Investigation of Registered Nurses' Clinical Decision-making Processes in Aged Care

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Abstract

An ageing global population places increasing humanitarian and financial loads on government, health and welfare agencies; necessitating change and innovation to meet and manage clinical and physically complex needs and demands. Australian residential aged care has been influenced by these international and jurisdictional socio-political forces. This thesis aims to inform healthcare professionals and others about Australian aged care registered nurse (RN) decision-making processes, as well as convey understanding of the responsibilities and contextual influences upon RNs working in this sector and scope of practice according to their professional responsibilities. National legislation and regulations such as the *Aged Care Act* 1997 and principles—including the charter of ageing resident rights, service delivery accreditation standards and aged care service reforms involving person-centred care, and consumer choice—make aged care RNs legally accountable for their individual practice, as well as the practice and conduct of others. This includes care assistant staff employed by their organisation, other services staff and multidisciplinary team collaborators. As a result, there is renewed interest in aged care consumer needs, service delivery models, improving aged care RN workforce participation, refinements of aged care staff skills, RN task delegation, RN legal obligations as a health practitioner and as an employee, continuity of care, modification or adjustments to the aged care RN's scope of practice, professional registration and licensing. This qualitative study uses grounded theory methodology to analyse data collected during interviews supported by questions and observations of participants. Data collection occurred from August 2010 until December 2012. Twenty-eight participant RNs were recruited from six aged care service organisations operating within New South Wales, Australia. The study investigated influences on the decision-making processes of aged care RNs identified from their responses to *a priori* situations commonly occurring in aged care practice involving clinical decision making. Within these decision-making situations, individual aged care RN role complexity, characteristics and influences from key aged care stakeholders that influence RN clinical decision making and resident outcomes were able to be explored and compared. Findings revealed that clinical practice and resident outcomes are greatly influenced by an RN's experience, how they perceive and manage context-specific factors, and the authority or power of stakeholders in relation to their own. Some RNs revealed ethical dilemmas in situations that impede RN advocacy for resident wishes or when deliberating over clinical decisions and professional advice that they believe will preserve or promote quality of life or improve resident health. Emergent theory relates to the influence of person-centred care and manager/employer delegation of nursing work and informs understanding of the aged care RN clinical practice environment. These influences are depicted within a decision-making practice map that combines two emergent theories with analysis of aged care decision-making guidelines and policies that influence practice in Australian aged care settings. The resulting Australian contemporary aged care RN clinical decision-making model of nursing practice reveals two aged care operational levels working simultaneously. The first level indicates RNs' claims to be operating according to their scope of professional and individual practice within the constraints of their legal responsibilities to implement safe and effective clinical care. In the second level, employers were found to operate according to their own expectations and those of stakeholders resulting in the delegation of clinical tasks and nursing work to increase efficiency of service delivery and in that process, limiting RN professional authority. Further exploration and consideration of the complexities of influences on aged care RN decision making are recommended, as study evidence reveals an evolving model of aged care RN nursing practice that explicates the challenges to their autonomous clinical decision making in this context.

Keywords: Aged care, clinical decisions, delegation, person-centred care, residential aged care, RN decision-making processes.

Statement of Authorship and Sources

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution. No other person's work has been used without due acknowledgement in the main text of the thesis. All research procedures reported in the thesis received the approval of the relevant Ethics Committee (where required) or a relevant safety committee if the matter is referred to such a committee.

Marina LoMonaco RN

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What began as a quest for knowledge to understand ‘why RNs make the decisions they do’ has led to new knowledge of influences on aged care RN decision-making processes. My search for this knowledge began in 2006, within my Master of Philosophy candidature at the Australian Catholic University, and concludes with the submission in 2014 of this dissertation, *Investigation of Registered Nurses’ Clinical Decision-making Processes in Aged Care*, to fulfil the requirements of a Doctorate in Philosophy, edited by Elite Editing, to Standards D and E of the *Australian Standards for Editing Practice*.

The steps involved in undertaking this journey were difficult, albeit enlightening. In some ways, the research journey is similar to a novice learning to dance with a dancing instructor for the first time. As a novice researcher, I learnt and followed the steps of research project design, analysis, reporting of findings and discourse to dance in the musical genre of grounded theory methodology, to perform the ‘mid-range’ theory under the guidance of my inspirational academic supervisor, Dr Tracey McDonald AM, whom I sincerely thank for those moments of clarity, truth and encouragement.

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List of Abbreviations

A&E	Accident and Emergency
ACAP	Australian College of Ambulance Professionals
ACD	Advance Care Directives
ACET	Aged Care Emergency Triage
ACFI	Aged Care Funding Instrument
ACP	Advance Care Planning
AHD	Advance Health (Care) Directive
AHPRA	Australian Health Practitioner Regulation Agency
ANCI	Australian Nursing Council Incorporated
ANF	Australian Nursing Federation
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMC	Australian Nursing and Midwives Council
ANMF	Australian Nursing and Midwifery Federation
APADRP	American Philosophical Association's Delphi Research Project
CD	Care Directives
CMA	Comprehensive Medical Assessment
CSE	Care Service Employee
DOHA	Department of Health and Ageing
EG	Enduring Guardian
EPOA	Enduring Power of Attorney
GP	General Practitioner
HREC	Human Research Ethics Committee
LHA	Local Health Area

NMBA	Nurses and Midwifery Board of Australia
NSW	New South Wales
NUM	Nursing Unit Managers
OACQC	Office of Aged Care Quality and Compliance
PCC	Person-centred Care
POA	Power of Attorney
PRN	*Pro re nata*
RACGP	Royal Australian College of General Practitioners
RCNA	Royal College of Nursing Australia
RN	Registered Nurses
SOB	Shortness of Breath
UAP	Untrained Assistive Care Person
UK	United Kingdom
WA	Western Australian

List of Terms

Aged care	Under the Aged Care Act (Schedule 1, Australian Government, 1997) aged care is described as residential care, home or flexible care provided by service operators to an eligible care recipient “whose physical, mental or social functioning is affected to such a degree that the person cannot maintain himself or herself independently”
Allied health practitioner	Registered healthcare professional who can be part of the multidisciplinary healthcare team or a consultative professional, including a registered nurse, physiotherapist, occupational therapist or podiatrist
Assistive care worker, care assistant, assistant in nursing (AIN) or care service employee (CSE), however titled	A person working in care services who is not registered as a health practitioner, including as a nurse, but may or may not hold community care services certification or other allied health qualification and is working in residential aged care facilities
General practitioner (GP) or medical practitioner	A person with authority to work as a medical professional, including a medical doctor or psycho-geriatrician
Person-centred care (PCC)	A philosophical approach in which a person who is a recipient of health or care services and is experiencing dementia or cognitive difficulty and/or comorbidity is

	acknowledged as a human being with life experiences, cultural values and personal beliefs, and who is able to choose their own preferred and informed care pathway that is advocated, respected and implemented by healthcare and medical practitioners
Scenarios or situations	A term used to describe an RN activity or resident-related outcome developed (*a priori*) to investigate RN decision-making processes and to organise data
Registered nurse (RN)	A person who is registered and authorised to assess resident needs, perform nursing tasks and coordinate clinical care activities

Chapter 1: **Introduction**

1.1 Investigation of RN Clinical Decision-making Processes in Aged Care

1.1.1 Purpose of the research.

The project to investigate influences on clinical decision-making processes by registered nurses (RNs) working in aged care arose from employment prior to 2006 that involved the scrutiny of RN decisions in practice. This study was prompted by a realisation that inconsistent decision-making processes of RNs working in aged care practice can lead to outcomes that vary from the expectations of residents, families directing care, RN colleagues and managers. The researcher posed the question ‘What influences aged care RNs decision-making processes?’

The aim of this research is to generate theory to inform understanding by healthcare professionals and others about Australian aged care RN decision-making processes, as well as to convey understanding of the role complexities and subverting context-based influences that influence Australian RN’s scope of practice and affect resident outcomes.

1.1.2 Significance of the study.

A preliminary review of published texts identified key principles related to RN clinical decision-making processes and metacognitive theories. The literature search found many studies about RN decision-making in healthcare settings but relatively few that explore aged care RN decision-making processes. Thus, the researcher was prompted to undertake an investigation of influences on aged care RNs’ decision-making processes about resident clinical care that would be of significance to aged care RN knowledge, continuity of resident care and aged care clinical services management.

This investigative study sought to identify and explore the attributes of aged care RNs’ clinical decision-making processes and identify the major factors influencing that process and resulting resident outcomes. Moreover, this study explores the value or use of RN experience and knowledge as well as identifying potential power-based dynamics with significant effects on aged care RNs’ scope of practice by challenging their clinical–ethical position and authority to implement care they believe to be in residents’ best interests.

During the initial literature review (2006–10) it became apparent that aged care is not recognised by the Australian Nursing and Midwives Council (ANMC) as a clinical specialty context in the way that acute care is regarded (Ballantyne, Cheek, O’Brien & Pincombe, 1998). Further, the extent to which RNs in aged care transfer knowledge and use evidence to support clinical decisions in practice has attracted little attention or interest from nurse researchers, especially in Australia. This prompted the researcher to work towards understanding and gathering knowledge about the context of nurse decision-making processes and any associated influences on clinical practice of RNs working in Australian aged care environments.

This new knowledge and insight will benefit novices as well as postgraduate RNs, their managers and employers, by improving understanding of aged care nursing competencies, scope of practice and role flexibility. It is hoped that discussion leading to practice development will be promoted. Moreover, the study findings can contribute innovative changes to aged care curricula as well as to the professional development of RNs practising in aged care contexts, and highlight the influences of person-centred and consumer-directed care trends that can alter clinical outcomes as a consequence of stakeholder negotiation of care and service expectations.

1.2 Thesis Outline

The research comprised several phases that were undertaken consecutively to culminate in emergent theory and discourse about influences in aged care RN decision-making processes that influence resident outcomes and nursing practice. Three of the project phases are research background and design; preparation of *a priori* clinical decision-making situations and surveys to prompt consideration of issues by participants prior to interviews; and data collection, collation and analysis to reveal findings.

Chapter 1 introduces the project aim and the significance of the study. The study aims to explore the RN scope of practice and clinical decision-making processes to identify context-related influences on resident care, RN professional autonomy and resident clinical outcomes.

Chapter 2 presents an initial literature review that provides theoretical insight into clinical decision-making theory, decision-making characteristics and research design. This review facilitated the identification of common situations involving RN clinical decision-making, the Australian aged care context and authenticated aged care RN responsibilities, and established known influences upon RNs' decision-making processes to provide a background for the study.

Chapter 3 introduces information about the chosen methodology and study design and how the data collection was undertaken, and informs data analysis. Analysis was facilitated by open, axial and selective codification processes adopted from the grounded theory work of Corbin and Strauss (2008), which incorporates Mead's (1925, 1934) social symbolic interaction theory. Grounded theory offered a framework for project design, data collection and analysis that is compatible with the context in which the study occurred, that is, to explore power-related dynamics of aged care stakeholders and reveal influences upon RN decision-making processes. Grounded theory analysis required data to be progressively compared and sorted into categories and groups, producing evidential threads that formed themes that were further analysed and reconstructed as influence-related theory, as described in Chapter 5.

An examination of the theoretical perspectives of the researcher revealed personal experiences resulting in a life-long commitment to improving customer service and a passionate need to contribute to the quality of life for people who are frail or ageing, through reflection that may influence aspects of this study and interpretation of findings through a symbolic interactionism lens. Mead’s (1925, 1934) theory supports the researcher in adopting an objective interpretive perspective to data, in order to deduce meanings; identify relationships; and describe the social, communicative, personal and professional interactions of stakeholders as well as the effects and contributions of their input on influencing clinical outcomes, RN autonomy and authority. The theory that emerges explains contextually influential information and circumstances that affect aged care RN clinical decision-making processes.

Chapter 4 contains data gathered from the two phases of the research study. In Phase One, preparatory data collection included a participant matrix to ensure homogeneity, and pre-observational questions about clinical situations followed by Phase Two, observation of participants in their practice roles. Preparatory data helped to focus the investigation on influences on RN decision-making processes in a variety of aged care situations from which commonly occurring decision-making situations were identified. Pre-observational data from Phase One guided by the outcomes of Phase Two observations and interviews helped to extend, authenticate and ground the data. Initial responses from participants to the key question ‘What is a clinical decision?’ endorsed the relevance of the *a priori* clinical situations established from the literature and unpublished clinical data that were used to focus data collection. Had participants not responded during interview to the primary clinical decision-making situations as being authentic, any that were unsupported would have been discarded. The study commenced in 2010 with data from 28 RNs progressively collected on decision-making characteristics and influences until data saturation was reached.

Chapter 4 documents the various research perspectives with researcher reflections and symbolic interpretations about RN experiences. It initially follows the example of Corbin and Strauss (2008) by employing social actor’s theory (Mead, 1925, 1934) to describe RN perspectives drawn from the interview data, to describe symbolically and explain the importance of contextual influences around RN decision-making processes. Discussion explores RN ethical–clinical conflict involving situations where resident outcomes differ from expected aged care industry policy and practice to explain why contextual influences affect RN decision-making processes.

The researcher’s perspective contains a reflective account of learning new skills, gaining knowledge and evolving competence in grounded theory research methodology. This narrative adopts the interpretive art form of dancing to compare and explain steps made along the way to completing the study and looks ahead to learning new moves to different music in order to learn new expressive dances.

Chapter 5 contains the final comparative analysis of evidence-based preliminary themes, contemporary aged care applied clinical decision-related approaches and practice guidelines (ANMC, 2006; Kitwood, 1997; McDonald, 2007) identified from the literature to reveal new theory. The evidence reveals subversive influences affecting RNs’ ethical values, clinically related decisive autonomy and assertion of their professional authority, as a response to their disempowerment by others in embracing person-centred care (PCC) practice governing resident care situations and dismissing

RN clinical and professional authority. The new theory is depicted as an Australian model of aged care RN decision-making practice. It is then applied within a contextual mapping of RN clinical practice modes in which the focus of the RN role is located within the influences identified in this research.

Chapter 2: **Review of Published Research**

2.1 Introduction

The study aimed to investigate aged care RN clinical decision-making processes to identify specific factors that influence their scope of practice and clinical-resident outcomes. The review facilitated a framework of understanding of established clinical decision-making metacognitive processes and an overview of theory aligned to models of nursing care practice as well as circumstantial considerations of RNs working in aged care. Moreover, it established that the exploration of aged care RN practice or aged care clinical decision-related processes has been given little attention in comparison to acute or hospital-based clinical nursing specialities or primary care RN evidence-based clinical practice. It has also been overlooked in scholarly clinical decision-related theoretical discourse.

Research theorists offer a range of opinions related to undertaking literature reviews prior to data collection and analysis. There is concern that information obtained prior to data collection will influence data analysis and findings. However, some contend that a literature review will enhance subsequent data collection by promoting deeper probing and use of rigid theoretical sampling processes, thereby facilitating quality information collection and analysis.

Following considerations of these differing points of view, an initial literature review was undertaken. The aim for the review was to provide a framework of understanding in research methodology, project design, clinical decision-making theory, acquiring knowledge for developing competence and identified contextual elements relevant to this study. From 2010, further literature searches were conducted during data analysis and these are presented along with the findings.

2.2 Defining and Understanding Clinical Decisions

‘Clinical’ in the *Macquarie dictionary* (Macquarie dictionary, 2009, p. 7), is defined as ‘concerned with observation and treatment of disease in the patient’ or ‘scientific; involving professional knowledge and not affected by emotions’. The term ‘decision’ relates to the ‘act of deciding, determination of a question or a doubt’ and the word can mean ‘choice, verdict, conclusion, judgement, resolution, assessment, evaluation, pronouncement, or result’ (Macquarie dictionary, 2009, p. 11).

‘Clinical decision-making’ is similarly defined across nursing–medical field specialisations while decision-making in other domains such as sociology and psychology is described as outcomes related to critical thinking, metacognitive processes or its elements (Boychuk-Duchscher, 1999; Rashotte & Carnevale, 2004). One-hundred-and-ten decision-making publications were identified during the literature review in which keywords such as critical thinking, metacognition and reflection were discovered.

Twenty-five peer-reviewed journal articles (from published journals and internet-accessed texts), 17 books and eight other texts or resources in the form of reports, papers and statistics were identified as contextually relevant. These facilitated an understanding of broad decision-making frameworks and the identification of nursing decision-making attributes, and explored fundamental relationships of knowledge, skills acquisition, competence and expertise.

‘Critical thinking’ is described or defined by researchers and theorists in a variety of ways. For example, Carper (1978) describes it as an overlapping of layering or connection of memories or cognition processes that link conscious thoughts while seeking further information before a decision can be made. Benner (1984) broadens cognitive processing theory to include components of creative thinking and imagination, so that different possibilities or innovative problem solving can arise.

The American Philosophical Association’s Delphi Research Project ([APADRP], Facione, 1990) proposed a definition and description of critical thinking. APADRP views it as a process of ‘interpretation, analysis, evaluation and inference as well as the explanation of evidential, conceptual, methodological, criteriological or contextual considerations upon which that judgement is based’ (Facione, 1990, p. 2).

In a meta-analysis of critical thinking literature, Boychuk-Duchscher (1999) suggests it involves attributes or critical skills within the processes of conceptual analysis and reflective reasoning. Other researchers and theorists confirmed the value of reflection (experience) with ‘dialogical reasoning’, ‘multi-logical thinking’ or ‘critical consciousness’ in which opposing or alternate views are rationalised or used to determine action (Freire, 1970, pp. 17–18; Paul, 1996).

2.2.1 RN decision-making theories and frameworks.

Muir (2004) describes a cross-discipline decision-making theory in which two main ‘opposing conceptual frameworks’ (p. 48) had been adopted within nursing. These are termed ‘analytical framework’ and ‘intuitive framework’ (pp. 48–49), which include elements of critical thinking, cognitive processes and reflection. Muir believes that clinical decision-making occurs within analytical or intuitive conceptual frameworks throughout the day, either simultaneously or separately, according to the situation. Within this perspective, clinical care management decisions use an analytical conceptual construct, whereas decisions that are not consciously based on evidence are attributed to intuitive (and reflective) ‘scaffolding’ that provides continuity of contextualised care interventions (p. 49).

Muir (2004) agrees with Kenney (1995), that two conceptual frameworks evidently work side by side for analytical or intuitive decisions. First, active cognitive processing enables the making of decisions, collecting relevant data, setting priorities, solving problems and planning nursing care within context. Second, these essential processes, which involve rational and logical thinking for making decisions, are in tandem with reflective and autonomous thinking that is creative yet contextualised to guide actions and decision-making. This is generally accepted as the traditional rational decision-making model known as ‘the nursing process’ (Kenney, 1995, p. 7) in which concepts of care practice are aligned to pre-defined steps or stages and outcomes.

Junnola, Eriksson, Salantera and Sirkka (2002), using research evidence-based practice models, came to a different view on critical thinking related to RN decision-making, which they described as a ‘two-phase process’ (p. 186). The first phase is termed the ‘diagnostic phase’ while the second is called the ‘management phase’ (p. 194). These two phases of critical thinking involve collecting information (data) and processing it using specific contextual knowledge and experiential reflection platforms to create or implement an individualised plan or model of care. In their study involving pain management problems, Junnola et al. identified that 94% of 107 nurses used assessments of patients to inform clinical decisions. Further, 90% of these nurses incorporated ‘knowledge based on earlier professional experience’ (p. 192) to guide patient care interventions.

The same study found that only 20% of nurses used knowledge from the literature, journals or supplementary training’ (Junnola et al., 2002, p. 192). Rather, decisions are primarily informed by contextualised data involving physical assessment, which is validated by reflected experience and not significantly influenced—at the time of making the decision—by published literature or training.

