviews may provide interesting perspectives and insights (Nagy et al 2010).

Whilst interviews are the principal method of choice of data collection in grounded theory research (Mills et al 2014), the use of focus groups are also considered to be useful (Birks and Mills 2011). The use of focus groups for this study were considered and rejected. Their advantages were recognised in that a group of participants with common interests can generate rich discussion and can feed off and respond to each other (Lambert and Loiselle 2008). Also, participants may feel more comfortable in a group discussion and therefore disclose more information than on an individual basis (McLafferty 2004). However, it was considered their disadvantages outweighed their advantages. The presence of dominant participants my hinder discussion with others reluctant to articulate views and opinions. Also participants not knowing each other may impact upon willingness to speak and group size may have a similar effect

(McLafferty 2004). It was anticipated that the variety of clinical backgrounds of participants in this study may impact upon the effectiveness of the use of focus groups. Differences in clinical settings and differing levels of multi-professional support for participants in their day-to-day functions may complicate group discussion and detract from assessment strategies used, if participants compared detail and differences in the nuances of care and management interventions. Therefore, for example, the uncontrolled nature of an emergency department or the controlled nature of an intensive care unit may influence and impact upon assessment strategies used by qualified nurses.

4.4.3 The Interviews

A semi-structured framework was prepared prior to each interview with the evolution of themes as interviews progressed (please see Appendix 6 for some examples of interview schedules). During initial interviews, participants were asked what they understood about the concept of mental capacity and the ways in which they assessed the mental capacity of patients in their care. They were also questioned about factors that influenced their processes of assessment. As themes emerged, interview questions were refined to facilitate depth of discussion. For example, it emerged that participants appeared to rely on obtaining baseline information about patients from family members, questions were therefore asked regarding the role that family and/or carers played in assessment processes. Also, a significant theme emerged regarding the ways in which participants were alerted to the presentation of patients which gave cause for concern and which initiated questions being asked about the capacity status of patients. Open-ended questions were therefore asked about cues or stimuli for feeling concerned which prompted subsequent assessment processes.

Each interview lasted approximately 50 to 60 minutes and was audio recorded to provide a verbatim account of what was discussed and to facilitate reflection on the responses of participants. Each interview was also transcribed verbatim by hand by the researcher as soon possible after each interview. Word documents were then made of each interview transcription. This provided a comprehensive written record of each interview and allowed for immersion in data. Field notes were also compiled during and immediately after each interview to record observations, impressions and thoughts. This enabled an organised approach and ensured that being overwhelmed with data was prevented. Also, after each interview the schedule for the next was modified according to broad themes that emerged from the previous interview. This allowed an approach which was consistent with grounded theory methods whereby data collection and analysis occur simultaneously.

Interviews were conducted in two locations. Participants were invited to choose locations, dates and time for their convenience. Four participants chose to be interviewed at the University, two because this was convenient for reasons of travel and two because they were attending the University for other reasons and were in the location. These interviews were conducted in a private office with the work commitments of the researcher organised to ensure privacy and a period free from interruptions. The remainder were set in the clinical environments of the participants, again for reasons of convenience. These were conducted during the span of a shift. It was recognised that proximity to busy clinical environments may result in these interviews being interrupted for a number of reasons due to the demands of busy schedules and the unpredictable nature of the conditions of the patients in each of these areas. It was organised in advance that a private and quiet area was provided in which to conduct each interview and that each participant was supported by other members of qualified staff on a shift to avoid being called away on numerous occasions. Most participants chose to be interviewed during the evening for this reason and all interviews were conducted in private offices which had been pre-arranged by each participant.

All interviews were conducted using an informal manner and one which was respectful to participants as busy clinicians. Some occasionally had difficulty in articulating what they actually did to assess the mental capacity of patients in their care and what influenced their judgements about levels of mental capacity of patients. An encouraging, non-direct questioning approach was used to ease such difficulty and an atmosphere provided which was suitably comfortable and conducive to facilitate discussion. All participants demonstrated confidence as experienced and knowledgeable clinicians and worked hard to communicate and reflect upon actions and processes used to assess patients. At the end of each interview they were thanked and asked for comments regarding the interview. All readily agreed to be re-interviewed again if appropriate and one actually admitted to having enjoyed the experience of being interviewed. A number of them articulated that the interview had made them think about what they actually did to assess the mental capacity of patients and that there appeared to be more depth to their actions and assessment processes than they had realised. Some participants indicated that they had not thought about this before and one, a ward manager, stated a discussion would be arranged with the ward team as the interview had highlighted the importance of assessing mental capacity and this warranted further discussion.

4.5 Data Analysis

At the start of this study a decision was made to use the qualitative analysis software programme Nvivo 8 (the current version at the time) to support processes for data analysis. Such programmes assist in managing data and facilitate ease of data handling (Burnard et al 2004). A training course was therefore attended as it was recognised that Nvivo 8 would assist in the management of large amounts of data. Alongside this, and before using Nvivo 8, a decision was made to analyse all data by hand. This was intended to establish closeness to and immersion in data and to seek self-assurance that in-depth analyses of themes and nuances implicit in data were possible. Self -assurance was also needed to establish that data could be analysed manually. This resulted in the identification of concepts from each interview transcript and tables of open codes were produced for each interview. As more data were collected, open codes were analysed into groups where common ground could be identified. Thematic analyses were undertaken of these which resulted in the formation of nascent categories. These were further analysed as more data were collected using processes of axial coding with the application of the organisational scheme, or paradigm, recommended by Corbin and Strauss (2008). After these processes of analysis were undertaken manually it was considered that depth and consistency had been achieved and a central category identified. Consequently, a decision was made not to use computer software to support processes of analyses such as Nvivo 8, as it was considered that this would not add depth or breadth to what had already been analysed. It was also recognised that using computer software for analysis is an adjunct tool for analysis rather than an analytical tool in its own right (Birks and Mills 2011).

In the need to outline processes of analysis without using computer software, to support each interview a record of thoughts, feelings, impressions and insights were maintained. These formed aspects of memos which are recognised as being fundamental to the development of grounded theory and which are recognised as the most significant factor in ensuring quality in grounded theory (Birks et al 2008). Memos were used to assist processes of analyses which recorded notes of thoughts and reactions to what was said during each interview and the manner in which it was said. Personal observations made during each interview were also recorded in note form. In addition, immediately after each interview personal reflections were noted and questions posed regarding what had emerged from the interview. After the analysis of each interview transcription personal observations and reflections were re-visited and compared with what had emerged from the interview. Further thoughts, observations and insights were then recorded in the form of memos. Examples of these can be found in Appendix 7. Microanalysis, a detailed form of open coding designed to break open data to consider all possible meanings, is recommended at the beginning of analytic processes of a study (Strauss and Corbin 2008), but it was found that this in-depth analytical approach was useful and productive and was subsequently employed across open and axial coding processes for this study. Therefore, processes of asking questions of the text, thinking about meanings of words and language and making constant comparisons of data were employed.

4.5.1 Open Coding

Open, initial codes were identified that were close to data and which were recognised as closely related to one another. These were labelled in a way that stayed close to the language of participants and therefore data. These are regarded as “in vivo” codes (Glaser 1978, Charmaz 2014). A suggested effective strategy is the use of gerunds, words ending in “ing” or nouns, when coding as this is a way of identifying process in data as well as focusing on the experiences of participants (Birks and Mills 2011). Nouns turn actions into topics and are regarded as heuristic devices to enable the researcher to get close to data and to study fragments of data (Charmaz 2014). Participants in this study described actions and processes they employed in assessing the mental capacity of adult patients and it was therefore appropriate that a number of open codes were phrased as nouns, in keeping with the language used by participants. Table 5 provides examples of the identification of concepts against verbatim quotations from two participants:

Table 5: Identifying Concepts from Data: An Example

Interview Data: Verbatim Quotation	Concepts Identified
"There is a formal assessment but it will only decide if patients have got capacity at a particular time it is not a long term thing. Nurses don't do this. Nurses sort of do is anyway, you ask the patient do they know where they are, do they know what is happening to them. All of this goes to assessing if they have capacity at that particular time. I just take each patient individually and assess them in my own mind if they have got capacity, if they know what they are going to have done. You sort of do a mental assessment of them but you do not actually put it down anywhere" **(Participant F01)**	**Formal assessment** **Assessing at that time/Functional approach** **Nurses do not assess/Role of the nurse** **Informal assessment/Nursing assessment** **Assessing awareness** **Assessing for that time/Functional approach** **Assessing informally/personalised approach, in own mind** **Assessing understanding** **Assessing informally/not documented**
"…very subtly as a nurse, I wouldn't formally say everybody stop we are going to assess this patient's capacity. It's done almost instinctively that this patient is not actually taking in this information, either by the way they are verbalising or by their physical actions or that they are not retaining information. I probably do this every day but I don't actually realise that I am doing it, it's part of my role" **(Participant F03)**	**Assessing subtly** **Informal assessment processes** **Assessing instinctively** **Assessing retention** **Assessing ability to verbalise** **Assessing behaviour** **Role of the nurse** **Assessing unconsciously**

A detailed example of methods used to identify open codes and the use of memos made during interview can be found in Appendix 8. This is an extract from the transcribed interview with Participant F06. The memo made after this interview is also presented which serves as an example of the way in which memos were constructed for this study.

Sixteen open codes were identified for this study which represent and contain processes of assessment and personal, professional, environmental and contextual factors that informed these processes. They also represent the role of the nurse and others in capacity assessment processes and in the care and management of patients, during and after conclusions about capacity were made. Fourteen of these were identified on the completion of phase one of this study. As more data were collected and analysed these initial open codes did not change but two more were identified during phase two. Open codes are listed in Table 6:

Table 6: Open Codes Identified

Open Codes Phase One		Open Codes Phase Two
Definitions of capacity	Unchanged	
Influences on capacity		
Impact of environment		
Factors influencing capacity assessment		
Decision making		
Supporting the rights of patients		
Assessing best interests		
Role of the nurse		
Legal position of the nurse		
Role of family/carers		
Role of multi-professional team		
Assessing formally		
Assessing informally		
Nursing assessment		
	Further Developed	Using prior knowledge and experience
		Using gut feelings

4.5.2 Category Development

Six categories were identified from data and named in a way that stayed close to the language of participants and sourced from the open codes which had been identified. To ensure critical analysis, properties and dimensions of each open code were explored and processes of microanalysis employed. Categories were therefore established which were anticipated would give the most effective path to eventual theory development and which represented the reality of what was happening in data expressed in the words of participants.

To facilitate the process of category development, it was recognised that mechanisms of theoretical sampling become valuable once categories had been developed with the gathering of more data which focused upon categories. This assisted in refining each category. Categories identified from open codes are presented in Table 7:

Table 7: Categories Developed

Open Codes	Category
Definitions of capacity Using prior knowledge and experience Using gut feelings	Factors informing nurse-led assessment
Assessing informally Nursing assessment	Nurse-led assessment
Role of family and carers Role of the multi-professional team Assessing formally	Influence of the role of others
Factors influencing capacity Influences on capacity assessment Impact of environment	Impact of clinical setting
Decision making Supporting the rights of patients Assessing best interests Role of the nurse Legal position of the nurse	Caring role of the nurse

Further analyses of the above categories were achieved using processes of axial coding.

4.5.3 Axial Coding

During open coding it was recognised that relationships between categories were subtle and also that subcategories would potentially lie at the boundaries of more than one category. Therefore, the coding paradigm of Corbin and Strauss (2008) was used where the framework of the paradigm was applied to each category. To achieve this, the central phenomenon of each category was identified and components of the paradigm applied to assist in the systematic organisation of data. Table 8 provides an example of processes of analyses used when applying the paradigm of Corbin and Strauss (2008). These processes were used for all categories.

Table 8: Example of the Application of the Paradigm: Category Nurse Led Assessment

Central Phenomenon: Assessing Patients	
Conditions	Recognising change in the physical and/or capacity status of patients,
Actions	Assessing patients using: • Informal, personal processes incorporating formal criteria • Listening and visual skills • Information about physical status • Baseline information
Consequences	Assessment initiated and led by the nurse

Examples of the application of the paradigm of all categories can be found in Appendix 9. The above approach enabled the identification of seventeen subcategories which added depth to levels of analyses and developed and linked categories together. Subcategories identified by processes of axial coding processes are summarised in Table 9:

Table 9: Summary of Axial Coding: Categories and their Related Subcategories

Category	**Subcategory**
Factors informing nurse-led assessment	Using personal definitions of normal Using personal standards Using memory and prior expectations Assimilating present with knowledge and expectations
Nurse-led assessment	Assessing subtly Using informal and formal criteria Conducting visual assessment Listening to patients Assessing physical status Establishing a baseline
Influence of the role of others	Gathering information from family Making referrals and assimilating medical assessment into nursing assessment processes
Impact of clinical setting	Assessing in context Recognising the capacity continuum
Caring role of the nurse	Safeguarding standards of assessment and outcomes (nursing and multi-professional) Advocating for patients Protecting decision making abilities of patients

4.5.4 Relationships between Categories

The identification of categories and subcategories necessitated the need to explore ways in which they related to each other and the relationship between them. The paradigm model of Corbin and Strauss (2008) was therefore revisited for clarity. Processes inherent in the Conditional/Consequential Matrix (Corbin and Strauss 2008) were explored for conceptual guidance and the need to identify multiple and diverse patterns of connectivity between the categories and subcategories was recognised (Corbin and Strauss 2008). In order to conceptualise this, questions were posed, namely, how do categories and subcategories relate to each other, can or should they exist as distinct entities, at what point are the boundaries between them blurred. However, firstly consideration was given to the need to identify the central phenomenon of this study, or the event, the goal or the major idea contained in a set of data (Corbin and Strauss 2008). The central phenomena identified for categories were summarised to visualise an underpinning event or goal. There are summarised in Table 10:

Table 10: Categories and Their Central Phenomena

Category	Central Phenomena
Factors informing nurse-led assessment	Responding to patients
Nurse-led assessment	Assessing patients
Influence of the role of others	Inviting others into assessment processes
Impact of clinical setting	Impact of clinical setting
Caring role of the nurse	Patient focused role of the nurse

This assisted in the visualisation that the central phenomenon or context for this study was the adult patient in acute and/or critical hospital settings, displaying signs, symptoms and behaviours that stimulated a response in the qualified nurse. The presentation of the acutely and/or critically ill patient created circumstances which initiated responses of participants. Their actions, assessments, judgements and interactions were therefore identified as process, so defined by Corbin and Strauss (2008) as sequences or series of actions or interactions in response to problems or issues. Furthermore, analysing data for process is advantageous in that patterns or similarities can be identified in data and links between categories can be established (Corbin and Strauss 2008). The paradigm model was therefore applied to categories and their central phenomena to assist further analysis. This is summarised in Table 11:

Table 11: Central Phenomena and Component Part of the Paradigm Model

Central Phenomenon for the Study: The Presentation of the Patient		
Category	**Central Phenomena**	**Component Part of the Paradigm Model**
Factors informing nurse-led assessment	Responding to patients	**Condition**
Nurse-led assessment	Assessing patients	**Action**
Influence of the role of others	Inviting others into assessment processes	**Action**
Impact of clinical setting	Impact of clinical setting	**Consequences**
Caring role of the nurse	Patient focused role of the nurse	**Consequences**

The relationship between structure and process is regarded as complex and can lead to a variety of relationships between context and actions, interactions and emotions in response to a central phenomenon (Corbin and Strauss 2008). Applying component parts of the paradigm model to central phenomena of categories highlighted that categories were closely related. To explore this further, the paradigm model was applied to the subcategories which had been identified during axial coding. This reaffirmed the fit of subcategories to categories and also that axial coding had facilitated the identification of patterns and relationships between these. A summary of this can be found in Appendix 10.

4.5.5 Selective Coding: Identifying a Central Category

In the need to identify a central category, memos kept for this study were revisited and analysed. This was done with particular focus on the ways in which relationships between concepts, codes, themes and categories had been identified. Also, questions posed during processes of axial coding, such as who, when, where, why were revisited in the need to establish explanations of main themes of data. Corbin and Strauss (2008) suggest that writing a story line is a technique that can be used to facilitate identification of a central category. This technique was favoured but, in the first instance, a decision was made to construct a theoretical paradigm model of the relationships between categories to assist in establishing a story or the main event in data. Categories and subcategories are used to form the basis of this. The theoretical model is presented in Table 12:

Table 12: Theoretical Paradigm Model of Relationships between Categories

	Central Phenomenon: The Presentation of the Patient	
↑	**Conditions: Responding** **(Factors Informing Nurse-Led Assessment)** Using personal definitions of “normal” Using Personal standards Using memory and prior expectations Assimilating present with knowledge and expectations	↓
	Actions: Assessing **(Nurse Led Assessment and Influence of the Role of Others)** Assessing subtly Using informal and formal criteria Listening to patients Assessing physical/psychological status Establishing baselines Gathering information from family Making referrals and assimilating medical assessments into nursing assessments	
	Consequences: Patient Focused Outcomes **(Impact of Clinical Setting and The Caring Role of the Nurse)** Assessing in context Recognising a capacity continuum Protecting decision making abilities Advocating for patients Safeguarding standards of assessment and outcomes	
	Summary of Theoretical Model Initiating, influencing and managing processes for assessment of capacity status and on-going care of patients	

The exercise to construct the above model facilitated clarity of thought and resulted in the realisation that a story line was not needed to identify a central category. Constructing the model re-affirmed the central phenomenon of this study and leading component of the model, as the presentation of the patient. The model also illustrated the close relationship between categories to explain processes of assessment and the care of patients by participants. At this point the advice of Corbin and Strauss (2008) was revisited regarding a central category has the power to explain what is at the centre of a research study. A decision was made therefore to label the central category for this study Nurse Managed Patient Focused Assessment and Care.

4.5.6 Retelling the Story around the Central Category

Corbin and Strauss (2008) assert that theoretical integration means choosing a core category then telling a story around it using other categories and concepts identified during the research. Integrative, theoretical memos are regarded as a useful tool and can give the researcher a sense of security drafting this type of storyline (Birks et al 2009, Birks and Mills 2011). An integrative memo was therefore used and can be found in Appendix 11. This uses categories and subcategories derived from data of this study, thus encapsulates main themes implicit in data. Writing the memo confirmed that the central category of Nurse Managed Patient Focused Assessment and Care appeared to fit data and provided an interpretation of what was at the centre of this research study. It was concluded therefore that this was the concept that all other concepts related to (Corbin and Strauss 2008).

4.5.7 Theoretical Saturation

Data were collected until no new properties or dimensions were added to all categories and subcategories leading to the central category. This is referred to as theoretical saturation and occurs when categories are conceptually well developed to a point where subcategories and their properties and dimensions are clearly articulated and integrated (Corbin and Strauss 2008). Therefore it was considered that patterns established in data demonstrated levels of analysis which established theoretical relationships between these patterns and also re-affirmed the fit of the central category.

4.6 Rigour

Grounded theory involves processes that go well beyond the gathering of data. Such processes must be rigorous, provide evidence of quality processes and products and stand scrutiny regarding what is described as procedural precision (Chiovitti and Piran 2003, Birks and Mills 2011). Rigour is the subject of much debate in qualitative research, so much so that contention exists regarding the ways in which this can be achieved (Mills and Birks 2014). In quantitative research rigour is established through concepts such as reliability and validity. These concepts are traditionally associated with the prescriptive objectivity required for scientific methods in providing a framework for the evaluation of studies in which numerical data are the unit of analysis. Measures to ensure that results are valid and reliable are central to the issue of control and standardised instruments for measurements are used (Parahoo 2014). However, a perceived value of objectivity in a positivist paradigm has resulted in a devaluing of research which uses qualitative methods with the suggestion that these methods are inferior and therefore lack rigour (Mills and Birks 2014). This has further resulted in researchers using qualitative methods sometimes apologising for perceived shortcomings when qualitative methods are compared with quantitative approaches (Sandelowski and Leeman 2012).

Alternatively, in the need to address issues of quality, validity and reliability are regarded as worthy aims in qualitative research but procedures to realise these are adjusted to the specific nature of the research (Boeije 2010). Therefore, researchers using qualitative methods should maintain due cognisance on how the research process and the presence of the researcher affect results of the research (Sandelowski and Leeman 2012). Corbin in Corbin and Strauss (2008) provides a discussion on concepts such as rigour, validity, truthfulness, goodness, integrity and credibility when referring to qualitative evaluation and suggests that creativity should also be included. For Corbin, credibility indicates that research findings are:

> *"…trustworthy and believable in that they reflect participants', researchers' and readers' experiences with a phenomenon but at the same time the explanation is only one of many possible plausible interpretations possible from data"* (Corbin and Strauss 2008 page 302).

Furthermore, the concept of quality is generally regarded as synonymous with rigour in the context of qualitative research (Nelson 2008, Mills and Birks 2014). Here, researchers are advised not to stifle creativity, rather to maintain control of processes employed in order to explain all factors that can impact on the value of research outcomes. This has resonance with the description of quality applied to qualitative research by Corbin in Corbin and Strauss (2008):

> *"….qualitative research resonates with readers' and participants' life experiences. It is research that is interesting, clear, logical and makes the reader think and want to read more. It is research that has substance, gives insight and shows sensitivity……It is research that blends conceptualisation with sufficient descriptive detail to allow the reader to reach his or her own conclusions about data and to judge the credibility of the researchers' data and analysis. It is research that is creative in its conceptualisations but grounded in data. It is research that stimulates discussion and further research on a topic"* (Corbin and Strauss 2008 page 302).

There is much in the literature regarding the issue of quality in qualitative research but there does not appear to be agreed criteria to define validity and reliability (Silverman 2013, Urquhart 2013, Gibson and Hartman 2014). Boeije (2010) maintains that in qualitative research it is difficult to establish reliability by repeating research, as researchers will have differing perspectives and emphases when using similar methods and data. Also, if the same participants are approached, their views, perspectives and responses may not be the same at a given point in time due to their intervening experiences and potential for differing perspectives. Validity or trustworthiness is therefore linked to truthful responses and relates to the ways in which the researcher creates an environment which facilitates honesty. Validity, therefore, must focus on research findings which are believable and trustworthy (Corbin and Strauss 2008) and which have been developed through open processes of discovery (Thomas and Magilvy 2011). Therefore the need to emphasise the importance of attention to quality in grounded theory studies is highlighted (Birks and Mills 2011).

To ensure rigour in qualitative research, there are a number of strategies available to a researcher. Common methods are identified as validation by participants or experts and the need to create audit or decision trails (Parahoo 2014). A decision was made to consider both of these for this study. In addition the use of a reflexive approach was identified as a key strategy to promote quality and to evidence accountability in the use of essential grounded theory methods (Birks and Mills 2011). Further information on how this worked in practice is provided in Section 4.6.4, page 94.

4.6.1 Participant Validation

Participant validation assumes that when qualitative research succeeds in providing accurate descriptions and interpretations of participant experiences, they are able to recognise these as their own. This approach generally involves returning to participants and asking them to read through interview transcripts, or to validate process of data analysis to confirm or reject the findings of the researcher (Boeije 2010). This process was considered appropriate for this study as it is regarded as a means of giving participants some control of the research (Holloway and Wheeler 2013). Furthermore, a decision was made to use participant validation as a means of providing assistance in the critical refinement of themes and theory development and in providing some feedback regarding the findings of this study. Also it was recognised that this would go some way in protecting against lone researcher bias. Ultimately, the main focus of participant validation is to seek clarity regarding meanings of words or descriptions of actions of participants to avoid misunderstandings and to clarify emerging themes (Holloway and Wheeler 2013).

There are, however, disadvantages with using participant validation. Some of these are due to time commitments and availability of participants, others relate to participants changing views and opinions due to time lapse between actual collection of data and a validation exercise (Cutcliffe and McKenna 2002). In addition, it is argued that the relationship between the researcher and participant may result in participant feedback being uncritical of findings if there are presented to them (Boeije 2010). However, it was considered that the main advantage of participant validation would be if participants commented that findings presented to them for this study were accurate, plausible and meaningful.

Consequently, a decision was made to undertake a credibility exercise by returning to some participants to validate the central category and findings of this study and to comment on a visual representation of processes of assessment and emerging theory which had been identified in data. A decision was made to use a focus group for this exercise. It was anticipated that participants may feel more comfortable discussing themes and potential theory development in a group setting. It was also acknowledged that being part of a group may generate more information and rich discussion (Mclafferty 2004, Lambert and Loiselle 2008). The focus group discussion occurred in August 2013 and was conducted in a private office away from the clinical areas of each participant but within a district general hospital. An invitation was sent to all participants in this study to attend and six participants agreed to take part. This was considered a good response rate and a viable cohort to generate discussion. Telephone conversations were then used to agree a date and time convenient to all to meet.

Discussion in the focus group was initiated with a visual presentation of processes of data analysis leading to the central category of Nurse Managed Patient Focused Assessment and Care. This is presented in Appendix 12. Participants discussed their reaction to this and all identified themselves in what had emerged from data. The findings of this study were validated as all participants reaffirmed their role and function in assessing capacity status and in caring for patients before, during and after this. This confirmed the central category of this study and also the fit of the emerging theory. Participants were given their own interview transcripts and invited to comment on accuracy and omissions. There were no significant comments in this respect. Furthermore, all participants stated that, as a result of the research, they had given more thought to assessing capacity status of patients in their care as an aspect of their wider assessment role and they had discussed hidden complexities of what they did with other colleagues. These hidden complexities were regarded as issues of significance by participants, with one describing surprise when thinking about the role of nurses in this respect. One participant alluded to an increased personal insight into the significance of the role of the nurse in a multi-professional setting and to a sense of increased confidence in referring to doctors and in relaying the results of nursing assessments of capacity.

4.6.2 Validation by Experts

Validation of the progress and findings of this study was achieved by the PhD supervision process and by the support of a PhD Advisory Board, comprising the supervision team, a Critical Care Nurse Consultant and a Professor of Psychology who is also an expert in grounded theory research. In addition, validation was also achieved with the support of an Expert Advisor, a leading authority in healthcare law with a particular interest in nursing.

Supervision processes involved all stages in this study being scrutinised by supervisors. Here interview schedules, interview transcripts and evidence of coding processes leading to the identification of a central category were submitted for discussion and review. Also, the emerging theory was subject to this scrutiny. Adding to levels of validation from external expert sources, the Advisory Board for this study was established in 2012. Two meetings were held, in July 2012 and November 2012 where progress was discussed and current findings at the time scrutinised. Discussions at these meetings confirmed the appropriateness of the use of the methodological pathway of Strauss and Corbin for this study and assisted in the development of the analysis of findings, in particular those involving intuitive responses or gut feelings.

Furthermore, at the start of this study a leading authority in health care law agreed to act as informal expert advisor for this study. A meeting occurred in September 2011 to discuss the legal context of this research which is reflected in the literature review presented in Chapter 2. Confirmation was obtained regarding the accuracy of the legal context presented in this study. Findings were discussed in a telephone conversation in February 2014.

4.6.3 Audit Trails

In order for processes of quality to permeate all aspects of this study, the need to develop and maintain systems for leaving evidence trails of methodological decision making, methods used and conclusions made was identified. Also, there is need to justify any theoretical leaps made in the generation of theories at the end of data collection and analysis processes (Mills and

Birks 2014). Failure to leave a record of processes of decision-making may result to backtracking and confusion at later stages in a study and may result in making unsubstantiated leaps during processes of analysis and theory generation (Corbin and Strauss 2008).

There is some debate regarding the value and need to plan and create audit trails. Aspects of this debate suggest that audit trails do not contribute to the credibility of research findings in studies using qualitative data and any research methods and conclusions will be acceptable as long as they are evidenced and justified (Cutcliffe and McKenna 2002 and 2004). However, it is generally recognised that audit documentation contributes to rigorous research (Mills and Birks 2014). Audit documents should provide evidence of field notes complied during interviews, processes of data analysis leading to theoretical insights and personal thought processes and insights of the researcher (Boeije 2010). Examples of these can be found in Appendix 7. Accountability is a key theme throughout any research process and it was considered appropriate to recognise the need to demonstrate that decisions made in this study had been made in a logical and careful manner. Evidence trails of thoughts, insights and pathways taken during the course of this study ensured trustworthiness and credibility (Mays and Pope 2000, Koch 2006). As a result, a detailed journal was kept during this study in which all thoughts, ideas, insights, milestones and decisions were recorded. Field notes were made during each interview and attached to interview transcripts. These were then combined with appropriate reflective journal entries after each interview to add meaning to interview data and to form the basis of processes of thematic analyses that informed coding mechanisms.

4.6.4 Reflexivity

Adopting a reflexive approach during all phases of a study, in particular those concerning data collection and analysis, is regarded as an important consideration in the need to evidence an approach that values integrity and quality (Birks and Mills 2011, Gibson and Hartman 2014). This, in turn, leads to facilitating a sensitive approach, referred to as a, “fascinating interplay” of researcher and data from which an emerging theory is apparent (Corbin and Strauss 2008 page 33). Reflexivity is defined as an active process of systematically and logically developing insight into to the work of a researcher to guide future actions (Birks and Mills 2011). A reflexive approach is also one of comprehensive scrutiny in that a researcher adopts a critically analytical approach to all aspects of the research experience, especially so of the ways in which data are collected, analysed and lead to the development of theory (Charmaz 2014).

Throughout the course of this study a reflexive approach was employed on a number of levels. A reflexive journal was maintained from the start of this study and through all elements which led to the development of the eventual theory. Thoughts and insights were recorded acknowledging the prior knowledge of the researcher throughout all aspects of the research process and the impact upon eventual theory development (Chiovitti and Piran 2003). In addition the journal contained entries highlighting the implications of research methods used, analyses of the significance of words, phrases and meanings of participants during the collection of data, ideas about connections between themes and analyses of insights and interpretations. Thoughts and ideas were compiled as, or soon after, they occurred and ranged from moments of insight unrelated to any particular activity through to those as a result of the adoption of systematic processes of data analyses. Here recognition was given to the need to compare prior knowledge and experience against data but not to lose sight of data (Corbin and Strauss 2008). These processes were discussed regularly with the supervision team for this study. This resulted in the provision of valuable feedback and guidance which further facilitated range and depth of the reflexive approach employed.

Reflexive consideration was given to the impact of self in the planning of, and collection of data. For example, regarding the recruitment to this study, a decision was made not to approach participants directly, thus reducing the potential of researcher bias. Rather the assistance of Senior Nurses was used to approach potential participants using agreed inclusion/exclusion criteria which are outlined in Section 4.3 of this study (pages 72 to 76). In addition, reflexive consideration was also given to the potential of power differential in the relationships developed with participants during semi-structured interviews (Birks and Mills 2011). A method of data collection was chosen that would enable participants to articulate assessment and intervention processes they employed and it was anticipated that there may be a need for a reflective element in the ways participants discussed what they did to assess capacity status of patients in their care. Therefore using semi-structured interviews as a vehicle of flexible data collection would facilitate such reflective discussions. This type of interview is regarded as assisting the participant to assume more control of the direction of the interview (Nagy et al 2010). Furthermore interviews were conducted in an informal manner and an encouraging, non-direct questioning approach was used to provide an atmosphere which was suitably comfortable and conducive to facilitate discussion.

During all phases of data analysis, a focus was maintained on how participants articulated what they did to assess the mental capacity of patients in their care, what informed them and how they managed the contexts in which their assessments and actions occurred. This supported processes of theoretical sampling until categories were saturated with data. Here a reflexive approach was used to visualise how emerging theory directed future data collection by revisiting reflexive notes and accounts regarding thoughts and analytical processes.

To facilitate processes of data analyses, and to contribute to the accumulation of evidence leading to theory development, field notes and memos were created and formed an essential part of the comprehensive reflective journal. As previously indicated, field notes consisted of thoughts, observations and reactions of the researcher during and immediately after each interview. These were subsequently attached to interview transcripts. These notes are considered to contain data that may contain some analysis and conceptualisation (Corbin and Strauss 2008). In addition, and away from the field, memos were created as processes of data collection and analysis progressed. These were more in-depth than field notes and were constructed after interview transcripts were created. These enabled the researcher to articulate, explore and question interpretations gained from data and thus enhanced theoretical sensitivity and assisted in answering questions about what was happening in data (Birks et al 2008). Here discussions with the supervision team for this study were invaluable, not only in supporting a reflexive approach, but also in encouraging greater depth of though, insight and analysis.

Memos were also used to record insights and interpretations through each phase of coding processes. They assisted and supported the construction of the theoretical paradigm model of the relationship between categories and in the identification of the central category for this study. This resulted in the use of an integrative memo, found in Appendix 11, to confirm the fit of the central category. Therefore memos were used as working documents which became more valuable as processes of data analysis become more complex. They enabled a reflexive approach, both retrospective and prospective, and supported the momentum of processes of analyses through each phase of this study. Momentum was also maintained when reviewing the key findings in relation to existing literature and in subsequently positioning the framework of the developed grounded theory. The reflexive journal was used to connect main themes, insights and interpretations captured in field notes and memos to extant literature and thus to situate the grounded theory.

4.7 Ethics and Governance

Ethical approval for this study was granted by the Research Ethics Committee, Faculty of Health Sport and Science, University of Glamorgan, in September 2010. Confirmation of this approval can be found in Appendix 13. An application was then made to a University Health Board for specific approval to recruit qualified nurses employed in the delivery of acute and critical healthcare to adult patients.