Within nursing practice, critical thinking is viewed as an ‘interactive’ process or period of ‘reflective reasoning’ that is ‘purposeful’ with ‘self-regulatory judgment’ (Facione & Facione, 1994, p. 345). Similar views are expressed by others, with the inclusion of experience and knowledge developing and reflected over time (see ANMC, 2007; Brookfield, 1987; Crook, 2001; Forneris, 2004; Kuiper & Pesut, 2004; McCallum, 2004; Moore-Schaefer, 2002; Rashotte & Thomas, 2002; Schön, 1983, 1987; Schumacher & Severson, 1996; Williams, 2002). Benner (1984) extended development of knowledge over time through research and debate relating to nurse competence and technical expertise in a similar way to that used for the current research.

2.2.2 Knowledge and competence related to RN clinical decision-making.

There is agreement among the reviewed studies that while acquiring or applying knowledge and mastering skills, an intuitive knowledge (Schön, 1983, 1987) or layering process exists (Brookfield, 1987; Crook, 2001; Forneris, 2004; Williams, 2002). This ‘layering’ process was further explored by Dreyfus and Dreyfus (1980), who identified distinct levels of skill development of novice, advanced beginner, competent or proficient, expert and mastery. Dreyfus and Dreyfus (1980) detailed a layered model of skills acquisition with the assumption that with increasing situational related experience progressing towards expert, there is less reliance on rules and principles. By using reflected knowledge acquired in previous experiences, decisions made using analytical or rule-based thinking progressively relied on intuition through a filtering layering process towards full engagement in the situation (see also Christensen & Kenney, 1995).

In nursing, Benner (1984), Kuiper and Pesut (2004) and Benner, Tanner and Chesla (1992) applied these levels to describe increasing nurse skills from novice to proficiency or expert. Ericsson (1996), a researcher into the development of expertise, further found that experts process and organise their thinking systems differently to novices. Novices are found to have concept-driven thinking. Whereas experts have a procedural thinking process with an established practice-related knowledge base that enables ‘automaticised perceptive responses in a familiar situation’ (Frensch & Sternberg, 1989, pp. 167–188) as long-term memory knowledge from experience or repeated practice is easily retrieved as expert skills or knowledge.

Studies of experts in non-expert environments or changing situations have found that the procedural thinking process can be so entrenched that experts may find it difficult to adjust to new information (Frensch & Sternberg, 1989; Kossowska et al., 1996). These experts are subject to ‘proactive interference’ as changing or competing unfamiliar situations challenge their skills and knowledge base, thereby ‘inhibiting flexibility and innovation’, which is outside their procedural thinking (Kossowska et al., 1996, pp. 36–38).

In some circumstances, understanding proactive interference may help to explain RN decision-making processes. RNs with specific expertise or specialisation and competence located in a particular field, such as midwifery, acute, chronic or aged care areas (Ballantyne et al., 1998, Cooper & Mitchell, 2006; Ericsson, 1996) may experience issues relating to their nursing competence. Discussions of competence in the literature linked performance in relation to nursing processes; as well as the power imbalances interposed through language within nursing practice through terms such as ‘non-compliant’, ‘dysfunctional’ or ‘compliance’, which are often used to evaluate or judge processes or practice (Boychuk-Duchscher, 1999; Cholowski & Chan, 2004; McAllister, 2003).

2.2.3 Decision-making competence.

While recognising the diversity in skills and competencies of RNs within different working environments, the ANMC (2006, p. 26) broadly described ‘nursing competence’ as the ‘combination of knowledge, skills, attitudes, and values necessary for nurses and midwives to practice at a standard acceptable to clients and others in their respective profession with similar background and experience’. The ANMC identified seven universal elements or principles in competent clinical decision-making that in combination explain a decision-making framework or algorithm that applies to all nursing and midwifery contexts (see Chapter 5 for more information, pp. 208–228).

Further work by the ANMC (2007a, 2007b) regarding continuing competence of RNs involved decision-making principles, associated risk management principles with RN reflection, assessment of self-competence and relevant experience when making nursing practice decisions. Further, RNs are prompted in this framework to use experienced RNs or other health professionals to advise, educate or inform practice, clinical decisions or interventions.

In 2009, AMNC became the Nursing and Midwifery Board, Australia. From 2010, this new national board was involved in nurse registration, investigation of RN practice, approval of RN education programmes and continuing development competencies. At the same time, the Australian Health Practitioner Regulation Agency (AHPRA) was formed to maintain health professional registers and refer complaints or issues for investigation (AHPRA, 2013). At least until 2013, the 2006 ANMC competencies continued to be applicable and were endorsed by the Nursing and Midwifery Board, Australia (AHPRA, 2013).

2.2.4 RNs working in an Australian aged care context.

In an analysis undertaken by Ballantyne et al. (1998) of nurse competencies in the Australian Nursing Council Incorporated (ANCI, 1993), it was noted that the ANCI made ‘a useful but incomplete contribution to understanding the perceived role of nursing in aged and extended care’ (pp. 156–157). The literature review revealed discussions and debate related to skills and knowledge of RNs within the context of aged care standards of practice, in which different and modified clinical performance indicators, skills mix and work competencies are required (Andrews, 1995; Angus & Nay, 2003; Ballantyne et al., 1998; Cooper & Mitchell, 2006; Spilsbury & Meyer, 2001). Despite debate and submissions of support at that time, aged care was never and is not now recognised by the ANMC as a specialty context similar to acute care (Ballantyne et al., 1998).

On the other hand, an aged care employer peak body known as the Aged and Community Services Australia (ACSA, 2010, p. 22) acknowledges that ‘aged care is a specialist setting’ with ‘expertise in health conditions and associated problems found in higher prevalence among older people’. This highlights the disparity between how aged care RNs are regarded by different stakeholders including employers, and especially in contrast to the status given to other specialist RNs.

As a result of Australian aged care nursing not being acknowledged as a clinical specialisation, aged care RNs receive less attention from researchers than do other nursing clinical specialities. Research related to aged care nursing has the potential to facilitate understanding and gather knowledge of decision-making processes and how these are influenced by factors in contemporary aged care clinical contexts.

In order to investigate influences on clinical decision-making by RNs working in residential aged care, it is important to understand the role of the RN in aged care and how it differs from the role of RNs in the acute care health context. Differences in RN autonomy, responsibility, workload and practice context can influence decision-making considerations, actions, clinical competency or clinical outcomes.

Much of the role of RNs in Australian aged care employment is regulated by the *Aged Care Act* 1997 (Commonwealth Department of Health and Ageing [DOHA], 2000) which outlines the mechanisms for implementing and maintaining residential aged care services by approved providers and those they employ. Provision of care is monitored and evaluated by government agencies within a quality accreditation system containing four aged care standards and within which there are 44 outcomes that must be met for continued government licensing and funding. These outcomes are mandated under the Act, to which clinicians and managers must adhere.

During 2013, review of the aged care legislation and subsequent regulations resulted in changes aligned to the Living Longer, Living Better (Australian Government, 2012b) aged care reforms scheduled for implementation commencing from July 2014. However the four accreditation standards within the Aged Care Act, 1997 remain as written. *Standard 1* deals with administration and governance areas. *Standard 2: Clinical care* mandates requirements for specialised nursing including health care, medication management, pain and palliation, nutrition and hydration, skin care, continence and behavioural management which involves the major areas of clinical decision-making for RNs. *Standard 3: Emotional support* covers independence, privacy and dignity, leisure, cultural and spiritual life, resident decision-making and tenure of occupation. *Standard 4* relates to hospitality, safety and living environment. All four standards maintain the requirements for continuous improvement, regulatory compliance and education, and practice development.

Implementation of these standards in aged care incorporates an individualised plan of care that enables nurses to assess, record and evaluate interventions related to nursing care practice. This process tightly focuses care for recipients or clients, who in the Australian aged care context are referred to as ‘residents’ of the institution in which they also receive clinical and personal care. Within nursing practice, resources are available to assist in decision-making (Randell et al., 2004; Thompson et al., 2004). However in the current study such resources were not used or mentioned by the participants. Two aged care guidelines relevant to the role of RNs in clinical decision-making were identified in the literature review: the Australian nursing decision-making frameworks of ANMC (2006, 2007a, 2007b) and the Model of Nursing for Contemporary Aged Care Environments (McDonald, 2006).

2.3 Decision-making Guidelines and Role Responsibilities Relevant to Aged Care Clinical Decision-making

2.3.1 Guideline one: Nursing practice decision flowchart.

The first guideline contains the RN ‘clinical decision-making’ algorithm (ANMC, 2006) incorporated into the National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice (ANMC, 2007). This ‘tool’ was rebranded and released during the transitional process to the new nursing regulatory, practice and competency structure under AHPRA legislation (AHPRA, 2009; Nurses and Midwifery Board of Australia [NMBA], 2013). An ‘RN decision-making flowchart’ details key principles and considerations linked to competent clinical decision-making in the broad context of nursing practice. In addition, the flowchart highlights the alignment of RN decision-making to considerations of risk management, professional scope of practice, regulation-based accountabilities, organisational capacity and support through policy, procedure and delegated staff competence. While the guideline acknowledges the above considerations it provides no indication of external or environmental influences that may also contribute to RN choices around undertaking a decision-making process.

The NMBA RN decision-making flowchart (2013), outlines four statements of principle that guide contemporary RN decision-making. The first principle dictates that ‘the primary motivation for any decision about a care activity is to meet clients’ health needs or to enhance health outcomes’ (NMBA, 2013, p. 6). This principle is based on the premise that client health and wellbeing is the expected outcome; however it fails to acknowledge the choice of clients (residents) through self-determination processes and their right to negotiate outcomes from nursing involvement that may be contrary to health. In aged care services, residents and their families often seek to negotiate outcomes that may not be considered to be as ‘health enhancing’ as indicated or expected in the nursing practice decision flowchart (2013); for instance, the use of alcohol or tobacco or insistence by family member on the use of physical restraints for their relative.

In Principle Statement Two (NMBA, 2013), a set of considerations associated with competence in clinical nurse decision-making, previously termed an ‘algorithm’ (ANMC, 2006, p. 3), underpins the processes of decision-making. Considerations include legality (national/state or territory standards of practice); clinical assessment (performed by a competent and authorised person); beneficial outcomes (for client); authorisation and competence (the person delegated to proceed with the intervention must be authorised and competent with acceptance of accountability); professional fit (intervention fits within definition and values of nursing or midwifery); risk management (identified and minimisation of risk with appropriate strategies) and agency support (policies, resources of staff or expertise available).

Principle Statement Two does not mention client self-determination, other than within the objective of ensuring ‘beneficial outcomes’ for the client. These outcomes are potentially ambiguous at the point of implementation. For example, ‘beneficial’, from the client’s perspective, can mean the client benefited from making their own decision about their care or palliation. Similarly, outcomes that are clinically required to achieve health benefits may not be client-preferred outcomes.

Principle Statements Three and Four (NMBA, 2013, p. 8–10) involve RN accountability related to delegation, supervision, accountability and risk management. In examining the ‘nursing practice decision flowchart’, RNs are required to ‘achieve desired/beneficial client outcomes’ in ‘partnership with the client’ (p. 8). The flowchart relates to the RN skill and competence to undertake activities or refer clients to other professionals for complex needs to be met. Further consideration is given to delegation policies and workforce capacity to meet client needs by adopting a risk management approach to delegated staff competence. All of this assumes that RNs have the authority to achieve these elements or have influence in operational–clinical-related decisions.

In 2004, the Australian Nursing Federation (ANF) and Royal College of Nursing Australia (RCNA, now the Australian College of Nursing) clarified the position of RN accountability and employer support regarding the supervision of delegated tasks to ‘assistants in nursing and other unlicensed workers (however titled)’ (ANF & RCNA, 2004, p. 1). The joint statement affirmed that ‘Registered nurses retain overall responsibility for any aspects of nursing care delegated. The employer is responsible for the provision of services and for setting the policy framework in which the service is provided’ (p. 4).

RNs are trained to work according to their scope of practice defined within legislation that ensures individual and professional compliance to ‘competency standards; codes of ethics, conduct and practice; and public need, demand and expectation' (ANMC, 2007, p. 23), as well as evidence-based outcomes. Moreover, employers of RNs are required to provide a work environment and work roles consistent with their professional scope of practice (ANMC, 2007). RN task delegation to other nurses requires them to evaluate and 'consider outcomes for the client, for the person performing the activity, for the person delegating the activity and for any others affected by the decision' (ANMC, 2007, p. 11). In reality, employers use position descriptions and work design to delegate nursing work to care assistants rather than the RNs that are responsible for overseeing their work. Moreover, RNs have no authority to reassign employer-delegated work even when it involves RNs undertaking nursing interventions without nursing input or supervision.

2.3.2 Guideline two: Model of aged care RN practice.

The second identified guideline is the Model of RN Practice in Contemporary Aged Care (McDonald, 2007, p. 1), which describes the role and responsibilities of RNs by focusing on evidence-based practice linked to legislated aged care standards (*Aged Care Act*, 1997) and incorporates the organisational philosophy and ethical values of RSL LifeCare (McDonald, 2007). The model of contemporary aged care practice affirms the clinical and non-clinical scope of RN practice within Australian residential aged care settings.

In this model, RNs are guided by identified nursing philosophy, legal and professional obligations, and the requirement to meet aged care accreditation standards. McDonald (2011) considers aged care contextual factors, RN capability, organisational capacity and multidisciplinary team approaches as being guided by RN-resident consultative decision-making processes. As a context-specific model to guide RN individualised nursing practice to enhance an organisation's cultural vision for individualised or resident chosen nursing care, the model of practice offers an opportunity to validate continuity of care approaches across different care sites. Widespread adoption of this model enables care to be evaluated against RN nursing practice using quality indicators that enable comparative site analyses, benchmarking and continuous improvement monitoring and planning.

Dewing (2004) acknowledged the difficulty in developing conceptual frameworks that are inclusive of person centredness, which often relies on the professionalism of aged care RNs engaged in day-to-day practice. The influences in everyday decision-making processes are clearly identified in this model (McDonald, 2006) with emphasis on resident choice and optimal self-determination, as well as acknowledging RN regulatory responsibilities and authority to coordinate care and oversee care delegations to maintain safe and effective clinical practices. Further, the McDonald model of practice works as a conceptual framework that clarifies clinical rationale and allows RNs to design pathways for clinical decisions, implement interventions and generate different outcomes. However, assumptions underpinning the conceptual framework are that the professional authority of the RN remains intact within the employment and clinical decision-making environment, and that RNs will be supported by the organisation in exercising their full professional role.

2.3.3 Responsibilities of RNs in aged care.

The primary responsibilities of RNs in residential aged care according to the *Aged Care Act* 1997 (Australian Government, 2012c; DOHA, 2000) are to assess, plan, implement and evaluate care. However, the role of RNs in aged care has moved from the traditional model of holistic clinical caregiver to include a more contemporary role of leader or supervisor of clinical care (Courtney & Minichello, 1997; Hansebo & Kihlgren, 2004; McDonald, 2006) where clinical leadership sets the standard of care to be delivered by the team and organisation. Therefore, the delivery of quality care, accommodation and services to residents unable to independently care for themselves is dependent not only upon the funding provided, but also on the professional competence of the RN and supporting workforce employed to work under the direction of RNs.

Care interventions can change or be guided by knowledge, situational and resident-related factors (Mezey, 2004). Resident or related factors can include informed choices by their legally recognised representative, or utilising the Charter of Rights and Responsibilities from the *Aged Care Act*, 1997. These can influence care interventions, acute or emergency management, palliative care planning, advance care planning and advance care directives, as can organisational influences.

The contemporary role of RNs working in aged care has heralded the evolution of the RN to become a ‘multifunctional tool of management’ (Angus & Nay, 2003, p. 138). As a result, a change has occurred to the boundaries of accountability and responsibility to reflect the fact that RNs working within aged care share additional responsibilities, including delegation of medication administration or care tasks to support workers (non-licensed care staff); and management or oversight of staff rosters in care services. Further, their role involves unit and organisational administration; ensuring accurate and timely care funding assessments (using the Aged Care Funding Instrument [ACFI]); oversight of cleaning and catering with considerations of work, health and safety; ensuring infection control; integrity and continuity of resident care; and ensuring resident quality of life within a multidisciplinary team approach for health, financial, ethical, moral and legal frameworks (Courtney & Minichello, 1997).

The development of care plans by RNs to direct care for residents in high care units involves making clinical and non-clinical decisions, consulting with residents, relatives and other professional personnel and drawing this information together within a framework of professional, legal and employment requirements to decide on care type, intensity and frequency. In order to provide the standard and type of care required for individual residents, RNs working in contemporary aged care must also be competent in dealing with funding assessments, working with variable staffing and resources—including casual staff with varied levels of delegated responsibility—and workforce competence (Access Economics, 2004; Australian Health Workforce Advisory Committee [AWHAC], 2004; Western Australian [WA] Ministry, 2000).

A shortage of RNs who want to work in the health and aged care workforce has also affected operational management and model of care options. In 2013, King et al. reported staff skill shortages of up to 62% in RNs and 49% in personal care assistants (King et al., 2013, pp. 34–37) working in residential aged care facilities. Increasing management functions given to RNs by facility operators resulted in 41% of RNs reporting that they 'spend less than a third of their shift performing direct care' (p. 37).

RNs in aged care work simultaneously to balance operational management requirements of fiscal control, equipment, supplies, wages, human resources including recruitment, RN to non-RN staff skill mix required to implement care, rosters, staff training or competency while concurrently 'delivering or overseeing clinical or non-clinical care services' (Angus & Nay, 2003, p. 138). Additionally, aged care RNs work within a highly regulated service environment (Courtney & Minichello, 1997; Angus & Nay, 2003), requiring compliance with various industry-legislated standards under the *Aged Care Act* 1997 and Quality Care Principles (Commonwealth Government, 2013); the *Work, Health and Safety Act* 2011; and Health Practitioner Regulation National Law (No.42/2010). This ensures delivery of 24-hour, high-quality, closely monitored and legally compliant services to vulnerable Australians.

2.3.4 Comparing aged care and acute care RN responsibilities.

Aged care RN responsibilities differ in many ways from those of RNs working in hospital services. In the hospital service context, RN roles are ‘differentiated by qualifications, skill mix and technical expertise’ (Jackson et al., 2003, p. 42). Local health area (LHA) or hospital-based RNs are also employed in medically specialised areas in which they are trained to undertake roles in workforce management, case management, clinical care coordination, clinical consultancy, surgical or medical clinical practice, community nursing and so on. Hospital nursing unit managers (NUMs) access professional development through accredited frontline management and ward/unit-related budget training provided by their employing hospitals.

The responsibilities of an individual RN working in aged care residential facilities may include clinical and non-clinical activities designed to meet the needs of more than 30 people each shift. In some facilities, one RN can be responsible for up to 125 residents with high care needs for the entire day, evening or night shift, supported by care assistants and with access to fewer multidisciplinary staff than in acute settings where acute staff ratios managed through staff rosters drawn up by line managers are used to distribute workload.

In an aged care setting, one RN could be responsible for assessments of all residents’ high care needs as well as the creation, implementation, oversight and evaluation of individual care plans; and delivery of clinical and non-clinical care. The non-clinical responsibilities often involve experientially acquired operational management responsibilities associated with service delivery systems or accreditation requirements under the administrative, regulatory and educational standards mentioned earlier. RNs in aged care are expected to deliver clinical outcomes within a flexible service delivery model of care (DOHA, 2004) aligned to Kitwood’s (1997) PCC approach with associated responsibilities in funding accountability, resource management, regulatory compliance, information management and risk management for residents, visitors, staff and volunteers.

2.3.5 Understanding different models of care informing practice.

Clinical decisions can be made within a theoretical or philosophically driven model of care (AHMAC, 2001). These models of care originate from ‘acute clinical contexts’, ‘psychology or sociology disciplines’ that are ‘responsive to the context’ in which they are applied (Chenitz & Swanson, 1986, pp. 27–29).