Ethical approval was granted by the Research Risk Review Group, from a Health Board in January 2011. Confirmation of this approval can be found in Appendix 14. Approval was granted to recruit qualified nurses across the then Acute Division within the Health Board. This approval covered both district general hospital sites within the Health Board locality to facilitate ease of access to Health Board staff. The Research Risk Review Group anticipated staff may be required to move between both hospital sites as clinical services were being re-organised and re-designed at the time of approval. Also, the acuity of staffing levels may determine future need to cover front-line clinical services.

During the process of reviewing this study, the Research Risk Review Group of the Health Board concluded that the research proposal for this study represented an evaluative study rather than a research study. As a result advice was sought from the National Research Ethics Service, National Patient Safely Agency, which confirmed this study did not require ethical review by an NHS Research Ethics Committee. This was primarily due to the request in this study to interview qualified staff rather than patients. This was confirmed in December 2010 by correspondence via electronic mail. An honorary contract with the Health Board was approved in January 2011 and confirmed in March 2011 after a satisfactory Criminal Records Bureau check was obtained. Correspondence confirming this can be found in Appendix 15.

4.7.1 The Process of Gaining Informed Consent

The concept of informed consent is fundamental to any decision-making process. Therefore participants identified as being suitable for inclusion in the initial sample for this study were given consent forms in recruitment packs which were distributed by senior nurses. This facilitated immediate access to all participant documentation used for this study and to inform their decision making processes. Consent forms (Appendix 4) were distributed in recruitment packs and participants asked to post them to the researcher using the stamped, addressed envelope supplied in each pack. Consent forms contained a section for participants to indicate their clinical speciality, Agenda for Change Profile/Band, number of years qualified and contact details. They were informed that appointments would be made to meet with each of them on an individual basis to confirm their consent and to arrange and/or conduct interviews. Emphasis was placed upon the voluntary nature of their involvement and that they could change their mind at any time and withdraw from the study at any point if they so wished without prejudice. Before making a decision to volunteer and sign the consent form, participants were invited and encouraged to seek clarity regarding any aspect of the study and to ask questions.

Prior to each interview, a telephone conversation occurred with each participant regarding making appropriate arrangements to meet. The focus of this study was reiterated and the anticipated purpose of interviews and the role of each participant outlined. Here it was emphasised that the identity of all participants would be protected in all processes of this study, including the reporting of findings or any future publications, both within the Health Board and externally. Each participant was informed that interviews would be conducted using an informal approach which was intended to put them at ease and feel comfortable to discuss depth of detail regarding thoughts, judgements and actions. They were informed that their opinions would be valued and there was no agenda, other than to carry out a critical exploration what they did to assess the mental capacity status of patients in their care. It was also emphasised to all that their involvement was voluntary, that they could change their mind at any time and they should not feel obligated to continue even, if they had been interviewed. If this was the case, participants were informed that they would not be required to give reasons for their withdrawal. During these conversations participants were encouraged to ask questions. These ranged from how interviews would be conducted and length of interview to the purpose of the study and its future benefits. One participant expressed concerns regarding not having sufficient knowledge about the Mental Capacity Act 2005. In this instance reassurance was given that knowledge of this legislation was not a pre-requisite for participation in this study and the informal nature of the interviews emphasised. No participants withdrew their consent.

4.7.2 Anonymity, Confidentiality and Data Storage

To protect the confidentiality and anonymity of participants, all were allocated a unique identification code known only to the researcher. A simple numerical identifier was used and the codes 01 to 13 were allocated in order of sequence of interview conducted. Also, the prefix M or F was used to identify gender. Therefore, Participant F01 was interviewed first and

Participant F13 last, at which point data saturation was achieved. To further protect the confidentiality and anonymity of participants, a simple demographics form was devised and used to label transcriptions of interviews (Appendix 5).

Also all data generated during this study were managed in line with confidential processes. Recordings and transcriptions of interviews were stored on a laptop computer protected by password and paper copies of documents and notes generated during interview and data analysis processes were kept in locked filing cabinets in a private office on a University campus. University requirements dictate that data are stored in a confidential manner for a mandatory period of at least 5 years on completion of a study after which it is destroyed. There are, however, variations in timescales depending on when papers may be published after the completion of studies.

It was recognised that participants in this study may reveal data which could highlight poor levels of care or inadequate healthcare processes and for which there would be a need to report, through appropriate mechanisms in the Health Board, depending on circumstances. As a result, during the process to gain ethical approval for this study, the Research Risk Review Group of the Health Board required the following statement was included in the participant information sheet:

> *"If you disclose information of an exceptional nature, for example, that you have witnessed aspects of unsafe care or poor service experienced by patients, you will be encouraged to use systems of line management in your workplace to report this to an appropriate person. Additionally, if any serious clinical governance issue arise, these will need to be reported and this may compromise your anonymity"*
> (Participant Information Sheet Appendix 3).

Participants were informed of this during the process of gaining their consent for this study. None voiced concerns regarding this statement or its implications and all agreed to it in principle. During data collection, no information was revealed about unsafe or poor levels of care or service during interviews with participants, therefore reporting mechanisms were not needed. There were also no issues of clinical governance to report.

4.8 Conclusion

This chapter has outlined the design and implementation of grounded theory methods to explore the strategies and processes used by qualified nurses to assess the mental capacity of acutely and/or critically ill adult patients in a district general hospital setting. The collection of data were achieved using semi-structured interviews with 13 participants. Five categories were identified through processes of coding, categorising and a central category identified. These categories are used as themes to present the main findings of this study and can be found in Chapter 5.

Chapter 5: Findings

5.1 Introduction

This chapter presents findings as a result of analyses of data in this study and also presents data from interviews with participants. Verbatim quotations are used to convey thoughts, opinions and accounts of actions of participants, thus staying close to data in their own words. Analysis of data revealed that participants demonstrated similarities of descriptions of actions and strategies used to assess and care for patients despite representing a number of different clinical settings across acute and critical environments. They also used similar language on many occasions. This consistency is reflected in the presentation of findings in this chapter. Discussion of findings can be found in Chapter 6. This approach was taken to facilitate clarity and also to facilitate logical and systematic presentation, laying the foundation for the discussion of these in relation to existing literature in Chapter 6.

Qualitative data is, “inherently rich in substance and full of possibilities” (Corbin and Strauss 2008 page 50). Many stories can be gained from data and different researchers focus on different aspects of data, interpreting things differently, identifying different meanings. What is different about each study is the level of significance given to phenomena arising from data and how they are put together. At the centre of this study are process of assessment and caring for patients before during and after decisions made regarding the mental capacity of acutely and critically ill adults. Whilst this study represents an attempt to present data to relay the descriptions and meaning of participants, it is recognised that there are elements of interpretation and this study reflects the researcher’s “impressionistic understanding” of what is described in the experiences, spoken words, actions, interactions, problems and issues expressed by participants (Corbin and Strauss 2008 page 51).

5.2 Findings Identified in Open Coding Leading to Category Development

The analysis of data collected during open coding in this study revealed a number of findings from which open codes were identified. These laid the basis for all five categories which were subsequently identified. Therefore, there is a need to summarise these here prior to presenting detailed findings around the five categories.

During phase one of this study, all participants alluded to the complex and diverse nature of acute and critical care hospital environments and the challenging range of patients and their clinical presentations. Acute and critical care environments were described as providing clinical services to patients with needs ranging from the very acute to long term:

> *"Patients come in and they are very unwell. Then it's the basics, airway, breathing, the ABC approach up to full-on intervention. We often are trying to save a life and do all that comes with this. But many patients do not have acute needs or no longer have acute needs as they have been resolved. Very often these patients have dementia they are with us a while but they still need to be cared for up to the point of safe discharge. At any one time we can have a whole range of patients with capacity issues"* **(Participant F03).**

All participants also identified the impact of clinical environments upon patients and the affects these may have on the ability of patients to demonstrate capacity. They suggested patients may be frightened and feel out of their normal routines and normal environments which may result in "not being themselves":

> *"When patients are in hospital this is a false environment, they are surrounded by unfamiliar people. They can find it difficult to change their minds and decide if they want surgery or not. You can't underestimate the fright they feel or how much they need their family around them. At home they have all this and are more themselves"* **(Participant F01).**

Relatives and carers were identified as having significant roles in influencing capacity assessment processes prior to subsequent clinical decisions, both nursing and multi-professional:

> *"A lot of patients are dependent on those around them and without family they cannot function. We totally understand that. They are involved throughout the care of the patient if needed. They help us support the patient in giving the best possible care and also give us information about the patient which we may not be able to get directly from the patient for many reasons. We have to factor this into decisions we make about the patient"* **(Participant M02).**

Participants also described their roles in multi-professional teams and revealed awareness of the legal challenges with which they are faced. They also alluded to their legal position:

> "*I am aware of the legal side of assessing capacity, the legal test, making sure that patients are able to digest information, weigh it up and be able to reiterate it back. I sort of do this in practice myself. Doctors and nurses assessments are quite similar, we do the legal test but do it in slightly different ways. Nurses do it in a way that the patient is not aware, we do it in a gentle way. I try to go back to my patients at different times of the day and try to assess patients throughout different stages. I think as nurses we are more clued up to be an advocate from a mental capacity assessment point of view. We have more information, we have a rapport with the patients because we are with them all of the time"* **(Participant F04).**

However, data for this phase of this study revealed the complex nature of processes used by participants and their actions in making capacity assessments of patients. A number of issues were identified relating to the ways that participants assessed the capacity of patients, processes they adopted and events in which they were involved, leading them to form judgements of the capacity status of patients in their care. All participants recognised there were formal mechanisms and pre-defined assessment tools for assessing capacity but they indicated they used personal, informal processes for initial and on-going assessments of patients:

> *"There is a formal way of assessing which doctors use, it's the Mini Mental. I use this informally and it's a safety net for me, its ammunition. I can go up to a doctor and say, well look, I have done a Mini Mental on this chap and he has scored very low. This can help you pin point the ones with poor memory recall and we can see exactly where we are coming from. This gives a red flag but I would have probably made my decisions about the capacity of this patient without using this. I assess capacity as I go along when I am assessing and looking after patients" (***Participant F03).**

They also articulated what appeared to be a recurring statement, "something not quite right". This was used as a nursing label for patients who warranted either immediate or more in-depth assessment and/or healthcare intervention:

> *"I would assess a patient by giving them information, give them time to absorb it and see if they understood what that information was by asking them questions. I may think something is not quite right here and would repeat the information, ask them to tell me about what I was trying to say to them. If something flagged up that wasn't quite right I would say there was no capacity"* **(Participant F03).**

Phase two of this study resulted in open codes identified during phase one remaining unchanged. However, it was recognised the open code which was labelled, "nursing assessment", was becoming large and increasingly participants discussed experiencing "gut feelings" which become a recurring theme. This was combined with comments regarding using prior knowledge and experience to inform assessing the capacity of patients:

> *"I tend to know if a patient is not understanding what I am saying, it's sort of a gut feeling before I find out that they are not able to repeat back to me. It's about the way they look, you can tell if they don't understand, it's not that they look with a blank expression, but you have a feeling they are not able to grasp what you are saying. I look at their facial expression, they can look confused, I have dealt with many patients over the years and you get to know that look"* **(Participant F06).**

As a result, two new open codes were identified and labelled "using prior knowledge and experience" and "using gut feelings". The summary of open codes for this study are presented on page 82 in Chapter 4.

5.3 Findings Identified Through Processes of Category Development

Five categories were identified from processes of analyses and the findings in this chapter will be presented using these as headings:

- Factors informing nurse-led assessment
- Nurse-led assessment
- Influence of the role of others
- Impact of clinical setting
- Caring role of the nurse

5.4 Factors Informing Nurse-Led Assessment

The presentation of patients in acute and critical clinical environments resulted in participants responding by using and applying knowledge which informed the need to investigate the capacity status of patients in more depth. Data analysis revealed such knowledge originated from personal definitions of "normal" and professional definitions of mental capacity. These were supported by personal standards, personal and professional expectations and the application of prior knowledge. This resulted in participants assimilating detail from what was observed about patients with their personal and professional knowledge and expectations. Some participants subsequently articulated having "gut feelings" about the capacity status of patients in their care. Table 13 presents a summary of open codes and subcategories relating to the category, Factors Informing Nurse-led Assessment:

Table 13: Factors Informing Nurse-Led Assessment: Summary of Open Codes and Subcategories

Open Code	Category	Subcategory
Definitions of capacity	Factors informing nurse-led assessment	Using personal definitions of "normal"
Using prior knowledge		Using personal standards
Using gut feelings		Using memory and prior expectations
		Assimilating present with knowledge and expectations

An aspect of the knowledge of participants, and starting point to their response to the presentation of patients, lay in their definitions of capacity and ones they considered appropriate for acutely or critically ill adult patients in their care. All participants provided evidence of understanding legal definitions of capacity, such as decision making abilities with required levels of understanding, retention and communication abilities (Mental Capacity Act 2005):

> *"I would define capacity as the persons' ability to make their own decisions for themselves. This can be about health, finances, welfare and these types of things. A person must be able to understand and remember and need to be aware of what is going on. Communication is important here, you've got to understand what the person wants it is their decision at the time"* **(Participant F05)**.

Reference was also made to more informal definitions of capacity such as "frame of mind" at any particular time and one in which there is a "perceived normal" (Participant F01). The label "normal" was discussed by all participants and appeared to be linked to awareness of situation and appropriate levels of understanding:

> *"Normal is a frame of mind at a particular time when patients know their surroundings and environment, they know why they are in hospital, they know they understand a bit about their disease, what the doctor or nurse is saying to them, they understand how they are meant to behave in a hospital setting. Abnormal is if the patient is confused, they are not aware of their surroundings, they do not know that they are in hospital, they do not socialise like other people"* **(Participant F01).**

In addition, normal behaviour indicating the presence of capacity was defined as needing to be logical by one participant (M02), emphasising perceived appropriateness of the responses of a patient. The assessment of the quality of the concept of "logical" was dependant on perceived definitions of this by this participant:

> *"You are looking at cognitive ability of an individual and how their thought processes are working. If they are thinking logically, can they give logical answers, do they know where they are, do they know the time of day, can they remember this? Their thought processes have to make sense and fit to the situation they are in. I suppose they would have to make sense to me, did I think that they were thinking logically"* **(Participant M02).**

Emphasis was placed upon having a normal conversation described as being able to give appropriate answers to questions as an indicator of capacity. The ability to do this was included in definitions of capacity with the quality of what constituted "normal" conversation interpreted by participants:

> *"When I am speaking to patients it's about the conversation you can have with them. It's about what they are saying and whether it all makes sense. It's also the way they are communicating with you, the way they are listening, eye contact, the way they are responding, smiling. It's all the communication bit about patients, the conversation you can have with them. They can be frightened and ill or not very happy about things but the conversation you can have with them is really important"* **(Participant F06).**

The definitions of capacity used by participants appeared to arise from previous knowledge and experience but also indicated that personal standards and criteria were used against which to start making judgements about the capacity status of patients. Participant F07 used the analogy of boxes when making reference to personal definitions and use of prior knowledge and experience. The term "appropriate" was used by all participants in describing behaviour, communication abilities and actions of patients which emphasised the application of personal criteria and indicators. The term "appropriate" was also linked to the concept of "normal", again with a focus on what constituted normal:

> *"Appropriate is normal and inappropriate is out of the norm. You have a mental picture of what somebody should be like. Every patient presents differently with different parameters but it our own boxing of what is appropriate or what the typical picture of somebody is without capacity. For example I have a typical picture of a patient with chest pain, the one that is in my box. Also I have a picture of how somebody should behave, that's probably in another box. I think this does influence. If you have somebody who does not fit your picture, your box, you think of other things that are going on you need to look outside of your box sometimes"* **(Participant F07).**

However, recognition was given to disadvantages of relying on personal criteria such as information in "boxes". Participant F08 alluded to the potential for a "blinkered" approach and the unpredictable nature of using personal standards, in particular when working in specialised clinical settings and the danger of a presumption that all patient reactions were due to urgent, clinically focused reasons:

> *"A lot of us (nurses) and doctors can have tunnelled vision and can be blinkered. Sometimes working in general settings gives you a broader view. Working in a speciality can make you focus on just that. This is where things can be missed and your views on what is normal can be coloured by what you expect to see in the speciality. How good you are really depends on what you focus on and what you pick up on"* **(Participant F08).**

Furthermore, some participants demonstrated appreciation that personal standards and definitions were used not only for definitions of capacity but also to define "normal", appropriate and socially acceptable behaviour. Participant F11 articulated the need to observe for "mannerisms" and "levels of politeness" which were outside of "normal expectations". Participant F08 discussed the notion of "mental clarity" of nurses, having clarity of realisation of norms of behaviour and of awareness of how to assess and judge patients against these. In this respect the notion of a personalised assessment tool was described by Participant F09:

> *"When a patient is doing something out of the norm, something not normal, we should realise what normal behaviour is. I think this is a starting block anyway. Thinking about it now, I am using my standards of normal and what's to say this is right. It's almost like the (gives own name) assessment tool. You just know what to expect as normal behaviour and when you don't see this you start to question that something is not quite right"* **(Participant F09).**

The prior knowledge, experience and personal definitions and standards of participants appeared to be enhanced by having what were described as “gut feelings” or “instinctive feelings”. These were regarded as adding to judgements about patients described as “something not quite right” which was articulated by all, but one (M02), participants. This was a label that re-occurred frequently as participants discussed their thoughts, actions and strategies for the assessment and care of patients:

> *“You are talking to patients and you can see that something is not quite right. You have a gut instinct, hang on now, this patient does not seem to be taking in what I am saying. I think it’s a gut feeling sometimes as a practitioner when a patient does not feel comfortable. I think it’s quite difficult to actually put into words. As a practitioner I think that sometimes it is something that can be gained from experience. You get a gut feeling when a patient is not with it, sometimes they are not well and their observations are not showing much. You think, hang on, something is not quite right here, it’s a sort of a nagging feeling. You think I need to keep an eye here. I suppose its patients behaviour and being aware of body language with patients who are receiving information. I think that you need to be a person with instinct and to be thinking that you are continually assessing your patient and analysing their behaviour. I think that all practitioners do it when you are watching and receiving information. It’s that period afterwards when you are thinking about your patient and how you assessed them”* **(Participant F04).**

Whilst Participant M02 did not articulate having “gut feelings”, this participant described methods of informal nursing assessment in similar ways to other participants and indicated depth of information gathering processes. This participant also used the description “something not quite right”.

The articulation of “gut feelings” appeared to indicate that most participants were utilising processes of continual information gathering and processes for initial assessment, the results of which were expressed as “gut feelings”. Information gathering was described as appearing to be in-depth and an analogy was used by Participants F03, F04, F06 and F11 of putting pieces together to inform judgements about patients. Therefore in applying this analogy, these participants suggested there was a need to get a full picture of the presentation of a patient, thus laying a detailed foundation upon which to base an assessment. Also the speed of assimilating this information appeared to lead to conclusions and articulation of experiencing “gut feelings”. However what was defined by participants as “gut feelings” were also based upon prior exposure to patient scenarios, and therefore prior experience:

> *"I think it's putting the pieces together when a patient first comes in and making sure you follow ABCD, and as you go along you look at your patient as well. The more information you get I think this gut feeling sort of builds sometimes. When you are given your patient scenario first of all, you make a judgement, we all gather our own opinions first off, and in your mind you think that you make a diagnosis like the doctors and jigsaw pieces come together. Sometimes this has to happen with speed due to the condition of patients. With nurses you are looking at the patient and the more that you learn the more that feeling can change. Or the patient had presented in a way that you have seen many times before, a gut feeling might be there that makes you think that something is not quite right, could be very wrong. This is brought on with experience, you might have been on edge with a previous patient, something that you have met before and you think you will never forget that. Then the feeling comes back and it's an experience sort of feeling, it's a gut feeling but it's one that you have felt before"* **(Participant F04).**

The articulation of "gut feelings" as a precursor to the assessment of capacity status of patients revealed depth of process regarding assimilating information. This appeared to be based upon prior knowledge and experience and information which was stored in the memory of participants. Using this as a basis for comparison with the presentation of patients in similar circumstances resulted in synthesis of information in real time to inform assessment processes. Participants implied this was done instinctively and without any prior thought which resulted in the articulation of "gut feelings". This indicated that participants articulated they were assessing in real time, and due to the nature of their clinical environments and the acute and/or critical needs of patients, such assessment was often done rapidly. Participants also described their assessment strategies in the context of their daily routines and they cared for and managed the needs of patients in their care. Also some participants articulated feelings of unease when there was insufficient evidence to justify this. Participant F07 described feelings of unease being "subtle" but to which response was required:

> *"When you think that something is not quite right, I'd like to say this is a gut feeling. Sometimes it's about seeing patients like it before, past experience. Sometimes you look at a patient and you know something is wrong. You can't always put your finger on it. It's like you know that something is wrong and without having assessments that show you something is wrong. Sometimes assessments tell you that nothing is wrong but you know that something is not quite right without the proof"* **(Participant F05).**

5.5 Nurse-Led Assessment

A recognition by participants that the capacity status of a patient required further investigation resulted in the application of informal nurse-led assessment processes. Participants used indicators to inform opinions and judgements when questioning the capacity status of patients and then applied these when conducting more in-depth assessments of patients. These indicators continued to be influential during the on-going assessment of patients. Analysis of data revealed nuances of assessment strategies used by participants. These included methods of gaining depth and range of detail regarding the physical, psychological and social status of patients. In addition, information gathering was achieved with the use of subtle processes which were identified as informal by participants but which actually included formally recognised criteria. Table 14 summarises open codes and subcategories for the category, Nurse-Led Assessment:

Table 14: Nurse-Led Assessment: Summary of Open Codes and Subcategories

Open Code	Category	Subcategory
Assessing informally	Nurse-led assessment	Assessing subtly
Nurse-led assessment		Using informal and formal criteria
		Conducting visual assessments
		Listening to patients
		Assessing physical status
		Establishing a baseline

In responding to the presentation of patients, and after forming opinions that the capacity status of a patient required further investigation, participants revealed that informal assessment strategies were used. The application of these were evident despite the existence of knowledge of pre-defined assessment of capacity criteria. Also all but one participant (M02) articulated understanding of the need to begin assessment processes with a presumption of capacity (Mental Capacity Act 2005):

> *"I always assume that everyone has capacity unless I am given a reason to think something else. It's important to start at this point. It's quite difficult but for me their behaviour often makes me think otherwise. I think I do these things without realising. We do not use a structured tool on this ward. I know there is a Mini Mental Test but in the first instance we would not go that way. It would be more about what you see and how the patient comes across. It's a lot to do with their behaviour and the types of questions they ask us, whether these are appropriate. Sometime I say there is something not quite right about a patient and I will then ask the patient more questions to find out if they are orientated. I may use some of the questions from the Mini Mental, like what year is it, or ask them about who is at home but it's my assessment"* **(Participant F09).**

Participant M02 initially described assessments of capacity status being conducted by doctors and, as such, capacity "was not so much of an issue for the nurse" in that nursing care would be given anyway in response to the needs of patients at any given time. Therefore an assumption of capacity was not considered relevant as capacity status would be confirmed by doctors. However, this participant also stated that nurses "can see capacity a mile off" and also articulated methods of assessing capacity status in a holistic manner, indicating detailed methods of informal nursing assessment.

All participants also demonstrated knowledge of other assessment criteria such as the four-stage test for capacity (Mental Capacity Act 2005). These appeared to be used as capacity markers and used informally:

> *"Nurses level for capacity assessment is about assessing if the patient is alert and orientated. You assess cognitive status and are they orientated to time, place and person. You have to get underneath this and you are looking to see if they understand and if they can remember things back to you, this is where you see what they communicate like, are they making sense. You are setting the patient up to see if they can make decisions. I suppose this is the same as the Mental Capacity Act which came in a few years ago. We have all done training for this but our level is the patient"* **(Participant F13).**

In addition, all participants demonstrated awareness of the functional approach to capacity assessment. This is the approach taken in the Mental Capacity Act 2005 and instructs that capacity is decision-specific and related to the ability of a patient to make a decision at a particular time when a decision needs to be made. This approach allows for a temporary loss of capacity or capacity which fluctuates. In discussing informal nursing assessment strategies, all participants provided evidence of the adoption of a functional approach, using prior knowledge about patients as appropriate and also awareness of the implications of the challenges of caring for patients with unstable and unpredictable diagnoses during which capacity may fluctuate:

> *"We had one patient we had nursed before and who usually was admitted in a poor state, he had the worse heart failure ever. This patient was very particular and always had capacity until his last admission. His level of understanding and capacity changed in front of us and at that time he was unable to decide for himself. He kept refusing treatment and wouldn't let us do anything. We ended up making decisions for him which was not like him at all but he was really ill at the time. There is a range of capacity and you have to assess where patients are at any point in time, you have to interpret degrees of capacity. Once this patient was stabilised he was still very poorly but he regained his capacity but couldn't remember a thing. It just proves you have to be with your patients all the time to assess them"* **(Participant F12).**

The proximity of participants to patients appears to have enhanced the informal nature of assessment processes used. Participants described spending time with patients in the provision of care and management interventions which provided opportunities to assess capacity unobtrusively or to assess at differing times to confirm capacity status:

> *"As I am caring for somebody I also ask questions, give them information and time to absorb it to see if they understand. I try to do this in a subtle way to try to get a sense of capacity. I sometimes do this during conversations as I am doing something like checking an infusion. If I think something is not quite right I might leave the patient for a short while and observe from a distance. If later something flagged up that wasn't quite right I would say there is no capacity or reduced capacity"* **(Participant F03).**

Also participants recognised the advantages of being able to assess patients continually due to their proximity to patients on a 24 hours basis. They described being able to gather and assimilate detailed information regarding the capacity status of patients and the advantages of assessing in a manner that was not obvious to patients. They considered this would give them a realistic view of the capacity status of patients, many of whom were ill and frightened and may have difficulty in demonstrating capacity:

> *"We have got a patient at the moment who was so frightened when she was admitted, we couldn't do anything with her. We needed to observe her because her physical condition was unstable, but it was hard to know if her extreme fear affected her capacity or not. We didn't have doctors on the unit at the time so I went about my nursing role with her and other patients and kept a close eye on her. She didn't exactly relax but I was able to see that she did in fact have capacity. Assessing her in this way was a big advantage as she didn't know I was doing it"* **(Participant F08).**

The proximity of participants to patients and working as a nursing team appeared to have enabled the pooling of information about the capacity status of patients and also provided opportunities to validate the results of nursing assessments. This appeared to provide mutual support amongst the nursing team and also enabled opportunities to obtain second opinions regarding the accuracy of nursing judgements and assessments of the capacity status of patients. Participants F10 and F13 described nurses working as a team and sharing information about patients to authenticate opinions and judgements about capacity status. This was also highlighted by Participant F05 who indicated that when "alarm bells ring about the level of capacity of a patient", obtaining other nursing opinions were necessary, if time allowed, prior to making referrals to doctors. Participant F11 highlighted a team approach and also that assessment of capacity was "automatic":

> *"Assessment is something I do automatically and I guess so does the team. We talk about concerns we have about patients amongst ourselves. If I am not sure I will ask one of the girls (qualified nurses) to see the patient, to chat to them and to tell me what they think. I guess we all do it automatically as we are always asking each other to see patients and then give our opinions"* **(Participant F11).**

In addition Participant F12 recognised that patients respond differently to different nurses, therefore articulated a need to work as a nursing team and obtain different opinions and assessments of capacity status to ensure accuracy due to the significance of concluding that capacity was reduced or absent:

> *"I can go and speak to a patient and get nothing out of them. The patient may not be really responsive and this makes it difficult to assess. I can ask one of the team (qualified nurses) to go in and they get a conversation going in no time. This can be down to personality, patients cannot like everybody all of the time. Sometimes patients shut off to you because they do not like you. Being a patient in this Unit is frightening and alters perception so patients react in a way that it not always logical. We have to give patients the benefit of the doubt and make sure that we get a full picture of patients"* **(Participant F12).**

A team approach was also highlighted by Participant F06 who described nursing hand-overs between shifts containing discussions about the capacity status of patients. This participant also highlighted a team understanding of the label "something not quite right" which suggests a universal recognition and use of this:

> *"I hear in report time and time again nursing staff saying, nothing obvious, but there is something not quite right and they have handed this over to the next team. At the time they may not be able to describe exactly what they mean but the rest of the team knows there are concerns because we all know what this means. Sometimes other staff on the shift will be asked their opinions so it's a team opinion you get"* **(Participant F06).**

The significance of a nursing team approach was highlighted by Participant F11 in situations where difficulty was experienced in making referrals to doctors where the capacity of patients was in question:

> *"Some doctors will come and assess patients but, I shouldn't say this, but some will not come to see the patient and ask what do I want them to do about it? Then I may insist that they come. If for some reason they don't then I will go back to the team (nursing) and speak to the ward manager to get another opinion about my concerns about the patient. We may then refer to the consultant if needed but this would be rare as we can usually assess ourselves as nurses"* **(Participant F11).**

A nursing team approach therefore appeared to be evident across the range of clinical settings represented by participants. This appeared to provide support for participants and also opportunities to authenticate and validate conclusions about judgments and assessments. A team approach was considered to be a strength and provide a safety net in ensuring the accuracy of conclusions about, not only capacity status, but also the physical status of patients:

> *"We have a patient in at the moment and only about 30 minutes ago he was really muddled and the girls (qualified nurses) on the ward said he was really confused. I was surprised by this as he was fine when he came into us and they asked me to check him. As I approached him I could see that something was not quite right but I knew he was a diabetic and he had told me earlier that he would get hypo really quickly. We did his blood glucose and he was hypo. This is why us nurses all work together, sometimes we all have different bits of information about patients. Patients can change so quickly we need to be safe"* **(Participant F05).**

The informal and subtle nature of assessment processes used by participants did not appear to detract from their significance. All participants discussed multi-professional contexts in which assessment of capacity status of patients occurred, in particular relationships with doctors in ongoing assessment processes. Recognition was given to the need to make multi-professional decisions and the advantages of a team approach:

> *"It is never a single decision. You work with everything you have in front of you from everyone in the team"* **(Participant F03).**

As participants described what they did to assess patients and their subsequent referrals to medical teams, it became evident the opinions of participants appeared significant in influencing multi-professional team conclusions about the capacity of patients:

> *"We call the doctors to the ward and they ask our input regarding if a patient is confused, do we think they are aware of their surroundings, do they know where they are. They sit down and talk to the patient but this is a one off so they tend not to get a full picture of what is going on. With us we may have spent some time with the patient and alarm bells go off if they are confused, they are not orientated. The doctors come along and do their assessment but we give them the full information they need"* **(Participant F04).**

In this respect a circular process was described which was initiated by the nurse and returned to them after the input of doctors. Thus an assessment of capacity cycle was described which appeared to be a dynamic process:

> *"Its nurses who call the doctors when it's identified there are problems with capacity. We flag up the problems and get them to see the patient. We highlight the problem, they may do a Mini Mental but a great deal of the time the doctors go with the nurses. So nurses identify the problem and they (the doctors) go in keeping with the nursing assessment. Nurses spend most of their time with the patient, the doctors tend to listen to us because of this. If for example we refer to a consultant, this consultant comes back to the nursing staff to ask what is going on. It's the same thing, it's a circular thing. The nursing staff identify the issues, the team (the doctors) do a referral to a consultant, then the nurse gives the consultant all the information they have on a patient. Nurses start it off, it goes round and comes back to nurses. I suppose, thinking about it, what I am saying is that by nurses identifying a problem they are sort of assessing capacity and the doctors tend to go with this as nurses have the biggest knowledge about the patients"* **(Participant F10).**

A number of participants indicated the essential nature of qualified nurse assessment of capacity and highlighted the significance of not doing this or not doing this in sufficient depth:

> *"Nurses are more approachable because we have more time with patients. Doctors flit in and out with a ward round or brief interventions of 5 minutes. Nurses have more interaction with the patient and flag up assessments should be done by the nurse rather than the doctor. I know there is not just us, there are other multi-disciplinary people but I would like to think that it would be us that flag if capacity assessment is needed. If we do not do this or assess ourselves there is a danger in not assessing at all and patients will get missed"* **(Participant F03).**

In addition, levels of experience of qualified nurses were regarded a potential barriers to effective nurse assessment of capacity status. Two participants, namely F01 and F06, alluded to less experienced nurses experiencing some hesitancy in articulating nursing opinions regarding the capacity status of patients in their care. Participant F06 discussed the potential for less experienced nurses to lack confidence in making assessments and in reporting the results of these to more experienced nurses and doctors. Participant F01 considered that occasionally less experienced nurses, when working with doctors, may be passive in assessing the capacity of patients and feel reluctant to voice differing opinions:

> *"I think that newly qualified nurses sometimes let doctors sign (consent forms) merrily away without giving their opinions if they think patients do not understand. They should say if they think patients do not have capacity, or if capacity is intermittent. I always encourage staff to speak up and say their concerns to the doctor otherwise patients do not know what they are having done. It is nurses who need to speak up about if patients are able to understand or not, this is important"* **(Participant F01).**

However, Participants F04 and F09, the least experienced of the 13 participants recruited to this study, had been qualified for three years at the time of interview. Their responses did not appear less detailed or insightful from other, more experienced participants.