Nursing models of care purport to guide ‘structured thinking’, nursing actions and clinical decision-making processes within an applied nursing care philosophy or nursing theory (Christensen & Kenney, 1995, p. 19). Other models can ‘describe and explain the nature of nursing’ and move towards goals or outcomes (Kenney, 1995, p. 13). However, their ability to ‘control and predict outcomes’ is often untested and fails to holistically address client needs within their context or applied situation’ (Christensen & Kenney, 1995, p. 24). This can impinge on relevance and utility of current nursing theory or inhibit the development of new nursing theory in a flexible practice setting that is adopted as evidence-based nursing practice.

Evidence-based nursing originates from decisions made using clinical expertise, evidence from research, clinical observations, care directives and other health care information. Additionally, evidence-informed clinical practice is grounded by evidence-based health care that is influenced by RN ethical perspectives, personal values, client choice, monetary considerations, legislation applied model of care, critical thinking, legislation and work contexts (Canadian Nurses Association, 2010; 2012).

Three broad categories of care model types used in aged care nursing were identified during a 1995 review. These models include (a) ‘developmental models’ that are client focused and promote development of self-responsibility; (b) ‘systems models’ that view clients as interrelated ‘biological, psycho-social systems where an imbalance in one disrupts the other’; and (c) ‘interactional models’ where client nurse interactions focus on goal-oriented outcomes in a partnership arrangement (Christensen & Kenney, 1995).

Phillips et al. (2007) confirms that residents and their families are in partnership with aged care providers (including RNs). There are three interactional care models within contemporary aged care services. One interactional model of care is used in residential aged care where outcomes are measured in terms of the Charter of Rights and Responsibilities contained in the *Aged Care Act* 1997 and quality of life outcomes through PCC approaches aligned to the aged care accreditation standards framework (DOHA, 2004).

Another interactional model associated with desired outcomes according to individualised negotiations of care is called an advance care directive. Advance care directives require chronically ill or elderly residents and responsible persons such as family to discuss and approve certain RN interventions specifically for palliative or emergency care circumstances that are likely to occur.

The third model involves consumer-directed care, which is another form of collaboration and partnership between consumer or client and service provider. In 2013, home-based and community care services were introduced with the Australian Government initiative Living Longer, Living Better (2012b), which strives to give consumers the responsibility of having their needs assessed and care negotiated according to financial constraints and service provision availability. A government trial of consumer-directed care for older Australians (Australian Government, 2012a) indicates that PCC home care services are able to provide consumer-directed care in which consumers become fiscally accountable, thereby ensuring self-management and transparency of service delivery aligned to care expectations.

All models contain specific, unique characteristics. These distinguishing model characteristics include ‘theory-based’ applied nursing practice of assessment, nursing diagnosis, care planning, implementation, evaluation, and application of nursing process in hospital and community settings. Both McDonald (2007) and the ANMC (2007a; 2007b) have developed a RN practice approach or ‘clinical decision-making algorithm’ (ANMC, 2006, p. 21) consistent with integrated theory-based nursing practice, which is useful across all nurse practice contexts. These are discussed in Chapter 4 (pp. 79–206) and Chapter 5 theory (pp. 207–228).

2.3.6 Adopting a PCC approach in Australian aged care settings.

In recent years, the introduction from the United Kingdom (UK) of PCC (Kitwood, 1997) has been widely endorsed by government bodies and aged care agencies. Person centredness is a trichotomy of ‘patient values, the nurse’s values and expertise, and the context of care’ (McCormack, 2003, p. 205) that facilitates self-determination in health care and wellbeing decisions through partnership and negotiation (DOH, 2005; Ford & McCormack, 2000; Peek et al., 2007; Price, 2006).

This approach was adopted in the UK as a government-led strategy to address ageism and incidents of abuse by care workers, aged care services and the community at large. In practice, this approach focuses on a resident’s personal needs and choice as considerations in the development and delivery of care interventions. In Australian aged care settings, a PCC approach is advocated as best practice by aged care industry bodies (Aged Care Services Association, 2013; Aged Care Standards and Accreditation Agency, 2013) in conjunction with the *Aged Care Act* 1997, Aged Care Principles (1998) and established aged care resident rights.

2.3.7 Consumer-directed care in Australia.

Axtell-Thompson (2005, p. 208) compared consumer-directed care with traditionally managed care, stating that the ‘financial success and political failure of managed care were the result of a third party saying no to patients’ and pertained mostly to services provided to people with disabilities who reside in their own homes. With consumer-directed care, consumers ration their care by choice to formulate their own unique, self-managed care packages. Therefore, the consumer may actually say ‘no to themselves’ (Gabel, Lo Sasso & Rice, 2002, p. 396) and align self-designed care to predetermined limited monies and the available range of provider options, rather than opting for the services or care they actually need.

The Australian Government’s pilot trial of consumer-directed care for older persons in Australia conducted between 2010 and 2012 was informed by similar UK and United States (US) programmes. The Australian pilot, evaluated in January 2012, limited home care-based options to care packages negotiated by consumers with professional care providers already familiar with PCC (Australian Government, 2012a). This prompted discussion on future policy and practice (Low, Chilko, Gresham, Barter & Brodaty, 2012) as the success of consumer-directed care models is reliant upon consumer willingness or capacity to be responsible financially or to make suitable informed choices.

In the literature examining world trends to trial and run consumer-directed care programmes, ‘Older people have been found to be less likely than younger people to direct their care plans’ with many preferring the ‘traditional notion of case management models over consumer-directed models’ (Low, Chilko, Gresham, Barter & Brodaty, 2012, p. 50). Therefore, consumer capacity to enter into ‘self-management of care’ appropriately and with sustainability warrants further scrutiny (Australian Government, 2012a, p. 4), as does the future role for aged care RNs working within these models of service delivery.

Concerns raised overseas relate to the impact that consumer-directed care may have upon health care and disability insurance. In the UK and US, health and disability insurance organisations modify health cover options where consumer-directed care is in place, thereby influencing long-term care costs, care options, insurance premiums and market competition (Axtell-Thompson, 2005). While the Australian consumer-directed care approach differs somewhat from overseas options, the concept of greater consumer control, increased transparency and proposed competitive services would appear to benefit the consumer. However, the effect of consumer-directed care on RN decision-making processes and clinical autonomy remains unknown.

2.4 Aged Care Practice Situations Identified to Assist Exploration of RN Decision-making Influences

Contemporary clinical decision-making principles and theory establishing RN competence characteristics, themed clinical practice situations, and government policy that may influence RN decisions and clinical consequences were revealed through a review of published research (Cholowski & Chan, 1995; Corbin & Strauss, 2008; Courtney & Minichello, 1997; Junnola et al., 2002; Meleis, 1985; Mezey, 2004; Scott, 2003; Strauss & Corbin, 1994; Thompson et al., 2004; Tilly & Rees, 2007). As a result identified principles and characteristics informed the data collection approaches following the development of five clinical aged care practice-related situations. These contextualised situations were used during the post observation interviews to explore the various factors of influences upon RN decision-making processes, and reflect on the situations experienced during observation and interview.

2.4.1 Situation one: Using data, methods or other resources to inform clinical decision-making.

This clinical practice situation reflects an exploration of literature to establish how nurses gain knowledge and apply it in context through cognitive processing and reflective, evidence-based practice over time. Carper (1978, pp. 13–23) identified four distinct nurses' 'patterns of knowing'; that is, knowledge acquisition or application. These are (1) 'scientific knowledge' in the form of senses, observation, evidence-based models or principles that relate technical knowledge; (2) 'ethical knowledge', which is guided by philosophy, expected standards, scopes of practice, macro or micro-organisational policy and codes of professional conduct; (3) 'aesthetic knowledge', which incorporates creative conceptual thinking with meaningful links to experience, applied practices and knowledge described as the 'art of nursing' and (4) 'personal knowledge', which interprets data, reflects on experience or knowledge to form actions on a 'whole person' or situational level and will 'dominate as experience grows'.

In the development of nursing knowledge, Meleis (1985) holds that four key aspects are required: (1) knowledge of major concepts and problems of nursing is necessary; (2) the processes of assessment, diagnosis and intervention, followed by; (3) the development and application of resources to assess, diagnose, intervene and evaluate; and (4) research designs and methods congruent with nursing (e.g. evidence-based practice findings). In this way, nursing knowledge guides nursing actions, selection and application of 'models for care' to clients (Christensen & Kenney, 1995, p. 5). Further, knowledge is viewed as the product of skills and experience that is gained through cognition (thinking), action and reflection (Schön, 1987).

The issue of quality of clinical decision-making outcomes by nurses was considered to involve the use of prior knowledge and motivational drivers (derived within empirical, ethical, aesthetic or personal modes), other personal attributes, performance or competence in cognitive tasks associated with diagnostic reasoning processes and outcomes resulting in personal satisfaction (Cholowski & Chan, 2004). In that study, to ascertain if knowledge quality was a factor that influenced RN decision-making practice, a reflective question was added to the interviews and observation data collection in each circumstance or clinical practice situation, thereby establishing relevance to each individual work context. The question, 'If the situation occurred again—what would you do differently?' elicited responses related to the quality of data in terms of usefulness and value for informing decisions.

In asking RNs the above question, the value of RN experiential knowledge and its application by RNs in their practice raised the issue of power dynamics involved in decision-making processes in aged care. Strauss and Corbin (1994, p. 276) explain that 'grounded theory procedure forces us to ask, for example, about the role of power in certain situations and under specified conditions. How is it manifested, by whom, when, where, how with what consequences (and for whom or what)' and that by exploring 'power in situ' further knowledge can be developed about the phenomenon allowing for the formulation of theories.

As a result, data gained from exploring the value in and practice of applying reflective knowledge through an exploration of power in situ in each of the five *a priori* situations used to focus data helps to confirm situational themes and validate emergent theory. More importantly, new knowledge about influences on aged care RN clinical decision-making processes has significant implications for the RN's professional scope of practice. Chapter 4 details the influence of stakeholders over the approval and control of care interventions, which at times creates a clinical–ethical impasse for RNs who are legally and ethically responsible for continuity of care and evidence-based practice when employed as RNs.

2.4.2 Situation Two: Delegation of tasks to staff in a multidisciplinary team.

RNs manage and lead staff, coordinate rosters, oversee care services and undertake organisational administration. This commonly occurring situation explores RN team leadership and clinical management qualities. Additionally, RN responsibilities include assessments of need for government funding (*Aged Care Act*, 1997), environmental hygiene, nutrition and hydration with considerations of occupational health and safety, ensuring infection control, and the integrity and continuity of resident care. Their function in delegating tasks to a multidisciplinary workforce ensures resident quality of life and health within financial, ethical, moral and legal frameworks (Courtney & Minichello, 1997).

According to researchers in this field, influences on RN clinical decisions and care practices fundamentally derive from internal or external factors. Nurse clinical leadership occurs within an environment buffeted by organisational policy directives including memos; statements, procedural flow charts or decision trees; maps or models of care; resident rights; advance care directives; palliative care consultation; evidence-based or government information sources of industry guidelines; better practices or policy implementation from a range of sources; poor communication or lack of information; inappropriate or unsupported staff delegation; competence of staff employed; resources available for appropriate care, or additional RN role responsibilities associated with organisational management (Access Economics, 2004; Cooper & Mitchell, 2006; Courtney & Minichello, 1997; Howe, Rosewarne & Opie, 2002; Phillips, Davidson, Ollerton, Jackson & Kristjanson, 2007; Spilsbury & Meyer, 2001).

2.4.3 Situation three: *Pro re nata* medication administration.

Medication administration issues frequently occur in RN practice and this situation was designed to identify RN decision-making processes in likely or anticipated clinical situations in relation to medication administration. Administering *pro re nata* (PRN) medication (*pro re nata* is a Latin term meaning ‘as needed’) is a randomly occurring activity with actions involving immediate resident assessment, clinical judgement, proficient intervention and monitoring by RNs. However, in practice, these events may be anticipatory, resulting in provisional medical practitioner prescriptions for pain relief, and bowel elimination problems or indigestion, which leaves the clinical judgement of need up to the RN.

Often PRN medication administration occurs within a palliative and pain management context. A study by Junnola et al., (2002) identified clinical practice-related decision-making elements that highlighted the need to gather and use physical assessment data collected from the patient in situations involving palliative and pain management. The study revealed the high use of ‘reflective practices’ to inform nursing decisions related to pain management (Junnola et al., 2002, p. 192). In that study, this reflective process contributing to RN interventions was explicated through questions posed in the pre-observation survey as well as in the post-observation reflective interview, to explore RN views on the value or use of experience and knowledge. It also enabled the identification of existing power dynamics in the clinical situation (Strauss & Corbin, 1994) and confirmed data that led to revealing new knowledge.

2.4.4 Situation four: Referring residents to specialist or emergency service providers.

In emergency or referral situations, RNs utilise their clinical knowledge and skills to assess, collaborate, coordinate and intervene. In aged care settings, residents or others (acting as legal advocates or guardians) can determine interventions and provide consent for their implementation, or decide not to proceed with an RN planned intervention. This unique circumstance was drawn from studies involving situational and resident-related factors that are known to influence care decisions involving assessment, stabilisation and referral of residents to emergency providers or general practitioners (GPs) (Mezey, 2004).

2.4.5 Situation five: Facilitating resident choice in care decisions.

While this situation is generally applicable in other exploratory circumstances, it is relevant to this research as it focuses attention on a key factor in nurses’ clinical decision-making processes. The clinical situation was developed using literature that identified RN decision-making attributes and considerations within practice-based or theoretical frameworks identifying resident or advocate decisions (ANMC, 2007;

McDonald, 2007; Mezey, 2004; Phillips et al., 2007; Spilsbury & Meyer, 2001; Scott, 2003; Thompson et al., 2004). Data gathered within this frame establish the social context within which aged care RNs interact and negotiate with others to inform, guide and progress outcomes desired by residents (Dressler, 1973).

In an Australian aged care context, facilitating resident choice in all aspects of their care aligns to notions central to PCC, maintenance of resident rights, advance care directives and consumer-directed care models (Australian Health Ministers' Advisory Council [AHMAC], 2011; Australian Government, 2012a, 2012b; McCormack, 2004; Mezey, 2004; Tilly & Rees, 2007). This situation establishes the values inherent in expert RN knowledge, skills and competence as well as their ability to effectively communicate with and inform residents or others about options for care, support and treatment.

Alternatively, exploring resident choice situations identifies influences upon RN decision-making processes. These can be directly attributed to the power that is given to and/or exercised by other aged care stakeholders, such as family or managers, in any clinical situation. Resident choices have the potential to result in changes to RN decision-making processes, ethical–clinical practice and resident outcomes; for instance, in circumstances where resident or family decisions may be in conflict with the RN's legal and ethical duty of care. Moreover, residents may reject advice in relation to best practice; overlook potential beneficial outcomes; make choices that undermine quality care interventions; or be in conflict with expectations held by their family, RNs colleagues or their employers and others. In every instance there is the probability of undermining RN performance and accountability as clinicians.

2.5 Conclusion

In the early phase of data collection, participant RNs returned inadequate data from questionnaires distributed pre-observation. The main source of data in this study was derived from observations that then informed post interviews. During these interviews RNs were encouraged to explore, reveal and confirm any power dynamics between stakeholders involved in determining resident care witnessed during observation of their practice. Literature about resident decisions and self-determination improving quality of care overwhelms the relatively small amount of research into the effects of resident or PCC decisions upon the quality of care, and dilemmas caused to Australian aged care RNs working within professional and legal frameworks.

Chapter 3: **Methodology and Approach**

3.1 Introduction to Grounded Theory Methodology

This chapter is divided into two sections. The first introduces the grounded theory concept of theoretical sensitivities. Transparency and understanding of researcher perspectives is facilitated through a self-reflection activity undertaken before implementation of the study. This identified personal frame of reference (Bolman & Deal, 2008) contributes to researcher perspectives associated with the investigation, analysis and discussion. The second section outlines considerations of grounded theory methodology, rigour and project design pertinent to this research.

3.1.1 Theoretical sensitivities.

The subjective or personal bias of any researcher poses risks to the integrity of the collection and management of study data. Subjective thinking can influence data collection, analysis and outcome, thus it is necessary in qualitative research to address and document self-values or assumptions associated with personal beliefs and paradigms before the project commences. This chapter provides an insight into biases and perspectives of the researcher, a professional nurse (RN), by providing an account of historical and reflective contemplations.

Researcher perspectives were termed by Glaser and Strauss (1967) as theoretical sensitivities. Sensitivities are values and context-derived beliefs that can influence researcher behaviour, data collection, analysis and reporting. Theoretical sensitivity derives from researcher experience or meaningful interpretation of data at any stage of research including literature review, data collection and analysis (Annells, 2003).

During the 1970s and 1980s, Glaser (1978) and Strauss and Corbin (1990) maintained and published their different grounded theory approaches, while emphasising the importance of examining and reviewing researcher ‘theoretical sensitivities'. By acknowledging theoretical sensitivities as personal perspectives of the researcher and their world view, the body of research work can accordingly be considered within these unique perspectives.

A simple example of acknowledging different perspectives is found in visiting a garden of colour, texture, indigenous and exotic plantings. This garden can be viewed differently according to the viewer's perspective and point of reference. In this garden, some people will be in awe of the colour, diversity and beauty. However, when the same garden is viewed by an experienced gardener, it is considered from a technological and horticulturalist perspective. From this other perspective, the garden's beauty is appreciated through an understanding of the effort in ground preparation for each different species of planting, their positions, growth patterns, colour and texture, watering, feeding, maintenance, expertise in caring and pruning for each planting for successive longevity. Therefore, each perspective is unique.

Similarly, in this project, my perspectives or views contained within the methodology, findings and discussion may differ from the perspectives of those reading them. In acknowledging that different perspectives abound, my primary role is to facilitate or convey meaningful dialogue and knowledge that pertains to this unique 'frame of reference' (Bolman & Deal, 2008) or paradigm (Grbich, 1999; Kermode, 2004; LoBiondo-Wood & Haber, 2006).

In research, subjectively held beliefs form an individualised epistemological stance. A process of self-reflection (Marcus, 1994) or researcher reflexivity was undertaken to ensure that the epistemology of the researcher values, views or experience (Cohen, 2007) is acknowledged, and that theoretical sensitivities are known prior to the data collection and analysis.

3.1.2 Researcher perspectives.

During the process to identify researcher theoretical sensitivities, past experiences of working in family-owned/operated businesses has led to a strong customer service focus in all professional interactions. This customer service focus is maintained in situations where individual needs and preferences are expected or met. Further, life experiences gained through caring for ageing or ill family members provide an empathetic insight as a home carer and family member of a resident accessing aged care services, and their expectations about the quality of services.

In contemporary aged care services, PCC is negotiated through partnership and collaboration between the resident and their family or supporting network, to facilitate or maintain the resident’s sense of self, self-esteem, needs, preferences and quality of life (DHS, 2003),and ensure they are respected for their individuality as a person, with choice and decision-making responsibilities (Kitwood, 1997; McCormack, 2003). I believe that this approach reasserts personal perspectives and values that have been influenced by life experiences involving the care of ageing or ill family members as well as professional aged care experiences. Expectations formed from this perspective respectfully acknowledge individuals for who they are, the life lived, choices made, self-determination and their quality of life going forward.

Professionally, my self-reflection identified other frames of reference drawn from experience working as an RN in education, quality assurance and residential care coordination roles. These roles involved investigating clinical decision-making processes by individual RNs working in aged care when they appeared to deviate from policies or standard practice expectations. As a result of investigations into influences on RN decision-making processes, recommendations were developed to include organisational policy reviews to promote procedural transparency, RN education or training approaches to improve practice and develop or confirm competency (see Chapter 5, pp. 207-228).

In undertaking professional development activities in adult education, I found resonance with the theoretical frameworks and considerations of Freire (1970) and Schön (1983), as well as the belief in life-long learning. Through the work and theory of Freire (1970) I realised that knowledge is socially constructed and empowering. Empowering people through literacy, education and dialogue occurs through thinking and action known as praxis. Dialogue involves encouraging opposing views or differing perspectives through respectful exchanges to enrich personal perspectives of those involved, thus creating learning opportunities.