Therefore, the informal assessment strategies used contained a variety of processes, the results of which appeared authoritative. Participants alluded to using recognised criteria to assess but assimilated these with their own methods, thus regarding their actions as informal. Added to this, assessing unobtrusively and not indicating to a patient that an assessment of capacity was ongoing, participants appeared to be gathering valuable information about patients which they regarded was more realistic and representative of actual levels of capacity of patients in their care. Depth of detail was revealed indicating a number of components of nursing assessment of capacity status, at the same time highlighting processes used. However, all participants revealed the complex nature of assessing the capacity of acutely and critically ill patients and discussed a number of factors upon which they focused. For purposes of clarity these are presented under the following headings:

- Visual assessment
- Listening to patients
- Physical Assessment
- Establishing a baseline

5.5.1 Visual Assessment

Participants described the impact of the appearance of patients as a stimulus to investigate further. This appeared to be an initial, often quick visual assessment but one which sometimes resulted in immediate follow-up. Participants alluded to walking past patients, observing from a distance whilst carrying out day-to-day nursing activities as a matter of co-incidence, or directly providing nursing interventions for patients and being alerted to what became the label, "something not quite right". They described responding to cues coming from patients which initiated a more in-depth nursing assessment:

> *"Sometimes you get a general feeling, it's something you can't quite put your finger on, if that makes sense. You just don't know what it is but you know that something is not quite right. You look at the patient and think that you need to follow up on what made you feel this. You are led into going to the patient because you want to check on them"* **(Participant F09).**

Whilst the appearance of a patient was influential, some participants articulated a particular focus on looking at the person in a holistic manner rather than simply the person as a patient and described being patient-centred in their approach in this respect. Here the eyes and face had a strong impact upon the conclusions and action of some participants, with Participant F06 using an analogy of "lights going out" and no "spark" present in the eyes of patients:

> *"It's not that they look at you with a blank expression, they can sometimes look at you and you can see that they are not there, not like a blank expression, but that they can't grasp things. Their facial expression looks like the lights have gone out, there is no spark there. They eyes and face can tell you so much. I think I focus on the head, face and eyes, then seeing the person further than this. It is the whole body language and what they are doing but the face and eyes give you the biggest signs"* **(Participant F06).**

Some participants also revealed particular focus on the quality of eye contact when interacting with patients. Here participants discussed using interpersonal skills in making assessments of the responses of patients as they investigated for indicators of capacity. These skills included understanding the need to engage with patients and also the need to interpret the ways in which patients presented. This was described by Participant F01 as "looking at patients to see if there were glimmers of capacity", namely, the presentation of patients evidenced appropriate non-verbal communication such as listening, and appearing to follow conversations:

> *"It's just whether they have eye contact with you or whether they can actually hold eye contact with you. Just subtle things like that where you think, yes he is here with me, is listening and there is listening going on. Some patients can't communicate but you have engaged with their face and they look at you. The way they do this can tell you if they have capacity. Their eyes can give you the expressions you are looking for"* (**Participant F03).**

The appearance of patients also encompassed their physical condition and all participants alluded to the unstable and unpredictable nature of these across acute and critical care settings. Participants described the need to make rapid assessments of visual appearance and recognised this may also reveal capacity status. Here they alluded to responding to physical and capacity status at the same time, regardless of what had actually prompted them to approach the patient:

> *"I notice if the patient changes colour even if observations are fine. I had one patient, there was something about him that I can't put into words, he looked a grey colour and there was something not quite right about him. There was nothing that I could put my finger on, but his colour had changed. We treated this as an urgent situation but there was nothing physical that would explain this. At the time I thought that he was odd, his behaviour was odd. I realised that he was confused. Later that night he had a major cardiac event"* **(Participant F08).**

In addition, being alerted by the demeanour of a patient was discussed which appeared to be a strong indicator that reinforced the opinion that "something was not quite right". Participants provided evidence that this added to the assessment of appearance and also appeared to reinforce their opinions that more in-depth assessment was needed:

> *"I had this patient, from the moment I clapped eyes on him, you should not assume, but he appeared completely lost in the sense that he was looking in awe, absolutely overwhelmed by what was going on. He had gone past the stage of being self-aware and I knew there was something wrong. There was nothing there just bewilderment. In fact he looked blank like somebody who is sedated in a way that they are coming around from an anaesthetic, they are looking at you vaguely"* **(Participant F03).**

5.5.2 Listening to Patients

In the need to assess capacity, the significance of making assessments of the ability of a patient to understand and retain information was highlighted by all participants. A variety of indicators were articulated as being utilised to measure and assess understanding and recall. In this respect participants described similar ways of listening to patients. These ranged from understanding and awareness of surroundings and events leading to admission to hospital, understanding and recall of information given whilst in hospital, and understanding of the types of behaviour to adopt whilst residing in hospital as an in-patient. These were described by Participant F05 as "being orientated to time, place, person and situation" which are universal and recognised criteria across urgent, acute and critical care settings. Also the ability of patients to make decisions based upon understanding and recall were considered to be significant:

> *"I look at the whole of the information the patient is giving back to me after I have explained it to them, or if the doctor has. I see if they can recall events leading up to their admission. If they can recall everything that happened to them and information they have had since admission. I question them on it, and if they say the same things again, even ask me questions, I get a picture that they know what has gone on and their capacity at that time is ok and they are aware"* **(Participant F07).**

Adding to this, the communication abilities of patients were used as indicators of capacity. Here participants articulated listening to patients during day-to-day interactions but at the same time assessing ability to understand and retain information. The nature and quality of the verbal responses of patients therefore provided participants with information upon which to make assessments of capacity status and form judgements and conclusions:

> *"When I assess mental capacity I have got to be happy that there is understanding of what I am saying, that the patient can retain information, but especially that they can answer me appropriately. The patient needs to be able to know the benefits of the pros and cons, and they understand and they can give me an answer back. I tend to know if they are not understanding, they can't repeat back, they can't understand why I am talking to them. It's the way they look, you look at them and they are not understanding, they are not verbalising back to you, you can't have a conversation with them. Sometimes they look at you with a totally blank expression and you get a feeling that they are not able to grasp what you are saying and they haven't got a clue how to respond to you. The conversation you get with them tells you a lot of things. You can be anxious and nervous but still understand and retain something and give appropriate answers back. Without capacity you are not able to have a conversation with the patient, you do not get back much from them"* **(Participant F06).**

5.5.3 Physical Assessment

Once participants suspected that patients appeared to have either fluctuating, diminished or no capacity, they described ways in which they continued to assess in the need to gather more information to confirm and justify initial conclusions of their assessment. Participants described making assessments of the physical status of patients once they had been alerted by appearance which gave them cause for concern, or odd behaviour that indicated confusion. Participants described adopting processes of elimination. Once they had concluded "something was not quite right" they described ways of proceeding to assess until they had excluded physical causes for the manner in which patients presented. Participants discussed the need to assess the physical status of patients and to establish differential diagnoses and, in doing so, reflected physiological markers related to their clinical specialities. They recognised the potential for physical reasons for odd behaviour, fluctuating capacity or complete lack of capacity. Participant F01 described "investigating for pyrexia that could indicate something more serious". Participant M02 discussed the need to investigate, "if the patient is in pain as too much of this can take capacity away". Participant F03 discussed the need to be vigilant about "altered levels of consciousness due to keto-acidosis, or under the influence of drugs or alcohol". Participant F12 described looking for a "trigger mechanism" to explain altered or absent capacity. All participants indicated they would be alert to an alteration, if not deterioration, in the physical status of patients if they assessed patients lacked capacity. Here they articulated and demonstrated the acute and complex nature of the presentations of patients in their care:

> *"Many patients have medical illnesses that affect their capacity and ability to understand. You assess, you do a clinical examination. You find out oxygen saturation levels, blood pressure, there may be reasons that affect their NEWS (National Early Warning Score). We have to be aware that clinical signs are important. Also the medication that the patient has taken could have a bearing on their awareness and ability to understand. Sometimes you do observations and there is nothing but you still think that something is not quite right. Maybe there is an infection or something brewing. Sometimes the patient looks off colour, pale, pasty, clammy, not their normal selves so you start looking for physical reasons for confusion, odd behaviour or lack of understanding"* **(Participant F05).**

Due to the time limited nature of acute and critical care environments and the unstable and unpredictable nature of the condition of patients, all participants highlighted the need to prioritise the physical assessment of patients and recognised the impact of physical condition upon levels of mental capacity. In this instance the assessment of capacity status became a secondary priority:

> *"We tend to deal with the physical first to get that under control because this is going to take over the patient. They may be in a great deal of pain which needs to be controlled. After this we can normally see if the patient has capacity and if they have other physical conditions that need to be managed. We tend to rule out any conditions and then make a judgement about capacity"* **(Participant F08).**

Participants alluded to gathering depth of information when using processes of elimination to rule out physical reasons for alteration in capacity status such as disease processes and/or their related symptoms. Once this was established, participants described ongoing processes in making attempts to reaffirm conclusions that patients lacked capacity and to establish the cause of incapacity:

> *"When a patient comes into an acute ward, you are watching them and receiving information. You can see things in the patient's mood or a patients' behaviour. If their condition changes there is sometimes a different aura around the patient, they can become withdrawn or they can go totally the other way. You are then looking for physical reasons and also if they are confused or disorientated. You can see a change in that patient even if you have only seen them and been with them for a short time. I think if you really assess your patient as a person and try to get to know them as much as you can this makes a big difference"* **(Participant F04).**

5.5.4 Establishing a Baseline

As part of an ongoing assessment process, all participants indicted that establishing a baseline and context for patients was a significant phase in the need to gather information in order to inform their judgement about capacity status. This occurred after initial assessment which indicated the capacity of the patient was fluctuating, diminished or absent. When physical reasons for alteration in level of capacity had been excluded, participants articulated a strong desire to establish what was "normal" for patients, such as, normal levels of behaviour, demeanour and communication skills. Here all participants highlighted the significance of the role of family and carers in gathering intelligence. They also recognised that being ill and admitted to hospital environments may have an adverse impact upon the capacity of patients:

> *"We need to find out what is normal for a patient. We ask the family because what they (patients) are like in the community may be nothing like they are in a hospital setting. If the patient is normally lucid and sensible, this confirms that the patient may lack capacity at this time"* **(Participant F01).**

The family unit of the patient was identified as being significant in the provision of information regarding establishing a baseline and starting point upon which to build an understanding of what was "normal". The need to make family and carers comfortable in acute and critical care environments was acknowledged as was the need to assess patients in the context of a family unit:

> *"Family have a valuable role as they know the patient. They have had a longer time with the patient than we have. I try to make relatives and carers as comfortable as possible so that they can come up with as many issues as possible and I will try and get as much information as I can. So it's sort of assessing the patient as an individual but you also need to assess them in a family unit, assess as a whole, that's their home unit. You need to be aware of their settings and their surroundings. You look at the family big time from the patients' journey to hospital and beyond, they play a big part in the patient's journey"* **(Participant F04).**

Participants also discussed using other sources of information in the need to establish a baseline for a patient. They identified using information, both oral and documented, from members of multi-professional teams who may have had prior involvement with patients:

> *"Because of the type of patient we get we tend to get information from social workers, district nurses, GPs, clinical nurse specialists who have seen patients in the community, or anybody else who has been involved with the patient. They can give us a lot of background that we can use as a starting point and this gives us a grounding. We try to access notes, we try to get any information we can if we have time and the patient is not too poorly. A lot will depend on past history as well, this can give you a good starting point"* **(Participant F05).**

Adding to this, participants alluded to the examination of clinical documentation to establish a starting point for the assessment of capacity. This was referred to as the "bar" by Participant F06 to start an assessment process and indicated a comprehensive approach in the gathering of intelligence of patient-specific detail. Again processes of elimination were used to ascertain probable causes of reduced or absent capacity:

> *"When you first meet patients you have got to look at them, for example, have they been confused before, have they had episodes like this before. It may be that they have got a urine infection and this has made them quite confused. You have to look at notes, past medical and nursing notes, previous admissions, any episodes of confusion. We go down the organic route, look at bloods, try to eliminate this first. If we cannot find any reason, we start thinking that lack of capacity is going to be a more permanent state. I would also probably look at medication to see if there is anything new or different there. It's basic stuff like this that we look at first. If the patient was ill they may know what is going on and can tell you that they understand. This is the bar to start assessing. If their condition changes I would be on medical alert and we would try to treat and stabilise or resolve the patient's condition*" **(Participant F06).**

The above illustrates the ongoing and investigative nature of assessment processes described by all participants. Individual strategies were discussed in the need to persist in exploring options and gathering information until participants were satisfied they could account for the ways in which the patient was presenting at a given time. Participant F09 articulated the need to, “keep going until I am satisfied that I have got all the information we need about a patient”. Participant F11 referred to this as “I would keep onto it until I got what I thought I needed”. This highlighted the need to fact find and to establish starting points from which to make clinical judgements about patients.

5.6 Influence of the Role of Others

The role of others was acknowledged in the provision of information which contributed to the assessment of capacity status of patients by participants. Others were identified as members of multi-professional teams and family and carers. The significant event in this instance was recognised as the actions of participants to invite others into assessment process. Relatives and carers were used to provide information regarding norms for patients. Multi-professional team members were consulted for similar reasons and also to provide information regarding previous care and treatment interventions. Referrals were made to doctors who were invited into assessment process to confirm or refute reduced or absent capacity, to reaffirm or change conclusions of nurse-led assessment and to formalise assessment processes. Table 15 summarises open codes and subcategories identified for the Category, Influence of the Role of Others:

Table15: Influence of the Role of Others: Summary of Open Codes and Subcategories

Open Code	Category	Subcategory
Role of family and carers	Influence of the role of others	Gathering information from family
Role of the multi-professional team		Making referrals and assimilating medical assessment into nursing assessment processes

Relatives and carers were used by participants in gathering intelligence regarding establishing baselines for patients in the need to ascertain patient-specific definitions of “normal”. However, participants described an on-going role for family and carers in processes of assessment which extended their role further than provision of information to establish baselines. All participants recognised the valuable information provided by relatives and tapped into insights of definitions of “normal” for patients. However, participants alluded to challenging timeframes in which they functioned in acute and critical care settings. The unstable and unpredictable nature of the physical status of patients often resulted in participants needing to gather and assimilate information rapidly and to assess in ways which were cognisant of the physiological priorities of patients:

> *"In a difficult situation, where a patient comes in and is very ill, I would assess how the patient was responding verbally, but I would also go on what the family said if they were there. If not, and there was time, I would get somebody to contact them. But it would have to be more than this so we would have to go with what we assessed as we waited for more information. With the luxury of time it would unfold and develop, but you haven't got time for this with acutely ill patients. Although even with acutely ill patients, most will be able to talk, communicate and you can get a sense of understanding and capacity"* **(Participant F09).**

In addition to requesting information from family and carers, Participant F12 provided evidence that assessments were made of the reactions of family members. This appeared to provide information which was used in the assessment of patients:

> *"The look of the relatives can tell you a lot about the patient. You can tell what the family unit is like and this sort of gives you some clues about the patient. Sometimes you can tell if the patient is really different or ill just by looking at the way the family is responding to the whole situation. They can look worried or upset especially if the patient is really confused. This can give you a few clues to what the patient is normally like before you start talking to them. Patients are usually very ill when they come into us so you've got to expect that relatives are going to be really anxious, they reflect how ill the patient is sometimes"* **(Participant F12).**

The context for this study is a geographical area containing many socially deprived communities which have experienced high levels of unemployment for many years since the demise of heavy industries for which the area was once renowned. Associated problems for communities are high risk health behaviours resulting in poor levels of health, poor levels of education and significant levels of poverty. One Participant (F13) demonstrated recognition of the impact of social deprivation upon patients and relatives and also appreciation of the need to factor this into assessment of capacity status. Here the family unit provided insight into the presentation of patient, thus unwittingly provided Participant F13 with information:

> *"Lots of our patients are affected by social issues outside of the hospital, they don't look after themselves. They come from very deprived areas. You meet families and you can see this, the family confirms things about the patient. These families very often have poor education and I think a lot of patients' capacity is affected by their education. Some of them don't know how to read and write. If you meet this kind of patient without the family you may not get this at first as patients usually are too ashamed to talk about it. When you see the family you think, yes that makes sense. To get patients to understand what's going on, we are taking about high level understanding. I am sorry I am not being derogatory, but your social circumstances, your education affect you greatly, your understanding and your ability to look after yourself and everything. If families or patients are not confident about speaking to us, they may feel stupid and intimidated. This can be very misleading, they may be poorly spoken and we haven't factored this in. If they have difficulty in expressing themselves due to their social and educational background we can misinterpret this"* **(Participant F13).**

Information appeared to be gained from families in two ways. Participants described ways on which they were directly asking for information and inviting contribution to inform assessment processes. Also family units and family dynamics were used to inform them regarding family and social context for patients. Participants described using verbal and implied information from families to inform nurse-led assessment processes.

Members of the multi-professional team were also recognised as being able to contribute in clarifying detail about the background and prior history of patients and in supporting nursing assessment of the mental capacity of patients and in taking this further. Participants, however, identified the significance of the doctor in the multi-professional team. They described processes and actions employed to make referrals and discussed their role and that of doctors in subsequent on-going assessments of patients.

In making referrals to doctors, all participants described caring for patients with complex health and social care needs, many of which were enduring. They also alluded to the on-going management of patients with mental health needs and the formal assessment of capacity processes required:

> *"Big assessments are done by the doctors, and if it is a complex individual with mental health issues they will ask for a full mental health assessment by qualified psychiatrists. That goes into a multi-disciplinary meeting about the capacity of the individual which we as nurses can feed into"* **(Participant M02).**

When caring for acutely ill patients, participants discussed working with doctors at the point of administering acute and critical clinical interventions in time limited situations. Participants alluded to working as members of multi-professional teams, at the same time influencing team assessments of the capacity status of patients by making nurse-focused contributions. Participants also highlighted differences in the role of the nurse and doctor in making capacity assessments and the ways in which patients responded to both professional groups. Here participants alluded to the informal, but essential, nature of nurse assessments and calling doctors in to formalise and continue assessment processes. Also the subconscious or automatic nature of nursing assessments were described. These differences were articulated by all participants:

> *"When I am working with a patient who is on a trolley I am looking to see if the patient can hold eye contact, or I am thinking subtle things like, yes he is here with me and there is listening going on. It's the way the patient responds to me as a nurse. The things that I am shouting across the trolley to the doctors is not the patient has got capacity, or he's consented to this, it's more I've got a pulse and an output. Some patients cannot communicate but you have engaged with their face, I will have done this and not the doctors, I may have done this before the doctors got there. So it would be me the nurse thinking about capacity and patients dignity more than doctors. I would then tell them that capacity is there or not there and they factor this in. This is what the nurse does in these situations and doctors know that. They tend to accept our opinions about patients"* **(Participant F03).**

However, the majority of contact with doctors involved the referrals made to them by participants after informal nurse-led assessments had taken place. All participants provided evidence that the reactions of patients were different to the nurse and doctor which resulted in differing depth of information gained to inform capacity assessment processes. Participants considered their close proximity to patients and the 24 hour exposure of the nursing role gave them opportunities to get to know patients and gave time for patients to feel more relaxed with them. As a result participants also indicated that their opinions and judgements of the capacity status of patients were generally accepted by doctors and used as the basis for medical assessments:

> *"We get the doctor to look at the patient but we will have done the assessment without the patient knowing. Patients are less intimidated by nurses. When they are approached by the doctor, this puts a lot of fright into some people. It's like when some patients go to their GP and get white coat syndrome and their blood pressure goes through the roof. Patients feel a lot more relaxed with us and I think they tell us more because we spend more time with them. They give information to us that they might not have given to the doctor so when the doctor comes and sees the patient we usually tell them what we think and the usually go along with this. Most of them know that we get much more information out of patients* **(Participant F04).**

All participants also alluded to their continued role once referral to doctors had been made. They discussed accompanying doctors who had attended a clinical area to conduct medical assessment of capacity status of patients. Participants outlined their role as reiterating and reinforcing information they had already given to doctors and trying to secure appropriate outcomes for patients. Here their role was described as patient advocate:

> *"I have been in situations where I have said there is something not quite right here, some of the things a patient is saying do not quite add up. Then when the doctor is with the patient I have reminded them that the patient will probably not be able to understand, so I have gone with them to see the patient. It is more difficult for doctors because they do not know the patients, especially the on-call doctors. So I will reiterate what I have found about the patient and tell them that it is out of character for that patient. I will back up my concerns as I think this is my role as advocate, I have to say what I have seen and heard, I have to give them a full picture so they can fully assess from their point of view. I would continue to keep pushing if I thought the doctor was getting it wrong. I think that if we think that something is not quite right we should go with these feelings. Maybe it's our inner self, we should be a proper advocate. I think it's the drive behind why we are nurses, we spend a lot of time with patients and we get a feeling about the patient. I always treat patients as I would like to be treated. I suppose what I am saying is that I always try to do the best that I can for patients. I will keep going until I think the team are getting it right, I would relay my concerns to the doctor until I thought that we were doing the right thing for the patient"* **(Participant F09).**

The accounts of the influence of others appeared multi-faceted. The need to gain depth and range of information was highlighted as was the need to make referrals to facilitate the on-going assessment and subsequent care and management of patients. Participants provided evidence in which they appeared to start capacity assessment processes and then make referrals to doctors. Participants described doctors' acceptance of nurse-led conclusions about patients and assimilating these into medical assessments. Participants also alluded to doctors conducting their own assessments using the Mini Mental State Examination. Evidence provided by participants indicated this did not appear to have much impact on assessment processes apart from appear to confirm what they had assessed using nurse-led processes. By their admission, participants did not consciously use what they considered formal assessment criteria, yet the formal assessments which participants considered were the role of the doctor did not appear to have any significant impact upon the assessments that participants had already initiated. In addition, participants described acting as advocates for patients in ensuring the achievement of accurate assessments of capacity. This was identified as an aspect of the role of the nurse in caring for patients who may be very ill and vulnerable.

5.7 Impact of Clinical Setting

The contexts of acute and critical hospital settings to which acutely ill patients were admitted were identified as having an impact upon both patients and participants. Participants demonstrated appreciation of a range of factors which influenced levels of capacity of patients and also the ability of patients to demonstrate the presence of capacity. It was also recognised that levels of capacity could fluctuate. Therefore, assessing capacity in context was significant as was the need to be cognisant of the notion of a capacity continuum. Here the patient could be placed on any point of a continuum and could move along this at any time. This suggested the need to stay vigilant to the capacity status of patients and reinforced the need to assess capacity on a continual basis. Table 16 summarises open codes and subcategories identified for the category, Impact of Clinical Setting:

Table 16: The Impact of Clinical Setting: Summary of Open Codes and Subcategories

Open Code	Category	Subcategory
Factors influencing capacity	Impact of clinical setting	Assessing in context
Influences on capacity assessment		Recognising the capacity continuum
Impact of environment		

The impact of setting upon patients was recognised as complex. It was also recognised that the nature of acute and critical care environments may exacerbate fear, anxiety and bewilderment of ill patients. This, in conjunction with physical symptoms of acute and/or critical illness, may render patients having reduced capacity, no capacity or inability to demonstrate the presence of capacity. Participants also appeared to be influenced by the complexity and time pressured nature of these environments and by the weight of responsibility in providing safe and appropriate care, at the same time assessing capacity status of patients:

> *"Patients get overwhelmed by being brought into a hospital environment. This can be daunting for many patients, the amount of people who are there, the speed, the noise. I think it all plays a big part, a big factor. They are scared at times, they see you rushing around and it all seems manic to them. Sometimes you can see they just want to get out of the environment as they feel they have lost control, they have no control over what is happening to them. If I can see this happening I try to reassure patients, sit down and talk to them, try to tell them what is happening, tell them that the unit is normally like this. Sometimes I leave them alone and observe from a distance to give them time to get used to it all. You have to take all of this into consideration when you are looking for ability to understand what is happening"* **(Participant F04).**

The impact of physical status upon the capacity of patients was discussed. Recognition was given to the implications of managing acutely ill patients who were experiencing symptoms that were distressing. The effects of pain and medication were identified as having significant impact upon capacity status. Also the effects of sudden, urgent admission to hospital environments and the complex nature and pace of these were acknowledged as adding to levels of fear and distress of patients. Levels of fear, anxiety and of being overwhelmed were articulated in detail, all of which were acknowledged as affecting the ability of patients to understand and retain information in order to make decisions:

> *"Patients look scared sometimes you can see the fear in their eyes, they are somewhere totally different. I always refer to myself in a theme park, somewhere where I would not enjoy and the panic I feel. I can see this in them. I can see their expression, you go up to them and they are not really talking to you. They have a vague expression because their eyes are wandering around everywhere else and they ask repeated questions, is everything all right? Is this Unit is normally this busy, do you always have this many patients? They want to be reassured that this is the norm, the busy pace is the norm"* **(Participant F04).**

All participants recognised that both seemingly straightforward and more complex health problems could affect the capacity status of patients. These combined with being frightened could erode capacity:

> *"We have very ill people who come in but they are not normally unconscious, so they are able to answer some questions. So we talk to them, but simple things like a UTI may mean that they are quite confused. They may be really ill and needing big surgery and sometimes the fright they might feel makes them seem a bit confused, they don't talk sense sometimes". At the time you have to decide if it is fear or a bigger physical reason for their confusion"* **(Participant F01).**

Also participants described complexities with which they were faced when making assessments of capacity status of patients who were frightened, in pain or experiencing any other symptom of acute and/or critical illness. They identified the need to establish capacity in patients who were fearful or those in intense pain and recognised that levels of capacity may fluctuate. They also indicated the limited time available for assessing physical status of patients added to the pressure of making accurate assessments:

> *"Sometimes the individual is in too much pain to have capacity. Therefore capacity is taken away from them by the fact that they cannot cognitively think because there is too much pain. This may be an emergency situation which you have to deal with you still have to get this right as so much rests on assessing capacity is not there, but the pain takes priority at that point. When this is settled you can get a more realistic picture. If the individual still cannot think cognitively when pain is controlled then you have to look further, you look for other physical reasons or you start to think that this individual may have been confused anyway. At this point you cannot rule out that you may have a very frightened individual, this can affect cognitive thinking, you have to take this into account"* **(Participant M02).**

The changing nature of capacity and the impact of illness combined with the acute nature of clinical settings appeared to be significant factors in assessing capacity status of patients. Participants articulated knowledge and awareness of the notion of fluctuating capacity and made reference to a range or degrees of capacity and also to the transitory nature of the capacity of acutely ill patients. These were described as "glimmers of capacity" (Participant F01). Reference was made by all participants to the potential for ebb and flow of lucid moments and to capacity returning if physical symptoms were managed and alleviated:

> *"The capacity of ill patients has to be affected, capacity has to be fluctuating for everybody to a certain extent, especially for patients in hospital, who are in pain, or ill, or confused, or frightened. There seems to be a range of capacity and you have to assess where they (the patient) are at any point in time. How do you interpret degrees of capacity, for us this is an issue? We start off with thinking that everybody has capacity then you have to factor certain things in"* **(Participant F13).**

The need for continual assessment of capacity was articulated by participants due to the impact of experiencing acute illness and the impact of clinical setting, both having an influence on levels of capacity of patients. The interactions with patients described by participants focused on the need to assess understanding and awareness of patients due to the realisation that capacity status could change at any time. Participants described a capacity continuum, a range of capacity, from no capacity to full capacity with levels of capacity appearing to fluctuate at points between the two.

In articulating the need to provide timely healthcare interventions for acutely and critically ill patients who may be vulnerable due to the transitory nature of mental capacity, all participants alluded to the importance of demonstrating a kind and caring approach towards patients who were challenged by unfamiliar and frightening environments to which they had been admitted. This consisted of making attempts to ensure that patients received information, primarily to begin processes to assess understanding and also to affirm a starting point for assessing patients. This demonstrated consistency with the starting tenet of the Mental Capacity Act 2005 that capacity must be assumed unless it is proven otherwise. Participants also articulated a need to demonstrate a caring and person-centred approach to patients who were experiencing distressing symptoms and who may not have sufficient capacity to be fully aware of their circumstances. In this respect they were consistent in their responses despite representing a range of acute and critical clinical settings:

> *"We have many patients with problems of communication. Some are very unwell, some patients have MS, and you take all of this into account and not just assume that because they have got these issues they do not have capacity. Sometimes we have patients with Alzheimers, who do not know where they are or what time of day it is. I think as nurses we look at the bigger picture to see that they still might have some qualities there that they should be supported to have some independence and choice. We cannot assume that they do not have capacity and we have to try to give them information like any other patient. We need to be aware of the needs of all patients, most of these will be ill and very frightened. Many will think they are going to die. Acutely ill patients can be very vulnerable"* **(Participant F10).**

5.8 Caring Role of the Nurse

The caring role of the nurse was highlighted which consisted of a number of components. It was recognised that the patient needing acute and/or critical care interventions was at the centre of the context of this study. Therefore processes employed to assess capacity status involved participants leading and co-ordinating assessments and on-going support which was necessary to assess and manage patients whose capacity was in question, whose capacity could fluctuate or who had sufficient capacity to make decisions. Table 17 summarises open codes and subcategories identified for the category, Caring Role of the Nurse:

Table 17: Caring Role of the Nurse: Summary of Open Codes and Subcategories

Open Code	Category	Subcategory
Decision making	Caring role of the nurse	Safeguarding standards of assessment and outcomes (nursing and multi-professional)
Supporting the rights of patients		Advocating for patients
Assessing best interests		Protecting decision making abilities of patients
Caring role of the nurse		
Legal position of the nurse		

Participants made reference to a number of aspects of their caring role as they articulated what they did to assess and care for acutely and critically ill patients. They appeared have a strong professional drive to secure what they regarded as the best outcomes for patients during nurse-led and multi-professional assessment processes. As they made referrals to doctors to continue and formalise assessment processes, participants described making attempts to safeguard the quality of these. The professional drive of participants was articulated in what they regarded as their responsibility. They demonstrated awareness of their accountability when making decisions about the capacity status of patients and expressed concerns regarding the difficulty in assessing capacity. They regarded this as clinically challenging due to the complex mix of physical symptoms of patients, their unstable clinical status and the impact of the clinical environment upon them, often in time pressurised situations. They also alluded that capacity was difficult to interpret and assess:

> *"It is hard to assess capacity. You can't see it like a physical symptom, but you have to interpret the signs of it like how patients look, how they behave, the way they respond to you. This is such a grey area, not black and white, and is really hard to get right. It's a matter of interpretation. When you factor in the very ill patient there is little time for this but these patients may have capacity and will need to make decisions. We have responsibility to get this right because all patients need support due to being ill"* **(Participant F11).**

Also some participants demonstrated awareness of the implications of assessing and arriving at conclusions that a patient lacked capacity. They regarded this as a significant responsibility, the implications of which were considerable for patients because they were potentially denying patients opportunities to make their own decisions. They expressed some hesitancy about doing this as this would enable them and the wider multi-professional team to provide care and treatment without the consent of patients. They articulated this as eroding autonomy of patients and recognised that they may make decisions on behalf of patients which could have significant implications due to side effects of some treatments. One participant described this as "taking a part of the person away" which appeared to refer to depriving patients of autonomy and their rights. This Participant also suggested that concluding a patient was without capacity was stigmatising (F09). All participants regarded themselves as advocates for patients and considered that assessing capacity accurately was an essential aspect of their advocacy role:

> *"There is a big stigma to saying that a patient is without capacity. If I am questioning capacity, I would prefer to say that they are not capable to decide for themselves, that they are not in the right place to make decisions like this. To be honest I am a little bit intimidated to say that a patient does not have capacity. If I do, I feel as though it's taking away such a big part of the person. I feel that being an advocate means that we have to assess properly, if not we take decisions away from a patient which is a really big thing. Making decisions on behalf of a patient is a big responsibility. We should not label a patient as being without capacity lightly, there in a danger in saying without capacity and also in not assessing regularly to see if they have regained any capacity"* **(Participant F09).**

The caring role of the nurse in supporting the rights of patients was evident when participants discussed the need to support decision making abilities for those with capacity, and acting in the best interests for those without capacity. Reference was made to the duty of the nurse to assess accurately and the challenges of doing this without much prior knowledge about patients was acknowledged. Participants referred to their professionalism and linked this to sound judgement in the need to make accurate assessments of capacity status. They also linked making decisions for patients to protecting them, the basis for which were accurate capacity assessment:

> *"Your judgement comes down to your professionalism. You have got a duty to assess the patient. Your judgement is when you make a decision as a professional and you think something needs to be done here. You have got to assess everything to get it right so that when you assess a patient does not have capacity you are saying the right thing. Your judgement is your professionalism to protect your patient because you will have to make decisions for them and this is without their consent. That's a big responsibility, especially with us as we usually don't know patients before them come into us. Patients should be able to make decisions if they are able to, they have a right to do this and we have to make sure we protect this. The ones we make decisions for also need to be protected, we have to get it right for them in their best interests this is how we support their rights"* **(Participant F12).**

When working directly with doctors participants regarded their role as overseeing the quality of assessment of capacity processes and also of the ways patients were managed. This included providing information for those with sufficient capacity to make decisions and making decisions in the best interests for those without capacity. Participants described their advocacy role as speaking up on behalf of patients to ensure that capacity status was represented in an accurate manner. This also included reiterating information to ensure understanding or seeking information from family to inform assessment processes. However, participants described the need to be professionally assertive when working with doctors to ensure that patients were supported and their best interests were served:

> *"I think sometimes doctors railroad patients into surgery and perhaps this is not the best thing for them. They may not be fully aware of what is going on and the doctor is standing over them saying sign this form. I advocate for patients, I always say, do you understand what the doctor has said to you, can you tell me what he has said to you and what do you think you are going to have done. If I think the patient is not aware of what is happening and they do not have full understanding I will speak to the doctors and also get more information from family. If the patient is not with it and their capacity is reduced I will say this to the doctors and make sure that we are going with best interests, if surgery is the best thing for that patient. If a patient is proven to have intermittent capacity I will say this to the doctor. I will also say that I do not think that the patient is able to sign the consent form and there is no understanding. I would easily say to a doctor you cannot let them sign a consent form as they do not know what they are having done. Sometimes the doctors do not see the bigger picture, we are with the patients on the ward and we have first-hand knowledge about the patient".* **(Participant F01).**

The advocacy role of participants was also highlighted when they discussed the urgent care of acutely and critically ill patients and the need to prioritise interventions. They acknowledged the occasional primacy of clinical imperatives to preserve life and to stabilise patients. They also acknowledged that capacity assessment sometimes came later. However, advocacy was linked to securing the best outcomes for patients in the justification of best interests. Participants defined their role as advocate in a broad sense and linked this to assessing and securing the best interests of patients:

> *"When we get a call to say that someone is coming in and they are very unwell capacity is pretty low down on the list. When we get the patient it's all about the ABCDE approach, we are trying to save the life of the patient and when things settle down we will then actually think about the capacity of the patient. Our priority at the time is dealing with the life threatening stuff in front of us. This is about us deciding on the best interests of the unwell patient even though we do not assess capacity at that point. It's about doing our best for that patient at that time and we then deal with the less urgent stuff. I like to think that we do our best by prioritising physical status when there is no time to waste. Best interests is about this as well as longer term things like assessing capacity once the patient is stabilised. We advocate for patients in this way"* **(Participant F03).**

For patients with capacity and able to make decisions, the advocacy role of participants was linked to the need to reassure patients, to support them, calm them and begin to help them feel settled in acute and/or critical care environments. All participants described this as essential to enable them to determine what was "normal" for patients and to enable them to assess best interests. In addition, participants highlighted the importance of ways in which information was provided to patients and recognised their role as advocate included supporting the decision making abilities of patients:

> *"Helping a patient to settle and reassuring them can go some way to calming them down. This gives the nurse a better chance of doing what is best for the patient as you can sometimes see what they are normally like. I always go to my patients and ask is there anything that they don't understand especially when the doctors have spoken to them. They need nurses do to this as they feel more comfortable with us and we can support them to make decisions. I always try to talk to the patient as much as possible as soon as they come in. Sometimes we can overload patients with information and it's no wonder that they seem disorientated. They have the right to make decisions and to change their minds and I think we should be there for them, to make them feel comfortable and to advocate for them if needed. The nurse plays a very big role in advocacy for the patient"* **(Participant F04).**

Supporting the rights of patients in a multi-professional approach was regarded as a significant aspect of the role of participants. They discussed qualified nurses supporting each other and being assertive in the need to serve the best interests of patients and to support the rights of patients. However, emphasis was placed upon the importance of multi-professional decision making in serving the needs of patients. Participant F03 articulated that "all information needs to be put together" and one professional group cannot be "arrogant" to presume that they assess patients in isolation. The team approach was considered to be the most effective for depth of assessment processes. Here Participant F06 alluded to establish a "hook" upon which to base nursing judgements of reduced or no capacity before making referrals to doctors. This "hook" consisted of information indicating clinical imperatives and perceived priorities to provide doctors with helpful, clinically focused information as a starting point to more formal assessments of capacity by doctors. Two participants, M02 and F10, also appeared to express a degree of passion regarding this aspect of their role and alluded to fighting for the rights of patients:

> *"We have joint meetings to look at things together when we are concerned about the capacity of patients. If we raise concerns we get the community nurses in, we look at this as a group. It is not just the nurses and doctors, in hospital we are in a false situation here because we can't see what goes on at home. I try to fight for the patients' rights, to get the care for them that we can. I try to influence the team about what is best for patients. If patients have got full capacity and they want to go home, then I will fight for this, even when community staff say that the house is a hovel. The patient has a right to choose and we should try to support this as best we can. I try to support the patient in the choices they make"* **(Participant F10).**

In discussing supporting the rights of patients, serving best interests and their advocacy role, all participants recognised the legal implications of their actions and their legal position in a multi-professional team approach. They recognised the central role they had in the assessment of capacity status of patients and also their influence upon multi-professional processes. Here they alluded to a developing role of the nurse:

> *"We have a lot of, not so much control, but a lot of effect on a patient. We are in very powerful positions if you want to say that. We are able to help patients make the biggest decisions of their lives. So yes, there is a lot of legal emphasis on what we do and nurses are becoming more autonomous and need to be legally aware. We have taken some of the legal responsibilities away from the doctor. We are a lot more experienced and we do a lot more education. I think this is good as we are in a good place to help patients make the biggest decisions of their lives"* **(Participant F04).**

Developing the role of the nurse was also considered to be required due to pragmatic reasons. Participants F01 and F10 alluded to processes of assessment being slow with unacceptable timescales in doctor to doctor referrals, where expertise of other medical practitioners was needed or required. This resulted in a perceived increase in anxiety for patients who were in situations in which their best interests were not served:

> *"Sometimes referring patients is unmanageable and takes too long. We (qualified nurses) can usually get doctors on the ward quickly but if they need to refer the patient on it can take ages. The patients and relatives get fed up and so do we as we are not able to do our best for the patients. There must be an easier way of assessing patients, there must be some kind of process to speed things up to say whether at that particular time the patient has capacity or not. Nurses can do this and that would free things up without waiting. I think doctors would have something to say but I think nurses have the skill and information about patients to do this. It would make all our lives easier especially the patients"* **(Participant F01).**

In linking their caring role to what they regarded as their central role in processes of assessment, some participants indicated that they would like to have a guide or framework to assess the capacity of patients in their care and considered this would support them in their assessment of patients. Participant F04 highlighted the time-limited nature of caring for acutely and critically ill patients and the need to have "something that could be used quickly but not tick boxes". Participant F11 suggested a "guide or a structure or something to support asking questions and having an outcome". Participant F13 used the term "framework" in suggesting the need to support assessment processes that needed to be systematic. Participants appeared to recognise that the developing role of the qualified nurse in initiating and managing process of assessment required a tool or guide which may assist in formalising what they did to assess capacity. They also recognised that there was a need to document what they did to assess and record their conclusions about the capacity status of patients. Participants M02 and F03 discussed the professional and legal requirements to leave evidence trails that would stand scrutiny in environments that are "litigation driven" (Participant F03). Nursing documentation was considered to be an appropriate way of doing this and also to add to what doctors documented in the medical notes of patients:

> *"Formal assessments (of capacity) are not done for day-to-day care, nurses give care according to the needs of patients and write this in the nursing record. For less urgent situations, for example, putting in a PEG (percutaneous, endoscopic gastrostomy tube), I would get the doctors to do a formal assessment and they document this in the notes. I do not do the formal assessments although doctors ask me all the time what I think. They usually listen to me as I have been with the patient longer than them. We agree what we think about the patient and we write this in our notes. Them in the patients' notes and me in the nursing record"* **(Participant F06).**

Data analysis processes revealed the caring and developing role of the nurse in the assessment of capacity status and on-going management of patients. Participants alluded to initiating processes of assessment and influencing standards and outcomes of the multi-professional team. The concept of advocacy appeared to be well understood by participants and they linked this to protecting the decision making abilities of patients. Also participants articulated the need to advocate for patients in securing what they considered the best outcomes for them.

5.9 Conclusion

This chapter has explored the key findings of this study. These include the ways that qualified nurses use informal processes to assess the mental capacity of acutely and critically ill adult patients in their care. These processes are informed by a variety of criteria, such as personal, legal, professional and clinical. Of note is the apparent hidden nature and depth of assessment. Qualified nurses appear to assess patients in real time as they execute their day-to-day care and management interventions. They do this as nurses and also as members of the multi-professional team. Processes and strategies used to assess from initiation through to completion and on-going perpetuation are nurse initiated, influenced and managed. Findings reveal that the caring role of the nurse is evident but also significant when supporting acutely and/or critically ill patients who may be vulnerable, frightened and physically compromised.

Findings also confirm and explain the theory of Nurse Managed Patient Focused Assessment and Care to account for the ways in which qualified nurses assess the mental capacity of adult patients and support their ingoing care and management.

Chapter 6: Discussion

6.1 Introduction

This chapter reviews the key findings of this study in relation to existing literature. In doing so, it sets out a theoretical framework of the grounded theory for this study, Nurse Managed Patient Focused Assessment and Care. This explains how participants in this study articulate how they respond to acutely and critically ill adult patients in their care, are informed by influencing factors, conduct informal assessments of mental capacity and contribute to and manage on-going processes of assessment and care of acutely and critically ill adult patients. This theory also highlights the caring role of the qualified nurse in meeting the holistic needs of patients and in supporting autonomy and essential rights.

This framework encompasses the paradigm of Corbin and Strauss (2008) and reference is made to the theoretical paradigm model of the relationship between categories and subcategories. A concluding section presents the grounded theory of Nurse Managed Patient Focused Assessment and Care. A visual representation of this is provided with Figure 2 (page 178) and Figure 3 (page 179), illustrating the theory of how qualified nurses assess the mental capacity of acutely and/or critically ill adult patients in their care and their role and interactions in multi-professional processes of assessment.

6.2 The Presentation of the Patient

The lead into the theory of Nurse Managed Patient Focused Assessment and Care is the central phenomenon of this study which is identified as the presentation of adult patients who are admitted to acute and critical clinical environments within hospital settings for a range of reasons. These patients may have a variety of healthcare needs of differing levels of acuity, complexity and severity, all of which may present and manifest in different ways. In addition, the reactions and responses of each patient to their admission to acute or critical hospital environments may be unique and individualised and may impact upon the manner of their presentation to qualified nurses. This study demonstrates that the presentation of patients is a significant factor for the qualified nurse in setting circumstances leading to processes of initial and on-going assessment and management of patients. The complexities of the needs of patients are acknowledged by participants in this study when considering the levels of patient acuity, especially when critically ill patients may be placed in acute ward settings in addition to specialised units (Bench 2007). For this reason, it is well recognised that the physiological and psychological status of acutely and critically ill patients can be unstable and ever-changing and there is a need for practitioners to be vigilant and to assess on a continual basis (NICE 2007, NPSA 2007, Higgins et al 2008, Banner 2012). Timely responses by practitioners are therefore essential to assess and intervene in the care of acutely and critically ill patients (Day 2003, Aird and McIntosh 2004, Johnstone et al 2007, Oakey and Slade 2010).

Furthermore, it has been noted that physical illness may have a significant impact on the capacity status of acutely ill patients and their ability to make decisions (Raymont 2004, Owen 2009, Fassassi et al 2009, Burton et al 2012, Stevens 2013). Some patients with acute physical illness may have difficulty in processing information necessary to give an informed consent due to a number of factors such as pain, fear, hypoxia or the effects of medication and/or illness (Jacob et al 2005, Applelbaum 2007a, Akinsanya et al 2009, Cork 2014). Findings in this study suggest that acutely or critically ill adult patients may experience altered levels of mental capacity due to a range of factors associated with their physical condition and/or their emotional response to being admitted to fast-moving clinical settings. This may not result in a complete lack of capacity, but rather capacity is diminished or is not sufficient at a given time to enable patients to make decisions. Here the concept of fluctuating capacity is significant, as patients may be distracted and not able to process information which may result in their ability to make decisions being temporarily lost (Cassaret et al 2003, Palmer et al 2005, White-Bateman et al 2007 Emmett et al 2013).

Alternatively, some patients may have a complete lack of capacity due to the intensity of their physical and/or psychological status which may result in complex presentations for which the qualified nurse has to remain alert (Aird and McIntosh 2004, Odell et al 2009, Griffiths 2015). Awareness of the surveillance necessary to respond to the presentation of patients is demonstrated by participants in this study. They also appear cognisant of the potential for the deterioration in the physical condition of patients which may be proceeded or accompanied by deterioration in levels of awareness and lucidity.This may affect capacity and decision making abilities. Therefore, the mental capacity of patients may be compromised by a range of factors of varying degrees of acuity and complexity and can be ever changing (Hodgetts et al 2002, Mohammed et al 2009, Hands et al 2013).

Interpretation of data in this study highlight the importance of the physical and professional proximity of qualified nurses to patients, with their ever-present status placing them in prime positions to be responsive to the presentation of patients. This appears to result in depth of knowledge about patients and their social circumstances and enables qualified nurses to inform and support other professionals who may also contribute to the assessment, care and management of patients. However, the proximity of qualified nurses to patients may only be advantageous if the presentation of patients is actually observed, investigated and provides a base for the engagement of effective processes of assessment and care. Acute and critical clinical settings present qualified nurses with a number of challenges which may impact upon opportunities to do this effectively and in some depth. These include levels of staff and the skill mix of staff (Twigg et al 2012).

Evidence suggests that qualified nurse staffing levels and the skill mix of levels of nursing staff, both registered and unregistered, can have significant impact upon patient outcomes (Twigg et al 2012, Ball et al 2013). Whilst both of these did not feature in the findings of this study as such, they are worthy of note as acute and critical care settings are dynamic and, by implication, are unpredictable regarding numbers and types of staff available at any one time to meet the levels of dependency of patients (Dubois et al 2013).

A cross sectional survey of 2917 qualified nurses working in 401 general medical and surgical wards in 46 general acute NHS hospitals in England concluded that lower nurse staffing levels are associated with poor patient outcomes (Ball et al 2013). This indicated that 86% of qualified nurses reported that one or more nursing activities had not been carried out due to lack of time on their last shift. Furthermore, the aspect of nursing care reported to be most frequently left undone was comforting or talking to patients (66%). A recent systematic interpretive review conducted in Canada reported similar conclusions in linking qualified nurse staffing levels to the quality of patient outcomes and the efficacy of care and management interventions (Dubois et al 2013). This review also reported links between levels of patient dependency and resultant workloads of qualified nurses to the quality of outcomes of patients. Here it was observed that inappropriate staffing levels and/or the demands of the workload of nurses may not necessarily result in patient harm but may reduce the “nurse surveillance function”, thus creating conditions in which patients are not assessed in depth, or not assessed at all due to the need to initiate assessments being missed (Dubois et al 2013 page 15).

The conclusions of both the cross sectional survey and systematic interpretive review above would therefore appear to be significant when applied to data in this study which indicate that participants allude to responding to the presentation of patients by being in close proximity to them, being exposed to them and by communicating with them. Levels and availability of staff may therefore appear to be influential in acute and critical care environments due to the time-limited nature of these and the pressures of meeting the needs of many ill patients simultaneously. Such complexity is compounded by the range of physical and emotional presentations of patients and the need to be vigilant in responding to these, as the lead into processes of assessment and subsequent care and management. This study, therefore, highlights the importance placed by qualified nurses on the presentation of patients as a lead into nurse managed aspects of the theory of Nurse Managed Patient Focused Assessment and Care.

6.3 Factors Informing Nurse Managed Assessment

The conditions that encompass the central phenomenon of the theoretical framework for this study represent the qualified nurse response to the presentation of patients and the ways in which participants are informed, use, gather and interpret information which serve as the foundation of subsequent actions resulting in the employment of initial and ongoing processes of assessment.

The ability of the nurse to make timely and accurate clinical assessments and to provide appropriate care and management interventions is essential to the delivery of safe and effective nursing care in fast moving clinical settings (Johnstone et al 2007, Perez and Folse 2011). In particular is the need for nurses to accurately identify a change and/or potential deterioration in the condition of patients and to conduct swift and effective processes of assessment. Clinical assessment and decision making are therefore identified as vital functions of the nurse, especially in the consideration of the wellbeing of patients (Higgins et al 2008). Also, the speed with which decisions are made, the establishment of priorities and their accuracy are fundamental to the safety and wellbeing of patients with acute and/or critical health care needs (Crosskerry 2003, Adshead and Thompson 2009, Pearson 2013). Speedy and effective decision making processes are therefore regarded as fundamental in clinical settings in which the physical condition of patients is unpredictable with the potential to deteriorate. Precursors to these processes are the ways in which nurses are informed that assessments are indicated.

Participants in this study appear to be influenced by a number of issues which inform their judgement that patients in their care require further investigation. The criteria upon which these judgements are made are subjective, informal and personal to each participant, although all describe similar personal criteria and personal definitions, despite working across a variety of acute and critical care settings. These include personal standards such as perceptions of "normal" frames of mind, "normal" behaviour or the ability of patients to have a "normal" conversation. These also include professional expectations, for example, behaviour expected of hospitalised patients and expectations of patients when demonstrating decision making abilities, and therefore mental capacity, in clinical settings. This indicates that subjective data may be used to inform assessment processes which is recognised in published research (Cork 2014).

It is suggested that nurses rely heavily on subjective data to recognise patients in early states of physical deterioration. Such data are subjective as personal criteria are used, such as own interpretations, preferences and knowledge gained by learning through past experiences (Morrison and Symes 2011). Nurses recognise that patients are different, that there are things about patients which alert them or that patients present in ways which are similar to previous patients to which they have been exposed (Coffi 2000, Morrison and Symes 2011, Cork 2014). This results in nurses processing and assimilating what they observe with personal expectations and past experiences. They may do this rapidly, in real time, as they respond to what they encounter and cues which they observe and interpret (Coffi and Markham 1997, Coffi 1998, Coffi 2000, Morrison and Symes 2011, Cork 2014). It is also recognised that nurses use memories of similar patient scenarios or situations to assimilate physiological and psychological cues and to put these together in the need to assess in a holistic manner. This often results in recognition of patterns which are compared to what is already known (Evans 2005, Elliot 2010). The use of subjective indicators, therefore, appears a plausible lead into processes of assessment in time limited clinical settings.

This study highlights that, whilst assessment tools exist to support the assessment of capacity status of patients, there is no specific nursing focused tool available which would be suitable to be used by qualified nurses in acute and critical care settings. As a result, the use of subjective data such as personal standards, recall of prior experiences and the application of individual clinical judgement become more significant, as nurses sometimes rely on these in the absence of anything else (Odell 2015). It is noted by Odell (2015) that, for some patient presentations, little use is made of objective data by nurses as a result of using pre-defined assessment tools and physiological markers, such as blood results or x-rays, when assessing the needs of patients in emergency departments. This is due, in part, to a lack of objective data available at a time when an urgent assessment needs to take place, but also that nurses initially use their own subjective criteria in ways that are rapid, unconscious and effective (Odell 2015). Furthermore, reliance on subjective criteria is evident even when objective data, such as scoring criteria, blood results, x-ray and previous notes, are at hand. It would appear that subjective data is utilised, in the first instance, in the need to form rapid assessments of patients in time-limited contexts, objective data may then be used to support and/or confirm detail needed to assess. (Gerdtz and Bucknall 2001, Perez and Folse 2011, Odell 2015).

In the absence of specific, formal tools to assess the mental capacity of patients, participants in this study indicate reliance on personal definitions, use of personal standards and prior experience. This results in the use of subjective data to inform assessments of adult patients. Tools designed to generate specific objective data in these clinical contexts appear to be limited, with participants indicating the Mini Mental State Examination (MMSE) the only tool in use and mainly applied by doctors.

Due to the individualised, unpredictable and co-incidental nature of the application of subjective data, there is general agreement that there is a need to improve upon and standardise processes of assessment for acutely and critically ill patients (Kolic et al 2015). Here the focus is upon the assessment of the physical status of patients. Thus, the increasing use of assessment tools such as early warning scoring systems, or track and trigger systems as they are also known, across acute, urgent and critical care settings has represented an attempt to improve the efficacy of assessment strategies in the need to ensure systematic and objective approaches to patient assessment (Oakey and Slade 2006, Johnstone et al 2007, Higgins et al 2008). These are regarded as an oversimplified solution to the complex problem of patient deterioration (Odell 2015) but are in widespread use across acute and critical clinical settings, in an attempt to improve the performance of nurses and others in the assessment of physically ill patients who have the potential to deteriorate (McAuthur-Rouse 2001, Rose 2011). These operate by allocating points to vital sign measurements on the basis of physiological deviations from a predetermined normal value and points are aggregated to create a numerical score which directs the nurse and others to suggested predefined routes for action (Adshead and Thomson 2009).

Despite national recognition that there is a need to identify the deteriorating patient in a swift and timely manner (NICE 2007, Kolic et al 2015), there is minimal evidence that patient outcomes have improved significantly as a result of the introduction and use of these scoring systems, although the reasons for this are not entirely clear (Fullerton et al 2012). One suggestion is that nurses do not use scoring criteria in an appropriate manner, as the numerical value placed upon the status of patients when a scoring tool is applied is not recognised across different professional groups, rending the score meaningless. The effectiveness of a scoring process is therefore limited as a result (Mohammed et al 2009, Odell 2015). Another plausible reason is the suggestion that nurses prefer to rely on their own subjective criteria when they make "fast and frugal" judgements and decisions about levels of patient acuity (Johnstone et al 2007 page 222). The assertion here is that this appears to be more effective than sole reliance on scoring systems, especially so as some physiological parameters may not be a sufficient trigger to instigate a score which indicates response and action are needed (Ryan et al 2012). This may result in scoring systems which are not valued and therefore considered ineffectual (Johnstone et al 2007). This is compounded by the time limited nature of very acute situations when nurses have pressing clinical priorities other than using scoring systems (Ryan et al 2012). Also, the abilities and competence of individual nurses may impact upon the use and application of pre-determined criteria, as would their desire to use them. The suggestion is, however, that the judgement of nurses, based on subjective criteria, should be utilised in conjunction with decision making tools which generate objective data such as early warning scoring systems. The physical proximity of nurses to patients and the constant surveillance that occurs as a result is not only essential but valuable in the need to establish triggers to processes of assessment (Crocker and Timmons 2008, Fullerton et al 2012). However, this proximity will only be effective if nurses provide appropriate responses and interventions.

Whilst assessment tools such as early warning scoring systems are not directly related to the context of this study, there are valuable parallels of principle. Participants in this study confirm the use of subjective criteria in the main to form judgements about patients, as participants do not consider they currently have any other alternative apart from the MMSE. Participants indicate this is not valued highly due to its perceived limitations but is used by some to a small extent. Therefore, this is not used to any effect by participants in this study when assessing the capacity status of patients. As the initial literature review in Chapter 2 of this study indicates, assessment tools and interview guides for assessing and evaluating the mental capacity of patients have been developed and used with some success in some clinical settings with elderly patients, those with acute confusion and those with mental health problems (Grisso et al 1997, Smithline et al 1999, Raymont 2002, Appelbaum 2007a, Okai et al 2007, Brown et al 2013). These do not relate directly to the role and function of the nurse or to acute and critical care environments in which the condition of patients can be unstable and ever changing and often require urgent clinical attention. These assessment tools and interview guides may also be regarded as problematic to use in fast moving clinical settings due to, for example, the length of time taken to use them and the requirement of some that prior knowledge of the patient is assumed for their application (Lamont et al 2013). There are also further limitations to the use of tools due to an inconsistency of conclusions made and their applicability when used by a range of clinicians (Owen et al 2007, Fassassi et al 2009, Hein et al 2014).

This study highlights the use of subjective, personalised criteria in the absence of anything else, despite the knowledge of participants about the MMSE and its use by one participant, Participant F03, in particular. The perceived informal nature of assessment processes employed by participants would appear to justify the use of subjective criteria in the delivery of routine nursing care and management interventions. There are, however, limitations in the use of personalised, subjective criteria to inform assessment processes. The individualised nature of these and nuances of different approaches taken are informed by the knowledge, skill, culture and sum of experiences of the practitioner (Lynch et al 2012). This may lead to unpredictable and unsystematic approaches to assessment with the potential for variable outcomes (Prytherch et al 2010). When taking a cognitive approach to assessing mental capacity, it is observed that reliance on clinical judgement is inferior when compared with objective physiological markers and psychological assessments based on rating scales (Banner 2012). Reliable criteria and testing procedures facilitate transparent and standardised approaches (Banner 2012). This view, however, is predicated on the assumption that mental capacity can be measured in an objective manner and there is general agreement that when using assessment tools, clinicians often reach very different conclusions about capacity when simply using pre-defined tools in blinkered ways (Kim 2006, Lammot et al 2013). Some capacity assessment tools are also complex and time consuming to use and may therefore not be suitable for use in clinical settings where the needs of patients may be ever-changing (Emmet at al 2013). This would appear to reinforce the notion that assessment tools may complement clinical judgement and not replace it (Morrison and Symes 2011, Odell 2015).

Despite the lack of directly related research about the ways in which qualified nurses assess the mental capacity of adult patients, there is some discussion regarding the nursing role in assessing levels of delirium in patients in critical care settings. Participants in this study do not mention delirium when discussing mental capacity, but delirium is increasingly used as a clinical label to describe confused states in elderly patients across acute care settings (Schofield et al 2012). However, this is of some relevance here as there are similarities between delirium and mental capacity, although both are recognised as different concepts (Schuumans et al 2001, Schofield et al 2012). Mental capacity and delirium are characterised by fluctuating mental status and confusion, both of which are components that impact upon capacity and decision making abilities (Devlin et al 2008). Evidence suggests that nurses are not effective at recognising delirium and consistently underestimate incidence of this in those patients who are acutely and/or critically ill. Therefore, the use of objective assessment tools may go some way to remedy this situation (Lemiengre et al 2006, Devlin et al 2008, Steis and Fick 2008). This is partly supported by a recent study in the Netherlands which used a retrospective patient record review and examined influences on nursing adherence to the use of a delirium observation screening scale (Ijkema et al 2014). A total of 1881 patient records were examined. In 55% of these the screening tool was used which resulted in 44% of patients identified with a high risk of delirium. A significant methodological limitation in this case relates to the review of patient records which the authors identified may not correspond to actual care received by patients, as standards of record keeping can be highly variable with many being often inadequate. However, the conclusions are of relevance as it was observed that the use of screening tools by nurses can be moderately successful. Their use were influenced by the presentations and characteristics of patients which necessitated nurses needing to be flexible in their approach in meeting the needs of acutely ill patients. Ijkema et al (2014) support the view that is not sufficient to simply follow assessment or screening tools strictly or in a formulaic manner, rather these should be used in conjunction with clinical judgement in the context of clinical imperatives.

The use of subjective and objective criteria to assess delirium have been compared in an observational cohort study in a 31 bedded cardio-thoracic surgical intensive care unit in a university hospital in Germany (Guenthar et al 2012). The delirium status of patients were rated and assessed daily by qualified nurses on the basis of subjective, individual clinical impressions. These were compared with the assessment and rating of the same patients by medical students on the basis of the use of a pre-defined and objective assessment tool. 106

patients were identified as suitable for analysis and the rating and assessment of these, both by nurses and medical students, resulted in the analysis of 436 patient observations of assessment. Delirium was recognised in 26% of patients (n=114) in observations when objective criteria were used by medical students. This percentage included 6.4% of patients (n=28) in whom delirium was not recognised when subjective criteria were applied by nurses. In the application of subjective criteria by nurses, delirium was assessed as present in 29.4% of patients (n=128), with 9.6% (n=42) of these having no objective indications of delirium. This study concludes that nurses underestimated the incidence of delirium and also medicated a total of 8 patients inappropriately where there was no evidence of these having delirium when objective criteria were applied by medical students. Such conclusions are, however, predicated on the accuracy of the pre-defined assessment tool used and the manner of its application. In addition, a significant limitation of this study appears to be that medical students were given five, 15 minute educational sessions on the use of the tool before the start of this study, whereas the 147 nurses had no prior knowledge of this. The manner of these sessions may have influenced the ways in which these students applied this tool. Also, the qualified nurses had at least 5 years experience in critical care settings. The differences in levels of knowledge, experience and exposure to critical care contexts would appear, therefore, to question the validity of conclusions made.

However, despite the limitation of the study by Guenthar et al (2012), the suggestion that nurses underestimate levels of delirium in patients is of note in critical care settings. When this is applied to the context of assessing the mental capacity of patients, the implication is that this may also be underestimated. Whilst this is not evident in the accounts of participants in this study as they articulate how they assess the mental capacity of patients, this suggests that further research in this area may be indicated. Therefore, a qualitative study using an ethnographic approach may further interrogate the findings of this study to establish how the informal processes used by participants work across acute and critical care settings and the reliability and validity of these. This may be a precursor to further work to develop a tool or guide which can be used by qualified nurses to assess the mental capacity of patients.

The variable nature of the results of assessment processes when subjective or objective criteria are used are therefore highlighted. This is compounded with the acknowledgement that some assessment tools are complex and open to interpretation (Smith et al 2013). These are factors which may inhibit effective assessment of patients and stymie the application of clinical judgement. Rather, it is suggested that nurses should use their views and judgements to assess patients alongside assessment tools despite the potential for the variable nature of individual judgement (Schuurmans et al 2001, Kyriacos 2011, Aydin 2014). A key component of this study identifies that informal assessment processes are not a panacea for effective and detailed assessments, rather formal and informal processes may complement and inform each other. Participants, in using informal processes of assessment, consider they assess in sufficient detail to make decisions regarding the capacity status of patients in their care. They therefore use a variety of personal and subjective data, although the recurring theme highlighted in the literature regarding the use of clinical judgement in combination with pre-defined tools in the assessment of patients is acknowledged. This study demonstrates the use of subjective data to inform assessment processes and indicates that levels of detail appear to be achieved by participants. However, the use of individual and subjective data are unpredictable and predicated upon the knowledge, expertise and abilities of those in close proximity to patients. This would appear to imply the need for a tool or guide, supported by programmes of education and training, to inform processes of assessment and one which may inform and support clinical judgement. This may also inform clinical practice in this area of assessment and care of acutely and critically ill patients. Evidence in published literature appears to indicate that tools using scoring systems have limited success in the context of assessing the physiological status of patients (Mohammed et al 2009, Odell 2015). Equally, evidence suggests that the use of structured tools to assess the mental capacity of hospitalised patients may lead to unpredictable and inconsistent results and that some tools are complex to use and are not appropriate for fast-moving clinical settings (Kim 2006, Emmet et al 2013, Lammot et al 2013). The notable lack of evidence of the use of structured tools to assess the mental capacity of adult patients in acute and critical care settings would indicate the need for the development of a tool or guide which would be suitable for efficient and timely application in fast-moving clinical environments. It is regarded that this is one of the key recommendations of this study.

6.4 Nurse-Led Assessment

The actions implicit in the theoretical framework in this study are represented by the actions of participants in response to the presentation of patients. These consist of processes and strategies for the immediate and on-going assessment of mental capacity and care of patients. The significance of the need for nurses to conduct these assessments is recognised as is the need to make timely decisions about patients (Baid 2006, Stevens 2013). Furthermore, it is also recognised that nurses have a good understanding of capacity issues and the implications for patients despite the complexity of clinical settings in which physical illness and impaired or absent capacity are linked (Wilson et al 2010, Lamont et al 2013). This necessitates approaches in which assumptions are not made that a patient is lacking in capacity if behaviour displayed gives cause for concern (Moye and Marson 2007, Newberry and Patchet 2008, Jones 2014) although having the time and opportunity to interrogate such concerns are challenging in acute and critical care settings (Chow et al 2010, Jones 2014a). This may be compounded by the fact that assessing mental capacity is difficult and susceptible to the interpretation of individual nurses (Avery 2013, Jones 2014).

The challenges and difficulties in assessing mental capacity are reflected by participants in this study with Participant F11 stating, "you can't see it like a physical symptom, but you have to interpret the signs of it". Therefore, a continuous approach must be taken to assessment as capacity may be transitory and may fluctuate according to the condition of the patient and the environment in which the patient is cared for (Lamont et al 2013, Humphreys et al 2014). Capacity is both time and decision-specific and it is well established that capacity can fluctuate (Re MB 1997, Stevens 2013, Jones 2014). The descriptions of participants in this study indicate depth of knowledge regarding the transitory nature of capacity which is described as a capacity continuum and in which the ebb and flow of capacity is acknowledged (Carroll 2010, Coggan and Miola 2011, Griffiths and Tengnah 2014, Dimond 2015). In particular, participants acknowledge that the condition of patients may change due to, for example, the effects of hypoxia, hypoglycaemia or sepsis. The concept of a capacity continuum is therefore significant as it suggests continuity of process and vigilance in the need to ensure effective and accurate assessments of capacity status.

6.4.1 An Intuitive Response

Acute and critical care environments may often require assessments of patients which are conducted with speed and may involve and include situations where qualified nurses recognise changes in the condition of patients in their care as a result. These are often described as gut feelings and a sixth sense, "something you cannot put your finger on", knowing that something is going to happen and using past experiences and recall of patterns stored in memory (Coiffi 2000 page 110). These themes occur frequently in published literature with authors using similar language, such as having feelings of unease or of concern about patients or that something is not quite right (Coiffi 2000a, Coiffi 2001, Andrews and Waterman 2005, Lyneham et al 2008, Cork 2014).