While working as an adult educator, it was important for me to understand how knowledge is acquired and to identify strategies suitable for diverse learners working in aged care. After 12 years of professional experience I have come to the view that RNs individually acquire and consider information within a specific personal frame of reference or perspective. This view is supported by research into adult learning. Data are gathered or determined using intuitive or decisive processes to progress conscious thought into considered action (Junnola et al., 2002; Muir, 2004), reflection of practice using experience that develops layering of knowledge (Schön, 1983) over time. Similarly, case studies or situation-based reflexivity facilitate tacit or intuitive knowledge over time (Vygotsky, 1978).

In professional practice, my employment in aged care RN roles linked responsibilities around quality management and education. This dual functional role enabled trends in practice or gaps in knowledge to be promptly identified and, through education, rectified. Trends or gaps were addressed promptly through group education, or negotiated using an individual performance and professional development plan.

In developing understanding and knowledge associated with education and quality management, studies highlighting the work of Deming (1986) and involving the theory of profound knowledge and the ‘plan–do–check–act cycle’ were informative. As a result, application of this knowledge theory in aged care settings revealed the potential for empowering workers to improve quality outcomes as well as promoting a positive workplace culture.

Continuous improvement processes are found in everyday aged care practice. Deming’s (1986) ‘plan–do–check–act cycle’ enables resident needs to be identified by RNs in order to formulate care plans. RNs identify individual needs and goals, and personalise any interventions that are implemented. Interventions involve the *do* component of the cycle. The *check* element of the cycle involves an evaluation to ensure strategies are effective in progressing towards the goals. The *act* component refers to changing the intervention or goal where necessary. Thus, care management occurs within a cycle of continuous improvement that ensures resident health, comfort and wellbeing with the opportunity to accommodate changing or emerging needs.

Another approach in bridging knowledge, skills and experience gaps among aged care staff was achieved by applying Piaget’s equilibrium model (1997). The adoption of Piaget’s model by my employer led to the implementation of modified staff self-performance appraisals. This encouraged staff to determine their own work quality, knowledge level and experience necessary for quality improvement, efficient customer service provision and increasing job satisfaction through career promotion or recognition of contribution in quality service delivery.

By undertaking this reflection, perspectives relating to RN decision-making processes, service expectations and aged care practice have been identified to promote understanding of data interpretation and add depth in discussions of findings. In moderating the influence that theoretical sensitivities may create, objective data collection tools have been designed to prompt and record responses during the study.

3.1.3 Grounded theory.

This section outlines the rationale for determining a suitable qualitative methodology, elements of research project design including developing and piloting of the work-based circumstances and questions for use in the data collection approaches. The ethics application approval, project implementation details, and recruitment and analysis process are described later in this chapter.

During the search for a research methodology for this study, several approaches and methods were identified that could explore the complex cultural and social contexts that make up the aged care environment. Three different qualitative methodologies were examined and considered for this study, each with its own methods of data collection, collation, interpretation, analysis and presentation. The methodologies considered were phenomenology, ethnography (Crotty, 1996; DiCenso, Guyatt, & Ciliska, 2005; Sadala & Adorno, 2002) and grounded theory—the approach that was eventually chosen for this research (Denzin & Lincoln, 2000; Glaser & Strauss, 1967; Grbich, 1999; Strauss & Corbin, 1994). Phenomenology gathers data from participant perceived reality or experiences using first-person point of view interpretation of lived events. Ethnography gathers data from researchers observing, interviewing and living shared experiences to understand participant or group behaviour and culture over time.

Grounded theory offered the most appropriate methodology enabling the generation of mid-range or substantive theory (Strauss & Corbin, 1990). Denk, Kaufmann and Carter (2012, Section 4.2.1, para 10) explain that ‘grounded theory aims at the understanding of complex, social processes that are relevant for the individuals involved’. Strauss and Corbin (1994) highlight the efficacy of grounded theory to probe and explore a phenomenon, its significance to others or their behaviour in context, and data relevance in specific situations and relationships, to reveal emerging themes and generate substantive theory. Grounded theory is useful to explore stakeholder relationships and ensuing power dynamics, and to establish the inherent value and uptake of aged care RN knowledge, especially as it is applied in ethical–clinical decision-making situations.

In this study, grounded theory facilitates generation of new knowledge by identifying aged care RN clinical decision-making attributes, exploring their social reality and identifying influences on RN actions and their clinical consequences. New theoretical knowledge can be compared to existing aged care-related decision-making frameworks or models to identify particular influences on contemporary aged care RN clinical decision-making processes.

3.1.4 Generating new theory.

The purpose of the current study is to bring new understanding of nursing in aged care. The development of theory around the factors influencing clinical decision-making and RN scope of practice was always going to be complex. Grounded theory was developed by sociologists Barney Glaser and Anselm Strauss (Glaser & Strauss, 1967), whose work involved the application of a constructivist framework to interpret qualitative data as meaningful exchanges or relative social interactions (Barbour, 2008; Schnieder et al., 2003). The grounded theory methodology and approach enabled Glaser and Strauss (1967) to identify themes and generate theories that explained events, behaviour or situations in their social context when they occurred (Benoliel, 1983; Blumer, 1969; Glaser & Strauss, 1967).

Since 1967, Glaser and Strauss have independently redefined two distinct data-gathering and management approaches (with different terminology applied to each) from their original grounded theory (Chenitz & Swanson, 1986). Glaser (1978) highlights one approach that uses an unstructured process in data collection through naturalistic inquiry or unstructured questions, which enables a broad analysis to generate formal theory (or grand theory).

Strauss (Strauss & Corbin, 1990) adopted another approach that is suitable for contexts that generate vast amounts of disparate data. Using semi-or fully structured questions related to a particular field or area, the focus of inquiry is set within manageable parameters. The data are then symbolically interpreted as text, patterns and meanings within their context to generate what is called substantive theory or mid-range theory (Strauss & Corbin, 1990). Collected data are systematically sorted through an ongoing process called theoretical sampling. Data are progressively sorted into text–phase related groupings containing similar meanings, constructed patterns and other distinguishing characteristics by using an interpretative approach. Verification of data occurs through comparative analysis of all data to enable the generation of the mid-range or substantive theory (Denzin & Lincoln, 2000; Finch, 2008; Glaser, 1978; Maykut & Morehouse, 1994; Strauss & Corbin, 1990, 1998).

Glaser and Strauss (1967) held that grounded theory has two theoretical paradigms—pragmatism and symbolic interactionism—that are exemplified in Mead's work (1925, 1934). Pragmatism involves rationalisation and metacognitive analysis 'to resolute or explain' qualitative data collected (Jirojwong, Johnson & Welch, 2011, p. 119). Symbolic interactionism involves 'meaning, language and thought' (Carlson, 2013, pp. 458–459) in which 'the relationship between individuals and society' (Schreiber & Stern, 2001, p. 178) is symbolically constructed, meaningfully interpreted, or differentiated and negotiated according to their functionality or purpose. Mead's actors theory (1934, 1938), previously used by Corbin and Strauss (2008), offers an interpretivist–symbolic perspective to the objective analysis of the data. Theoretical sampling enables progressive codification of data.

This study follows the approach of Strauss and Corbin (1998) by using open-ended semi-structured questions to gather data with the inquiry limited to commonly occurring clinical situations in order to focus data collection. In this way new knowledge is generated about power-related influences at play that determine resident clinical outcomes. Similarly, open-ended questions in the three data collection approaches were duplicated in each of the five clinical situations to consistently explore areas as well as record data and undertake comparative analysis. Information gathered during the pre-observational and observation stage was used to guide all participant interviews.

Strauss and Corbin (1990, 1998) applied three stages of codification known as open coding, axial coding and selective coding, to create theory. These codification stages are employed in this study (see Figures 3.1, 3.2 and 3.3). Open coding of data from self-completion questions, observations and interviews involves collation of meaningful attributes or characteristics. In the next stage, termed axial coding, sorted data are grouped into central themes linked as circumstances, actions or other interactions. Themes are able to be reinforced or grounded through constant comparisons of participant input from interviews and literature where found. The last stage, termed selective coding, is applied to each theme to reveal an overarching emerging theory that fits to explain or describe the phenomenon under investigation (Strauss & Corbin, 1998).

3.2 Developing Data Collection Tools

Given my own experiences in aged care, I considered the functional elements required of a researcher in the field wishing to gather data from RNs. To facilitate an objective approach, Strauss and Corbin’s (1997; Corbin & Strauss, 2008) method of data collection as a non-participant researcher was used in this study. This approach comprises three data collection approaches including pre-observational questions, observation of participants working in an aged care context and participant interviews to clarify and ground data collected during the study (Corbin & Strauss, 2008; Dearnley, 2005). Each approach consistently applied semi-structured open-ended questions (Corbin & Strauss, 2008) with an additional component of five commonly experienced aged care clinical situations to explore power relationships and influences on RN clinical decision-making processes, and to focus data collection (see Appendices A–C).

3.2.1 Identifying five work-related situations for exploration.

The literature provided understanding in how nurses communicate, think, use or obtain knowledge to inform clinical decision-making in the workplace. In a nursing context, effective communication relies on nurses, patients and situations (Caris-Verhallen et al., 1999) as well as shared understanding of language and culture. This implies that nursing occurs within a social context where the quality of communication is influenced by staff attitude to the resident, and their level of job satisfaction, education or training that enables them to apply empathy with positive feedback to residents, thereby ensuring that resident dignity, self-esteem, choice and independence is maintained. Therefore, individual factors or combinations of these influence nurses’ knowledge, inform clinical decision-making processes and consequently influence care provision.

The five clinical practice situations used in this study reflect an aggregation of relevant factors in RN clinical decision-making considerations drawn from researcher experience and the literature review; and were endorsed and confirmed by pilot study participants. They represent broad clinical decision situations commonly experienced in aged care nursing. However if the process of participant confirmation had revealed that any were not valid, that situation would have been removed from the process. As it turns out, all clinical situations used in the study were acceptable to participants and this enabled contextualised clinical decision-making responses and actions to be identified, collated and then coded as attributes, or properties specific to aged care settings. Data yielded from each of these clinical situations termed ‘scenarios’ in the ethics approved data collection tools revealed influences on RN decisions in their practice that had not yet been investigated in aged care (see Appendices A,B, C and D).

3.2.2 Developing the questions.

Semi-structured questions developed to assist data collection during interviews served to focus and bring consistency to the exploration of aged care-related phenomena involving stakeholders and workplace circumstances in which decisions are made, and to identify factors that influence clinical or resident outcomes. They enabled ease of comparative analysis of characteristics or themes and transferability of group characteristics within different situations.

Pre-observational and observational data informed interviews, with additional questions raised to investigate themes, concepts and stakeholder power-related relationships, to ground data. Reflective elements of questions related to each clinical aged care situation were informed by the literature, with particular emphasis given to ANMC (2007); Brookfield (1987); Junnola et al. (2002); Schön (1983); Scott (2003) and Williams (2002).

The questions are common to each data approach and consistent across all predetermined clinical decision-making situations. Each participant was prompted to respond to the following questions:

1. What is your professional experience in managing the scenario?

2. What influences your clinical decision-making in practice?
3. Are there any other influences or reasons for your professional actions and thinking?
4. What were your thoughts in the first instance for action regarding this scenario?
5. Why do you do things in the way that you do?
6. Do you talk to other RNs regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?
7. Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.
8. Does your employing organisation influence your thinking when making decisions? If so, how?
9. If the situation occurred again, is there anything you would consider or do differently? If yes, briefly describe what you would do.

3.3 Applying Rigour in Grounded Theory Qualitative Research

A key component in the success of sharing new knowledge is author/researcher responsibility, which ensures rigour across all aspects of the research design, implementation and outcomes that will be subjected to academic and peer scrutiny. Using grounded theory to conduct an investigation of influences in aged care RN decision-making processes presents an opportunity to describe the complex influences upon aged care RNs' everyday clinical decision-making processes. Findings can better inform professionals and other stakeholders of influences that translate into nursing interventions that can vary clinical pathways and affect individualised resident outcomes.

In 2010, a five-year review of 10 major published journals exploring rigour in research by Gibbert and Ruigrok established that qualitative researchers continue to address the issue of rigour differently and uniquely. Some researchers follow a standardised approach for a particular methodology, while others adopt rigour criteria drawn from different methodologies to varying degrees; hence the adoption of language and criteria sourced from quantitative research within qualitative studies, as suggested by Guba (1981). This raises issues associated with the view that qualitative research is considerably less rigorous than quantitative research.

Researchers are obliged to ensure rigour, either within a defined proven methodology with existing criteria, or by using approaches that cross-check criteria (Beck, 1993; Burns, 1989; Sandelowski, 1986; Shrivastava, 1987; Taylor, Kermode & Roberts, 2007; Tobin & Begley, 2004).

One grounded theory study used credibility, validation and triangulation of findings to facilitate rigour (Forbes-Thompson & Gessert, 2005). Contemporary researchers argue that in the absence of defined rigour criteria in qualitative research, an evolving suite of rigour criteria can be applied provided its application is adequately described (Cooney, 2011; Gibbert & Ruigrok, 2010; Hunter, Murphy, Grealish, Casey & Keady, 2011a, 2011b). Consequently, criteria from qualitative and/or quantitative domains can be utilised, accommodating positivist or interpretivist perspectives aligned to researcher preference and methodology. The rigour criteria used in this study are discussed in detail later in the chapter.

The question of rigour in grounded theory research ignites debate about the role of researcher perspectives when recording and later analysing data; that is, how data are viewed during collection and analysis, and how the data are evidently truthful. The positivist view of discovering the truth is that it was hidden until it was observed, examined, measured, documented, compared, determined reliable and validated with a degree of scientific approximation. An alternative approach is that data are subjectively interpreted within social contexts with truth constructed from reality, experience, deductive reasoning and empirical data (Lincoln & Guba, 2000; Strauss & Corbin, 1999).

Glasson (2004) believes that in some instances, positivists can view events subjectively—that is, interpretively—resulting in different outcomes. This occurs through different perspectives held when observing the same event or accessing the same data that will influence the analysis to then significantly vary the findings. Moreover, Glasson (p. 88) emphasises these differing perspectives in the following example: ‘Phenomena that we observe are only meaningful in terms of individual experience and interpretation: one person’s shooting star may be another person’s alien spacecraft.’

The challenge for any researcher is to present data that will reveal truth from a shared perspective. The falling star and alien spacecraft example highlights the importance of rigour and validation for accurate representation of the data. This emergence of truth depends not only upon how data are viewed, but what is reported according to the perspectives used in its analysis. Therefore, these data must be able to withstand scrutiny for ‘trustworthiness’ when they are ‘comparatively determined’ either inductively or deductively by others (Glasson, 2004, pp. 84–85).

Grounded theorists Strauss and Corbin (1998) contend that an acceptable standard in rigour is achieved when the data collected adequately detail a research participant’s world view and within their context. The conduct of the study is explained in such a way as to ensure that another observer or researcher can understand the participant’s social reality—the subjective stance of the researcher when data are obtained and when analysis is underway. The discourse in Chapter 4 depicts findings using the aged care RNs’ world view.

In discussing ‘classic grounded theory’, Hunter et al. (2011a, p. 9) revisits Glaser’s (1978) definition of rigour applicable to core categories or theory. Glaser’s criteria of rigour are (a) the extent to which coded categories ‘fit’ the problem; (b) ensuring the theory will ‘work’ in explaining behaviour; (c) assessing ‘relevance’ according to others, of category ‘fit’ or theory to ‘work’; (d) category or theory ‘modifiability’ demonstrated by being readily adaptable to ‘fit’ or ‘work’; and (e) an ability to achieve ‘parsimony and scope’ of data, coding and categories relating to ‘emerging theory’. Guba (1981) held the view that qualitative researchers require criteria that universally apply to both qualitative and quantitative research. This became known as Guba’s ‘model of trustworthiness’. The criteria included truth value, applicability, consistency and neutrality. Guba and Lincoln (1985) further explored common elements of universal research criteria until 1989 when Lincoln and Guba stated that specific terminology should be adopted to adequately define qualitative research criteria, which could clarify rigour and accommodate variables in research. These research variables consist of research design, contexts of study, study purpose, researcher positioning or bias, data interrogation and processes to ensure truth and rigour (Kefting, 1990; Sandelowski, 1986).

In 2000, Lincoln and Guba further sought to establish criteria more suited to qualitative research that were inclusive of elements associated with other forms of rigour or criteria from quantitative paradigms. Subsequently, rigour terms such as ‘confirmability’, ‘auditability’, ‘authenticity’, ‘credibility’ and ‘transferability’ (modifiability) were aligned to qualitative research whether from interpretivist or positivist perspectives. Another criterion mentioned in the literature pertaining to grounded theory interpretivist rigour is ‘fittingness’ (Beck, 1993; Cooney, 2011; Glaser

& Strauss, 1967; Miles & Huberman, 1994; Sandowski, 1986; Strauss & Corbin, 1998). These terms are further explained below.

‘Confirmability’ involves corroboration of data from subjects and the circumstances of the study to yield the outcomes without significant researcher interpretation. Theoretical sampling enables the participants’ own world view to be documented and shared with others. In addition, evidence that the study was conducted using consistent approaches ensures internal consistency over time with research uniformity in the procedures, to enable ‘confirmability’.

Data ‘credibility’ and demonstration of ‘authenticity’ of the situations, contexts and participants studied are established through a process of continued internal consistency (Strauss & Corbin, 1998) by using detailed records to ensure the theory relates to or explains the data. In grounded theory, this is somewhat similar to undertaking comparative analysis and/or triangulation of qualitative data gathered in different ways such as questions, observations and interviews as well as from different participants. ‘Authenticity’ in data and findings are confirmed from people involved in the study, or are significant as another form of data from the same or similar research context, situation or literature.

‘Transferability’ relates to the application of findings or new theory into other contexts or conditions to assess portability and relevance in different domains. Theory transferable into other contexts enables the ‘generalisation’ of theory as it can apply outside the context or situation in which it was generated. Similarly, ‘external validity’ is evident when theory is able to be fitted into other contexts or situations. In grounded theory, this can be referred to as ‘fittingness’ of theory as the theory ‘fits’ the purpose in different situations (Glaser & Strauss, 1967). Therefore, ‘fittingness’ can be juxtaposed according to researcher perspective and methodology.

Other quantitative rigour criteria identified in qualitative studies include: validity of construct, internal validity, external validity, reliability and generalisation (Gibbert & Ruigrok, 2010; Kefting, 1990; Tobin & Begley, 2004). From the positivist perspective, the term ‘construct validity’ implies that the study uses structured or planned elements, including questions or lines of inquiry, within guided study implementation and analysis processes to ensure data objectivity. The result of such measures was considered to represent a non-biased reality as observed and documented (Denzin & Lincoln, 1994).

In a qualitative paradigm, researchers employed ‘internal validity’, which can apply to two or more variables (a quantitative term) that relate to each other in different ways (Cohen & Crabtree, 2008; Kefting, 1990). This can occur within data triangulation or becomes evident when data are repeating. External validity occurs when findings are applicable in different contexts and are therefore ‘generalisable’ (Gibbert & Ruigrok, 2010, pp. 718–719), whereas ‘reliability’ applies to data or findings that are evidenced at any time, irrespective of context or researcher perspective.

In 2012, Denk, Kaufmann and Carter also confirmed that grounded theory researchers apply broad qualitative or quantitative criteria to ensure rigour is achieved. Moreover, some researchers fail to explain their inclusion or to align their research to purist Straussian approach or Glaserian approaches, thus raising the question of whether mixed methods were employed.

Grounded theory contains two differing approaches, known as positivist and interpretivist world views, in which data are analysed. Some grounded theory researchers adopting an interpretivist approach ‘explicitly label the rigour criteria in terms of the concepts commonly used in the positivist tradition’ (Gibbert & Ruigrok, 2010, p. 710). The current study follows the qualitative Straussian approach and adopts an interpretivist analytical process to incorporate Mead’s actors theory (1934) as a means of augmenting understanding of power interactions and effects on players.