This study demonstrates that the views and opinions based on the application of subjective data by participants results in the recognition of "something not quite right". This label occurs frequently and appears to represent informal descriptions that encompass a range of concerns about the appearance of patients, types of behaviour displayed, communication abilities and/or the physiological status of patients. Interpretation of data also suggest that similar experiences, words and phrases are used to describe feelings of concern about patients. This is worthy of note as participants represent a range of clinical backgrounds and have varying clinical experience across acute and critical care settings. Furthermore, participants use language which appears to be common across the clinical contexts represented by them.

Of note is the context for the study by Coiffi (2000) above which relates to the experiences of nurses in assessing the physiological status of patients. This signals that similar techniques may be used for assessments of physiological and capacity status of patients. Such techniques include making rapid observations of patients which are based on feelings of concern, or increasing worry that there is something different about a patient. Also, techniques include seeking the opinion of others to validate initial concerns, in particular when difficulty is experienced in articulating the reasons for feelings of unease and concern (Odell et al 2009, Ludikhuize et al 2012, Cork 2014). Participants in this study indicate they assess physical and capacity status of patients in their care simultaneously which, in view of the clinical environments in which they practice, may be regarded as an anticipated, clinically effective and time-efficient way of assessing the needs of patients. This further implies that assessing capacity status is not a separate process and should be placed in the context of the individual presentation of each patient. This may provide a more holistic and accurate view of the status of patients and take account of timely clinical imperatives and the need to support the autonomy and decision-making abilities of patients. This is regarded as a key contribution of this study which may be used to inform a fundamental aspect of assessment processes employed by qualified nurses.

An exploratory study using questionnaires and a semi-structured interviews to explore the ability of qualified nurses (n=36) to recognise and manage patient deterioration in emergency departments in London UK (Tippins 2005), presents relevant findings in the context of the above discussion. Qualified nurses responded to obvious signs of deterioration in patients such as physical appearance and "looking awful" (Tippins 2005 p 28). They could recognise patient deterioration from feeling that something was not quite right but had difficulty in articulating what that actually was. Here the influence of using clinical judgement was regarded as significant in addition to the use of recognised assessment tools, such as the Glasgow Coma Scale. Also highlighted was the need to assess both physical markers and other reasons for the presentation of the patient. In addition, Tippins (2005) indicates that continuity of care based on subjective data and intuition was a necessity for effective assessment in complex clinical environments. This signposts the potential value of intuitive, personalised nursing responses which are generally underestimated (Andrews and Waterman 2005, Effken 2007, Higgs and Jones 2008, Robert et al 2014).

The role of intuition in nursing has been the subject of some debate. This involves the practitioner not being consciously aware of their practice because they are familiar with it. It therefore becomes part of their being and they are deeply involved in the environment in which they function (Benner and Tanner 1987, Lyneham et al 2008a, Lake et al 2009). An intuitive response is also directly linked with the label something not quite right (Cork 2014), a response which is becoming an increasingly acceptable way of thinking and knowing in clinical decision making (Pearson 2013, Robert et al 2014). There is also recognition that intuition is linked with perceptions which are characterised as the direct detection of environmental information consisting of complex relationships and patterns that are meaningful (Green 2012). Therefore, there is a suggestion that intuition is a recognition skill which is used to assist assessment, in turn leading the nurse to meaningful action that is patient-centred. Intuition is a result of direct perception of information which is used to initiate and inform assessment processes (Robert et al 2014).

This study demonstrates that terms such as “feelings” and “gut feelings” are used interchangeably, the expression of which are associated with informal and unconscious assessment processes. Interpretation of data suggests these feelings about patients are the result of rapid and detailed assessment processes which are in response to evidence arising from the patient and their clinical situation. Published evidence recognises that intuition is not mystical or irrational but a product of the interaction of knowledge, expertise and experience and of knowing a patient directly (McCutcheon and Pinscombe 2001, Perez and Folse 2011). The intuitive response is regarded as being based on the application of the sum of knowledge and experience of nurses to patient situations and the rapid processing of hard evidence arising from such situations. Also, evidence can be gained from other sources such as the family who are identified as valuable resources regarding background information needed for patient assessment (Minick and Harvey 2003, Tippins 2005, Emmet et al 2013). The intuitive response, therefore, is about recognition of all of these things (Kahnerman 2011).

For most participants in this study, the articulation of “feelings” or “gut feelings” poses some difficulty. Findings suggest this can be attributed to the speed by which information is processed and the informal, day-to-day context in which this occurs in administering care and management interventions and carrying out usual nursing routines. In addition, there appears lack of appreciation and realisation regarding the depth of processes, knowledge and skill applied when rapidly assessing patients on informal bases. This lack of appreciation may also appear to be attributed to a dearth of opportunity and encouragement to reflect upon own practices to facilitate self-realisation of nuances and depth of function. Some participants indicate they have not really thought about their use of “gut feelings” or appreciate the value of these. This is consistent with published evidence in which similar issues are reported (Cork 2014). Furthermore, it is suggested that making reference to “gut feelings” tends to diminish the validity of intuition as critical thinking processes that are used rapidly and which are important when making timely responses to situations in which there is potential for the deterioration of patients (Robert et al 2014). In clinical environments where evidence based approaches to healthcare are the required norm and regarded as authoritative, this may result in hesitancy in regarding intuitive responses as significant and may also deter practitioners reflecting and acting upon them (Santiano et al 2009, Ludikhuize et al 2012).

This study indicates that conclusions regarding the use of “gut feelings” appear the result of analytical processes, ones which are employed by participants as they assess and manage patients. They describe processes for gathering and assimilating information about patients in their care and allude to doing this with speed as they interact with patients. A counter-view asserts that intuitive responses and decisions do not involve analytical thinking processes (Pearson 2013). This view acknowledges that subjective data are based on individual interpretations and may vary greatly between practitioners. Also, recall and processing of subjective information is restricted by the capacity of the memory of individual practitioners (Pearson 2013). However, this study suggests that this view can be challenged with the suggestion that intuitive thought can be ordered, rational and logical and is an essential part of decision-making processes (Traynor et al 2010, Morrison and Symes 2011). Participants in this study allude to using similar techniques across differing clinical settings which suggests some consistency based on their descriptions of actions and thought processes despite their different clinical backgrounds.

The speed with which participants respond to and interact with patients and the context of day-to-day routines appear to indicate that processes of elimination are employed to reach conclusions about the capacity status of patients. These consists of gathering information to establish baselines for patients and adopting processes of elimination to exclude physiological reasons which may account for the presentation of patients. Also, the speed with which this is done appears to add to the lack of realisation by participants of the depth and complexity of actions taken to arrive at conclusions about patients. Processes of elimination are linked to the application of intuitive thoughts and rapid analysis which can assist in prioritising the complex needs of patients (Lake et al 2009). The principles implicit in these processes are likened to hypothesis testing, the latter carried out in order to choose one of several options. This view suggests that nurses recognise signs, symptoms and cues which are analysed in real time and synthesised with existing knowledge and other subjective and objective data. Hypotheses are then created based on the gathering of evidence which, in turn, results in the nurse ruling out some hypotheses, gathering more evidence until they are satisfied that they have a credible explanation for the presentation and context of the patient (Ramezani-Badr et al 2009, Pearson 2013). This then enables effective prioritisation based on a range of clinical imperatives (Lake et al 2009).

Processes of elimination may also be applied unconsciously and may be instinctive. Debate within the literature suggests that intuition is linked to unconscious thought (Kahneman 2011). This is regarded as effective where nurses receive much information, processing this rapidly if necessary, and often articulate this as being carried out unconsciously (Nyatanga and de Vocht 2008). However, to ensure that unconscious thought is effective it is important that the nurse has access to sufficient data and relevant information. Thus, the nurse needs to have a store of information to ensure that personal, subjective data are available at the point at which they are needed and that data are synthesised and used appropriately when required. Also memory, and therefore the unconscious, need to be supplied with new information on a continual basis (Nyatanga and de Vocht 2008).

Process of elimination, therefore, appear to be credible explanations for supplying the nurse and, by implication their unconscious thoughts, with new information. Participants in this study describe the ways they assess the mental capacity of patients as they carry out their normal nursing functions and routines. They do not consider that they actually assess capacity or use pre-defined assessment tools. They also do not consider that what they do is in any depth and describe their actions as unconscious. As they pursue information, which will provide them with reasonable explanations for the ways in which patients present, participants indicate they gather information which gives them new meaningful data. When this is combined with conscious thought, the nurse has a considerable armoury of information upon which to call (Nyatanga and de Vocht 2008). Such an armoury may include a range of subtle data that will enable a nurse to "sweep" a situation and gain a great deal of factual information about, for example, physical signs of disease and normal patient responses and knowledge (Green 2012 page 106). Data in this study also highlight the processing of information on both conscious and unconscious levels. This is referred to as cognitive intuition and is the:

> *"..consequence of a relationship between knowledge and experience and occurs in clinical situations where action appears to precede assessment or appears in the consciousness without any evidence of processing. However, the clinical incident can be rationalised and explained in hindsight"* (Lyneham et al 2008 page 383).

The ability to rationalise and explain using hindsight adds to knowledge and insight and when subtle clinical signs are observed the nurse unconsciously looks for what has been seen and experienced in previous patient presentations and encounters. This type of intuition involves using stored memory, learning and prior analysis that can only be tapped when connections are made between these (Lyneham et al 2008).

6.4.2 An Intuitive Response in Other Professional Groups

Whilst this study is focused on the role and function of qualified nurses in acute and critical clinical settings, the phenomena of gut feelings, namely feelings of concern and/or unease which cannot be easily articulated, and intuition in other professional groups is recognised in published literature. Here the debate regarding the appropriateness and accuracy of intuitive responses to assessment and management of patients is similar in principle to that related to nursing. Clinical intuition is acknowledged amongst doctors and its historical use recognised (Chew et al 2014). However, the effectiveness of this is regarded as inferior when compared to using risk assessment and management scoring pre-defined tools. The assertion is that clinical intuition is highly individualistic, inaccurate, poorly correlated between clinicians, and only effective in supporting detection of extreme patient presentations (Chew et al 2014).

Alternatively, in an observational prospective study of the presentation of children and young people (n=3890) assessed clinically as having non-severe illness to general practice settings in Belgium, it was observed that gut feelings have diagnostic value and were specific in that they resulted in GPs assessing levels of seriousness of symptoms of patients. 6 (0.2%) were admitted to hospital and it was reported that responding to gut feelings prevented 2 of these 6 patients being missed (Van den Bruel et al 2012). Whilst statistically 0.2% may not be regarded as significant, clinically diagnosing two patients appropriately would appear to be valuable. It was observed that clinical reasoning involves the integration of intuitive and analytical processes which, in turn, involves the rapid framing of a problem, looking for specific features including "red flags" and connecting these to an existing "mental model" (Van den Bruel et al 2012 page 3). This has strong resonance with the debate in nursing about the value of an intuitive response. Of particular relevance is the suggestion that having gut feelings that something is wrong should stimulate in-depth assessment and/or examination and seeking advice from more experienced clinicians if appropriate (Van den Bruel et al 2012).

Expressing gut feelings, which may indicate the seriousness of situations, have also been recognised in the practice of social work. It is noted that repression of gut feelings may lead to confusion and indecisiveness regarding actions to take which may result in things being missed or no action taken (Ingram 2013). In this respect, gut feelings are linked to the emotional responses of social workers. These should be considered and explored as they can result in the initiating of investigative processes. These feelings should therefore be encouraged as a result. However, fears about being labelled as judgemental and unprofessional are regarded as barriers to social workers expressing and acting upon emotional and intuitive responses. This may result in the risk of "uncritical and repressed practice" (Ingram 2013 page 11).

Furthermore, links are made to the repression of gut feeling and levels of experience (Lynch et al 2012). Less experienced practitioners may rely more on procedures and tools to guide practice than more experienced counterparts due to lack of confidence and lack of knowledge and experience. This can result in gut feelings and intuitive thoughts remaining unspoken due to inexperience and lack of confidence regarding the ways that an articulation of these may be received by other professionals (King and Macleod Clark 2001, Lyneham et al 2008, Ingram 2013). Findings in this study suggest that participants were not differentiated by their levels of experience in their descriptions of how they assessed the capacity status of patients in their care. Two participants, F04 and F09, were qualified nurses of three years duration at the time of interview but their responses were no less insightful or in-depth than those with many more years experience. They articulated with some confidence the reporting of their opinions and judgements about the mental capacity of patients when making referrals to doctors. This was also observed by Van den Bruel et al (2012) who assert that levels of experience of GPs does not impact upon the use and effectiveness of gut feelings in the assessment of patients. In addition, evidence in published literature reports that more experienced practitioners may articulate gut feelings more frequently, something that they cannot articulate initially and admit to using these in the assessment and management of patients, due to levels of professional and clinical confidence. Here, these feelings may act as a type of early warning system which may indicate potential problems that warrant further investigation (Langridge et al 2015). This is reported in a qualitative study in Southampton which explored processes used by experienced, extended scope physiotherapists to articulate clinical reasoning methods used by them in making decisions about patients reporting low back pain (Langridge et al 2015). This study used a multiple case study design informed by grounded theory methodology, using focus groups and semi-structured interviews. It was found that gut feelings formed part of clinical reasoning processes, these were acted upon as a type of early warning system or alert mechanisms and enhanced the efficacy of assessment processes. This resulted in the provision of services that were responsive to the needs of patients (Langridge et al 2015).

6.4.3 A Context for an Intuitive Response

This study demonstrates that rapid unconscious thought do not occur in isolation, as responding to the presentation of patients and beginning processes of assessment occur simultaneously in real time. The articulation of “something not quite right” about patients, at the same time approaching patients, rapidly assessing appearance, behaviour, ability to hold eye contact and ability to have a conversation, results in conclusions which are articulated as the “look” of the patient. This has some acknowledgement in the literature where the look or appearance of patients results in the nurse scanning the patient and their environment which often results in a rapid initiation of processes of assessment (Edwards 2007, Lyneham et al 2008a). This study also demonstrates that assessing in a rapid and responsive manner to what is observed often results in the articulation of “gut feelings” which appear to act as types of early warning systems that lead to the application of conscious thought processes which are then used to assess patients in detail and to take the assessment further. Therefore, the intuitive response and the expression of having feelings is highlighted as one aspect of a cocktail of many related components of assessment. Other components are gathering layers of detail upon which to inform nursing clinical judgement that on-going assessment and care is indicated and making subsequent referrals to doctors to facilitate multi-professional contribution to assessment of capacity processes. This study, therefore, makes a unique contribution to inform the practice of qualified nurses in this respect by demonstrating the speed and depth of processes of the assessment of mental capacity which are informed by a range of elements. These findings may also inform the education of qualified nurses in the need to improve awareness and enhance critical analysis of what is identified as a fundamental role of the nurse. This study has captured the views and accounts of 13 participants. Whilst the unique contribution of this study has revealed depth of process of assessment, this is based on the accounts of these participants and therefore the reliability and validity of these assessment processes in clinical practice may be questioned. This indicates that further research is needed to establish how these processes work in the reality of fast-moving acute and critical clinical settings. This implies that a qualitative study using an ethnographic approach may be indicated to explore the reliability and validity of these assessment processes "in the field" by qualified nurses across acute and critical care settings.

6.4.4 Nurse Managed Decision Making

This study demonstrates that decisions made by participants are central to the assessment of capacity processes employed by them, in particular when making initial and/or repeated referrals to doctors. Decisions are made in response to the presentation of patients and decision making processes used through each aspect of the assessment of capacity status of patients. Decision making is the subject of some discussion in published literature. Terms such as clinical judgement, decision making and problem solving are used interchangeably to suggest an endpoint to thinking processes (Tanner 2006, Simmons 2010). Terms such as reasoning or clinical reasoning are used to describe processes by which nurses make judgements and include deliberate processes of generating alternatives, comparing these against existing evidence and choosing the most appropriate for a particular situation (Tanner 2006). Clinical reasoning is also considered to involve formal and informal strategies to collect and analyse information (Banning 2007).

The manner in which nurses use their clinical judgement and make decisions is complex (Bucknall 2003, Tanner 2006). Sound and effective reasoning and judgement requires a flexible approach and ability to recognise and act upon the presentation of patients in unpredictable clinical situations. Practitioners must adopt a manner of decision making with a high degree of specificity and sensitivity (Harper et al 2007, Mulryan 2011). Also, effective nursing clinical judgement needs to be cognisant of physiological and emotional parameters and the impact of the illness experience for patients, including their coping strategies (Bucknall 2000, Tanner 2006). Adding to this is the complexity of the nature of acute and critical clinical settings. In these, the status of patients is unpredictable and timeframes often pressurised. Research on the role and function of nurses in acute care settings indicate that the context has a significant influence on the exercise of clinical judgement and decision making processes. These are influenced by levels of patient acuity and the need for swift clinical response (Ebright et al 2003). This may result in poor decisions being made, such as inaccurate assessments of patients and the administration of inappropriate care and management interventions, due to pressures of time, levels of patient dependency upon nursing staff and levels of acuity of the condition of patients. This may also result in no decisions being made if the need to intervene on behalf of patients is missed (Odell et al 2009). This is consistent with some criticism of nurses in that deteriorating patients are not recognised and assessed in acute care environments (West 2006, NICE 2007, Bender et al 2013). Exacerbating this is a potential for the fragmentation of care in acute and critical environments where patients may be exposed to multiple members of multi-professional teams and where patients may be transferred across specialised wards and units during the course of an admission to hospital (Bender et al 2013). Whist participants in this study highlight the complex and time-limited nature of the clinical settings in which they work, they do not suggest that decision making processes do not occur and articulate processes which are the result of how they respond to and assess patients in their care. The potential for poor care, however, is acknowledged by them which relates to approaches that may be narrow in focus and that may miss essential detail due to the pace and pressures of workload.

Furthermore, the complexity and time limited nature of acute and critical care environments is such that practitioners are required to make an unusually high number of decisions, many of which may be of a complex nature, in the course of their day-to-day function (Crosskerry 2002, Cork 2014). Many patients will not be known to practitioners and their illnesses are seen though only small windows of focus and time. This is compounded by the pressures of workload and limited time to meet the complex needs of patients (Crosskerry 2002). Also, nurses are required to lead and manage highly complicated processes, such as managing the needs of family, managing patient placement to appropriate levels of care, co-ordinating the admission and discharge of patients and co-ordinating referrals to other professionals. These are in addition to assessing and managing the individual needs of patients on a day-to-day basis as the ever present professional group in hospital settings (Tanner 2006). As a result, practitioners may not methodically go through systematic approaches to decision making, instead they develop strategies that are rapid and informal which reduce decision complexity and build economy in the process as they respond to the needs of patients (Crosskerry 2013). The assertion here is that they have the knowledge, skills and confidence to use their clinical judgement and not to confine themselves to pre-determined decision making tools and processes (Crosskerry 2013). This has been described as "flesh and blood decision making" (Crosskerry 2003 page 775) which saves time and resources. This type of decision making is described as real decision making at the front line, when practitioners have to prioritise, when time constraints apply and when efficient solutions are being sought, often in an unconscious manner (Crosskerry 2003a). Therefore, acute and critical care settings may provide practitioners with little time and poor access to information and are where heuristics dominate which provide short cuts in problem solving and clinical decision making in responding to the conditions of patients (Higgs et al 2001, Crosskerry 2013, Bodemer et al 2015). This suggests that recognition and analytical processes leading to the articulation of "gut feelings" appear to precede fast and real time decision making, without resorting to structured approaches to support decisions. Heuristics therefore can be regarded as cognitive processes that can simplify decision making. These are shortcuts or strategies that achieve abbreviation and avoid a laborious working through of all known options in the course of problem solving. Heuristics denote the everyday intuitive decisions that practitioners make without resorting to a formal decision making criteria (Kovacs and Crosskerry 1999**,** Crosskerry 2000, Hoffman et al 2004, Simmons 2010).

However, heuristic approaches may be unpredictable and unreliable when based on the application of individual knowledge and skill of practitioners. These processes are informal and highly individualistic regardless their application by differing by professional groups (Bodemer et al 2015).They are also considered to be less accurate than more systematic approaches when used by doctors (Klein 2005) and introduce bias into medical decision making processes due to their dependency upon individualistic nuances, although it is noted that bias and heuristics have not been investigated sufficiently in real time decision making where doctors are interacting with patients (Blumenthal-Barby and Krieger 2015). Parallels may therefore be made with nursing as, in principle, decision making processes may be regarded as similar in acute and critical care environments regardless of professional groups to which practitioners belong. This implies that there is little related research in this area also.

Research suggests that time pressurised settings require responsiveness to levels of patient acuity (Judd 2005, Lyneham et al 2008b, Simmons 2010) in which practitioners link heuristic processes and clinical reasoning thus processing, assimilating and differentiating clinical evidence according to its usefulness and application to a specific patient (Simmons et al 2003, Carr 2004, Kuiper and Pesut 2004, Banning 2008). Furthermore, it is recognised that heuristics can represent a significant category of decision making tools in urgent clinical settings when used by doctors (Bodemer et al 2015). These authors acknowledge the risk of doctors making errors in diagnosis and therefore treating inappropriately as a result when applying heuristic approaches. However, the assertion is that some patients require speedy and urgent responses, in particular those with narrow time frames within which some treatments are effective, such as patients with acute myocardial infarcts. In these instances heuristic approaches are preferable to those which require the use of structured decision making tools and it is asserted that speed is not necessarily accompanied by less accuracy. However, further evidence would therefore appear to be needed to establish which approach is more reliable and valid (Bodemer et al 2015).

Whilst making judgements about the mental capacity of patients may not be as acute or urgent as those needed for some physical conditions, the need for accuracy and timely responses are no different. This study suggests that approaches used to make decisions about the mental capacity of patients appear to involve similar techniques to assessment of physical status and indicate that timelines are not differentiated. The approach taken is holistic in which mental capacity is not seen as a stand-alone entity but linked to the physical assessment of patients. Also demonstrated in the descriptions of participants are that informal strategies for decision making appear to include heuristics. Findings indicate that participants describe how they gather information, simultaneously analysing it and evaluating its significance in real time. Personal and subjective methods are used rapidly and occur without pre-defined criteria. Judgements are made about the capacity status of patients and about making subsequent referrals to doctors. This is articulated as “something not quite right”, which appears an unassuming, but common, label for layers of information gathering and conclusions about the status of patients. Participants allude to using what is described as cognitive flexibility which enables a nurse to simultaneously access cues, determine their relevance, apply knowledge and experience and evaluate the value of data and possible interventions (Simmons 2010).

These findings have important clinical implications due to the responsibility and significance of assessing that the mental capacity of patients is compromised or absent. This highlights the challenges for qualified nurses in assessing the presentation of patients and the complex nature of actually conducting assessments and making subsequent decisions. Also, the need for the qualified nurse to be open to possibilities and to be cognitively flexible is evident when faced with complex patient scenarios. It is acknowledged that serious and altered physiological states of patients can add to the challenge of assessing mental capacity and careful assessment is needed to ensure that it is decision-specific and applies to the time when assessment is indicated, rather than a more global approach (Akinsanya et al 2009, Carroll 2010). Findings in this study suggest that participants articulate the use of heuristic methods to assess quickly and in some detail and also make referrals to doctors to facilitate multi-professional approaches to care and management of patients.

6.4.5 Making Referrals

Nurse managed elements of processes to assess capacity status of patients by qualified nurses are highlighted in this study. The role of the doctor is also highlighted from the perspective of qualified nurses. Data suggest the value and strength of a nursing team approach and the importance of obtaining nursing second opinions regarding the accuracy of capacity assessments as appropriate. In the need to facilitate the ongoing assessment of the mental capacity of patients, referrals to doctors are made once initial nursing assessments are completed and judgements made about capacity status. Decisions are then made regarding the need for medical intervention where participants describe taking a co-ordinating and leading role in informing and managing some processes of multi-professional assessment of capacity.

Findings indicate assessment processes appear circular, the starting point of which are nurse initiated processes which precede referral to doctors and which appear to result in a pooling of nursing and medical information during and after medical assessments of patients. Nurse-led assessment of the capacity status of patients appears to continue after doctors have left clinical environments. This suggests an assessment of capacity cycle which may therefore be regarded as a process framework or structure to support strategies to assess the capacity status of patients. In this respect, this study therefore makes a contribution to existing knowledge which may inform future clinical practice. Participants allude to doctors conducting assessments using the MMSE, but findings indicate this does not appear to have any impact on assessment processes apart from appearing to confirm what nurses had assessed using nurse-focused informal methods. These findings, however, represent the views of participants, qualified nurses, and therefore caution should be exercised regarding the acceptance and assimilation of the conclusions of qualified nurses by doctors.

Data in this study indicate some dissonance with some tenets of published research, where the latter suggest that nurses lack confidence in their judgements and are unsure about making referrals to medical teams (Odell et al 2009). This is attributed to lack of confidence fuelled by fears of making inaccurate assessments of the condition of patients and also appearing to have insufficient knowledge about the physical status of patients (Hogan 2006). This study demonstrates participants use subjective data and informal, personalised assessment strategies to make conclusions about the capacity status of patients in their care. They also articulate and respond to “gut feelings” but have some difficulty in articulating these. For this reason, published research observes that nurses have difficulty in articulating subtle changes in the condition of patients (Andrews and Waterman 2005, Wong 2008). This may result in nurses regarding their information as unreliable and invalid. As a result, making referrals is described as “emotionally charged” as nurses question that they are doing the right thing in making referrals and seeking assistance (Coiffi 2000 page 113). It is also reported that nurses are fearful of calling for medical assistance and are uncertain about when to do this. This often results in nurses waiting until the condition of a patient has worsened before making referrals to medical teams (Tippins 2005, Gao et al 2007, Odell 2015). This has an impact upon timelines for appropriate diagnoses and interventions and the condition and prognosis of the patient. In addition, this may adversely affect the relationship between multi-professional team members (Cioffi 2000a, Tippins 2005). Nurses are also fearful of looking stupid or being undermined and ridiculed if they use medical terms out of context (Andrews and Waterman 2005). Therefore, an expression such as “something not quite right” may be regarded as nebulous and too informal to convey to doctors. If nurses have difficulty in expressing a range of nursing concerns implicit in the concept of “something not quite right”, this may result in some hesitancy to convey this onwards and may also affect the confidence of nurses.

The language that nurses use in making referrals to doctors has been explored in a grounded theory study by Andrew and Waterman (2005). This study was conducted in the UK on one surgical and one medical ward of an inner city university teaching hospital over an 11 month period. Data were collected using interviews and observations, the latter lasting between 3 and 8 hours and focused on the ways that ward based nursing staff (n=44) used vital signs and early warning scores to package physiological deterioration of patients to ensure successful referrals to doctors (Andrews and Waterman 2005). It was highlighted that nurses “pick up” changes in the condition of patients through intuitive knowing which then informed when medical attention was needed. As these changes were subtle, nurses made attempts to put them into the context of medical diagnoses and therefore contextualised the information that doctors received. As a result, this enabled nurses to grab the attention of doctors and made referrals that were persuasive. Therefore, in order to make successful referrals to doctors, nurses must be able to use language that is convincing and provides evidence of the change in the condition of the patient (Andrews and Waterman 2005).

This suggests that there is a need to interpret a concept such as “something not quite right” into factual, clinically appropriate language which signals degrees of nursing concern and unease about the condition of patients. Qualified nurses in this study combine the assessment of the mental capacity of patients with assessing physical status. This would suggest that in making referrals to doctors, qualified nurses could convey detail regarding physiological markers along with more subjective data expressed in statements such as “behaving oddly” or “appears confused”. Participant F03 in this study describes using the MMSE to package information when making referrals to doctors, thus contextualising it and making it credible. This assessment tool is viewed as providing “ammunition” and a “safety net” when articulating concerns about the capacity status of patients and is regarded as a way of providing “red flags”, to signal “something is not quite right”. This appears a valid and credible way of informing referrals to doctors and highlights the potential benefits of using universally recognised criteria when discussing the capacity status of patients. This is identified as a key finding of this study which may also inform the education of qualified nurses in the need to alert doctors and to assist them in prioritising which patients to attend across a number of clinical settings.

This study suggests that participants do not appear to lack confidence in making referrals to doctors or demonstrate that they are fearful in having lack of knowledge or getting it wrong when communicating and interacting with them. They articulate assertion in taking the lead in initiating and perpetuating processes of ongoing assessment and in informing and managing medical processes. Participants describe confidence in having increased knowledge about patients and consider themselves better placed to assess capacity status as a result. These opinions are common to all participants where they regard themselves as ever-present thus able to use a variety of knowledge to ensure care is safe, of high quality and is patient focused

(Carago and Mast 2015). Furthermore, it has been observed that nurses and doctors use similar ways of knowing that can result in no significant difference in the quality of such decisions made (Rashotte and Carnevale 2004). This implies that nurses should not be unconfident when making referrals to doctors. This study has not focused on the views of doctors but it is recognised that further research may be indicated to explore processes and strategies used by them, as they assess the mental capacity of patients and also their views on the role of qualified nurses across acute and critical clinical settings in these assessment. Doctors are not ever-present in these areas therefore their views on how their decision making may be better informed by nurses would also appear to be indicated.

However, the abilities of individual nurses will determine the quality and efficacy of processes of assessment and their impact upon patient outcomes. Thompson et al (2007) report that the assessments of nurses can be inaccurate and their decisions for timely referrals to medical teams can be delayed as a result. This may be compounded by tensions within professional hierarchies which may cause difficulties or lack of support when referrals are made by nurses (Morrison and Symes 2011).

Findings in this study do not suggest inaccurate assessments of patients or inadequate, ineffectual mechanisms for referral to doctors. Participants regard that they are subtle in their approach and effective as assessors of capacity. Research indicates that nurses are willing and confident to make referrals to doctors when they know them and are familiar with medical teams with whom they work on a daily basis (Hodgetts et al 2002, Tippins 2005). This is reflected to some extent in this study although participants articulate confidence and assertiveness when making referrals to on-call doctors with whom they have little or no prior relationship. One participant, F09, articulates some reluctance at labelling a patient as being without capacity when making a referral to doctors. This is not due to fear or being under confident in approach, rather, it is due to the significant responsibility of concluding and rendering a patient unable to make their own decisions which may result in care and treatment being given without a legally valid consent.

This study demonstrates that the actions of participants represent nurse managed aspects of the theory, Nurse Managed Patient Focused Assessment and Care. These actions represent assessment processes and strategies in assessing informally and subtly and gathering a range of detailed information upon which to form judgements about capacity status. Positioning this theory with the existing evidence base signals that participants use techniques to assess the mental capacity of patients which are identified in published literature as being effective in the assessment of physiological status of patients. Therefore, techniques for assessing mental capacity and physical status may be combined to facilitate a holistic approach. In acute and critical care environments and the time pressurised and unpredictable nature of these, such a combined approach to assessment would appear to be advantageous.

6.5 Ensuring Patient Focused Outcomes: The Caring Role of the Nurse

The consequences of the theoretical framework in this study are represented by the actions of participants which demonstrate aspects of the caring role of the nurse. There is a focus upon securing effective patient outcomes during initial and on-going processes of assessment of capacity status and subsequent care and treatment. Findings suggest that assessment of capacity status in this study is not a lone process but is one in which the continued care of patients is regarded as significant with recognition of the potential for patient vulnerability and dependence. In this respect, all patients are potentially vulnerable due to their physical and emotional responses to the urgency of their clinical situation, the impact of their physical symptoms and levels of mental capacity and awareness. Equally, all patients are also potentially dependant due to their need to have some control over what is happening to them. This indicates that the assessment of capacity should be informed by the concept of a capacity continuum in which the dynamic nature of capacity for those with acute and critical illnesses is recognised. For participants in this study, acting as advocates for patients include the provision of support and assistance for those patients with capacity to make their own decisions and assessing the best interests and securing effective outcomes for those with compromised or no capacity. An awareness of accountability and a focused professional drive underpin the desire to provide effective patient focused care.

6.5.1 An Advocacy Role

The physical and professional proximity of qualified nurses to patients who are admitted to hospital wards is significant (Josse-Eklund et al 2014). They are able to prioritise the needs of patients and function as reference points, sources of information and co-ordination for all other professionals involved in patient care (Skar 2009, Ryan et al 2012). Nurses are often the link between patients, their family/carers and other professionals in this co-ordination role. This central role is identified and reported (Odell et al 2009, Morrison and Symes 2011, Perez and Folse 2011, Pearson 2013). Proximity facilitates information about patients and becoming familiar with their responses and interpretations of what is happening (Tilden 2011, Josse-Eklund et al 2014). Therefore, gaining depth of knowledge enables the provision of care and management interventions that are specific to patients and which are individualised (Ryan et al 2012). This, in turn, informs decisions regarding what are the best and most appropriate outcomes for patients (Green 2009). Here is it argued that nurses, in seeking to achieve appropriate outcomes for patients, are guided by what corresponds to what they would find acceptable for themselves (Josse-Eklund et al 2014).

The personal standards of participants in this study appear influential in informing ways to advocate on behalf of patients. Participant F09 articulates the concept of "personal inner self" and using own standards to guide ways of supporting patients. This appears congruent with the assertion that inner beliefs and personal standards drive commitment to be persistent and willing to try different ways of achieving desired outcomes and having control over a clinical situation to influence outcomes for patients (Josse-Eklund et al 2014). This is highlighted when participants describe how they "keep going" until they are satisfied that effective and appropriate processes for assessment and on-going care are employed. This directly links to the professional responsibilities and duties of nurses who are required to empower and protect the interests of patients in their care. (Hanks 2010, Griffiths 2015a, NMC 2015). This also suggests an advocacy role which is wider than the traditional definition of speaking on behalf of patients (Seal 2007, Dimond 2015).

Furthermore, participants, in striving to secure the best outcomes for patients, may be unconsciously applying ethical principles to what they regarded as their role as advocate. Ethical judgement involves applying moral values, namely, understanding what is right, proper and effective (Standing 2011). Acting in the best interest of patients is regarded as acting with ethical and moral principle if assessment processes result in care and treatment which is individualised and effective (Pearson 2013). Also, the assessment of best interests is regarded as contributing to either facilitating the autonomy of patients or supporting it. Here advocacy is considered to be an inherent aspect of effective nursing practice where nurses support the rights, interests and decision making of patients (Vaartio et al 2009). Adding to this is the bond that nurses may have with patients, as they strive to develop trusting relationships with them. This is essential so that nurses are able to assess health and social care needs of patients and also to support those patients who are able to make their own decisions (Pols 2013). Acute and critical settings may result in some patients being confronted with their own mortality, therefore nurses need to be cognisant of this (Griffiths 2015).

An articulation of empathy appears to pervade the caring role of the nurse in this study and participants appear cognisant of the impact of illness and environment upon patients and their mental capacity. Hospital is recognised as a “false setting” in which patients are “different from their normal selves” and “unsettled”. This results in patients being regarded as being potentially vulnerable and highlights the importance of the family as means of support for patients. This has a direct link to the concept of relational autonomy regarding the social relationships and context that influence the decision making of a person, namely, those who are important to a person may have an influence on their decision making (Cole et al 2014).Therefore, in acute and critical hospital settings patients may rely on the support of families and/or carers to assist in making decisions. Alternatively, nurses and other members of the multi-professional team may also fulfil this role in the absence of supportive social networks (Green 2012).

However, the effectiveness of an advocate is dependent on a number of elements. An organisational environment may repress the functions and scope of the advocate (Seal 2007, Hanks 2010). Acute and critical care settings may involve patients being exposed to multiple speciality teams with a large number of staff interacting with them (Bender et al 2013). This may result in multi-professional teams consisting of practitioners with distinct professional identities and opposing priorities and agendas (Rose 2011). Therefore, the provision of seamless care would appear to pose challenges. This implies that the role of the nurse as the ever-present professional across acute and critical settings is key in the need to facilitate continuity of care and to be a constant advocate in the clinical journey of patients (Bender et al 2013). A further implication here is that the commitment and abilities of the nurse are influential in setting the scene for effective frameworks for advocacy. Advocacy will only be effective and beneficial if nurses are knowledgeable about the needs of patients and if they are enthusiastic and skilled when supporting them (Nicholls et al 2011). A multi-professional approach is demonstrated in the descriptions of participants in this study who allude to fulfilling what they regard as their advocacy role by co-ordinating processes for the assessment and on-going care of patients and by working with doctors to formalise conclusions about the capacity status of patients.

This study recognises that nurses in acute and critical care settings do not operate in isolation but are an essential element of wider multi-professional teams. The need to advocate for patients is therefore central to the efficacy of a team approach (Bender et al 2012). Each professional group will have views and definitions of their advocacy role. The advocacy role of doctors is described as getting it right for patients and securing best clinical outcomes which are regarded as fundamental components of the duty of doctors (Sigall et al 2011). Earnest et al (2010) assert that doctors are uniquely positioned to act as advocates for patients and are effective in this role when they ensure that patients get the levels of services they need to solve healthcare problems. This has echoes to the views and opinions of participants in this study when they articulate the role of the qualified nurse in this respect as securing the best outcomes for patients and "getting it right". This suggests that professional groups may have common views about their advocacy role. This also highlights that this role is not unique to nurses.

Perceptions of supporting patients in this study indicate that an advocacy role is linked to ensuring effective standards of assessing the mental capacity of patients and is linked to securing the best outcomes for patients. Therefore, a collaborative multi-professional approach suggests combining the desire of nurses, doctors and/or others to secure the best outcomes for patients and to pool knowledge and expertise in meeting their healthcare needs. A collaborative approach is considered to decrease fragmentation and to improve the quality and safety of care (Buchini et al 2014). Thus, implications for practice would suggest that a multi-professional approach is essential when assessing the mental capacity of patients in some depth and to facilitate assessment processes that are accurate and cognisant of the transitory nature of mental capacity. This suggests that programmes of training and education may also be indicated to facilitate inter-professional learning. This may inform an awareness of the value of a multi-professional approach to holistic assessment and care of acutely and critically ill adult patients.

6.5.2 Supporting the Rights of Patients

A patient focused approach to healthcare has legal, professional and social currency. Emphasis is placed upon the primacy of the rights of patients and their autonomy where choice and self-determination are fundamental concepts (Brazier and Cave 2011, Jones 2014). The expectations of society are also significant regarding the context of patient focused care. Welsh Government (2013) direct that ensuring good care involves providing care which is dignified, safe, effective and compassionate in meeting individual needs of patients:

> *"Patients are experts in their own lives...By making sure patients, their families and carers have a strong voice we can promote joint decision making about their care and treatment, in partnership with staff who care for them"* (Welsh Government 2013 Page 4).

The Mental Capacity Act 2005 brings such concepts under statutory control, placing the legal emphasis on supporting people to make decisions for themselves if they have the required level of capacity or to protect those who lack sufficient capacity (Brazier and Cave 2011). This study demonstrates that the approaches taken by participants in assessing the capacity status of patients are informed by criteria implicit in the Mental Capacity Act 2005 and the level of responsibility afforded to them for this aspect of their practice is recognised and articulated as significant (Griffiths and Tengnah 2010, Griffiths 2015). Adding to this is the professional requirement that registered nurses must comply with the laws of the country in which they are practicing and provide nursing care which is patient focused in a manner that upholds dignity, choice and is protective of rights and freedoms. In discharging their professional duty, registered nurses are reminded of their legal duty in this respect (NMC 2015). Similar principles apply to doctors who are guided in similar ways (GMC 2014).

The participation of patients in their care has been the subject of debate in published evidence and is regarded as fundamental to the legal, professional and ethical duty of the nurse (Hanks 2010, Cole et al 2014, Griffiths and Tengnah 2014). Patients who are assessed as having sufficient capacity require information to inform their decision making processes (Jones 2014). A grounded theory study in Sweden by Larsson et al (2007) focusing on patient participation in their care, highlighted a dynamic interaction process between nurse and patient, the focus of which was the necessity of patients having appropriate information and opportunity to consider participating in their nursing care. Patients who were recruited for this study, (n=26), were, or had been, admitted across a range of clinical settings including gynaecology, rehabilitation, care of elderly, heart failure and primary care, Larsson et al (2007) found that patients needed to acquire credible and sufficient knowledge in a safe and supportive environment. Nurses were expected to augment the knowledge of patients by assessing understanding on continual bases and customising information as a result. This involved consideration on the part of nurses to factor the opinions of patients into this process. Patients needed some preparation to become actively involved in their care which was facilitated by information giving. The preparation of the patient involved mutual trust, understanding and reassurance, all of which were central to decision making processes (Larsson et al 2007). This implies that patients need to understand what is happening to them and to be informed as a result. If they are assisted in this way their confidence may be facilitated and they may feel more in control of their own situation. This is supported with the view that patients are active participants in the care process and need to be supported and encouraged to take responsibility for their care and the decisions they make (Kangasniemi et al 2012, Edwards 2014).

Supporting patients and meeting their information needs are, however, predicated on patients agreeing to become involved in their care and having required levels of capacity and therefore decision making abilities. Being in acute and critical care settings may present patients with a number of challenges. These include the impact of acute or critical illness and time pressurised situations which may necessitate prompt or urgent healthcare interventions. This may culminate in the patient feeling a sense of being out of control and therefore needing the support of nurses and others as a result to feel comfortable to demonstrate levels of capacity (Brier et al 2015). Challenges are also presented to qualified nurses in acute and critical care settings. Managing the physical, emotional and information needs of patients simultaneously in settings where patient demand currently outstrips the supply of available beds and services, places great pressures of time on all practitioners (Griffiths and Tengah 2014). Also, many patients experience feelings of helplessness, place their trust in the healthcare team, are not receptive or feel too ill or too frightened to become immersed in receiving information or making their own decisions (Robson et al 2013). This should, however, not detract from the needs to support the rights of patients in these settings (Griffiths 2015).

This study highlights that the role of qualified nurses in assessing and supporting patients has many components in the context of approaches taken to care and management interventions. Participants in this study indicate ways in which they support the emotional needs of patients in their care and also how they serve the information needs of those who are assessed as having capacity. In this respect, this is linked by them to their advocacy role and the need to assess “properly”, in a manner that is sound so that assessments are accurate and reflect actual levels of capacity of patients. Also, participants suggest that support and reassurance for patients with capacity is fundamental in underpinning patient decision making processes.

However, for those patients who stimulated a reaction of “something not quite right”, the situation is more challenging. Here, the need to assess accurately carries greater responsibility, due to the implications of assessing that patients do not have sufficient capacity to make their own decisions. These patients therefore will receive care and treatment for which they have not consented and which is given under the legal justification of best interests (Jones 2014). For this reason appreciation of the weight of responsibility is regarded as essential (Griffiths 2014). Findings in this study indicate that participants understand their position regarding their role in concluding that patients lack capacity. They articulate a nursing team approach before making referrals to doctors to ensure accuracy of nursing conclusions. This highlights the importance of a multi-professional team approach and the advantages of pooling clinical opinions and judgements. For participants, however, the implications of concluding lack of capacity appears to result in some hesitancy of approach. Participant F09 describes this as eroding the autonomy of patients and "taking a part of the person away". By implication being assessed as without capacity is stigmatising. Whilst this represents the perspective of one participant all others echo similar hesitancy and also weight of responsibility.

The weight of responsibility when exercising the legal and professional duty of care is also recognised when using provisions implicit in the Mental Health Act 2007. As the initial literature review in Chapter 2 indicted, there is overlap with this and the Mental Capacity Act 2005, despite both statutes being designed for different purposes. However, boundaries between both statutes are becoming blurred with the Court of Protection, a specialist court designed to hear cases about those who lack capacity, being asked to make decisions regarding mental health law (Griffiths 2014). This has resulted in the Assembly of Northern Ireland proposing a Mental Capacity Bill which will replace its mental health laws with a single statutory framework, thus giving adults with capacity the right to consent or refuse all treatments (NI Assembly 2015). Currently the Mental Health Act 2007 provides procedures allowing compulsory assessment, treatment and detention in places of safety for those with mental health problems who may, or may not, lack capacity but who pose a risk to themselves and/or others. Research suggests that there is concern across professional groups regarding the implications and responsibility of assessing the extent of risk to self and other as a person will be detained against their will as a result (Coombs et al 2011, Mason et al 2012). Concern and hesitancy are expressed regarding the stigma attached to having a diagnosis of mental illness and this is exacerbated when assessment and/or treatment is given on a compulsory basis and a person is sectioned under the Mental Health Act 2007 (Bates and Stickley 2013).

There are therefore tensions between care and control which have a number of implications for practitioners seeking to promote the recovery and autonomy of patients (Sartorius 2002). For the physically ill, these tensions are between care and treatment without consent, the latter may include coercion depending on the results of best interest assessments (Mckie and Naysmith 2014). It is recognised, therefore, that practitioners from different professional groups may be faced with role confusion, whether their role is a caring one or whether they are agents for control and/or coercion (Bates and Stickley 2013). Consequently, practitioners across different clinical settings may experience hesitancy and reluctance to execute processes and actions which they regard as stigmatising and disadvantaging to patients in their care (Wojtowicz et al 2014). These patients are inevitably vulnerable which can result in nurses experiencing some kind of moral distress. This is especially so when limitations are imposed upon the rights and freedoms of patients which nurses find difficult to implement and for which they feel compelled to co-operate as members of larger multi-professional teams (Deady and McCarthy 2010, Wojtowicz et al 2014).

Participants in this study indicate the weight of responsibility felt by them in making accurate assessments of capacity status and the implications of their accountability regarding care and treatment regimes in the best interests of those patients who are assessed as not having sufficient decision making abilities. For this reason, participants describe their accountability as emphasising their legal role and the power this affords them as treating without the consent of patients is directly within their control and that of the multi-professional team.

Therefore, using the analogy of participants in this study, the need to “get it right” for patients, it is imperative that practitioners are cognisant and respectful of the powerful position in which the law places them. Research has shown that patients are exposed to inadequate care and treatment decisions that fail to take account of their wishes (Pauly et al 2009). Also, staff across professional groups may display poor attitudes towards the most vulnerable of patients (Pauly et al 2009, Deady and McCarthy 2010). Nurses may experience some difficulty in speaking up on behalf of patients if this is the case. Evidence suggests that some nurses experience lack of autonomy which erodes confidence and prevents them from representing the rights of patients. In this respect they are considered to have more responsibility than authority (Lutzen et al 2010). Even where some nurses have authority given to them by statute, namely the nurse’s holding power (Mental Health Act 2007 Section 5(4)), they are reluctant and hesitant to use it. They are also uncertain regarding the use of these powers and prefer multi-professional team decisions to be made for patients who are detained against their will (Ashmore and Carver 2014).

In hospital settings certain factors may impede the ability of nurses to act on what is legally acceptable for patients, such as limited resources, heavy workloads or hierarchical decision making process which discourage the application of sound clinical judgement (Deady and McCarthy 2010, Wojtowicz et al 2014). This may lead to the danger of staff becoming desensitised to the importance of everyday issues in which the rights of patients are involved (Mckie and Naysmith 2014). The physical and professional proximity of qualified nurses to patients would suggest, therefore, that they have a significant role in the provision of care and treatment which provides a positive experience to patients despite the intensity of some clinical settings (McAndrew et al 2014). This study demonstrates the fundamental nature of processes of assessment and of the need for these to be accurate and reliable and reflect the capacity abilities of patients, at the same time supporting the rights of all patients. Whilst this is not a unique perspective, the unique contribution of this study relates to the perspectives of qualified nurses in acute and critical environments in assessing the mental capacity of adult patients with acute and critical illnesses.

As the potential for patients in acute and critical care settings to be vulnerable and needing support has been highlighted, the need for these patients to be treated with respect and dignity appear central themes. The themes of compassion and dignity are significant in a post Francis era (Francis 2013) and should be valued as fundamentals of care across professional groups (Bryon et al 2012, Griffiths 2015a). One participant, F04, describes the caring role of the nurse as a “very powerful position” where securing and maintaining the dignity of patients and securing best outcomes for them should be a driving motivator. However, in acute and critical care environments nurses have to balance the need to provide technical care in pressurised environments at the same time ensuring compassion, dignity and respect for patients (Bridges 2012, Lindwall and von Post 2013). A review taken by the World Health Organisation, in the context of healthcare, across 41 countries found that dignity was regarded as the second most important domain from a list of 8. Promptness of care was the only domain rated more highly (Valentine et al 2008).

Defining dignity is, however, complex (Lin et al 2012, Cook 2014, Sabatino et al 2014). Definitions include dignity being concerned with how people feel, think and behave. To treat someone with dignity is to treat them as being of worth, in a way that is respectful, placing value on people as individuals (RCN 2008). Dignity is also regarded as the basis of human rights and suggests the inner worth of every person which should never be removed (Sabatino et al 2014). In clinical settings, where dignity is valued, patients feel in control and confident and able to make decisions (Buchini et al 2014). Alternatively, if dignity is not valued patients may feel humiliated and/or embarrassed (Buchini et al 2014). Dignity and respect therefore underpin the legal, professional and ethical duty of nurses and it is important that they promote the dignity of patients regardless of setting (Baillie and Gallagher 2012, Griffiths 2015a). All three aspects of this duty are evident in the professional standards required by the NMC (2015) which direct that people are treated as individuals whose dignity will be upheld and protected. Nurses are further directed that they must treat people with kindness, respect and compassion and ensure they deliver the fundamentals of care effectively (NMC 2015).

In acute and critical care settings, maintaining the dignity of patients is no more important than any other setting but the complexity and time pressurised nature of these and the acute and/or critical health needs of the patients pose particular challenges. Patients in these settings may have significant and potentially life threatening or life changing health needs. Therefore, supporting patients in making autonomous decisions and treating them as individuals demonstrates a dignified approach (Lin et al 2012). In addition, honouring the beliefs and culture of patients evidences their worth as individuals and demonstrates the provision of a dignified and compassionate approach (Lindwall and von Post 2013). Here patients may need access to family or carers to make decisions and to seek comfort and support. Nurses, therefore, need to be cognisant of protecting the privacy of patients in their care and in supporting both patient and family in what may be times of health crises. Demonstrating respect for patients is linked to protecting privacy and in recognising the individuality of patients. By implication, this is also regarded as protecting the dignity of patients (Lin et al 2012). However, being acutely or critically ill may render a patient vulnerable and in need of support and protection (Gastmans 2013). Many patients do not have supportive family or social networks and being acutely or critically ill can add to a sense of being alone and vulnerable. Also, the experience of acute or critical illness may result in patients being confronted with their own mortality and they may feel close to death. This is challenging for patients who have sufficient mental capacity to understand their situation. For those with either fluctuating capacity or no capacity their situation may be more bewildering and frightening. Consequently, it is suggested that vulnerability and care are “closely intertwined” and nurses respond to the vulnerability of patients by providing care which is supportive and dignified (Gastmans 2013 page 146).

The delivery of healthcare services in which dignity and compassion are valued are not unique to qualified nurses. They are, however, the only professional group who deliver essential care and treatment on continual bases across acute and critical care settings. Therefore, their professional capacity to demonstrate these values are greater (Robson et al 2013). This study demonstrates the value participants place on the need to support the rights of patients in their care and the value they place on their caring role. The consequences of their actions confirm outcomes which are patient focused and encompass assessment and on-going care of patients. Positioning patient focused aspects of the theory, Nurse Managed Patient Focused Assessment and Care within the existing evidence base highlights that participants not only assess the capacity status of adult patients but also articulate attitudes which demonstrate empathy and value dignity, autonomy and supporting patients in their care.

6.6 Nurse Managed Patient Focused Assessment and Care: A Grounded Theory

The theory of Nurse Managed Patient Focused Assessment and Care offers a framework which explains how qualified nurses in this study assess the mental capacity of adult patients in acute and critical care hospital settings. This theoretical framework has a number of components that are inter-related and linked and which provide cohesion to the overarching theory (Corbin and Strauss 2008). These components have been positioned within the existing evidence base to present critical analyses of the explanations of processes of assessment and to affirm the credibility of the explanatory power of the theory.

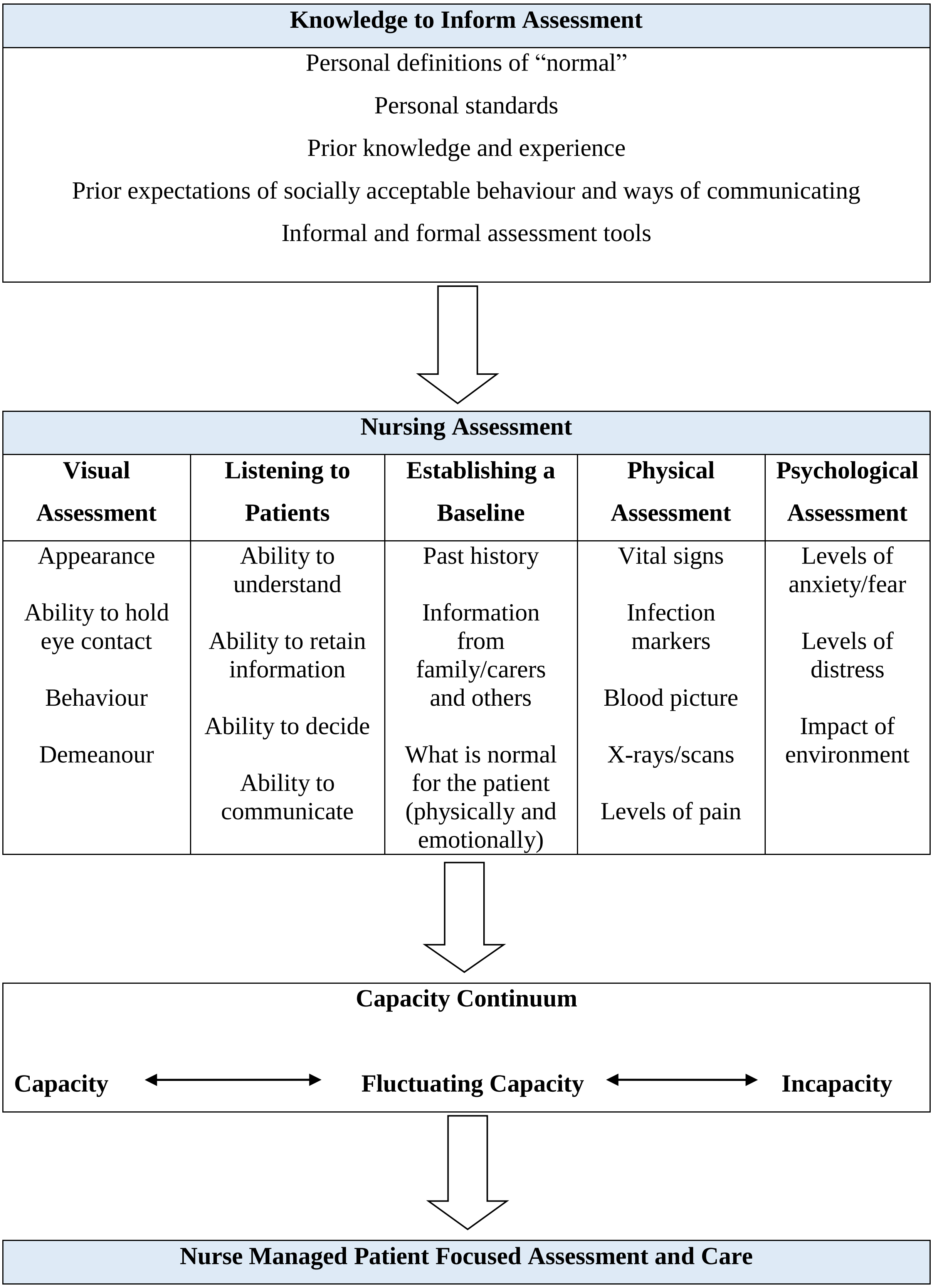
A visual representation of the theory of Nurse Managed Patient Focused Assessment and Care is presented in Figures 2 (page 178) and 3 (page 179) of this thesis. These represent the grounded theory of Nurse Managed Patient Focused Assessment and Care.

Figure 2 explains and summarises underpinning knowledge and assessment processes required to assess the mental capacity of acutely and/or critically ill patients. This visualises the context of what has been shown to be a holistic assessment process where an assessment of physical, emotional and capacity status may be combined. This reinforces that assessing mental capacity of such patients is not necessarily a separate process and should be placed, therefore, in the context of the individual presentation of each patients in clinical environments that may be complex and challenging for both patient and qualified nurse. This is regarded as a key contribution of this study which may be used to inform fundamental aspects of assessment processes employed by qualified nurses.

Figure 3 represents and explains process of assessment and on-going care of patients which is described as "The Assessment of Capacity Cycle". A cyclical process of assessment has been demonstrated which signals a necessity for continual multi-professional interaction. Of significance is a central role of the qualified nurse across acute and critical care settings in the initiation, assessment and co-ordination of assessment processes. As the ever-present professional group in these settings, their responsiveness to the presentation of patients in their care is essential as is the lead into accurate and appropriate multi-professional assessments of capacity status. The on-going care of patients in this cycle of assessment is evident with a true multi-professional approach indicated to best serve the needs of patients. Processes of assessment and care are interlinked thus providing holistic and appropriate assessments of acutely and critically ill adult patients.

Both Figures 2 and 3 must be used together to fully represent the theory of Nurse Managed Patient Focused Assessment and Care.

Figure 2: Nurse Managed Patient Focused Assessment and Care



Knowledge to Inform Assessment

Personal definitions of “normal”

Personal standards

Prior knowledge and experience

Prior expectations of socially acceptable behaviour and ways of communicating

Informal and formal assessment tools

Nursing Assessment

Visual Assessment	Listening to Patients	Establishing a Baseline	Physical Assessment	Psychological Assessment
Appearance Ability to hold eye contact Behaviour Demeanour	Ability to understand Ability to retain information Ability to decide Ability to communicate	Past history Information from family/carers and others What is normal for the patient (physically and emotionally)	Vital signs Infection markers Blood picture X-rays/scans Levels of pain	Levels of anxiety/fear Levels of distress Impact of environment

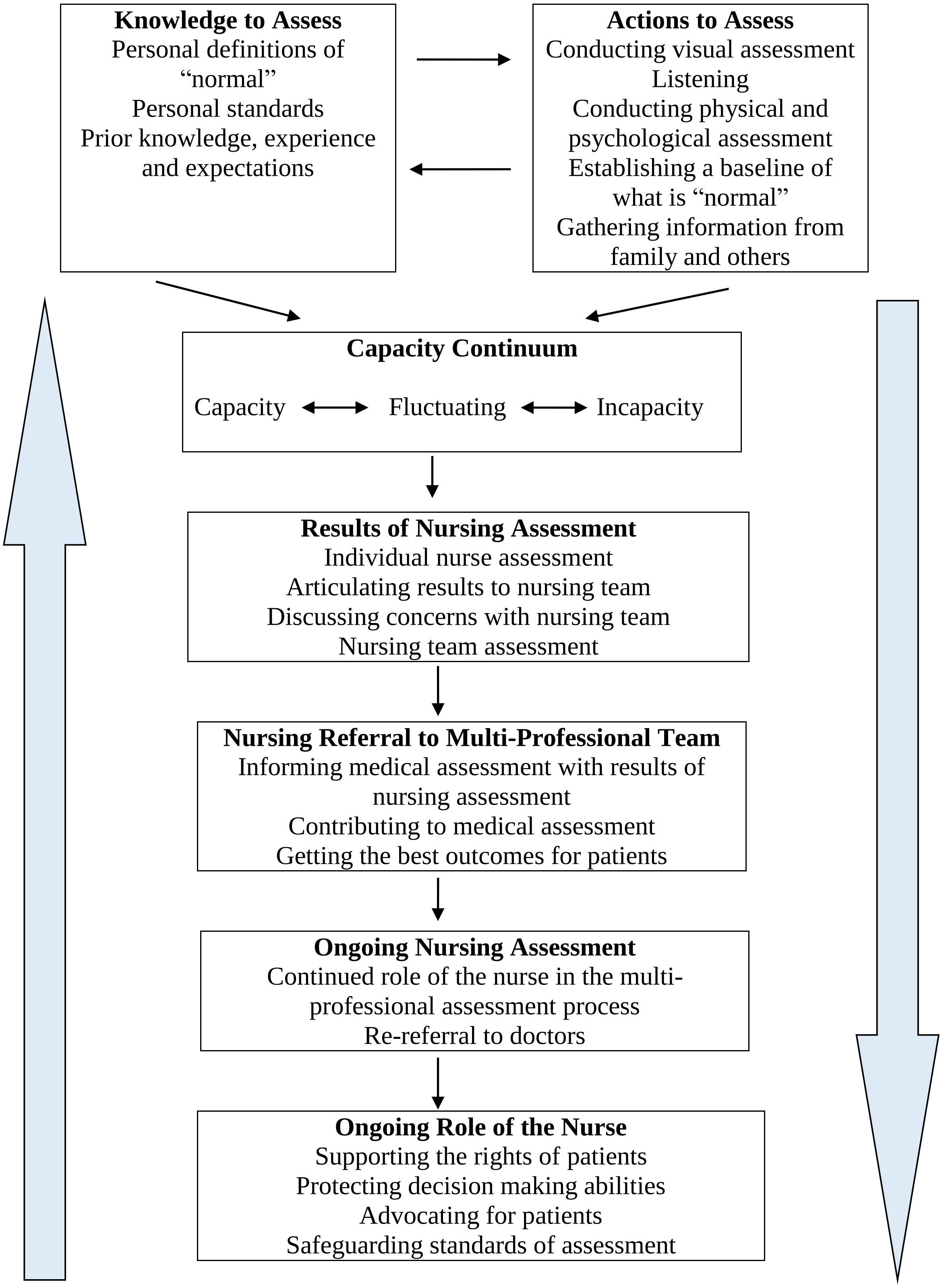
Capacity Continuum

Capacity ⟷ **Fluctuating Capacity** ⟷ **Incapacity**

Nurse Managed Patient Focused Assessment and Care

Figure 3: Nurse Managed Patient Focused Assessment and Care

The Assessment of Capacity Cycle



6.6.1 Contextual Issues: Impact upon the Theoretical Framework

The contextual positioning of the theoretical framework of the theory of Nurse Managed Patient Focused Assessment and Care is complex and comprises a number of dynamic elements. These elements may be ever-changing and their influence and impact may fluctuate due to complex ebbs and flows of day-to-day, often time limited, delivery of assessment, care and management interventions across acute and critical care hospital settings. These settings may have an impact upon the reactions of patients and also on the ways in which qualified nurses interact with them to provide healthcare interventions. In turn, the impact of environment may influence the wider multi-professional team and the relationships between professional groups within this team.

The complexity of the presentation of patients in acute and critical environments is such that clinical imperatives often dictate a context in which meeting the physical needs of patients has primacy. Therefore there is contextual significance in the proximity of qualified nurses to patients and the advantageous position in which these nurses are placed regarding the gathering of patient-specific detail and exposure to family and carers which may provide an insight into the reactions of family and/or carers and family dynamics. Here the geographical location of the clinical settings may add further contextual influence and it can be anticipated that patients and their family and/or carers will reflect and represent cultural norms and nuances of a specific locality. This coupled with cultural nuances of multi-professional team members may add factors which influence the ways in which the presentation of patients are interpreted and the ways in which these stimulate the responses of qualified nurses in the first instance. Such interpretations, assessment and responses may act as precursors to the employment of processes of assessment and referral and care and management interventions. In this respect the availability and skill mix of staff may be significant in multi-professional settings as these may determine levels and effectiveness of healthcare services delivered to acutely and critically ill patients. Here the impact of the demands on acute and critical care services and methods of patient admission, initial primary assessment and patient flow may impact upon the availability of staff and the time available to take advantage of proximity to patients.

Furthermore, the unpredictable physical and emotional status of patients may often be preceded or accompanied by deterioration in levels of awareness and lucidity. Inevitably this may impact upon capacity status of patients with potential for levels of capacity which may fluctuate. The notion of a capacity continuum sets a dynamic context and suggests that patients may move along this continuum at any time and in any direction. Such a dynamic context implies that there is a need to assess patients on continual bases. Contextual implications in this respect signal the impact of the motivations and application of knowledge, experience and skill of the qualified nurse when assessing the capacity status of patients in their care. Assessment processes adopted by qualified nurses may be informed by the sum of knowledge and skill. These may include personal and subjective standards and definitions of norms of behaviour and social skills and expectations of the trajectory of acute and critical illnesses and disease processes. In addition, levels of confidence underpinning the ways in which qualified nurses make decisions and their individual decision making styles add to the overall context in which patients are assessed, cared for and managed. This extends to the role of the qualified nurse in multi-professional contexts and their ability to make timely and informed referrals, thereby initiating, managing and maintaining continual assessment processes which are cyclical in nature.

An overarching contextual influence is the increasingly sophisticated legal environment in which qualified nurses function. Of significance here is knowledge of legal and professional standards and the synthesis of these into personal and professional philosophies so that such standards are apparent in the application of assessment, care and management interventions, in actions and in attitudes. The value placed upon concepts such a patient-focused care, fuelled by personal and professional recognition of legal and professional standards therefore sets a context in the desire and professional drive to support the rights of patients who may be ill, vulnerable and dependant and whose dignity and autonomy may need to be supported and protected.

6.7 Conclusion

This chapter has presented and discussed the theory of Nurse Managed Patient Focused Assessment and Care within the context of the wider literature. It has explored the assessment processes and strategies used by participants to make decisions about the mental capacity and on-going care of patients and also their role in a multi-professional context.

This study demonstrates a central, co-ordinating role of qualified nurses in responding to patients with acute and critical illness in some depth and in ways which inform assessment process for initial and on-going assessments of capacity status. Depth and nuance of process have been revealed which have primarily been “hidden” due to lack of existing published research on this aspect of nursing care. However, what has been highlighted is the interplay between techniques for the assessment of physiological status of acutely and/or critically ill patients and those to assess capacity. Both are connected and both contribute to a cyclical process of assessment in which a multi-professional approach is evident and necessary. The contribution of qualified nurses is, however, central to maintain a cycle of assessment. Their physical and professional proximity places them in a unique position, not simply to be the ever-present professional group but also to ensure that dignity, autonomy, care and support are valued and evident when facilitating patient focused assessment and care.

Processes of assessment are, and can be, informed with the use of pre-defined, structured tools and published research regarding the benefits and disadvantages of these has been discussed at some length in this thesis. Of significance is the need for clinical judgement to be used in conjunction with assessment tools or guides to inform and support the practice of professionals across a range of settings. This study, therefore, makes a contribution to existing evidence by offering a theoretical framework which may form the basis of a guide or draft tool which can be developed from the visual representation of the theory of Nurse Managed Patient Focused Assessment and Care.