In some studies, rigour within grounded theory involves terms such as ‘auditability’ or ‘trackability’, which describe an emergent theory ‘decision trail’ (Burns, 1989; Miles & Huberman, 1994). This involves data collection in terms of content and relevance in determining what was reported or reportable or how the author reports it, and the process of ensuring validity while data gathering and/or while progressively establishing data themes or relationships, either in the field as observations or interviews, or in analysis (Gibbert & Ruigrok, 2010).

Cohen and Crabtree (2008) emphasise the importance of establishing researcher bias to provide a balanced view ensuring validity. In this way, the researcher perspective can be ‘something used actively and creatively through the research process rather than as a problem … affecting trustworthiness, truthfulness or validity’ (p. 333–334). Grounded theory researchers are expected to adequately reflect on theoretical perspectives and position from study inception, ethics, data collection and analysis including coding and memos, and reporting findings (Blinkhorn, Carter, Sbaraini, & Wendell-Evans, 2011).

In a Straussian study, the researcher is required to ensure that data-gathering processes, interpretive analysis and findings are adequately described, and that the report is an accurate representation of ‘truth’ or theoretical statements known as theory emerging from the data. By adopting a Straussian interpretivist perspective in this study, the researcher assumes an inter-subjective stance to gather and analyse data (Glasson, 2004). In this way, all data are viewed from the perspective of participants, that is, aged care RNs. The intention is to gain an understanding of the nurses’ reality for the identification of influences upon their clinical decision-making processes.

In theoretical sampling each participant data set is compared to each other, which enables verification and confirmation of data. In this study, it was crucial that RN data, actions and social interactions be accurately described and reported for progressive coding to yield themes from which theories can emerge. Additionally, the purpose of researcher documentation is to convey and share the ‘phenomenon’ (Glaser & Strauss, 1967) with others who will simultaneously scrutinise empirical data and its management, and inductively determine explanations related to RN actions, behaviours or processes in order to evolve substantive theory shared by the author/researcher.

Further, by sharing the theory journey with others, the researcher aims to provide an understanding of interpretive and methodological rigour (Gibbert & Ruigrok, 2010). Interpretive rigour describes the steps of analysis or findings to explain or provide meaning from data and the applicability or transferability of data into other contexts (Burns, 1989; Cooney, 2011). Product rigour is possible when truth emerges through the sharing of an analytical journey to arrive at similar findings (Beck, 1993; Cooney, 2011; Guba & Lincoln, 1989). Methodological rigour details what the study explored and how it was done, including data collection processes. In some circles, this is similar to ‘process rigour’, which refers to the trustworthiness or adequacy of how the grounded theory study was done (see Section 3.3.1).

Interpretive researchers often prefer ‘methodological rigour’, especially in circumstances where relevant data in the literature are insufficient to establish new knowledge (Gibbert & Ruigrok, 2010; Glaser & Strauss, 1967; Kefting, 1990). Burns (1989, p. 48) details a series of ‘threats’ likely to influence methodological or process (that is, procedural) rigour. Several key threats pertain to participant actions and researcher presence, actions or possible perspectives during the study, especially when gathering data. These threats relate to appropriate wording of open-ended questions to invite responses that elicit participant experiences rather than share ‘theoretical orientation’ (Burns, 1989, p. 49) of the researcher. The researcher is responsible for ensuring data integrity through data quality; and establishing credibility of participants is the responsibility of the researcher. Threats to procedural rigour are further mitigated through data adequacy for analysis and documentation that accurately describes an event or records elements and actions within the study.

Drawing upon the accumulated findings of the published research and theoretical frameworks mentioned above, the researcher in the current study ensured objectivity, confidentiality and appropriate interactions aligned to ethical, professional, participating employer and university requirements and obligations (see Appendix E). Multiple data sets enabled comparison with other attributes found within existing clinical decision-making frameworks or approaches applicable to Australian aged care contexts.

In this qualitative study, rigour is viewed as multidimensional. Methodological rigour is purposefully considered as one of several strategies in which to ensure rigour is present and is further strengthened through researcher documentation describing study implementation and progression in ensuring objectivity, adequacy and accuracy in data collection (see Section 3.4).

Participant data collection involved three separate approaches as sources of pre-observation questions, observation of practice in the field and interviews. Questions provided to participants prior to the scheduled observation study date sought to elicit participant profile and identify in advance any interview informing comparative data involving common clinical situations.

Observation of aged care RNs practice yielded data related to contextualised decision-making influences, knowledge transfer and clinical determinations. As a non-participant observer during the study I was able to observe RNs in context interacting with staff, managers, residents and families. In order to preserve the central focus of this study on influences around aged care RN decision-related processes, residents—usually regarded as being central to nursing activity—are viewed as stakeholders embedded within in the RN context of clinical practice and decision-making processes.

Data collection involved researcher observational notes and memos documenting social and ethical–clinical level of RN complexity or familiarity with clinical nursing decision-making situations, collaborative stakeholder relationships as well as the value and application of experience in clinical practice and other RN responses to events occurring randomly during the observational period. Consequently, observational data, in addition to data collected in relation to the five situations, informed participant interviews. When possible (with due attention given to confidentiality and conduct protocols as required in aged care services), participants were asked to explain their thinking and actions to the researcher (de Groot, 1946) about different observed situations as well as exploring themes and concepts progressively sorted during participant data collection. Interviews were recorded as notations or were digitally captured for later transcription for progressive data analysis, facilitating validation and grounding of participant data to contribute to theory generation (Glaser; 1967; Glaser & Strauss, 1967; Grbich, 1999).

Procedural rigour occurred as participant data were sorted according to uniform coding properties or characteristics for each grouping by collection type, in a process called open coding. Each participant data set provides corroborative evidence for groupings that yield similar interpretative properties. Authenticity (a rigour criterion) was achieved by incorporating data collected from participating RNs and literature to authenticate the collated data from the participant situation-based data set. Sorting continued as each situation collection set was comparatively analysed to create further groupings known as categories to become grounded theory nodes. This was done using NVIVO (version 10, 2012; Qualitative Solutions and Research [QSR], 2010, 2011, 2012), a software program specifically suited for qualitative research, which was used to manage the data. These categories comprise meaningful text groupings of ideas, themes or relevance. Procedural rigour was demonstrated by confirmability of all multi-source data, which when documented ensures data accountability and trackability.

3.3.1 Strategic approaches to ensure rigour.

In this grounded theory study, it is not enough to merely state that methodological and interpretive rigour was applied. There is a responsibility to ensure that essential points of rigour are clearly defined and aligned strategically to areas of methodology, ‘process’ or procedural elements and ‘product’ rigour associated with theoretical concepts (Burns, 1989; Shrivastava, 1987).

Cohen and Crabtree (2008, p. 34) state that ‘divergent perspectives were observed in how these criteria should be applied to qualitative research with differences based on the paradigm embraced by the authors’, raising further concern that reviewers may be experts in their field of qualitative research and this bias may lead them to preclude certain criteria over another. To alleviate this risk in the current research, various strategies were employed progressively throughout the study to ensure rigour. Six specific criteria to ensure adequate rigour in the grounded theory–interpretive study were drawn from the work of Beck (1993), Glasson (2004), Glaser and Strauss (1967), Guba and Lincoln (1989), and Strauss and Corbin (1998). These points of rigour criteria—confirmability, auditability, authenticity, credibility, fittingness and transferability—will overlap during the progression of the study.

An outline of these strategies is provided in Table 3.1. Qualitative research points of rigour strategically aligned to study elements. In addition, Figure 3.1 outlines the progressive implementation of the study aligned to different points of rigour. Section 3.4 describes the implementation of this research.

Table 3.1

Qualitative Research Points of Rigour Strategically Aligned to Study Elements

Adopted rigour criteria	**Rigour applicable to study elements**
Methodological rigour includes documentation, procedures and reports to facilitate shared perspectives to determine truth.	Aspects of the study journey have been documented in various formats including Academic Progress Reports, reflective journaling, notations, memos, records, draft chapters and other records over the project period.
Threats include (Burns, 1989): • participant truthfulness • researcher influence on data collection, including: • appropriate wording of open-ended questions • data adequacy for analysis or documentation in accurately describing an event or recording elements and action within the study.	To address threats: • Three data collection types with five anticipated or hypothetical situations (Mezey, 2004) were compared to all participant data for credibility cross-checking (and multi-source data triangulation). • Participant data included semi-structured or open-ended questions pre-observation, during observation and in post-observation interviews. • The implementation of the study is described, as is the data analysis (coding) of RN decision-making events, experience, observations in context and reflection (Cooney, 2011; Hunter et al., 2011a, 2011b; Kefting, 1990).
Interpretive rigour includes: • researcher theoretical perspectives and interpretive stances as conceptual thoughts before analysis • theoretical sampling, which discloses how the data are coded over time, what they mean, and into which category or idea they fall with internal consistency and confirmability (Hunter et al., 2011b;	• Interpretive elements recorded as memos and NVIVO nodes indicating progression of ideas, coding properties and formation of categories. • Chapter on study implementation documents the process of ‘open coding’, in which properties are first identified; further coding identifies action items or social processes as properties of groupings known as ‘core categories’ through theoretical coding.

Adopted rigour criteria	Rigour applicable to study elements
Strauss & Corbin, 1998).	
Confirmability involves corroboration of data from subjects and the circumstances of the study to yield the outcomes without significant researcher interpretation.	Comparative analysis of data to data, participant to participant, situation to situation, and data source to data source with additional data confirmation from memos and literature (overlapping internal validity/consistency/ confirmability).
Dependability/auditability requires evidence of consistent approaches over time with research uniformity in data collection and data management.	Consistency achieved within data collection as questions were purposeful prompts by non-participatory primary researcher to focus investigation in each tool and each situation. NVIVO software used for data management, codification and categorisation to evolve themes within different situations; and RNs progressively analysed and documented during the study.
Credibility and a*uthenticity* include: • internal consistency of the situations, contexts, participants and data • authenticity in data and/or findings.	Internal consistency achieved by: • consistency of data collection questions (pre-observation, observation and participant interview) in situation and with participants. • data credibility via comparative processes including data to data, situation and participants. (overlapping criteria of confirmability and internal validity). • authenticity gained through RNs to validate and confirm data, relevance to context and related themed categories (overlapping criteria of credibility and internal validity).
Transferability. Relevance of data, categories or new theory to other contexts or conditions; that is, portability and application in different areas.	Properties of each of the five situations were compared and coded for each data collection type and participant. Participant nodes coded to form multi-source themed groups and categories. These individual nodes were comparatively analysed upon collection with axial coding undertaken of related social processes and actions (thematic relevance).
Generalisability and *fittingness* occur when findings or substantive theoretical concepts apply in other contexts or situations.	Data analysis revealed similar themes from multi-source coded situations demonstrating contextual relevance enabling new theory fittingness and generalised application to other contexts.

3.4 Conducting the Study

This section outlines the researcher’s journey in gaining ethics approval, piloting questions and situations, RN participant recruitment, data collection processes including distribution of participant questions, undertaking onsite observation visits, conducting interviews, progressive data analysis (theoretical sampling) and attention to rigour. The process has been a learning experience that undoubtedly affected the subjectivity of the analysis and interpretation of findings, and therefore justifies inclusion in the thesis.

3.4.1 Ethics application preparation.

The ethics application included a research proposal, decisions around the conduct and involvement of the researcher, ethical considerations and research design relating to data collection tools, ensuring confidentiality and data management. Prior to ethics approval (see Appendix E) it was important that each data collection tool for the five situations and questions was piloted to ensure wording appropriateness and situational fit to context, in order to obtain relevant data.

The pilot study established the appropriateness the wording of open-ended questions to ascertain possible ambiguity which would influence data adequacy. It also validated the relevance of the five clinical decision-making situations faced by aged care RNs on a daily basis. Participant pilot RNs were recruited from same employing organisation as the researcher. During the pilot, feedback from RNs identified ambiguities in the question which was able to be amended. Furthermore, RNs raised questions about study purpose and the confidentiality of data collected by the researcher, prompting changes in wording and redesign of the RN participant recruitment strategy.

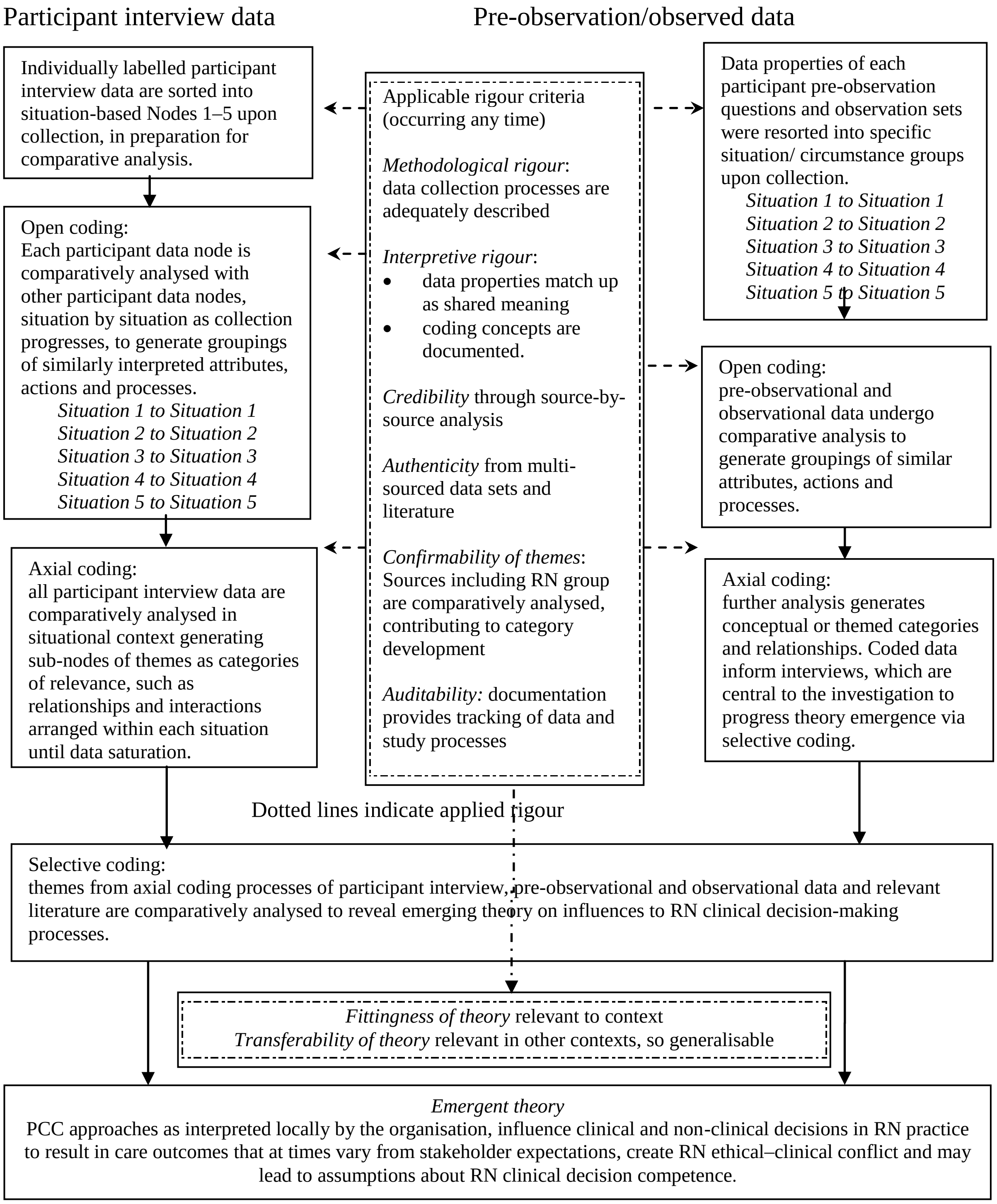

Participant interview data
Pre-observation/observed data
Individually labelled participant interview data are sorted into situation-based Nodes 1–5 upon collection, in preparation for comparative analysis.
Open coding: Each participant data node is comparatively analysed with other participant data nodes, situation by situation as collection progresses, to generate groupings of similarly interpreted attributes, actions and processes.
Situation 1 to Situation 1
Situation 2 to Situation 2
Situation 3 to Situation 3
Situation 4 to Situation 4
Situation 5 to Situation 5
Axial coding: all participant interview data are comparatively analysed in situational context generating sub-nodes of themes as categories of relevance, such as relationships and interactions arranged within each situation until data saturation.
Applicable rigour criteria (occurring any time)
Methodological rigour: data collection processes are adequately described
Interpretive rigour:
• data properties match up as shared meaning
• coding concepts are documented.
Credibility through source-by-source analysis
Authenticity from multi-sourced data sets and literature
Confirmability of themes: Sources including RN group are comparatively analysed, contributing to category development
Auditability: documentation provides tracking of data and study processes
Data properties of each participant pre-observation questions and observation sets were resorted into specific situation/ circumstance groups upon collection.
Situation 1 to Situation 1
Situation 2 to Situation 2
Situation 3 to Situation 3
Situation 4 to Situation 4
Situation 5 to Situation 5
Open coding: pre-observational and observational data undergo comparative analysis to generate groupings of similar attributes, actions and processes.
Axial coding: further analysis generates conceptual or themed categories and relationships. Coded data inform interviews, which are central to the investigation to progress theory emergence via selective coding.
Dotted lines indicate applied rigour
Selective coding: themes from axial coding processes of participant interview, pre-observational and observational data and relevant literature are comparatively analysed to reveal emerging theory on influences to RN clinical decision-making processes.
Fittingness of theory relevant to context
Transferability of theory relevant in other contexts, so generalisable
Emergent theory
PCC approaches as interpreted locally by the organisation, influence clinical and non-clinical decisions in RN practice to result in care outcomes that at times vary from stakeholder expectations, create RN ethical–clinical conflict and may lead to assumptions about RN clinical decision competence.

Figure 3.1. Theoretical sampling (analysis) and rigour.

In considering possible ethical issues arising from the study, two additional questions were developed for the pilot to enable possible ethical conflict to be identified should participants be recruited from the same organisation as the researcher. Non-identified pilot participants were asked to rate their level of difficulty or ease in responding, using a Likert scale of 1–5 (see Appendix D). As a result, several amendments to the wording of questions and sequencing in situations were undertaken to ensure clarity (see Appendix A, B and C). The pilot revealed the potential for ethical conflict if RNs were recruited from the same organisation as the researcher (see Appendix D). Moreover, the pilot identified concerns of RNs working in the same organisation as the researcher: ‘what effect will this have on me or what does this say about me’? To avoid further conflict, co-workers were not recruited.

3.4.2 Ethics approval.

The ethics application was submitted in June 2010, to the Australian Catholic University Human Research Ethics Committee (HREC), which granted ethics approval from 30 August 2010 to 31 December 2011. Following a review of collected research data for adequacy in 2011, an extension was granted to allow data collection to continue until 31 December 2012 (see Appendix E).

3.4.3 Selection and recruitment of participants.

At the onset of the study a minimum of 10 volunteer participants was considered to be required, based on the literature on qualitative research methodologies. Mason (2010) examined 149 grounded theory studies and reported participant numbers varying from 4 to 87, although much depended on the depth and extent of data from participants. Following a review of data adequacy in 2011, RN participant numbers in the current study were increased to no less than 20 RNs, to ensure sufficient data for analysis.

Homogeneity among RNs recruited for the study was achieved through an inclusion criteria matrix applied before obtaining consent to commence data collection. This selection matrix was applied to all study participants to ensure purposeful sampling of participants who were (a) RNs currently employed in residential aged care services willing to contribute to the knowledge of aged care RN clinical decision-making processes; (b) experienced in aged care for at least one year prior to the study; and (c) responsible for direct care and clinical decision-making processes being investigated in this study.

Approximately 37 residential aged care facilities from 10 national aged care service providers and six state-based organisations were contacted by the researcher from September 2010 to November 2011. Recruitment involved direct and indirect approaches and contact via websites, direct site emailing, telephoning and onsite visits arranged around researcher work commitments. Formal presentations to governing boards, management teams and RNs were conducted to discuss study project aims, benefits accruing from participation, RN recruitment and participation requirements.

In the first 16 months, 11 female RN participants located within two hours driving distance or 200 km of the Sydney metropolitan area were recruited from three aged care organisations. However, data saturation was not reached and data yield was limited and inadequate to support theoretical analysis. This necessitated an extension for collection of more data during a further 12 months to December 2012.

During the recruitment processes, opportunities arose to inquire as to possible reasons for the reluctance of RNs to participate in research about their practice. Feedback from RNs revealed that some RNs were ‘too busy’ at work to participate, while others highlighted a concern that the researcher would impinge upon resident–RN confidentiality. Concerns regarding confidentiality that arose in the feedback were proactively addressed during subsequent recruitment processes by the researcher in 2012. As a result, RNs were reassured that all records are de-identified and pseudonyms are used within written research findings with security of documentation maintained by the researcher and university. Employers would not see the data or be informed of the identities of participants.

Renewed recruitment strategies involved direct contact approaches to approximately 150 facilities. The geographic area was increased from 200 to 400 km, or six hours driving distance from Sydney, resulting in additional RNs joining the study. In some cases, organisations agreed to additional researcher recruitment of RNs during scheduled work visits. RNs working onsite during visits and aligned to the selection matrix were invited to join the study that same day or to participate at another scheduled time. This strategy proved successful in gaining additional participants. By December 2012, 28 RNs were recruited from 12 New South Wales (NSW) facilities located within 400 km of the Sydney metropolitan area.

3.5 Data Collection and Preparatory Processes

From August 2010, Phase One data collection involved pre-observational questions. Following receipt of signed consents from participating RNs, organisational or managerial approval for researcher workplace entry for observation during the participant’s nominated shift was obtained and pre-observation questions were distributed. In phase two, interviews were informed and guided by pre-observational questions and observed practice data. Interview data saturation point was reached in December 2012.

Work commitments of the researcher were redesigned to accommodate study project priorities such as participant recruitment, travel, scheduled workplace visits, data collection, entry, management and analysis, and documenting of findings.

3.5.1 Preparatory phase one: Pre-observation questions.

The self-completion data collection tool labelled ‘study questionnaire’ is in two sections (see Appendix A). The first section is designed to obtain demographic data such as age, experience, previous studies and qualifications (see Figure 3.3) as well as RN responses and perspectives about clinical decision-making perspectives. The first question asks ‘In your opinion, what is a clinical decision?’ This provided the opportunity for RNs to define ‘clinical decisions’ in relation to their context and experiences.

The second section in the self-completion tool related to participants’ consideration of five commonly occurring clinical situations, and they were asked to self-reflect with written responses including decision-making processes for each situation in advance of the workplace observation and interview. This self-reflection activity, conducted in their own time away from the competing priorities and possible time constraints of the workplace, provided information on influences upon clinical decision-making. This became a record containing experiential practice data applicable to the decision-making situations, which was later observed in the field, and grounded during participant interviews.

The response rate was determined by calculating the numbers of consenting RN participants that were expected to return the pre-observation tool. Data Analysis Australia (DAA, 2012, p. 1) note that the average return rate of written data collection tools with phone and personal contact follow-up is 8% and that ‘self-completion surveys often have lower response rates than telephone or face-to-face interviews’. According to research, respondents completing surveys or questions find it difficult to ‘fill in the questionnaire themselves without assistance, and then return it’ (DAA, pp. 1–2).

Ray (2012) established that general public surveys can generate written survey response rates ranging from 1 to 20%, with respondents asking ‘what’s in it for me?’ or ‘how much work is it’? The value or importance of information to be provided is determined by participants as measures of time or effort involved and the resultant benefit. Therefore, it was important to highlight the importance of the data and the research to RN knowledge and practice in order to encourage participation.

Once recruited, RN difficulty in returning the self-completion tool was addressed by strategies used to maximise return rates. These included provision of stamped self-addressed envelopes to a secure post box; sealed envelopes for researcher pick up; or editable word documents for return email directly to researcher by participants when convenient. Yun and Trumbo (2000) established that response rates via mail were higher than those returned via email.

Opportunities for data to be returned via email were not taken up by RNs, with two of the three pre-observational question tools being returned by mail. The third tool was picked up by the researcher during an observational site visit. Three RNs returned self-completed question tools. The remaining 25 RNs (almost 90%) that did not respond to the pre-observational questions were given an opportunity to complete a copy of the questionnaire and to verbally provide data to the questions from Part One of the data collection tool, to obtain demographic information useful for matrix-related data.

Data collection tools comprise participant written responses, non-participant researcher field observations and interview transcripts, as well as memos forming three sets of initial source documents. As participant data were progressively collected during the period of the study they were entered into NVIVO data collection ‘source’ files (self-completion, observation and interview data collection tools) using the participant label. This began the process of initial open coding to sort all participant data into five primary situation-based groupings known as ‘nodes’.

The use of consistently similar questions in all five situations within each set of data collection tools, additional probing questions asked during post-observational participant interviews and exploratory clarification questions to ground the data facilitated the process of sorting situational data nodes into comparative sub-nodes of aged care RN decision-related attributes, characteristics, relationships, actions, social elements and potential influences for each of the situations used to focus the study (see Table 3.1 and Figure 3.1). The findings were structured according to the five situations (see Chapter 4).

3.5.2 Preparatory phase two: Observations.

The second data collection source file involved onsite (field) observations of participants by a non-participant researcher. Observational data were used to guide interviews conducted individually with participants following workplace observation. Observation periods ranged from one to three hours during onsite visits as arranged with participants and according to onsite circumstances, number and frequency of situations observed during the visit. Data collection observation tools (see Appendix B) were used to collect data from individual participants. Data included noting the occurrence of and RN responses to clinical decision-making situations. Researcher-observed complexity of work context; approaches used by RNs to inform or determine interventions; and RN engagement in social interactions or considerations, and actions were recorded. Researcher notes or memos were made during or immediately following the observation—on the tool assigned to the relevant situation—or offered information useful in considering possible coding categories through and codification.

Throughout the observation period, RNs were asked to verbalise their thinking (Cheraghi-Sohi et al., 2007; de Groot, 1946; Ericsson, 1996) when possible without breaching confidentiality or privacy obligations. After each observation a reflective interview with each participant provided an opportunity to clarify details or confirm and ground study data.

At least four of the five situations were observed in the workplace allowing data to be easily contextualised and coded into related RN decision-making characteristics or as influences on practice. During the observation, it was necessary to carefully monitor the number of examples from the same situations. In several observations, multiple events of the same circumstances created recording difficulty for the researcher, in particular, being able to later track the influences and outcomes of RN decision-making processes for each example. In these instances, additional memos and numbered notations were required to record influences and factors occurring in similar situations, which were later grounded by repeating data recorded and participant interviews.

Workplace observations highlighted the multiple demands on RNs working in complex practice settings, where the numbers of residents allocated to each RN far exceeded acute setting ratios of nurses to patients (ANF, 2011). These extensive demands on RN time and expertise were observed to influence clinical decision-making processes. In one observation visit, the RN ratio to residents was one RN to 174 residents, many of whom needed concurrent complex nursing care or interventions. In this observation, approximately 32 resident-related decisions were assessed and determined by the RN in the first hour of onsite observation. In other high care residential aged care facilities more than 30 residents requiring complex care from one RN was a common occurrence.

3.5.3 Grounding phase two: Interviews.

Participant interviews provided an opportunity for both participant and researcher to positively reflect on aged care clinical decision-making practices and to clarify or ground data collected progressively. The interview data collection questions were designed for prompting reflection and discussion (see Appendix C). However, during the study, interviews were conducted onsite on the same day as observational visits with exploratory questions guided by pre-observation or field observation data. Digitally recorded interviews were later transcribed for analysis and entered into their respective data set node using NVIVO software, where they were sorted according to specific context or situation, coded and compared with other data sets during analysis.

3.6 Data Management

Following each observation, interview (and later transcription), participant and study data were entered into NVIVO data management software. Data were grouped according to data collection type (observation or interview) or ‘source data sets’ and then into situation-based data set nodes before coding of meanings, ideas or themes. It soon became apparent from initial analysis that RNs are being subjected to indirect and direct consultative influences in their decision-making practices and that these affect resident clinical outcomes. These preliminary findings are explored and discussed in Chapter 4.

Data management posed technical challenges for the researcher. Previous experience drawn from university studies flagged possible difficulties involving non-computerised forms of qualitative analysis and data organisation. In contrast, NVIVO software initially offered rapid data recovery, manual coding opportunities and efficient data management. The task involved entering, tracking, managing and analysing multiple data sources including participant questionnaires, observation, post-observation interview (notes and audios with transcriptions) and memos; with external sources such as relevant articles, texts, and many externally published sources being progressively entered in NVIVO software by the researcher.

NVIVO uses labelled nodes to separate data from sources using properties that later emerge as core characteristics of aged care RN decision-making influences. Each node was generated by the researcher with data shifted manually into unique groupings following intuitive and deductive processes. This was achieved by sorting texts of shared or similar meanings or properties, and memos from each situation in the subjective coding process to form nodes containing meaningful attributes or characteristic phrases or text.

Each participant data set became a data file labelled according to participant pseudonym and grouped by collection type or format including self-completed questions and audio recordings that were later transcribed. Data entry was completed progressively as data were collected from each participant. From the source file, five situation data set nodes were created with participant data, then sorted into their relevant situation-based nodes. Codification yielding multiple sub-nodes of attributes was later collated into thematic nodes to inform theory (see Figure 3.1).

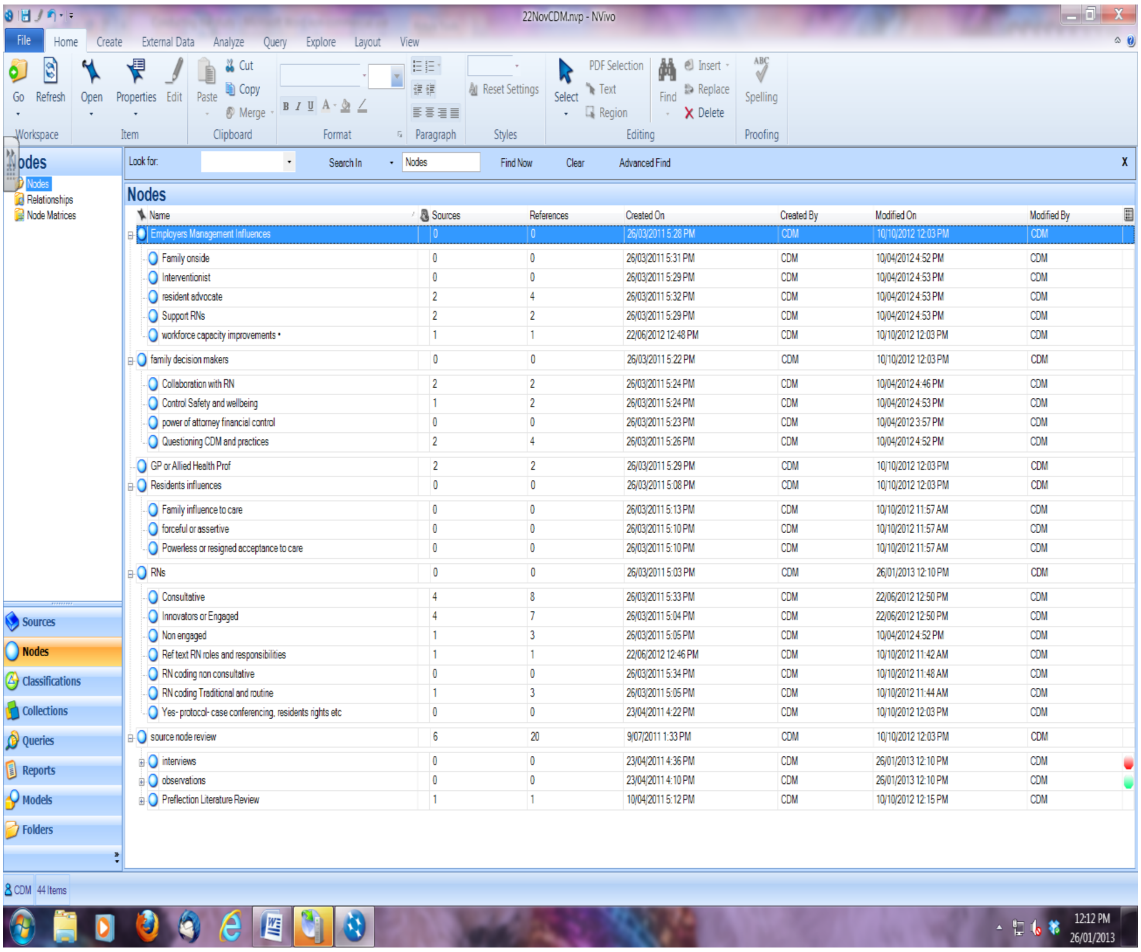
During the study, increasing difficulty arose with subsequent NVIVO program upgrades and coincidental annual replacement of desk and laptop computers over three years. Updating of NVIVO software (versions 8, 9.2 to 10) necessitated additional researcher training. Further, technical difficulties experienced in data storage and retrieval in late 2012 during reporting of findings prompted a review in overall data management, resulting in the production of contingency hard copy data and spread sheets to finalise analysis when NVIVO processing was not possible.

3.7 Researcher Perspectives and Data Coding

Multifarious decision-making influences and attributes were identified through a review of the research literature, which contributed to the development of data collection tools and situations aligned to grounded theory methodology. Researcher perspectives, drawn from personal experiences, created the possibility of identifying a variety of nurse attributes that could be relevant to my understanding of their decision-making processes. These included ethnicity, work culture, work communication patterns, professional experience, skills, competence, knowledge or deficits. Different perspectives in worker attitude, workload factors, policy or practice-related elements, or personal bias guided by ‘cure, care or treat’ motives, versus recipient entitlements to nursing care (Australian Government, 2012c) or self-determination of care and choice (known as person centred care [PCC]) in quality of life decisions, were also expected. Although data collection tools were developed using objective non-bias open-ended questions, which were piloted, researcher bias had an influence during codification processes.

Charmaz (2006, p. 149) considers that constructed ‘theory reflects the vantage points inherent in our varied experiences whether or not we are aware of them’. As a result of the researcher being unaware of preliminary perspectives, node categories were created from source files to establish phrases or texts shared by particularly influential groups of stakeholders, and sorted into nodes. These stakeholders include RNs, general medical practitioners or allied health professionals, residents, families and managers. Stakeholders were found to exert considerable influence over RN decision-making processes and consequently resident outcomes in different circumstances. By November 2012, over 40 stakeholder-related sub-nodes had been established from the five situation files (see Figure 3.2).

During this stage, a further 12 participants were recruited and studied from October to November 2012, resulting in increased data codification workload. However, data reduction or drilling down of stakeholder nodes became difficult as links or relationships to other data were dominated by the established stakeholder nodes. This coincided with redrafting chapter notes related to rigour (see section 3.3), which prompted researcher reflection about how data were being progressively sorted and whether the resulting arrangement of data truly reflected what was being experienced by participants.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Nodes

Name	Sources	References	Created On	Created By	Modified On	Modified By
Employers Management Influences	0	0	26/03/2011 5:28 PM	CDM	10/10/2012 12:03 PM	CDM
Family onside	0	0	26/03/2011 5:31 PM	CDM	10/04/2012 4:52 PM	CDM
Interventionist	0	0	26/03/2011 5:29 PM	CDM	10/04/2012 4:53 PM	CDM
resident advocate	2	4	26/03/2011 5:32 PM	CDM	10/04/2012 4:53 PM	CDM
Support RNs	2	2	26/03/2011 5:29 PM	CDM	10/04/2012 4:53 PM	CDM
workforce capacity improvements •	1	1	22/06/2012 12:48 PM	CDM	10/10/2012 12:03 PM	CDM
family decision makers	0	0	26/03/2011 5:22 PM	CDM	10/10/2012 12:03 PM	CDM
Collaboration with RN	2	2	26/03/2011 5:24 PM	CDM	10/04/2012 4:46 PM	CDM
Control Safety and wellbeing	1	2	26/03/2011 5:24 PM	CDM	10/04/2012 4:53 PM	CDM
power of attorney financial control	0	0	26/03/2011 5:23 PM	CDM	10/04/2012 3:57 PM	CDM
Questioning CDM and practices	2	4	26/03/2011 5:26 PM	CDM	10/04/2012 4:52 PM	CDM
GP or Allied Health Prof	2	2	26/03/2011 5:29 PM	CDM	10/10/2012 12:03 PM	CDM
Residents influences	0	0	26/03/2011 5:08 PM	CDM	10/10/2012 12:03 PM	CDM
Family influence to care	0	0	26/03/2011 5:13 PM	CDM	10/10/2012 11:57 AM	CDM
forceful or assertive	0	0	26/03/2011 5:10 PM	CDM	10/10/2012 11:57 AM	CDM
Powerless or resigned acceptance to care	0	0	26/03/2011 5:10 PM	CDM	10/10/2012 11:57 AM	CDM
RNs	0	0	26/03/2011 5:03 PM	CDM	26/01/2013 12:10 PM	CDM
Consultative	4	8	26/03/2011 5:33 PM	CDM	22/06/2012 12:50 PM	CDM
Innovators or Engaged	4	7	26/03/2011 5:04 PM	CDM	22/06/2012 12:50 PM	CDM
Non engaged	1	3	26/03/2011 5:05 PM	CDM	10/04/2012 4:52 PM	CDM
Ref text RN roles and responsibilities	1	1	22/06/2012 12:46 PM	CDM	10/10/2012 11:42 AM	CDM
RN coding non consultative	0	0	26/03/2011 5:34 PM	CDM	10/10/2012 11:48 AM	CDM
RN coding Traditional and routine	1	3	26/03/2011 5:05 PM	CDM	10/10/2012 11:44 AM	CDM
Yes- protocol- case conferencing, residents rights etc	0	0	23/04/2011 4:22 PM	CDM	10/10/2012 12:03 PM	CDM
source node review	6	20	9/07/2011 1:33 PM	CDM	10/10/2012 12:03 PM	CDM
interviews	0	0	23/04/2011 4:36 PM	CDM	26/01/2013 12:10 PM	CDM
observations	0	0	23/04/2011 4:10 PM	CDM	26/01/2013 12:10 PM	CDM
Preflection Literature Review	1	1	10/04/2011 5:12 PM	CDM	10/10/2012 12:15 PM	CDM

Figure 3.2. Stakeholder node list.

3.7.1 Recognising researcher bias within nodes.

Upon reviewing the draft chapter on rigour and transparency, the node categories were found to either defensively support, or negatively depict, RN decision-making competence, and at times the node categories directly sought to explain or defend outcomes in terms of how they varied from employer or other expectations. These early nodal categories included:

1. Employer (management) influences over RN choices or decisions such as keeping client families happy and satisfied with services and outcomes. Managers were seen by RN participants in several different ways. These included managers as interventionist (overriding RNs on clinical decisions), family advocate (non-resident advocate), supportive or non-supportive to RN processes such as evidence-based practice decisions for care and treatment.
2. Family nodes involved decision-making nodes such as collaboration with RNs; exerting control over their relatives safety and wellbeing; using power of attorney (exerting financial control) to force RNs to adhere to their choices; or questioning of RN clinical decision-making and practices even to the detriment of resident, or against professional nursing advice.
3. Medical practitioner or allied health professional influences on RN decision-making processes and interventions with attributes identified by the researcher as cooperative or non-consultative.
4. Resident influences incorporated family influence on care, resident attributes of being forceful or assertive, powerless or accepting, or being resigned to care offered by nurses.
5. RN influences of being consultative (with RNs or others) or non-consultative; innovative or engaged; maintenance of traditional care roles or routine; inherent aged care RN responsibilities as multidisciplinary leader; following through with case conferencing; and ensuring resident rights.

As a result of this researcher insight, data analysis and node development was halted pending review of possible researcher bias influencing nodal categories and findings.