Nurse Managed Patient Focused Assessment and Care therefore provides a theoretical framework to explain and expose strategies and processes used by qualified nurses in assessing the mental capacity of adult patients in acute and critical care settings and in the provision of on-going care of patients in these areas. An increased knowledge and understanding of this role of the qualified nurse, and the contextual positioning of this, may therefore inform and further develop clinical practice in this area. Also, the practice of others can be informed by the suggested guide or draft tool developed in this study. This may, in turn, inform the preparation and education of qualified nurses to improve what has been identified as a fundamental process in the care and management of acutely and critically ill adult patients.

Chapter 7: Conclusions and Recommendation for Future Practice and Research

7.1 Introduction

This chapter will present and discuss the main conclusions and recommendations that can be drawn from this study. The ways in which the aims of the research have been met will be discussed and the extent to which original contributions to knowledge have been made, positioning the main study findings with existing relevant research and literature. Implications for clinical practice are presented and recommendations for future research are identified. Finally, personal reflections provide concluding remarks.

7.2 Study Conclusions: Participants Assessment of Mental Capacity and the Care and Management of Patients

This study was originally undertaken to critically analyse the ways in which qualified nurses assess the mental capacity of acutely and critically ill adult patients in hospital settings and was undertaken for a number of reasons. As a practitioner of acute care, personal and professional recognition is given to the significance of assessments of mental capacity and their implications for patients and practitioners. The complexity of acute and critical environments are such that clinical imperatives often dictate focus on meeting the physiological needs of patients. Therefore, it was recognised that there was a need to gain insight into assessment of capacity processes employed by qualified nurses, to position these in assessment of patients generally by nurses and also to explore the wider role of qualified nurses within multi-professional team contexts. In this respect, this study has focused on the accounts and views of qualified nurses only, those of other healthcare professionals were beyond the scope of this study.

It was also recognised there was a need to understand these processes which may inform future practice and also the education and continued professional development of nurses. In addition, there is a lack of existing research regarding the role and function of qualified nurses in this area. Making a contribution to the existing evidence base may therefore assist in informing wider practice and also inform programmes of education and training to facilitate inter-professional learning. This contribution may have further relevance for related policy and strategic direction regarding assessment in multi-professional contexts.

Participants in this study articulate the ways in which they assess the mental capacity of patients in their care. They recognise their unique position as the ever-present professional group across acute and critical care environments and the advantage this gives them regarding proximity and exposure to patients. They consider themselves reference points, sources of information and co-ordinators of other professional groups who are also involved in patient care. In making referrals to doctors to facilitate medical intervention in the assessment of capacity status, participants describe their roles as information giving, supporting, managing and supervising to ensure that standards of assessment are maintained and their outcomes assured as appropriate and accurate for patients. Processes for referrals of patient to doctors are described as cyclical, where re-referrals are made, if and when, appropriate. This study indicates that participants appear to have a leading, initiating and co-ordinating role in this cycle. They also appear to maintain the momentum of this cycle due to their central role as the ever-present professional group across acute and critical care environments.

When assessing the mental capacity of acutely and critically patients, participants in this study appear to use a variety of indicators to inform their opinions and judgements regarding whether assessments are indicated. These responses are informal where mainly personal and subjective criteria are used upon which to base assessments of capacity processes. These assessments are conducted in real time, often rapidly, and in the context of daily routines. This results in the articulation of informal methods used, with an apparent accompanying lack of appreciation that capacity has been assessed and lack of insight regarding the range and depth of strategies employed.

However, data indicates participants assess the capacity status of patients using a range of communication and interpersonal skills informed by prior knowledge, experience and their expectations of appropriate and socially acceptable modes of behaviour and ways of communicating. They also describe assessment processes which have strong focus on establishing baselines for patients upon which to judge that capacity and decision making abilities of patients are intact, compromised or have the potential to fluctuate. Assessments of visual presentation, physical status, communication abilities and ability to understand are highlighted which are supplemented by information from families and/or other professionals who may have previously been involved in the care of patients.

During processes of assessment, participants recognise the potential for fluctuating capacity and articulate the notion of a capacity continuum, along which patients may move at any time and in any direction. Therefore, the need to assess patients on a continual basis is recognised, in particular due to the effects of physical illness, such as pain, altered levels of awareness, the effects of medication and the impact upon patients admitted to acute and/or critical clinical settings. Here, participants identify the potential for ill patients to feel vulnerable, frightened and bewildered. They therefore regard themselves as patient advocates and articulate the need to support the rights of patients, by protecting decision making abilities and also safeguarding standards of assessments and their outcomes. Data in this study reveal a strong professional drive which is articulated where participants acknowledge the need to protect the dignity of patients and to provide reassurance and support.

Therefore, the theory of Nurse Managed Patient Focused and Assessment and Care, presented in Figures 2 and 3 of this thesis, provides a theoretical framework which explains processes used by qualified nurses when assessing capacity status of acutely and critically ill adult patients in their care and in co-ordinating assessment processes in the context of multi-professional teams. This theory also explains the wider role of the qualified nurse in the management of care of acutely and critically ill adult patients. Thus, new insights are provided into these aspects of the role and function of qualified nurses in fast-moving clinical settings.

7.3 Relationship of Findings to Previous Research and their Original Contribution to the Body of Knowledge

Evidence from this study indicates that the grounded theory of Nurse Managed Patient Focussed Assessment and Care provides a theoretical framework to illustrate, understand and explain strategies and processes used by qualified nurses across acute and critical care settings in responding to, assessing and caring for those adult patients who require assessment of their mental capacity. This framework can assist to inform clinical practice in this area and can facilitate insight into ways of educating and updating qualified nurses and others across a range of clinical settings. This framework may also assist to inform wider systems which have influence upon related policy directions.

Assessment processes used by qualified nurses in acute and critical care settings have been well researched but appear to have narrow focus. These mainly relate to the assessment of the physiological status of ill adult patients, in particular the need to assess their potential for physical deterioration. These studies appear to be in direct response to criticism regarding the poor performance of nurses in acute and critical care setting in making timely assessments of levels of deterioration in the conditions of patients (NICE 2007, Banner 2012, Hands et al 2013). Many of these studies explore the use of pre-defined assessment tools or criteria, such as early warning scoring systems. These are intended to be used to support effective processes of assessment and can facilitate nurses making timely and accurate clinical assessments (Johnstone et al 2007, Perez and Folse 2011, Odell 2015). As this study demonstrates, there is little published evidence regarding nursing assessment of capacity status in adult patients with acute and/or critical health needs in time pressurised settings, although it is recognised that physical illness may have a significant impact upon the capacity status of patients (Raymont 2004, Owen 2009, Fassassi et al 2009, Burton et al 2012, Stevens 2013). Also, it is recognised that some patients with acute physical illness may have difficulty in processing information necessary to give an informed consent due to a number of factors such as pain, fear, hypoxia or the effects of medication (Jacob et al 2005, Applelbaum 2007a, Akinsanya et al 2009, Cork 2014). Of relevance here is that the capacity of patients may be hidden as a result and severe deterioration in the condition of patients is frequently preceded by changes of physiological parameters and accompanied by deterioration in awareness and lucidity of patients (Hands et al 2013). The mental capacity of patients may be compromised, but processes for assessing this are inevitably influenced by clinical imperatives to stabilise and treat immediate healthcare needs. Assessing the capacity status of patients can therefore pose a number of challenges and is difficult (Hodgetts et al 2002, Mohammed et al 2009). This indicates a need for further exploration in this area and this study therefore provides a unique insight and analysis into a key and essential aspect of the practice of qualified nurses which has served to inform the evidence base in this respect.

This study does not reveal that participants use new or different assessment techniques across acute and critical settings to those already identified in the literature regarding the assessment of the physical status of patients. The use of subjective criteria is demonstrated such as personal definitions of "normal", personal standards or personal definitions of socially acceptable modes of behaviour and communicating. These inform decisions to proceed with assessing capacity in more depth. Existing research regarding the use of subjective data provides a somewhat mixed message (Eliot 2010, Cork 2014). Elements of this suggest that such data are valuable, can inform processes of assessment and can be relied upon in urgent and time limited clinical settings (Morrison and Symes 2011). However, published research also indicates that subjective data are unreliable, too individualistic and reliant on the knowledge and skills of each practitioner (Lynch et al 2012). This study demonstrates that the application of subjective data occurs rapidly and seemingly without much conscious thought. This results in descriptions of "feelings" or "gut feelings" about the presentation of patients which is articulated and labelled as "something not quite right" by all participants.

This supports evidence from other studies, so much so that participants use similar language to that already reported in the expression of feelings of unease, concern and the articulation of gut feelings (Coiffi 2000, Andrews and Waterman 2005, Lyneham et al 2008, Cork 2014). The use of "gut feelings" or intuitive responses are also reported across other professional groups, such as doctors, social workers and physiotherapists. However, it is suggested that the effectiveness of these are inferior when compared to using risk assessment and management scoring pre-defined tools (Chew et al 2014). Alternatively, it is observed that gut feelings have diagnostic value and have specificity when used in assessing levels of seriousness of symptoms of patients (Van den Bruel et al 2012). Intuitive responses can lead into analytical processes of in-depth assessment and/or examination and seeking advice from more experienced clinicians if appropriate (Van den Bruel et al 2012, Ingram 2013). Also of note in this study is that in assessing the mental capacity of patients, participants describe similar experiences and use similar words and phrases, despite representing a range of clinical backgrounds and levels of clinical experience. This and exacting congruence with existing research appears to indicate the universal nature of indicators to inform these aspects of assessment strategies used by qualified nurses. Furthermore, this study has revealed that, in the need to assess capacity status, detailed assessments of adult patients are articulated and described as being conducted. Here, components of assessment include using visual and interpersonal skills and assessing the physical status of patients to establish baselines upon which to make judgements about capacity status. Participants describe the need to "keep going" until they have plausible explanations for the presentation of patients. In this respect there is similarity and fit with existing evidence regarding the need to use processes of elimination in the need to assess effectively, swiftly and to ascertain differential diagnoses (Ramezani-Badr et al 2009, Pearson 2013).

Congruence with existing evidence is acknowledged in principle as the context of what exists is not directly related to the assessment of mental capacity but to the physical condition of patients. Participants in this study articulate the use of processes, knowledge, skills and techniques to assess the mental capacity of patients which are identified in published literature as being effective in the assessment of the physiological status of patients (Higgins et al 2008, Elliot 2010, Perez and Folse 2011, Morrison and Symes 2011, Cork 2014). However, this study has demonstrated that assessment processes contain a number of related factors other than a sole focus on the physiological status of patients. The psychosocial and emotional needs of patients are included in the assessment of patients. This appears to bring together the concepts of mental capacity, mental wellbeing and/or mental health which also reflects the closeness of the main tenets of the Mental Capacity Act 2005 and the Mental Health Act 2007. The boundaries between these statutes are becoming increasingly blurred (Barker et al 2014, Griffiths 2014) and there appears to be increasing focus on the autonomy of those patients for whom both statutes apply (Bates and Stickley 2013). Recent legal cases before the Court of Protection have ruled in favour of patients detained for treatment under the Mental Health Act 2007 regarding respecting a valid advance directive for a patient receiving compulsory treatment (Nottinghamshire Healthcare NHS Trust v RC 2014) and ruling that compulsory treatment was not in the best interests of a patient (A NHS Trust v X 2014). This reflects an increasing scrutiny on the potential benefits of the capacity-based approach outlined in the Mental Capacity Act 2005 with the view that this could go some way to provide a more ethical and patient-focused approach to assessment and treatment for those with mental health problems (Bates and Stickley 2013). Currently, those with mental health problems are assumed to lack capacity to make decisions about assessment and treatment (Richardson 2010). Assessing a patient under the Mental Health Act 2007 has the potential to remove the right of a patient to take responsibility for themselves where there are concerns regarding mental health status (Mckie and Naysmith 2014). Patients who have physical health problems are assumed to have mental capacity, have a right in law to refuse treatment provided they have sufficient mental capacity to understand the risks and benefits of treatment, and have the ability to make their own decisions as a result (Jones 2014). Therefore, a system which uses mental capacity as a basis for the assessment of mental health and physical health problems may assist in promoting the autonomy of patients and ensure that decisions are made in the best interests of all (Griffiths 2014).

This study has revealed that techniques for assessing mental capacity and physical status of patients can be, and appear to be, combined to facilitate a holistic approach. However, it appears that the emphasis on the potential vulnerability and dependence of acutely and critically ill adult patients has broadened the scope of what may be assessed. This indicates that the assessment of mental capacity is not a lone process and the scope of what is assessed may have relevance and applicability for other healthcare contexts such as those providing continuing and/or primary care. In acute and critical care environments and the time pressurised and unpredictable nature of these, a holistic approach would appear to best serve the complex needs of patients, many of whom may have a range of healthcare needs, including those related to mental health and wellbeing. This study, therefore, appears to have provided confirmation of this and makes a unique connection between these components of assessment processes. Also, these processes contribute to a cyclical pattern of assessment in which a multi-professional approach is highlighted and in which the qualified nurse is central to the co-ordination of a cycle of assessment. This adds to the concept of a holistic approach to assessment which has potential implications for the care of adult patients. These include making timely diagnoses which are patient focused and the implementation of appropriate care and treatment regimes. This, in turn, may facilitate patient focused outcomes which may be applicable across a range of clinical contexts.

This study also provides a unique insight into assessment processes which appear to be hidden, yet have considerable significance in supporting the decision making abilities of patients across acute and critical care settings. Some participants do not think they assess the mental capacity of patients and regard that this is done primarily by doctors who use the Mini Mental State Examination as an assessment tool. This is regarded as a formal assessment and one which is conducted by doctors. A number of participants equate assessment to using a pre-defined assessment tool, as this will facilitate evidence that an assessment has been conducted. This study demonstrates that informal nursing actions and processes appear to contain in-depth and holistic techniques that are applied during day-to-day nursing activities. This results in opinions that these do not constitute assessments of capacity. Data in this study suggest otherwise, with participants articulating processes consisting of layers of depth and complexity. They also articulate processes which focus on social and environmental contexts for adult patients in their care. This study, therefore, makes a contribution to the body of knowledge in providing confirmation of assessment processes and techniques used by qualified nurses.

The value of the physical and professional proximity of qualified nurses to patients across acute and critical care settings is emphasised in this study. The time limited nature of these often means that information gathering is challenging and any information obtained is valuable. Qualified nurses therefore have knowledge about patients and their families in greater depth more than any other professional group (Skar 2009). Findings in this study provide a unique insight into the importance of the physical and informational proximity of qualified nurses to patients. This enables them to prioritise the needs of patients and function as reference points, sources of information and co-ordination for other professional groups (Ryan et al 2012). This study has emphasised the significance of this when assessing the capacity status of patients, the implications of which may be profound if patients are deemed not to have decision making abilities. Loss of autonomy, being stigmatised and receiving care and treatment without consent are recognised as potential implications of concluding that capacity and subsequent decisions making abilities are absent (Bates and Skickley 2013, Jones 2014, McKie and Naysmith 2014). This assessment is therefore highlighted as of fundamental importance, with qualified nurse positioned as key professionals in facilitating assessments that are accurate and supportive of the autonomy and rights of patients.

Finally, ill adult patients in acute and critical care settings have been placed at the centre of this study by participants. The significance of the assessment of mental capacity has been established but such assessment cannot be divorced from care which is patient focused and appropriate. Participants reveal a strong professional drive to support and uphold the rights of patients in their care. This also fuels a drive to ensure that the best outcomes are achieved and appropriate assessments are conducted, thus maximising decision making abilities of patients. Participants emphasise the legal context in which they practice and allude to the primacy of patients and the significance of acting as patient advocates in supporting those who may be vulnerable, frightened and confronted with their own mortality. This study has shown, therefore, that assessment of mental capacity has fundamental significance and is influential in the ways in which patients are regarded, cared for and managed in complex and fast moving clinical settings.

7.4: Implications for Future Clinical Practice

The following summarise the main implications of this research for clinical practice:

1. The assessment of mental capacity should be regarded as essential across acute and critical care environments and also recognised as a fundamental aspect of the role of the qualified nurse. For this reason, qualified nurses should have required levels of knowledge and skill to assess the mental capacity of acutely and critically ill adult patients in their care. This assessment must be based on established legal criteria and be decision and context specific. Qualified nurses should therefore embrace principles of lifelong learning and keep abreast with legal and professional requirements of legislation regarding mental capacity and supporting the rights of patients.

2. A framework to assess the mental capacity of patients with acute and/or critical illness is indicated for reasons previously highlighted. Thus the development of a guide or tool to support this assessment is also indicated, the use of which would be applicable in complex and fast-paced clinical settings. The theoretical framework and visual representation of the theory, Nurse Managed Patient Focused Assessment and Care, which is offered in this thesis, may form the basis of a draft tool. This may also inform a framework for an educational programme for qualified nurses in this area.

3. Multi-professional assessment of mental capacity should be conducted as part of a holistic assessment of the condition and needs of patients in acute and critical care environments. The results of this should be documented in the patient record and/or nursing notes as part of an on-going commentary of clinical decisions made and care and treatment given.

4. Recognition be given to the value of the proximity of qualified nurses to patients across acute and critical settings and the depth of information that nurses have about patients and their families. This information is needed to ensure that assessments of mental capacity are accurate, appropriate and patient-specific.

5. Qualified nurses manage and co-ordinate assessment of mental capacity processes and on-going care of patients. They initiate referrals to other professional groups and co-ordinate processes of assessment and it is essential that the approach taken to assessment is multi-professional. This key role should be recognised across

professional groups due to the significance of nurse initiated and co-ordinated assessment processes. This may be achieved by educating qualified nurses of their potential as a resource regarding information about patients in their care and their value in informing members of multi-professional teams. This also suggests that inter-professional programmes of education and training are indicated. This may inform different professional groups of the value and significance of a cohesive approach to the assessment of capacity status of patients and their contribution to a cyclical process of assessment.

6. Acutely and critically ill patients may be frightened and vulnerable. Qualified nurses should act, where appropriate, as patient advocates and should strive to maximise the decision making abilities of patients. Information must be provided to those patients who are assessed as having capacity. For those assessed as not having sufficient capacity to make their own decisions, their best interests must be assessed and served, where appropriate.

7. The education of qualified nurses may be informed by the findings of this study regarding the range of knowledge and skill required to conduct in-depth holistic assessments of adult patients across acute and critical care settings, with particular focus on the legal and professional implications of the outcomes of mental capacity assessments. Themes such as autonomy, dignity, fluctuating capacity and the impact of physical illness are suggested. Therefore, an educational package is suggested containing these themes.

7.5 Limitations of the Study and Suggestions for Future Research

A critical evaluation of an area of nursing practice for which there has been little published research has been presented in this study. Findings indicate the ways in which study aims have been served. Also the views of participants have been presented in a manner which attempted to stay close to their own words. However, it is recognised that many stories can be gained from data and different researchers focus on different aspects of data, interpreting things differently and identifying different meanings (Corbin and Strauss 2008). It is also recognised that there are elements of interpretation in the presentation of findings and this study reflects the understanding and particular interpretations of the researcher. This study serves as an attempt to recount the views, opinions and discussion points of participants in an honest and accurate manner. In the presentation of findings, focus has been placed on the principles of trustworthiness and believability, but it is acknowledged that the interpretations taken from data in this study are some of the many which are possible (Corbin and Strauss 2008). The importance of attention to quality in grounded theory studies is recognised (Birks and Mills 2011), a principle which has been valued in this study. However, interpretations of data leading to the development of the theory of Nurse Managed Patient Focused Assessment and Care may be regarded as limitations to this study due to the focus and identification of meanings of the researcher.

Further recognition is given to the limitations of the findings of this study. One district general hospital was used from which 13 participants were purposively recruited. This hospital provides a comprehensive range of urgent, acute and critical care and support services across wards, specialised units and departments and may be regarded as representative of a district general hospital serving an urban and semi-rural population. However, caution needs to be exercised in applying the findings of this study to other hospitals of similar profile. Participants in this study represented a range of urgent, acute and critical care clinical environments, yet they cannot be assumed to be representative of other staff of similar profiles and from similar clinical settings and also cannot be assumed to be representative of other staff in the district general hospital from which they were recruited. Furthermore, given the size and nature of the sample group in this study, findings cannot be assumed to be representative of those of other similar profiles.

In addition, 13 participants were recruited as willing volunteers, without a personal approach from the researcher and responded to a letter of invitation. An interpretation may be taken, therefore, that these participants were self-selecting and may have been interested and enthusiastic regarding the concept of mental capacity to volunteer in this way. Hence, this may limit the dependability and transferability of findings (Mills and Birks 2014) when applied to staff of similar profiles.

Furthermore, findings of this study are based on descriptions, articulation and discussion of methods of assessing the mental capacity of adult patients and their on-going care and management. Whilst there is no doubt, as such, regarding the veracity of these, they constitute verbal accounts only and may not reflect the realities of the role and function of qualified nurses in this area, for example, what they say they do and what they actually do in practice. All participants were enthusiastic and confident in their discussions and the only hesitancy they demonstrated appeared to relate to their lack of appreciation and realisation of the depth of their response to patients in their care and their subsequent actions in securing patient focused outcomes. Also, their apparent consistency of description and language appeared to reinforce their veracity. An area of particular note, however, are the accounts of participants influencing and managing overall assessment processes including those undertaken by doctors. These are the accounts of a sample of qualified nurses from one district general hospital only and provide one professional perspective. This study did not address multi-professional assessment processes directly nor did it capture the accounts of doctors in particular. This constitutes further limitations to this study. However, as discussed earlier, multi-professional processes were regarded as beyond the scope of this study but may well form a programme of related work.

Findings and the developed theory in this study, therefore, have raised questions and highlighted areas for further research which may inform future clinical practice and also the education and development of qualified nurses in this area. The legal context in which practitioners of acute and critical care operate is becoming increasingly more sophisticated in which the needs of patients are given greater recognition (Emmet et al 2013, Andrews and Butler 2014). This study has highlighted that the role of the qualified nurse is central to processes of assessing the mental capacity of acutely and/or critically ill adult patients in multi-professional contexts.

Therefore, potential areas for further research include:

- An exploration of processes and strategies used by qualified nurses in assessing the mental capacity of patients in other less acute clinical environments and comparisons made. This may provide different perspectives which may serve to highlight processes and strategies used in more detail and breadth. This may, in turn, further inform the grounded theory, Nurse Managed Patient Focused Assessment and Care and provide some insight into its applicability across a range of clinical settings.

- An analysis of the feasibility of the use of guidelines or an assessment tool to inform the assessment of mental capacity of adult patients and an exploration of the impact of this. The visual representation of the theory, Nurse Managed Patient Focused Assessment and Care may inform a draft tool which could be tested by qualified nurses across acute and critical care settings. This may comprise an evaluative study

- An exploration of role of the qualified nurse in the multi-professional assessment of mental capacity processes and the views of other members of the multi-professional team. The views and opinions of doctors regarding how their assessment of mental capacity processes may be better informed by qualified nurses appears to be indicated. This may, in turn, inform qualified nurses regarding the depth of detail required by doctors to ensure the effectiveness and timeliness of referrals. In addition, this may highlight effective and efficient communication and referral processes to both professional groups.

- An analysis of assessment of capacity processes that are actually employed by qualified nurses in practice using an ethnographic approach. This may establish the reliability and validity of these processes in the reality of acute and critical care settings.

7.6 Personal Reflection

This section is written in the first person due to its reflective nature.

This study represents a journey which has been enjoyable, thought-provoking and challenging for a number of reasons. As indicated in the introduction of this study I am a practitioner of acute and critical care and academic of long standing. Despite many years of experience as a clinician and educationalist, I am a novice researcher and this study represents a first attempt at a research study of this scale and magnitude. What I have learned has been invaluable, both personally and academically. I identified that the methodological approach of grounded theory was suited to the aims of this study and entered into an analysis of this with some trepidation. Understanding its philosophical and methodological approaches were challenging, in particular processes leading to the development of a grounded theory. My inexperience as a researcher led me to anticipate the value of using a reflexive approach which resulted in me maintaining a comprehensive and detailed reflexive journal in which field notes and memos were located. I realised the significance of doing this as I wanted to provide evidence of processes of quality permeating all aspects of this study and recognised the need to develop and maintain systems for leaving evidence trails of methodological decision making, methods used, process of analyses and conclusions drawn. I also wanted to be able to justify the progression of my theoretical conclusions made in the development of my grounded theory. With hindsight this approach was effective in assisting my adoption a reflexive approach, both retrospective, over the time span of this study, and prospective as methods of data analysis became more sophisticated, and supported the momentum of processes of analyses through each phase of this study. Detail in my reflexive journal proved to be an invaluable aide memoir in addition to a comprehensive record of the progression of this study. This approach also enabled me to use processes for axial coding which worked well. On reading the literature regarding these processes, I anticipated that I would find this difficult and would lose my way. This was not the case and I actually enjoyed this analytical phase of my research, realising that this led to the development of my eventual theory. My conclusions here are that this approach, whilst being incredibly detailed, is essentially logical. This appeared to suit my personal approach which facilitated my analysis of data in this study. I have also been challenged by the depth of thought and critical analysis needed to find my way through what data were telling me. Making the leap to my grounded theory was difficult but thought provoking and rewarding at the same time. Situating my grounded theory in extant literature has also been personally and professionally rewarding. I anticipate that I have developed a theory that has applicability across a number of clinical contexts and can be used for a variety of patient situations

As a clinician I have been surprised by some of the findings of this study. I anticipated that participants would primarily indicate that they did not really conduct in-depth assessments of the mental capacity of patients in their care. Findings indicate otherwise. I have been impressed with what participants articulated and also by their knowledge about the concept of mental capacity and its legal context. I found interviewing them informative, fascinating and enjoyable. I also realised that they are practitioners who appeared motivated to care for patients in challenging settings as they described how they would support the decision making abilities of patients and the ways in which they would advocate for them. As a practitioner of acute care I was surprised by the depth of some descriptions of ways of assessing and supporting patients. I also actually felt quite proud of some of the comments which were made as they reflected effective care in which dignity and the rights of patients appeared to be valued.

However, I have been interested and somewhat surprised by the similarity of actions, opinions and processes articulated by participants and in the use of what appears to be the universal label of “something not quite right”. This appears an unassuming label, beneath which layers of complexity of process and action are located. As a clinician I realise that I also use this but I had not thought about it until I conducted this study or thought about its significance. Also I now realise that this label is used frequently by students, both pre and post registration, when they discuss their clinical experiences in classroom and simulated clinical settings. For me this reinforces aspects of the universal language and meaning which practitioners use and understand, something which had not occurred to me until I analysed data in this study. It also reinforces the universal notion of what lies beneath the label “something not quite right”.

Finally, doing this study has given me a sense of achievement in that I did not think of myself as a researcher. I have developed personally, professionally and academically and my confidence is enhanced in each respect. The learning, teaching and scholarly activities in which I am involved as a clinician and academic have been informed as a result. As a clinician this has enhanced my interest and enthusiasm in the need to critically analyse assessment, care and management processes. So much so, that I realise this study represents a beginning in a process of enquiry and research.

7.7 Conclusion

This study has explored and provided clarity in an area of nursing practice for which there is little published evidence. Findings suggest that qualified nurses assess the mental capacity of acutely and critically ill adult patients in some depth. They also co-ordinate and manage processes for on-going assessment and care of patients in what is revealed as a cyclical process of assessment and one in which a multi-professional team approach is essential.

Informal, sometimes instinctive, assessment processes are used which lead to techniques in which the mental capacity and physical status of patients are combined. This appears to facilitate a holistic approach to assessment. This may be regarded as an anticipated, clinically effective and time-efficient way of assessing the needs of adult patients across fast-moving, front line, clinical settings. This further implies that assessing capacity status is not a separate process and should be placed in the context of the individual presentation of each patient. In addition, the potential vulnerability and dependence of acutely and critically ill patients is highlighted which indicates a patient focused element of an assessment process. This may provide a more holistic and accurate view of the status of patients and take account of timely clinical imperatives and the need to support the autonomy and decision-making abilities of patients.

This study therefore provides an insight into the caring role of the qualified nurse across assessment and management processes and the essentially patient focused nature of this. The grounded theory of Nurse Managed Patient Focussed Assessment and Care provides a theoretical framework which explains the strategies and processes used by qualified nurses and evidences the ways in which the aims of this study have been met, at the same time adding a unique contribution to knowledge to this key area of clinical practice.

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Appendix 1: Senior Nurse/Ward Managers Letter of Invitation

01443 483029 (Direct Line with Voicemail)
sjones@glam.ac.uk

Sian Jones
Acting Associate Head
Professional Education and Service Delivery
Faculty of Health, Sport and Science
University of Glamorgan
Glyntaff
Pontypridd
CF37 1DL

Dear Colleague

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

I am conducting a research study that will explore the above. I wish to recruit qualified nurses with at least 3 years post registration experience of acute and/or critical care and I would be interested in arranging to meet with members of your team individually who meet this criteria to discuss their experiences.

I would therefore be most grateful if you could distribute the enclosed information packs to those practitioners who have at least 3 years experience so that they can decide if they wish to participate in my study.

Enclosed is an information sheet which will clarify what the study is about. Please take time to read this and contact me if you have any queries or you would like to know more about the study.

Thank you for taking the time to read this

Yours sincerely

Sian Jones

Appendix 2: Participant Letter of Invitation

01443 483029 (Direct Line with Voicemail)
sjones@glam.ac.uk

Sian Jones
Acting Associate Head
Professional Education and Service Delivery
Faculty of Health, Sport and Science
University of Glamorgan
Glyntaff
Pontypridd
CF37 1DL

Dear Colleague

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

I am conducting a research study that will explore the above. If you are a qualified nurse with at least 3 years post registration experience of acute and/or critical care, I would be interested in arranging to meet with you to discuss your experiences.

Enclosed is an information sheet which will clarify what the study is about. Please take time to read this and contact me if you have any queries or you would like to know more about the study.

If you are willing to take part in the study then please complete and sign the enclosed consent form and return it to me in the envelope provided. I will then arrange to meet with you at a time and place that is convenient for you.

Thank you for taking the time to read this

Yours sincerely

Sian Jones

Appendix 3: Participant Information Sheet

Participant Information Sheet:

‘An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients”.

Invitation to take part in a research study

You are invited to take part in a research study. If you wish to volunteer it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss this with others if you wish. If you want to clarify anything or if you would like more information, please contact me at the address below. Thank you for your time and, if you decide to take part, I look forward to hearing from you.

What is this study about?

Qualified nurses in acute care settings often have to care for ill patients with complex health needs and whose condition may rapidly deteriorate. Decisions sometimes have to be made about such patients quickly and without much information about them. At the same time, patients have to be allowed to make decisions about themselves and for themselves. In order to do this, patients need to have sufficient mental capacity and this often has to be assessed by the nurse.

This study is therefore being undertaken to find out more about the experiences of nurses in the assessment of the capacity of patients, the ways that they assess, the decisions they make and the factors that may influence these. It is believed that a greater understanding of these aspects of the role of the nurse could help to identify if improvements are needed in the ways that patients are assessed and in decision making processes that nurses adopt.

Why I have been invited?

You have been invited to take part in this study because you are a qualified nurse with a minimum of 3 years post-registration experience of acute and/or critical care. Your views will probably be unique and extremely valuable and will, therefore, help to increase understanding in this area.

Do I have to take part?

No, it is up to you. If you do decide to take part, please sign and complete the consent form contained in this pack and return it in the freepost envelope provided. Please note, if you decide to take part in the study you are free to withdraw at any time without giving a reason. If you decide not to take part then no further action is required.

What will happen to me if I take part?

I would like to interview practitioners from a range of clinical environments across acute care settings. As a result, from all those who respond, I will select practitioners according to clinical areas in which they work, the amount of time that they have been qualified and their grade/band.

If you decide to take part in the study, you will need to send your consent form to me. When I receive this, one of three things could happen:

1. I may contact you to arrange a meeting at your convenience.
2. I may keep your consent form on file and contact you at a later date to arrange a meeting at your convenience
3. I may keep your consent form on file, contact you to thank you for volunteering and inform you that you have not been selected to take part in the study due to the numbers of nurses who have responded.

If I contact you to meet at your convenience, you will then be interviewed by me. The interview will be at a time and location that is convenient for you. For example, this could be at your workplace or somewhere mutually convenient.

The interview will be conducted in an informal and sensitive manner and will focus on your experiences as a qualified nurse in assessing the mental capacity of acutely ill patients, the decisions that you make and factors that may influence you in your assessment of patients. All interviews will be tape recorded, providing this is acceptable to you. Once this information is transcribed the tape recordings will be erased. Also during the interview I will take notes, but these will be for my own purposes only.

How much of my time will this take up?
If you choose to take part in the study, each interview is likely to last approximately 30-40 minutes and will be arranged at times and locations that are convenient for you.

What are the potential benefits of taking part?
There may be no direct benefit to you in participating in this study, but you will have an opportunity to talk about an aspect of your practice in some depth. This may help you to reflect upon your practice in this area.

It is anticipated that this study will increase understanding and insight into the experiences of nurses in assessing the mental capacity of patients. It is also possible that this study may help to highlight if improvements are needed in this aspect of patient care.