3.7.2 Changing researcher perspectives to ensure rigour.

As a new researcher, being immersed in the collection context resulted in empathising with RNs, which when followed by the immediate codification of data, affected researcher objectivity. In this case, data analysis led to characteristic groupings of shared phrases, words or themes emerging from the data that offered to explain possible reasons for the varied resident outcomes, rather than identifying or investigating influences upon clinical decision-making processes of aged care RNs. To overcome this subjectivity, a different approach in sorting data was developed.

To ensure rigour, a new separate NVIVO project analysis file was created from January 2013. As explained previously, data codification stages theoretically involve progressive sorting of all collected RN data from pre-observational questions, observations and interviews, into situation-based nodes. These situation-based data files enable a renewed approach that focuses on RN characteristics drawn from data that can be drilled down into, to form emergent new theory as described in the findings.

Mead’s (1934) social actor’s theory was employed to gain reflective objectivity about the symbolism and meaning of elements and events during final analysis. The discourse is further expanded in Chapter 4 (Section 4.6).

3.8 Data Analysis: Coding Following Review of Subjective Bias

Three data collection tool nodes were used as source documents. Each source document contained de-identified participant-labelled nodes. During data collection, participant nodes were openly sorted to establish groups or ‘key concepts’ (Kermode, 2004, p. 5) and arranged in particular situations (1–5) containing comparable attributes, themes or words in a process termed theoretical sampling.

Open coding of participant information arranged into the five situations enables further analysis through progressive axial codification situation by situation. In the preparatory phase, source document nodes of pre-observational data and participant observations yield evidence-based thematic concepts and thematic statements to inform the participant interviews enabling further exploration and grounding of participant data. Chapter 4 establishes preparatory-evidenced themes and interview-grounded study data findings. Chapter 5 outlines selective coding of evidence-based themes, grounded data and relevant literature to produce new knowledge emerging as theory about influences on aged care RN clinical decision-making processes. Figure 3.3 describes coding processes used in data analysis to generate theory.

→Source nodes (pre-observation questions, observations and interview source files)
→Each source node contained de-identified participant nodes (situation by situation) (open coding)
→Sub-nodes of collated characteristics and attributes
→Theme or concept nodes (axial coding)
→Theory nodes (selective coding)

Figure 3.3. Data analysis nodal progression.

Twenty-eight participant nodes pooled in source data sets of questionnaires, interviews and observations were sorted into five situation-based groups. Stakeholder attributes were used to separate data into branching secondary nodes. Through a process of exploration during interviews, data from participant nodes were scrutinised for particular characteristics through open coding processes that were organised into situation-based sub-node categories of characteristics sharing similar meanings.

Axial codification of data is undertaken in each situation to establish data relationships or interactions to identfy themes of similar concepts or grouped relevance within each of the five situations (see Table 3.2). Findings are revealed in Chapter 4 (from Section 4.2). In a process of selective codification, all nodal categories, themes or concepts arising from participant data findings and literature were comparatively analysed to reveal new theory in Chapter 5 (see Section 5.6)

The nodal pathway process created a funnelling effect as context-based data containing words, phrases, ideas and memo concepts from the data sources were progressively sorted according to their specific groups of shared or similar ideas or themes, and consistency of meanings. This continued until all participant data were sorted into attribute groups.

Rigour was incorporated by comparing data node to data node, text to text or phrase to phrase, and situation to situation. Comparative analysis facilitated transparency for rigour and transferability of themes in different situations by progressively confirming data with data. Data to data sorting criteria included:

1. What does this text or phrase mean?
2. When did it first become apparent or repeatable?
3. What makes it unique or important?
4. How does it relate to other nodes or context (comparative properties)?

Table 3.2

Data Codification Processes

Data sources	**Situation node**	**Open/axial coding node**
Organisation of sources is achieved by arranging specific data source nodes from which all data are sorted	Contains five data nodes labelled according to each situation containing all collected data obtained and recorded by using uniform questions in each tool to structure data	Contains comparative data from all situation questions re-sorted as nodes of properties, themes and categories of relevance
Participant nodes 1–28 Questionnaire demographics where completed	Situation 1: data, methods or other resource to inform Clinical Decision-making (CDM). a) gathering data useful in making decisions b) influences in decision-making practice c) consultation (with RNs, GPs or Others) d) resident factors that influence decisions e) organisational influences on decisions.	Established nodes contained: Visual, verbal or texts identified. Context, workload, staff, resident, organisation, others. Written text and each participant de-identified, person-to-person demographic data and questions about influences or contextual factors recorded. Resident or others such as family. Flowcharts, policy, routines, direct contact or unwritten expectations.
Questionnaire structured in situations 1–5. Observation structured in situations 1–5. Interviews and transcripts allocated to situation 1–5.	Situation 2: Delegation. Questions as above.	Established nodes contained as above
	Situation 3: PRN medication administration. Questions as above.	Established nodes contained as above
	Situation 4: Referring to specialist, includes GP or emergency providers. Questions as above.	Established nodes contained as above
	Situation 5: Facilitating resident choice. Questions as above	Established nodes contained as above

Data sources	Situation node	Open/axial coding node
Literature: data useful for grounding, generating and validating emergent themes.	PCC and other relevant aged care data. Identified elements of current applicable decision-making frameworks, aged care-relevant guidelines and situations.	Establish PCC and other known influences on RN decision-making themes. Generate meaningful categories of related texts linked to themes and theory for findings and discussion.
Selective coding processes		
Comparative analysis of memos, participant data sorted in situations 1–5 revealed themes or categories of relevance, forms emergent theory, which is collated to a current model of influenced-based RN decision-making processes in the aged care context.		

By comparing text to text and situation to situation in data collection tool-derived characteristic groupings, it was also possible to track and validate data from each participant. In this way, all data were explored with recurring concepts viewed as emergent themes that were confirmed in the different situations and by using follow-up RN interviews, or grounded through reference to research literature.

Data saturation was identified when no new data or concepts could be identified from the progressive data collection and analysis (Glaser, 1967; Kermode, 2004; Miles & Huberman, 1994; Silverman, 2000) following the renewed analysis. Saturation was recognised as coded data that were ‘similar in properties’ with no new groups (nodes) emerging (Annells, 2003, p. 169) during theoretical sampling. At the point of data saturation, in December 2012, data collection ended.

3.8.1 Emergent theory.

Grounded theory using theory generation methodology enabled theoretical sampling to be incorporated from early data collection. Theoretical sampling involves the process of simultaneous and progressive data collection, comparison and analysis that assists in the generation of mid-range or substantive theory (Denzin & Lincoln, 2000; Glaser, 1978; Maykut & Morehouse, 1994; Strauss & Corbin, 1990). Theory emerged when data were reduced to final groupings of meaningful attributes or characteristics, which formed context-based themes as circumstances, actions or other interactions to explain or establish the clinical decision-making influences and considerations of aged care RNs.

Researcher notes, reflections, data texts and literature were added to the 'evidence to explain a set of circumstances within a social context' (LoBiondo-Wood & Haber, 2006, p. 15) and revealed new theory. Emergent theory highlights the significant influence of PCC model approaches, family expectations and resident self-determination of care priorities on RN aged care decision-making processes across different aged care contexts.

3.9 Conclusion

Research methodology and preparatory data guide interview questions to explore influences upon aged care RN decision-making processes across five work-based situations. Analysis is undertaken participant by participant and situation by situation to produce evidence threads that build into thematic statements and generate theory about RN scopes of practice. These are discussed in following chapters.

Chapter 4: **Findings**

4.1 Introduction

This chapter details data-gathering phases and analysis processes, which will inform thematic discussion and theory development. Data collection is described in two phases. Phase one (see 4.1.1) is preparatory by gathering pre-observational data such as demographic information (see 4.1.2). Phase two (see 4.1.2) involves gathering non-participant research observation data and grounding interview data. Findings (see 4.2) comprise data from pre-observational questions and field observation of participants to inform participant interviews. Progressive comparative data analysis is undertaken participant by participant, situation by situation, phrase by phrase and then grounded with or without relevant literature in order to validate evidence as it emerged.

4.1.1 Preparatory Phase One: Pre-observation Questions

This section provides a demographic profile of participants and their written reflections prompted by the pre-observation questionnaire described above.

Of the 28 RNs, three participants, Bridget, Sharni and Alice (allocated pseudonyms) completed the written demographic information, two self-reflection questions and situations. Low return rates of the questionnaire resulted in incomplete data collection from participants, which necessitated the remaining 25 participants to be prompted verbally to provide demographic data and respond to pre-situation-related questions during scheduled observational visit or interview.

4.1.2 Questions part one: Demographic data.

Twenty-five RN participants provided written details of their formal and social demographic attributes. Formal attributes include age, sex and participant qualification information. Nursing attributes including qualifications and aged care experience were recorded. Attributes of several other RNs were incomplete as participant consent for observation or interview had been withdrawn preventing personal information from being collected. Their choice to withdraw due to choice or circumstance was accepted without question. Demographic data were used to ensure homogeneity of the consenting participants through the use of a matrix.

In this study, collated data were placed into four grouped sets in table form. Table 4.1 was constructed using RN information to establish descriptive data sets related to hospital or professional training, or university qualifications gained in Australia or overseas. Twelve RNs held hospital-derived nursing qualifications: 11 of these were Australian and one had an overseas hospital qualification endorsed by the Australian registration authority. Fifteen RNs had completed university qualifications: of those, seven had completed studies overseas. Data for three of the participants are unavailable as they chose not to provide them.

Participants ranged from 25 to 65 years of age. At the time of the study, 21 RNs were 40 years of age or more, with 15 of those being over 50 years of age, which highlights a mature and ageing aged care RN workforce. According to King et al., (2013) the aged care RN workforce median age is 51 years, with almost 60% of the aged care workforce RNs being 45 years or more.

Nine of the 28 RNs had been registered as nurses for more than 20 years, with 12 RNs stating 10 years or more experience in aged care. Four RNs had between one and two years' previous disability services and aged care experience prior to gaining RN qualifications.

According to the literature, the role of RNs within aged care settings consists of two distinct functions. RNs traditionally perform direct care and clinical activities, leading small care teams and coordinating care in collaboration with medical or allied health professionals. However, in contemporary aged care residential settings, a diminishing RN workforce services an increasingly frail resident population with complex health needs, as well as undertaking additional responsibilities to manage and coordinate care delivery within financial, legal and ethical constraints (see Section 2.2.4; Productivity Commission, 2005).

Such roles are evident in the positions held by RNs participating in the study: eight of the 28 identified themselves as being in-charge with management responsibilities, while the remainder identified their role as clinical RN only, not aligned to management functions. Several RNs were working in a facility where another RN on the same shift had managerial responsibilities assigned to them for that shift.

Table 4.1

Demographic Data

Hospital and qualifications data

Attribute	1	2	3	4	5	6	7	8	9	10	11	12
Qualifications	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	Hospital	U	U
Country of qualification	Australia	Not Australia	Australia	Australia	Australia	Not Australia	Australia	Australia	Australia	Australia	U	U
Studying	No	No	No	No	Yes	U	No	No	No	No	U	U
Years of experience	40	25	34	>20	32	>2	18	44	20	<20	U	>10
Years in aged care	12	12	10	10	2	>1	11	3	<10	?10	U	>10
Position	Manager	Manager	Manager	In-charge	RN	RN	RN	RN	RN	RN	RN	RN
Years held position	5	<1	7	2	2	<1	11	3	<10	10	U	>1
Age range	60–65	40–49	50–59	50–59	50–59	40–49	40–49	60–65	50–59	50–59	50–59	40–59
Gender	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female

RN demographic data for Australian university qualification

Attribute	13	14	15	16	17	18	19	20	21	22
Qualifications	U	University	University	University	University	University	University	University	University	University
Country of qualification	U	Australia	Australia	Australia	Australia	Australia	Australia	Australia	Australia	Australia
Studying	U	No	No	No	Yes	No	No	No	No	Yes
Years of RN experience	U	20	12	8	1.5	3	2	12	2	4
Years in aged care	>1	2	10	6	1.5	3	2	12	U	2 +AIN
Position	RN	In-charge	In-charge	RN	RN	RN	RN	RN	In-charge/ Educator	RN
Years held position	>1	2	7	>1	>1	3	2	12	U	1
Age range	50–59	40–49	50–59	40–49	30–39	20–29	20–29	30–39	30–39	50–59
Gender	Female	Female	Female	Female	Female	Male	Female	Female	Male	Female

RN demographic data for Australian university qualification

Attribute	23	24	25	26	27	28
Qualifications	University	University	University	University	University	University
Country of qualification	Not Australia	Not Australia	Not Australia	Not Australia	Not Australia	Not Australia
Studying	No	No	No	No	No	No
Years of RN experience	16	7	13	8	20	4
Years in aged care	8	1 +AIN	7	5	12	4 + AIN
Position	In-charge	RN	RN	RN	RN	RN/ Educator
Years held position	3	1	1	2	2	1
Age range	50–59	20–29	40–49	20–29	50-59	40–49
Gender	Female	Female	Female	Female	Female	Male

Note. U denotes unknown information. RNs were allocated pseudonyms with ages collated into brackets to maintain confidentiality.

4.2 Participant Conceptualisations of a 'Clinical Decision'.

Sachi stated 'A clinical decision is a process about the resident … It's like how you make decisions about resident care' (Sachi, 2012). By exploring the question 'what is a clinical decision?' many aged care RNs were forthcoming in discussing the processes involved in making decisions. This question revealed what RNs understood to be a clinical decision in the context of aged care, why decisions need to be made, how the RN is informed by data and evidence and who makes the final decision.

Initially, only three RNs completed the written questions before the interview and observation element of the data gathering. However, the 25 RNs who did not complete the written questions were offered an opportunity during their interview/observation time to share their views on what a clinical decision was to them. Twenty-two RNs accepted the offer and used different foundational perspectives to describe or explain their understanding of clinical decisions. Mostly, participant RNs confined their responses to influences that initiated actions aligned to resident need and/or family requests. Their responses reveal three themes related to RN perspectives on clinical decision-making.

The first theme was asserted by Sharni (a 40-49 year old RN who had been practicing for 25 years, with 12 years of aged care experience), who briefly stated that clinical decisions are 'based on evidence' as 'conditions necessitate', and is influenced by 'training of best practice'. Her description fits with the traditional view that RNs work as autonomous professionals, with the authority to make decisions aligned to evidence-based practice for clinical determinations, to achieve resident outcome (ANMC, 2006).

The second theme was initiated by Alice (aged 50-59 years, who has worked as an RN for 34 years, the last 10 of which were spent in aged care). Alice stated that a clinical decision is ‘deciding [on] what is the best course of action which will have the optimal outcome of benefit to the resident without causing further discomfort, or decreasing quality of life’. This viewpoint suggests that clinical decisions align with outcomes focused on resident quality of life.

The third theme was instigated by Bridget (aged 60-65 years, an RN for 40 years with 12 years of experience in aged care). Bridget surmised that clinical decisions are ‘any decision made on behalf of, or in collaboration with, a resident and/or their family for residents living in my facility’. She later added: ‘resident choices, not family choices’. Bridget advocates resident wishes and self-determination as considerations RNs should take into account when making clinical decisions. Her comments highlight the daily ethical dilemmas faced by RNs, when resident choice can differ from family wishes, requiring RNs to negotiate resident care as well as centrally important clinical outcomes. In later analysis, this issue again arises when considering resident decision-making and the influence family choice has in resident outcomes.

Theoretical sampling involves the ongoing comparison of data to other data sets obtained from RN participants and different situations explored. Comparisons of the participant data during the study confirms the existence of three RN decision-making perspectives that endorse an ethical-clinical stance contributing to the process of RN clinical decision-making, and introduces the idea of stakeholder expectations regarding outcomes of RN involvement. The first RN perspective—labelled ‘RN autonomy’—reveals historical understandings of RNs as clinical professionals and independent decision-makers. The second perspective—labelled ‘informed outcomes’—involves RNs who characteristically focus on resident outcomes or goals associated with achieving quality of life and comfort, irrespective of where data originated, to inform RN’s decision-making processes. The third perspective describes ‘collaboration shifts to care directives', which acknowledges a collaborative approach by RNs intent on informing decision-making, or to be informed of decisions made by others.

4.2.1.1 Evidence-based RN perspective one: RN autonomy.

Portrayals of clinical decision-making in theory, literature and academia, regarding traditional notions of RN autonomy and empowerment, depict nursing professionals as trained and legally authorised to develop and implement actions that benefit those in their care (ANMC, 2006; Registered Nurses Association of Ontario, 2009). This study confirmed that RNs do believe they have the authority to make clinical decisions from data gathered from assessment, observations, reviewing records, applying reflective experience and intuition, or through deduction of evidence, clinical or medical consultation to determine professionally clinical interventions.

Hunter and Levett-Jones (2010) established that Australian aged care RNs are 'specialist care facilitators' (p. 534), with their expertise in different nursing specialty areas, including continence promotion, pain management, dementia care, mental health, nutrition, family counselling and organisational management. During participant observation, Theresa demonstrated this expertise when dealing with multiple residents with differing co-morbidities, by being both decisive and flexible following assessment and using expert intuition to problem-solve in context, in order to 'deal with it'—that is, the situation as well as issues concerning individual residents.

In data related to this perspective, RNs were found to be confident in their ability to make decisions and implement actions that would produce resident outcomes to meet the expectations of all involved. Mary claimed that it is 'much better if clinical decisions are made on my own'. Erika agreed: 'I always make the decision myself, because I work here all the time... so, it's my decision', implying that she took responsibility for both the quality and outcomes of her decisions.

4.2.1.2 Evidence-based RN perspective two: Informed collaborative outcomes.

Alice was observed using her initiative for assessment, consult with residents and apply evidence-based practice to resolve clinical and long-term chronic wounds or skin conditions thereby asserting her clinical authority and expertise, while providing the family and resident with information and choice. Alice's response introduced the idea of a shift from RN authority and professional autonomy in holistic resident care, to a position of referring decision-making responsibility to residents and families observed in non-clinical matters, such as dietary choices, clothing preferences and social activities.

A shift such as this empowers the resident or family member to collaborate purposefully in aspects of daily life, in order to accentuate or hinder the quality of experiences. In this way, RNs are able to maintain separate areas of decision-making: one for the autonomous professional RN dealing with clinical treatment and care, and the other for being supportive of independent resident choice and family wishes regarding involvement in daily activities.

As the analysis progressed, it became clear that change might be on the horizon, and that conditional decision-making was emerging. The change towards collaboration in overall decision-making situations was further confirmed during an interview with Cris, an RN implementing PCC into the facility. Cris explained that when making decisions, priority is given to ensuring:

> benefits to the people I'm making the decision for, my rationale for making the decision, and what brought me to the decision. There needs to be a clear reason why a decision is made, so it needs to be a collaborative thing.

Australian aged care services have adopted PCC approaches with the aim of ensuring that the needs and rights of older, frail and cognitively affected individuals are respected by those providing care (Department of Human Services, Victoria [DHS], 2006). Governments of the UK, Australia, United States and European Community (McCormack & Dewing, 2010a; Lann-Wolcott, Medvene & Williams, 2011), for example, have also adopted policy to reflect PCC within their health and community service agencies. McCance, McCormack and Dewing (2011, paragraph 9) describe PCC as 'collaborative and holistic', a broad concept aligned with doing good for others, but which has particular meaning for service providers. However, this meaning may be different for the general public and those required to implement it.

In this study, aged care RNs were observed engaging in collaborative decision-making processes, further explored by probing questions about their experiences during post-observation interviews. This data confirmed many participants shared similar collaborative decision-making processes with residents or families, and consultation with other RNs, medical practitioners (also known as GPs) and facility managers. Hunter and Levett-Jones (2010) found RNs describing the family collaboration process as requiring 'a lot of time counselling, reassuring, explaining, trying to justify why you've done something' (p. 534). Similarly, Eryn surmised: 'we deal with families more than residents', further stating that this was 'frustrating'.