Who is organising and funding the research?
This study is being conducted by Sian Jones, an employee of the University of Glamorgan who is a practitioner of acute care and an academic specialising in health care law. This research is being conducted as part of programme of study that will lead to MPhil/PhD and is being supervised by a team of colleagues at the University of Glamorgan. This study has also been approved by the University of Glamorgan and the Local Research Ethics Committee.

What happens when the study finishes?
After you are interviewed your role in this study will be over. Information collected during the interviews will be analysed and will contribute to the eventual write up and conclusions of the study. The ways that this study has been conducted and its findings and conclusions will be published in appropriate journals and presented at appropriate conferences. Information gathered as part of the research will be stored securely at University of Glamorgan and then destroyed after a mandatory period of 5 years.

Feedback will be provided to you at the end of the study so that you will be informed of the eventual outcome, conclusions and recommendations.

What if there is a problem?

It is not anticipated that you will encounter any problems. However, if any untoward event occurs as a result of this research please contact the researcher, Sian Jones, in the first instance. Also any complaint you have about the way that you have been dealt with during the study will be addressed. If you require any further information, help or support as a result of participating in the study, information can be provided on request. The research is also covered by the University of Glamorgan indemnity scheme.

Will my taking part in the study be kept confidential?

All information collected during the study will be kept strictly confidential and used only for research purposes. However, if you disclose information of an exceptional nature, for example, that you have witnessed aspects of unsafe care or poor service experienced by patients, you will be encouraged to use systems of line management in your workplace to report this to an appropriate person.

Interview information will be stored with an anonymous identifying number (known only by the researcher, Sian Jones), not your name, so that you cannot be recognised from it. All information in this study will also be stored securely at University of Glamorgan premises, in accordance with data protection legalisation; either in a locked cabinet and, or on a secure, password protected computer.

What do I need to do?

If you would like to take part in the study, please complete the appropriate, attached consent form and return it to me in the freepost envelope provided, within approximately 6 weeks, to the address below. If you decide not to take part then no further action is required.

Thank you for taking the time to read this.

If you require any further information or have and queries please contact:

Sian Jones
Acting Associate Head of Department
Faculty of Health, Sport and Science
University of Glamorgan
Glyntaff
Pontypridd, UK
CF37 1DL

01443 483029 (Direct Line and Voicemail)
sjones@glam.ac.uk

Appendix 4: Participant Consent Form

Consent Form

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

Name of researcher: Sian Jones

Please tick box

1. I confirm that I have read and understood the information sheet given to me regarding the above study ☐
2. I have had the opportunity to consider the information, ask questions and, where appropriate, these have been answered satisfactorily ☐
3. I understand that my participation in this study is voluntary and that I am free to withdraw from the study at any time without giving a reason ☐
4. I understand that the content of the recorded interviews will be confidential and that I will not be identifiable in any subsequent reports or publications of the research findings. Once interviews have been transcribed the tape recordings will be erased. ☐
5. I agree to participate in the above study ☐

Name (Please Print):……………………………………………………

Date: ……………………………………………………………………….

Signature: ………………………………………………………………

Please <u>identify your clinical speciality, your grade/band and the number of years that you have been qualified.</u> Please also provide your contact details below, so that the researcher can contact you about the study:

……………………………………………………………………………………......

……………………………………………………………………………………..

……………………………………………………………………………………

Please sign, date and return this form in the Freepost envelope provided to:

Sian Jones
Acting Associate Head of Department
Faculty of Health, Sport and Science
University of Glamorgan
Glyntaff, Pontypridd, CF37 1DL
01443 483029 (Voicemail)
sjones@glam.ac.uk

Appendix 5: Participant Demographics Form

Sian Jones,

Associate Head of Care Science/Head of Simulation

Faculty of Health Sport and Science

University of Glamorgan

PhD

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

Demographic Form

Participant Number	
Gender	
Role Title	
Clinical Speciality	
Agenda for Change Profile	
Number of Years Qualified	
Date of Interview	

Appendix 6: Examples of Interview Schedules with Participants F01, M02, F03 and F04

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

Interview Schedule: Participant F01
01/06/2011

Main Questions:

1. Can you tell me what you understand about the concept of mental capacity?
2. What are your opinions and views of mental capacity?
3. How do you assess the mental capacity of patients in your care?
4. What factors influence you when you assess the mental capacity of patients?

Supplementary Questions:

1. What types of patients do you regularly encounter?
2. How do you know/decide that a patient has capacity?
3. How do you know/decide that a patient does not have capacity?
4. Once you have made a decision whether a patient has capacity or not, how does this affect the ways that you manage the care of the patient?

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

Interview Schedule: Participant M02
11/08/2011

Main Questions:

1. Can you tell me what you understand about the concept of mental capacity?

2. How do you assess the mental capacity of patients in your care?

3. What factors influence you when you assess the mental capacity of patients?

4. What role do family/carers play in your assessment of a patient?

5. In what ways do you regard nurses as advocates of patients when assessing capacity?

6. In what ways does your assessment of prognosis/quality of life influence your assessment of the capacity of a patient?

Supplementary Questions:

1. What types of patients do you regularly encounter?

2. How do you know/decide that a patient has capacity?

3. How do you know/decide that a patient does not have capacity?

4. Once you have made a decision whether a patient has capacity or not, how does this affect the ways that you manage the care of the patient?

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

Interview Schedule: Participant F03
16/08/2011

Main Questions:

1. Can you tell me what you understand about the concept of mental capacity?
2. How do you assess the mental capacity of patients in your care?
3. In what way does nursing assessment of capacity link to doctors assessment of capacity?
4. What factors influence you when you assess the mental capacity of patients?
5. What role do family/carers play in your assessment of a patient?
6. In what ways do you regard nurses as advocates of patients when assessing capacity?
7. In what ways does your assessment of prognosis/quality of life influence your assessment of the capacity of a patient?
8. What are your thoughts about the legal position of the nurse in the assessment of capacity?

Supplementary Questions:

1. What types of patients do you regularly encounter?
2. How do you know/decide that a patient has capacity?
3. How do you know/decide that a patient does not have capacity?
4. Once you have made a decision whether a patient has capacity or not, how does this affect the ways that you manage the care of the patient?

An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients.

Interview Schedule: Participant F04

14/09/2011

Main Questions:

1. Can you tell me what you understand about the concept of mental capacity?
2. How do you assess the mental capacity of patients in your care?
3. In what way does the ability of patients to understand information influence your assessment of capacity?
4. What factors influence you when you assess the mental capacity of patients?
5. In what way does your assessment of clinical priorities impact upon the ways that you assess capacity?
6. What role do family/carers play in your assessment of a patient?
7. In what way does nursing assessment of capacity link to doctors assessment of capacity?

Supplementary Questions:

1. How do you know/decide that a patient has capacity?
2. How do you know/decide that a patient does not have capacity?
3. Once you have made a decision whether a patient has capacity or not, how does this affect the ways that you manage the care of the patient?
4. What are your thoughts about the legal position of the nurse in the assessment of capacity
5. In what ways do you regard nurses as advocates of patients when assessing capacity?
6. In what ways does your assessment of prognosis/quality of life influence your assessment of the capacity of a patient?

Appendix 7: Example of Memos Recording Thoughts, Feelings, Impressions, Insights and Reflections During and After Interviews

Memo: Interview with Participant F04

Notes/Observations Made During Interview:

1. Knowledgeable about legal criteria to assess capacity, difficult to assess in fast moving settings will ill patients. Presumption of capacity, many factors influence this pain etc
2. Focus on patients being bewildered, can see fear in their eyes, patients need to feel safe. Analogy of a theme park and the fear experienced by circumstance. Stressed the need to reassure and support patients.
3. Importance of assessing in a non-obvious way to get a true reflection of the patient when they do not feel observed. Subtle approaches.
4. Example of a jigsaw puzzle, getting all the pieces and putting these together. Also the need to reassess getting more or different pieces and making a new picture
5. Stresses the importance of communication and giving reassurance, a caring role.
6. Gut feelings leading to something not quite right, having nagging feelings about patients. An aura about patients, cues given to the nurse, cannot explain or describe, but concern felt. Patients look as though they do not have control, a look of panic.
7. Doctors add jigsaw pieces, importance of multi-professional team approach, putting nurses and doctors pieces together. Nurses more subtle than doctors.
8. Nurses as advocates, a bridge between patients and doctors.
9. Family have a big role, can give information and put the patient into context. Need to assess a family unit as a whole.
10. A big legal role for nurses, powerful positions and help patients make the biggest decisions of their lives sometimes. Nurses need to be more autonomous because of this. Capacity can be overlooked in emergency situations, nurses need to remember their legal duty. Emphasis on responsibility and accountability.

Observations Immediately after the Interview:

Appeared confident and came across as experienced and knowledgeable. Has only been qualified for 3 years. Tried hard to express thoughts and appeared comfortable despite having occasional difficulty in articulating meaning. Came across as having a passion for giving good and effective patient care and interested in people. Also was very focused on the patient as an individual. Provided some interesting insights into what is done to assess capacity and how this is done. Gut feelings and something not quite right comes up again. This appears a common theme. Focus on appearance, aura, bewilderment etc. Also methods of subtle assessment. Strong focus on reassurance and supporting patients. Also the significance of a multi-professional approach and finding and putting pieces of a jigsaw together.

Themes Identified after Interview:

- Acute care makes assessment difficult, patient out of their normal setting has a significant effect
- Bewilderment, see the fear in their eyes, analogy of a theme park
- Assessing in a subtle way, nurses do this differently to doctors
- Assessment and jigsaw analogy, doctors and relatives create pieces of the jigsaw
- Importance of assessing the patient as a person, communication and reassurance
- Get feelings, something not quite right, nagging feelings, noticeable change in the patient
- Patients give an aura, revert to childlike behaviour, need a sense of control
- Impact of time and clinical priorities
- Nurses as advocates
- Role of family
- Legal position of the nurse and related responsibilities, assessment and decision making and the power of a nursing position
- The autonomy of the nurse
- Impact of time and environment

Appendix 8: An Example of the Identification of Open Codes and the Construction of Memos

Extract Taken From Interview with Participant F06

For ease of reading:

- Transcribed words are presented in black
- **Open codes are presented in blue**
- **Memos are presented in red**

SJ – let's start off, you deal with acutely ill patients, let's talk about your experiences of assessing patients. What do you assess and how do you assess?

F06 – I do not assess formally and document, I do not write forms as such. A lot of our nursing assessment is informal **(open code – assessing informally) (Memo – again focus on an informal approach that is not documented. This appears to be a common theme so far. Do nurses not recognise the significance of what they are doing because it is part of the everyday role and not documented?)**. An example that I can give, we have got a lot of CVA patients who come in and after about 24/48 hours if they have still not got a swallow, as part of the bundle we should NG feed. A lot of our patients who cannot swallow, perhaps are unwell, speech has gone. NG is an invasive procedure, to get consent **(open code – role of the nurse)** what I usually intend to do is explain what I am going to do and if they cannot actually verbalise I ask them either to squeeze my hand if they understand or nod their head if they are accepting that I am going to attempt the NG and why they need it **(open code - supporting the rights of patients)**. I say it's for their nutrition and why we need to do it and why it's important. I also explain that it is only a short term measure. If there is any hint of resistance we stop the procedure **(open code - supporting the rights of patients)** because then I feel perhaps they either did not understand **(open code - nursing assessment)** or they really do not want this **(open code - supporting the rights of patients)**. We then go back to the team **(open code - role of the nurse)**, or if they are persistently pulling them out we would not go any further **(open code - supporting the rights of patients)**. There is not really a written assessment for this, its informal and it's a nursing assessment **(open code – assessing informally)**. **(Memo – focus on the nurse. This could be the start of the assessment process for the patient, nurses do this as they are there with patients, the only 24hr presence, and this is part of their normal nursing role, hence the label informal?)**.

SJ – let's talk about this informal nursing assessment in some detail. If you think of a range of patients, what do you actually do to assess as an experienced practitioner?

F06 – to assess somebody understands for their mental capacity (pause) I have got to be happy that there is understanding of what I am saying, the patient can retain information, they can answer me appropriately, that they understand, that they know the benefits, pros and cons, and they understand and they can give me an answer back, they can reply to me yes/no or I don't want this procedure saying **(open code – nursing assessment)**. I can't say gut feeling **(open code – using gut feelings) (Memo – I am surprised that we got into this so quickly. This could be at the centre of the basis for the informal nature of nursing assessment. Need to relate this to participant F01, assessing in own head, F03 assessing instinctively and in a subtle manner "something not quite right", F04 picking up on cues from the patient and putting the pieces together like in a jigsaw puzzle?)**, I tend to know **(open code – using prior knowledge and experience)** if they are not understanding what it is I am saying, they can't repeat back to me or they can't understand why I am doing it **(open code – nursing assessment)**.

SJ – lets go back to that gut feeling……….

F06 – I don't think I can say that (laughter) **(This is an experienced practitioner who appeared confident and relaxed about laying out and exposing experiences. Could the laughter be because of the evidence based culture that is out there – need to keep in mind that nurses could hide these feelings for this reason? Are these feelings accurate – a potential line of enquiry??)**

SJ – you can say that, you just have. When you get that gut feeling how do you know it's a gut feeling, what is this?

F06 – it's just the way that they look **(open code – nursing assessment) (Memo – very interesting – is this about responding to visual and other cues and responding quickly in real time? Are nurses responding to the first indication that the capacity of the patient is fluctuating? Are gut feelings the label for a rapid response to cues from the patient – nurses are responding to empirical evidence coming from patients but do not realise that they are doing this????)**, you can look at them and tell that they are not understanding, they are not verbalising back to you, like a conversation that me and you are having right now, that they understand what you are saying. Sometimes they will ask you the same question over and over again so you obviously know that they have not retained what you have explained in the first place or they did not understand it. I would try to put it in a simpler way, in a way that they understand **(open code – nursing assessment)**. A lot of our patients can understand to a point, to their level of their competence **(open code – definitions of capacity)**

SJ – lets go back to something that you have just said, the gut feeling and the way that they look. How do patients look if you have this feeling?

F06 – it's not that they look with a blank expression, they can sometimes look at you and you can see that they are not understanding what you are saying, not like a blank expression but you have a feeling **(open code – using gut feelings)** **(Memo – is this a gut feeling and are these triggered by cues from the patient? The lead into gut feeling could be the significance of the visual assessment that is done by the nurse but which is not recognised and/or valued as an actual assessment. This is probably done in real time and rapidly. This could be reinforced by the fact that this is expressed as a feeling which may not be recognised as hard clinical evidence??)** that they didn't quite grasp what you are saying **(open code – nursing assessment)**. Sometimes I think if you go ahead and do the procedure, are they really giving consent for that procedure? **(open code – supporting the rights of patients)** Again it depends on what you are doing (pause)

SJ – I may seem to be nagging but if somebody looks as though they do not understand, how do you know, what is that look that leads you to believe they do not understand?

F06 – it's their facial expression, **(open code – nursing assessment)** **(Memo – again strong focus on the visual appearance of the patient. I need to look at this before the next interview, at how the visual grabs attention)** they may be repeating themselves, are they asking you the same question, their facial expression looks confused, can you look confused? You can tell that they are not understanding what you are saying (pause) **(open code – nursing assessment)**. I've nursed a long time and I can tell when people are not grasping what you are saying. **(open code – using prior knowledge and experience)** I try to put it in a simpler way (pause). **(open code – supporting the rights of patients)** A lot of the patients that I have dealt with over the years, I feel sometimes they understand one day, but understanding can come and go **(open code – using prior knowledge and experience)** **(Memo – again are nurses very sensitive to picking up on fluctuations in the capacity of patients??Are they using visual recognition of this but not realising this is what they are doing??)**

SJ – ok, if patients understanding comes and goes how do you know that, what leads you to form an opinion that one day they might understand and the next day not?

F06 – it is difficult but I think that a lot of patients have lucid moments, have a conversation and they are remembering everything, and they know who you are. The following day they don't and that is obviously a non-lucid moment. A lot of our patients are on the ward for quite a while. We get to know them quite well over several weeks. **(open code – using prior knowledge and experience)** We do get a lot of dementia patients they have lucid moments as well. Even if they have a diagnosis of dementia they still can make some decisions, eg, if they want a cup of tea or not, if they want a drink or not. There is still some level there I think, they can still make simple decisions of what they want. I think its wonderful if they can make these small decisions. **(open code – definitions of capacity)**

SJ – I want to do back…..

F06 – (laughter) I am having difficulty with these gut feeling (laughter) **(Memo – up to this point in the interview was obviously thinking about this. Gave the impression that this was the first time that this had been done in this depth? This could be a potential line of future enquiry beyond this study)**

SJ - in order to form opinions about patients, what you have just said is that you know and that you have these get feelings, how do you explain what these gut feelings are, how do you define them?

F06 – it's very difficult to describe (laughter) **(Memo – such difficulty is described at length in the literature. Do gut feelings really exist or are nurses doing rapid in-depth assessments, not valuing these as such, hence describing these are feelings???).** It's looking at the patients behaviour, what they are verbalising and looking at them when they do this, seeing how much it makes sense to me **(Memo – making sense of the information that the patient is giving off – signs are being interpreted?)** and sense to them. It's the way they behave, their whole demeanour **(open code – nursing assessment)** **(Memo – this seems to highlight bits of the assessment process and appears to illustrate that hard evidence coming from the patient is being assessed – is this a definition of gut feeling – processing information rapidly and interpreting cues?)**. Sometimes they are not quite grasping what you are saying and you have not to repeat it, **(open code – supporting the rights of patients)** they can get a bit agitated and they do not want to talk about it any more

Example of a Memo: Written on Completion of the Interview with Participant F06

On completion of a line-by-line analysis of the transcribed text above the following memo was written. This summarises significant themes and issues arising from the text and also from conducting the interview,

This was an interesting interview. This is an experienced practitioner who is confident and appeared passionate about patient care. I got the sense that much time is spent with patients on a day-to-day basis. Tried hard to articulate what was actually being done to assess the capacity of patients and was good humoured in coming to the conclusion that articulating this is difficult. Yet this appears to be an attempt to describe complex, in-depth and very subtle communication processes. These appear to be informal but indicate being attuned to patients' appearance, mood, body language and ability to communicate. Interesting comments about focussing on face and eyes, the look, the spark, something not quite right are labels that are used possibility to describe fluctuating capacity or a change in the patient. Something not quite right is a recurring label across all interviews done so far. This appears to be a complex process that is informal, not documented but in-depth. Does this indicate that nurses are alerted and respond to something about a patient which is the lead into an informal assessment process? Are nurses rapidly responding to deviations from normal if the patient is known to them? If there is no prior knowledge of the patient nurses appear to be using prior expectations of normal for the rapid informal assessments. The focus on visual assessment could be high impact which hooks nurses into an assessment process. If this response is rapid and done without thinking, this could lead to a gut feeling as nurses respond to cues. Do different nurses respond to different cues – a potential area of analysis? Conclusions – nurses could be using informal, intuitive, complex, rapid assessment processes to form opinions and judgements about the capacity status of patients. They appear to be using in-depth communication and interpersonal skills in order to do this informed by their prior

knowledge, experience and expectations of appropriate communication and socially acceptable behaviour

Appendix 9: Application of the Framework of the Paradigm to All Categories

Category: Factors Informing Nurse-Led Assessment

Central Phenomenon: Responding to Patients	
Conditions	Presentation of patients, "something is not quite right".
Actions	Using: • Own standards and definitions • Prior knowledge and experience • Memory and prior expectations • What is observed at the time and point of patient contact • What are articulated as feelings
Consequences	Informing nurse-led assessment

Category: Nurse Led Assessment

Central Phenomenon: Assessing Patients	
Conditions	Recognising change in the physical and/or capacity status of patients,
Actions	Assessing patients using: • Informal, personal processes incorporating formal criteria • Listening and visual skills • Information about physical status • Baseline information
Consequences	Assessment is initiated and led by the nurse

Category: Influence of the Role of Others

Central Phenomenon: Inviting Others into Assessment Processes	
Conditions	Identifying the need to gain information from family to inform assessment processes. Requiring assistance from the multi-professional team to facilitate ongoing assessment
Actions	Gaining information, advice and support from family Making referrals to the multi-professional team Influencing multi-professional team assessment process
Consequences	Multi-professional team assessment processes are influenced by nurse-led assessment

Category: Impact of Clinical Setting

Central Phenomenon: Impact of Clinical Setting	
Conditions	The response of patients and participants to clinical setting
Actions	Participants respond by: • Assessing in context • Recognising fluctuating capacity in ongoing assessment processes
Consequences	Nurse-led assessment is context specific and takes account of the impact upon patients

Category: The Caring Role of the Nurse

Central Phenomenon: Patient-Focused Role of the Nurse	
Conditions	Central role of the nurse in assessment of capacity and ongoing management of patients
Actions	Nurses: • Contribute to and co-ordinate ongoing assessment processes • Support patients in making decisions • Advocate for patients • Assist in making patients feel safe • Lead on processes to support the best interests of patients
Consequences	Multi-professional team assessment processes are co-ordinated and informed by the caring role of the nurse

Appendix 10: The Paradigm Model, Subcategories and Categories

Subcategories Identified from Axial Coding	Component Part of the Paradigm Model	Category
Using personal definitions of normal Using personal standards Using memory and prior expectations Assimilating present with knowledge and expectations	**Conditions**	**Factors Informing Nurse Led Assessment**
Assessing subtly Using informal and formal criteria Conducting visual assessment Listening to patients Assessing physical status Establishing a baseline	**Actions**	**Nurse Led Assessment**
Gathering information from family Making referrals and assimilating medical assessment into nursing assessment processes		**Influence of the Role of Others**
Assessing in context Recognising the capacity continuum	**Consequences**	**Impact of Clinical Setting**
Protecting decision making abilities Safeguarding standards of assessment and outcomes (nursing and multi-professional) Advocating for patients		**Caring Role of the Nurse**

Appendix 11: Integrative Memo: Story Around the Central Category

The storyline occurs in the context of acute and critical hospital environments. Qualified nurses are the ever present professional group and, by implication, they manage and control these environments. They support other members of the multi-professional team in the delivery of health care services by using referral mechanisms and other processes of communication. Also, and significantly, the physical and professional proximity of nurses to patients results in nurses having knowledge about patients and their families. Nurses therefore function as reference points, sources of information and co-ordinators for all other professionals involved in patient care. Nurses are often the link between the family/carers and other professionals in this co-ordination role.

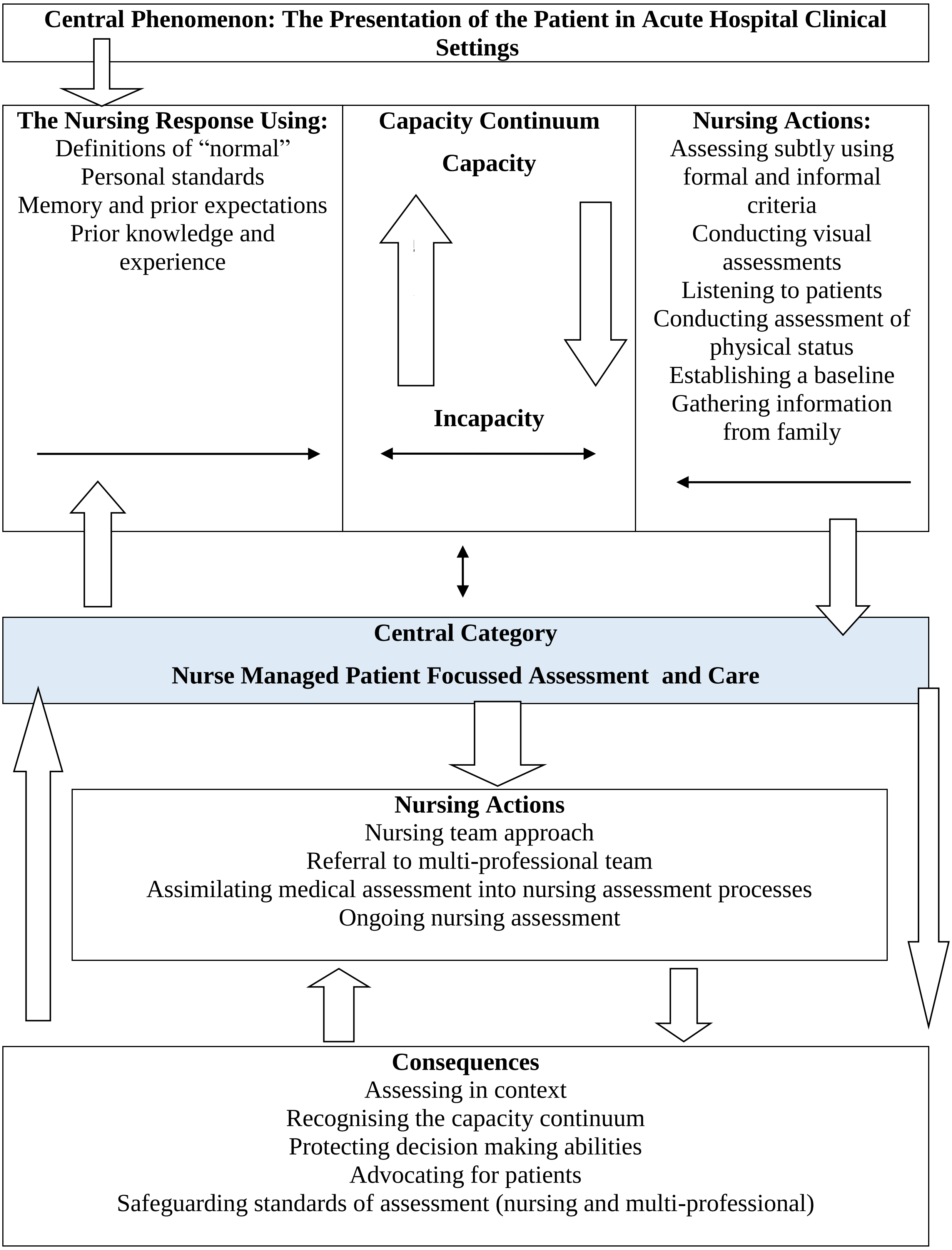
This study starts with the interaction and relationship between the patient and nurse. The presentation of the patient results in the nurse using indicators to inform judgement that a patient requires further investigation which leads to an assessment of capacity status. Nurses use own definitions of capacity, personal standards of what constitutes "normal" behaviour and levels of social skill and communication abilities. Nurses also use prior knowledge and experience and apply this to presenting situations. The lead into the assessment process occurs in real time, often rapidly and is done in the context of daily routines or getting on with the job. Therefore the assessment process is not identified as a distinct process which results in the nurse defining it as informal, not actually doing an assessment of capacity, and nothing is documented. This, in turn, results in the nurse describing this as done instinctively, unconsciously and having gut feelings about patients that "something is not quite right". What this actually means is that nurses are using in-depth communication and interpersonal skills to assess patients informed by their prior knowledge and experience and expectations of appropriate and socially acceptable behaviour/ways of communicating. Nurses are also using hard evidence that they assimilate and process rapidly, for example, what I see, observe, what I find out, but do not realise or recognise they are actually doing this, hence the articulation that they have feelings, an instinct that "something is not quite right.

The assessment process has a strong focus on establishing baselines for patients upon which to judge that capacity and decision making abilities are compromised. Here nurses are conducting in-depth assessments of visual presentation, physical status, communication abilities and awareness and understanding abilities. Also nurses are gathering information from families and other professionals who may have previously been involved in the care of patients which is then assimilated into the process. At any point in this process nurses use a capacity continuum to assess if capacity is compromised with the realisation that patients can move along this continuum at any time, in any way and at any point in time. This necessitates the need to assess continually as it is recognised that capacity status can be ever changing. A nursing team approach is also evident when opinions are checked and shared to ensure the accuracy of assessments.

Once nurses have formed judgements that capacity is compromised, this results in nursing referrals to doctors. Doctors attend clinical environments, nurses provide the information they have gathered and the judgements they have formed, doctors then assimilate this into medical assessments. Here nursing and medical assessments are combined and the information is pooled, although most of this appears to originate from nursing assessments. When doctors have left clinical environments nurses, the ever present professional group, manage on-going assessment and re-refer to doctors if they feel this is needed for patients.

Before, during and after the involvement and intervention of doctors nurses ensure that patients receive appropriate assessment and support. Nurses recognise that patients whose capacity is compromised are vulnerable and needy and patient responses and reactions to the situations they are in can often be influenced by many factors. These include the environment, their emotional response to this, their physical illness, the effects of medication, their responses to the doctors. Nurses therefore oversee and influence the standards of assessment processes and strive to secure the best outcomes for patients. In doing this nurses recognise that they act as advocates as patients need information to make choices, and patients with capacity need to be supported to make their own decisions. The rights of the patient are recognised and supported.

Appendix 12: Visual Representation of the Central Category: Nurse Managed Patient Focused Assessment and Care



Appendix 13: Confirmation of Ethical Approval from the Faculty of Life Sciences and Education, University of Glamorgan

6th September 2010

Mrs Sian Jones
C/o Faculty of Health, Sport and Science
University of Glamorgan

Dear Mrs Jones

"An analysis of processes and strategies used by qualified nurses in assessing the mental capacity of acutely and critically ill adult hospitalised patients".

I am writing to confirm that upon receipt of your revised ethics application, the Faculty of Health, Sport and Science Ethics Committee has approved your resubmission with immediate effect.

If you have any queries about the group's decision, please do not hesitate to contact me

Yours Sincerely

Prof Paul Rogers
Faculty Ethics Campion

Appendix 14: Confirmation of Ethical Approval from a Health Board

Mrs Sian Jones
Faculty of Health, Sport and Science
University of Glamorgan

Dear Mrs Jones

Re: CT/121/10 An Analysis of Processes and Strategies used by Qualified Nurses in Assessing the Mental Capacity of Acutely and Critically Ill Adult Hospitalised Patients.

Thank you for clarifying the points raised at the Risk Review Group (RRG) held on 18th November 2010. I have pleasure in confirming that this project now has full approval to commence in ………Health Board. However commencement of the project should be upon the receipt of ethical approval if required. If the project is a multi-site study if is advised that you also obtain approval from all other Health Boards before commencing the project at individual sites

The Group reserve the right to information on the progress of the project at any time and should receive a progress report six monthly and a written report on completion.

Random audits will be carried out to ensure that projects comply with the clinical guidelines of research. Any serious adverse incidents relating to the project should be reported to the R&D office and a Clinical Incident Form filled in.

It your project includes participants or resources from other Health Boards it is your responsibility to contact the relevant R&D Office(s) in order to gain R&D approval to commence. Without individual approval from all Health Boards involved in the study Welsh Risk Pool indemnity will not be afforded to the researcher.

On completion of the project it is important you inform the Health Board R&D Office.

It is a requirement of approval that a synopsis of your project and its findings (if not commercially too sensitive) be submitted to the R&D department upon completion. This synopsis can then be placed on the R&D departments web page to provide a useful R&D resource for other research active professionals across the Health Board.

It is also a requirement that an abstract is submitted for review and possible inclusion in the Health Boards annual R&D conference. This facilitates distribution of all researchers findings and any resultant changes in clinical practice.

I would like to take this opportunity to wish you well with your research and look forward to the presentation of your findings.

If you require any further assistance please contact the Research and Development Department

Yours sincerely

Dr…………..MSc, PhD, FRCPath
Associate Medical Director – Research and Development

Appendix 15: Confirmation of an Honorary Contact with a Health Board

22nd December 2010

Dear Sian Jones

HONORARY CONTRACT

I am pleased to confirm the offer of an honorary contract with …….Health Board to undertake the below project at ……..Hospital and……..Hospital with effect from January 2011 to December 2011.

- CT/121/10 Qualified Nurses Experiences of Assessing the Mental Capacity of Acutely Ill Adult Patients in General Hospital Settings

The purposes of this post is to enable you to interview qualified nurses from the Acute Division. You will be responsible to ……Lead Nurse, Acute Division.

The appointment will be subject to the Local Health Board Terms and Conditions of Service in so far as they are applicable to honorary staff. In order to ensure clarity the main points are contained below:

- Payment – There will be not payments made to you by ……Local Health Board and you do not have any entitlement to holidays or bank holidays, sickness payments or maternity leave payments from…..Local Health Board.

- Professional Accountability – You are required to maintain your professional accountability and adhere to the codes and rules of conduct of your profession, ensuring any statutory requirements or registrations are maintained.

- Confidentiality – You are required to maintain the strictest level of confidentiality at all times. Any matter of a confidential nature should not be divulged or passed on to an unauthorised person or third party under any circumstances except in the proper course of your employment or as required by law, or by …..Local Health Board. This may include clinical information relating to the treatment and care of patients, personal information relating to employees' confidential records or other commercial and business information.

- Disciplinary and Grievance Procedure – You are required to follow the terms and conditions as stated in the Local Health Board Disciplinary and Grievance Policy. Should you have any grievance relating to your Honorary Contract of employment, you are entitled to discuss the matter in the first instance with your line manager to whom you are responsible, either personally or in writing, to the Human Resources Department. Should you wish to view any policy of the Health Board these are available from the Human Resources Department.

- Loss of Property – The Health Board does not accept responsibility for your personal belongings which are lost, damaged in work by fire, theft or burglary.

If you agree to accept this appointment on the terms specified above, please sign the form of acceptance detailed below. A second copy of this letter is attached and should be retained by you for your future reference

Yours sincerely

Recruitment Team