Cris took the alternative view that PCC was empowering, and encouraged collaboration with families to generate advance care directives (ACDs):

> At the end of the day, they are the ones who are going to be living with the decision. I am formally the decision-maker who has to put it into the directive, but they are the guys who are going to be running with the decision, so it needs to be a collaborative thing.

During observation, Cris encouraged RNs to adopt and follow directives from families, RN colleagues and to support RN managers in advocating family decision-making authority through advanced care directives or verbal instructions.

4.2.1.3 Evidence-based RN perspective three: Collaboration shifts to care directives.

Some participants observed that family directives could be at odds with clinical decisions or interventions offered by the RN directly responsible for the resident's care. Erika replied that a clinical decision is 'one that is in writing, very important, like transfer to hospital … I go to the advanced directives and follow that'. This response indicates that some RNs understand, from their experience and practice that clinical decisions should take care directives from families into account, which can compete with professional clinical determinations from RNs who have comprehensively assessed resident needs, formulated interventions or evaluated individual resident outcomes.

For some RNs, having to accept direction from families on clinical issues has resulted in loss of confidence and the professional authority necessary to make clinical decisions, resulting in ethical uneasiness. Some RNs take an ethical stance about facilitating the wishes of lucid residents, and believe they have a professional responsibility to ensure competent evidence-based nursing practice is provided, even where a family member demands another, less efficacious or risky intervention (such as the unnecessary application of physical restraints). In order to work through the conflict that family directives can present, RNs often seek agreement or support from a multidisciplinary team, to validate or justify care decisions. As a result, RNs increasingly consult with or invite GPs, physiotherapists, educators, RN colleagues and managers to discuss options in care management with individual residents or families.

Eunice and Marni asked the medical practitioner to speak directly to family members or residents in situations where resident preferences differed from family choices or RN’s decisions. These participants felt disempowered and unable to convince the resident or family why their recommended clinical option was beneficial. A common situation in which RNs experience ethical dilemmas is when a resident prefers to remain in the facility despite the family wishing them to be transferred to hospital. Marni explains: ‘I will get into trouble if I do not send them. Most have dementia, if [the] family has directive, they [residents] can’t make any decisions for themselves’.

Cari reported that she will ‘do usually what the family says. We would run and look at the advanced care directives’. Notes from Jenny’s observation reflect the common practice of family involvement, which includes assisted daily living care and dietary needs. Jenny emphasised that she likes to ‘make sure family is involved and are happy with care’. Jenny further explains: ‘That’s the policy. If the family wishes to do it, we do it! It’s not really worth the risk here. If they want it, that’s our policy to do it’. This confirms the notion that in aged care nursing environments, according to employers, the customer is always right.

Power strategies also seem to be at the heart of clinical realities in residential aged care. Two RNs mentioned the risk of getting into ‘trouble’ from families, as well as management, if they went against family wishes or directives when considering clinical options, such as transfer for referral to specialists, or to an emergency department in a local hospital. Amy explained that legally, advanced care directives from a person of authority (with Power of Attorney, POA) or guardian take precedence over resident choice, indicating that ‘families win over resident’. Amy reflected on a previous situation in which a resident agreed to go to hospital and the family did not consent. This resulted in Amy ‘getting into trouble’ at work for not following family directives. For Amy, this experience of making a clinical decision based on the need to transfer a resident to emergency care continues to influence her practice. Consequently, Amy no longer makes critical clinical decisions, opting instead to not transfer residents to hospital unless directed by family, or with management permission, thus keeping ‘family and manager on side’.

By endorsing the general notion of PCC within aged care facilities, family members with an Enduring Power of Attorney (EPOA) are granted unquestioned authority as the person(s) responsible for making all resident decisions, even where legal authority pertains to finances only. Decisions including the resident’s clinical treatment or medical goals, quality of life and daily living choices such as clothing, food, leisure and lifestyle activities are made by legal representatives. In some situations, the professional judgement and authority of experienced RNs is dismissed in the process.

In these circumstances, RN clinical decision-making is increasingly defensive and not necessarily focused on meeting the resident’s needs. Nor is it associated with RN competence in making clinical assessments and decisions. Often, the decision involves following or obtaining family directives with approval from management. For the participants of this study, issues around the assertion of residents’ right to self-determination or choice have been accentuated by an imprecise interpretation of PCC by different stakeholders.

According to the Australian *Aged Care Act* 1997, RNs are coordinators of aged care. In 2012, the DOHA released the national reform agenda for primary health care professionals, to ensure residents, family consultations and health professionals provide pathways to resident self-determination, with the assertion that ‘advanced care directives are completed to ensure care recipients (residents) are supported in their negotiation of care pathways’ (Australian Government, 2012b, p. 23).

Advance Care Planning (ACP) is a process of communication about aspects of care or end of life care, medical conditions, values or beliefs of individual residents or clients and families, aligned to possible situations and outcomes with a medical practitioner and other health care team members (NSW Department of Health, 2005). The Royal Australian College of GPs (RACGP, 2013) states: 'ACP is about PCC and is based on fundamental principles of self-determination, dignity and the avoidance of suffering'.

ACP differs from ACD as it ensures that the values and beliefs of cognisant residents are discussed collaboratively with clinical team members, to progress anticipated health outcomes of common situations, including end of life care. Recognition of the legal authority of another person nominated by the resident to act on their behalf as a substitute decision-maker varies from state to state. In some states, the person assuming enduring powers associated with financial and legal matters may or may not hold medical care authority (AHMAC, 2011, pp. 10–12).

Currently, different Australian jurisdictions use different terminology to describe and legally recognise ACDs and ACP (AHMAC, 2011, pp. 1–2). ACDs, care directives (CDs), Living Wills or Advance Health (Care) Directive (AHD) contain similar elements of legal authority given to someone when a person can no longer make their own health care decisions (Office of Safety and Quality in Healthcare [OSQH], 2009; Western Australia State Law1990; Victorian State Law 1993; NSW State Law, 1987).

AHMAC (2011) confirms that ACDs are open to inter-jurisdictional interpretation. Substitute decision-makers are viewed as an appointed advocate by the resident within most states, and may or may not hold legal authority to make medical and health care-related decisions. Similarly, individuals, including family members with an EPOA, may not be recognised in some states. Therefore, treatment options are limited, or a specific medical authority may be required to make a decision.

The RACGP (2013) attempts to centralise medical control over the situation when it states that ACDs or AHDs are ‘legally binding documents’ within Australia, used to uphold the wishes and choices made by a person cognitively capable of or mentally competent in making their own medical and care decisions. Moreover, the RACGP claims that in all jurisdictions, a medical practitioner must initially determine the competence of the person engaged in making directives, and inform them of likely consequences when consent, refusal or withdrawal from medical treatment or personal care options are self-determined (Meller, Graham, Hindmarsh, Squires & Wall, 2010; NSW Health, 2005; OSQH, 2009). When circumstances arise, the medical practitioner further determines or consults with others, if the known ACD or AHD affirms the person’s values or beliefs in that instance, or if the ACD or AHD is not applicable to the situation necessitating substitute or emergency decision-making protocols to be followed (OSQH, 2009; NSW Health, 2005; NSW State Law, 1987).

In reality, all health practitioners regulated under the National Law, and acting within their scope of practice, have legal authority to determine mental competence in decision-making (NSW Government, 2008). For instance, aged care RNs assess residents to ascertain cognitive capacity and affirm ability to self-determine aspects of care and daily activities, as do mental health professionals.

RNs are professionally and legally vulnerable in circumstances where families or others attempt to direct care. In NSW, the state in which this study occurred, a POA should be in place when a cognitively aware person (such as a resident in aged care services) authorises another person to manage their business and financial affairs. When the resident’s mental capacity diminishes, an EPOA is enacted, and overrides the POA.

The POA and EPOA does not necessarily authorise someone to determine the resident’s medical treatment, lifestyle options or undertake personal care decisions. This responsibility is usually undertaken by a person appointed as an Enduring Guardian (EG) (NSW State Law, 1987) or EPOA for Medical Treatment (Victorian State Law, 2012). This person is legally authorised to express a resident’s wishes to consent or withhold consent for medical treatment, determine the care environment and care services.

In aged care or in emergency situations, a priority list for medical treatment and care consultation is applied, to ensure resident advocacy or wishes when authorisation by a POA, EPOA, EG or appointee by the Office of the Public Guardian is unknown or not in place. This list applies to State and Territory Guardianship and Administration Acts. It recognises the authority for substitute decision-makers to be involved in situations where the person is unable to make their own decisions, such as a life partner, unpaid domestic support person, closest family member, close friend, carer or a person prescribed in an emergency, such as a health practitioner under National Law.

In some instances, participant RNs reported that ACDs formalise the authority family members have to overrule a resident’s choice. Residents diagnosed with dementia-causing illness, or with fluctuating periods of lucidity or cognitive impairment can have an ACD in place, to obtain hospital treatment or other forms of care and intervention aligned to anticipated situations.

To ensure advance care wishes and needs are met, Yeun-Sim Jeong, Higgins and McMillan (2010) emphasise the inclusion of the GP. The GP is familiar with the medical management of the resident and family over time. Moreover, ‘they had legal authority to hospitalise’ and refer care to other multidisciplinary professionals (2010, p. 395).

RN decisions are influenced by PCC, ACP, ACDs and organisations. In some cases, RN decisions are dismissed or ignored, not only by family members but by RN managers. Sachi experienced a similar situation to other RNs, in which family choice was prioritised over resident choice or RN decisions, saying: ‘organisation wins over RN decisions’. Some RNs raised the issue of avoiding family complaints or employing organisation dissatisfaction with their decisions. According to Hopper, Allen and Cooper (2012, pp. 13–17), 42 per cent of RNs in both acute and aged care settings felt unsupported by management, whereas only 27 per cent of RNs believed management to be demonstrably supportive of their work. Further, almost 45 per cent of Australian nurses believed that their ‘employer did not value their contribution at work’ (p. 23), and that this has impacted job satisfaction and contributed to a reduction in levels of available nursing expertise and poor RN workforce retention rates (Jourdain & Chenevert, 2010; King, Wei & Howe, 2013).

The mitigation of regulatory and other legal risks through strategic complaint avoidance by an organisation, to ensure resident or family satisfaction, leads to defensive RN practice. Moreover, the situation adds to the disempowerment of RNs by devaluing their knowledge, expertise and competence in making decisions to achieve resident outcomes according to best practice.

‘It all depends’, explains Debra. ‘Sometimes, you just make a clinical decision and it doesn’t need anyone’, yet at ‘other times consultation is needed’. Debra relayed a situation in which she was required to make a clinical decision outside the current advance care directive, so asked a duty manager for advice. The first duty manager advised Debra to follow a certain clinical pathway. Shortly afterwards, two other duty managers directed her differently. Debra wryly describes the organisational support in decision-making as ‘dynamic’.

In Debra’s experience, ‘if there is no team work, working together from the management down to the nurse, it becomes a little bit tricky’. As a result, she has learned to document systematically family collaboration and team consultation processes separately. In addition and where necessary, Debra gains the involvement of the resident’s GP, to direct care or inform the family of care options. This shifts responsibility to the medical practitioner and family, and reduces the risk of family dissatisfaction. It also subordinates professional nursing to medicine.

Penny believes that GPs are responsible for all clinical decisions, and RNs responsible for implementing them. Penny trained and worked overseas, where the ‘Nightingale pledge’ ethically guides and limits nurse practice. Several RNs shared their experience of working under the supervision of medical practitioners in England, Ireland and Scotland. The Nightingale pledge avows: ‘with loyalty will I endeavour to aid the physician in his work’ (Gretter, 1893). Accordingly, the RN is expected to advocate and implement medical practitioners’ directives while believing they have little or no professional authority to make clinical nursing decisions unless medically approved.

Erika and Eunice drew attention to the practice of RNs relinquishing their clinical decision-making authority to not only families or GPs but to other RNs and managers. Eunice waived her responsibility to the shift RN in-charge, stating: ‘if major decision—refer to other RN’. David excused himself from making clinical decisions by comparing his experience of two years in aged care to that of other RNs and staff with five years or more, stating: ‘I don't know everything, so I talk to RNs, talk to [care] staff’.

This study established the influences of non-RN decision-making processes from notions of PCC and ACDs that encourage families to direct care, impacting upon

RN decision-making processes and their professional accountability. Further, the findings reveal the ethical conflict experienced by RNs when confronted by families who believe they are authorised to direct care and RN practice. This affects RN relationships with residents, families, multidisciplinary team members, managers and professional organisations in addition to influencing resident outcomes.

The long-term effect of PCC or ACDs upon aged care RN professional autonomy or clinical decision-making competence is unknown, and warrants further investigation. Moreover, there are noticeable changes to the future role of RNs in aged care services, as the government progresses consumer-directed care initiatives through the policy platform of Living Longer, Living Better (Australian Government, 2012b). Reportedly, these changes will enable residents, as consumers of care, to self-determine care options and service delivery modalities following professional assessment of needs and financial capacity.

In the second self-reflection question, three respondents indicated ‘resident family wishes’ or ‘expectations’ as important considerations, with high priority given to this aspect when deciding upon matters that could affect residents’ quality of life. The importance of resident family wishes is strengthened in Australia, through the widespread adoption by aged care services of ‘person-centred practice in residential services for older people’ (McCormack et al., 2010b, p. 93). Resident and family expectations and quality of life are also key features of Australia’s aged care accreditation standards (*Aged Care Act*, 1997; DOHA, 2011).

Bridget listed the following considerations, ranked in order of importance: ‘reassessment’, ‘resident family choice—case conference with resident, family, GPs and allied health’, ‘protocol’, ‘education—knowledge’, ‘good communication’ and ‘legislation’. These considerations are somewhat diplomatic and expected from an experienced RN. In the literature, the umbrella term ‘caring for residents’ reveals contemporary evidence-based RN clinical practice, including: an assessment of need, planning care, communication about care and context of care, involving the bio-medical-legal perspective using ‘PCC or palliative approach to care’ (Masso, Westera, Quinsey, Morris & Pearse, 2011, pp. 13–14).

In contrast, Alice ranked ‘quality of life’, ‘pain relief’ and ‘resident/relative wishes’ with ‘dignity’; ‘respect’ and ‘start low, go slow’ as important decision-making considerations. This was followed by the statement: ‘clinical decisions can change daily depending on resident response to decisions or medications’. For Alice, her considerations unveil professional empathy towards residents and their ongoing long-term care management from a clinical perspective. Touhy (2004) explains that nurses display different forms of empathy in different contexts, which can also facilitate reflection on practice and help consolidate nursing skills and experience.

Similarly, Sharni ranked ‘quality of life for resident or comfort’ and ‘family wishes’ above ‘GP input’ and ‘staffing level to carry out required care’, implying that resident needs and family wishes are met by an appropriate staff skill mix within a supportive multidisciplinary approach to effectively manage resident care. Manley et al. (2011) agrees that ‘achieving PCC consistently requires specific knowledge, skills and ways of working, a shared philosophy that is practised by the nursing team’ (p. 36), with strong clinical leadership that ensures the necessary supportive working culture to maintain it.

4.2.1.4 Pre-interview data collection on common decision-making situations.

Written responses to questions from the pre-observational situations were inadequate for analysis, and were augmented by pre-observational discussions. While these discussions, guided by the questions circulated prior to the interviews, truncated the opportunity for reflection, the responses were well considered and indicative of prior thought. This outcome was achieved by all pre-observational situation data being purposefully focused on situation-based data, explored during participant interviews and recorded to enable further analysis.

4.2.1.5 Summary: Preparatory data threads of evidence.

Government policy and aged care service organisations are amenable to PCC approaches and resident (consumer) directed care, both of which exert considerable influence upon RN clinical decision-making processes, even though nurses have always incorporated resident and family consultation into care planning. Families are encouraged to be actively involved and collaborate with RNs in all aspects of a resident's care and important clinical decisions. With the adoption of government sanctioned, PCC approaches, some RNs believe their aged care organisations are interpreting the approach in a way that encourages or advocates a service environment in which all family wishes are followed by RNs, despite their better clinical judgement.

4.2.1.6 Evidence-based thematic statement.

RNs in this study believe that their professional autonomy and clinical authority is conditional on attitudes held by employers and families about the value of nursing. The basis for this belief stems from their legal and social standing as representatives or advocates for residents, as well as constraints placed upon RN professional authority through legal instruments, employment role and the philosophical centralisation of resident rights and, by default, family decisions, in all circumstances.

Therefore, it follows that an exploration of RN perspectives of professional autonomy and authority as clinicians in relation to decision-making within clinically focused situations is warranted, to understand the influences that affect RN's choices in such decisions.

4.2.2 Phase two: Interviews—grounding data.

4.2.2.1 RN use of data, methods or other resources to inform clinical decision-making

Data from participants' written and verbal responses to pre-interview questions, non-participant researcher field observations and interview transcripts comprise the initial source documents. Situation-based findings are discussed collectively within each of the following sections.

Literature reveals two distinct approaches involved in decision-making. On one hand, there is an intuitive process and on the other, a rational or analytical process (Muir, 2004; Kenney, 1995). In 2001, Lauri et al. found that long-term care nurses use analytical decision-making processes, whereas short-term care nurses frequently use intuition to make decisions. The current study reveals that these paradigms are integrated into aged care.

Three participants (Bridget, Sharni and Alice) completed the written questionnaire situations, providing brief, reflective responses. The first question prompted them to 'describe your professional experience in managing this scenario', and asked: 'what were your thoughts in the first instance for action regarding this scenario?'

Bridget described her professional experience to inform clinical decisions with 'data used daily for assessment and reference'. The first thoughts for action related to using data 'as an accurate objective measure and reference'. In her practice, Bridget explained that she uses 'knowledge or experience of similar situations; family or resident choices; and GPs decision' when gathering data to make decisions and implementing them as the two paradigms work in tandem when responding to resident needs.

In aged care, RNs care for residents with cognitive difficulties arising from degenerative or genetic disorders, neurological disease, cardiovascular problems, acquired brain and trauma conditions. Residents with dementia as a consequence of intellectual or neurologic damage, cerebral dysfunction or trauma have impaired or limited communication abilities, requiring RNs to observe or intuitively identify and interpret non-verbalised needs. In the first instance, when gathering or using data, Sharni stated that she will ‘trust [her] instincts’. This would be followed by resident observation, individual needs assessment and the consideration of historical data, before intervention design or the evaluation of outcomes.

Other RNs shared similar patterns of observation and assessment, to gather evidence and be in a position of ‘knowing*’* (Carper, 1978, pp. 13–14). The term ‘knowing’ involves a set of four patterns, or types of knowledge, gathered by nurses for the purpose of making decisions. These types are ‘empirics, the science of nursing; esthetics, the art of nursing; the component of personal knowledge in nursing’ and ‘ethics, the component of moral knowledge in nursing’ (Carper, p. 14).

In practice, aged care RNs were observed identifying an unmet need, applying intuitive or analytical methodology, incorporating previous knowledge from professional experience, considering resident history, performing clinical assessments, and giving consideration to, or negotiation of, resident-relative directives to finalise collaborative decisions and implement actions.

When comparing Carper’s patterns of knowing to the study data, observations of RNs correspond to these four types. For example, Bridget acquired empirical knowledge through daily assessments, staff and resident feedback. Other patterns of knowing can be identified, as RNs adopt a collaborative framework involving resident or family wishes and medical practitioner considerations, in tandem with ethical deliberation prior to making decisions and taking action. RNs were observed conducting comparative analyses of resident status and reflecting upon previous experience or information to identify changes, prioritise care and consider responsive interventions (Duff-Cloutier, Duncan & Hill-Bailey, 2007).

Sharni explained that her clinical decisions were often made as a ‘response related to observations’, implying a set of biological measurements and physical observations gathered the ‘old fashioned way done by CSE [care service employee]’ provided adequate data to inform nursing decisions. A CSE is an assistive care worker trained at a basic level, often by the employer, in particular direct care skills necessary to undertake tasks directed by the RN. These tasks can include physical observation of the resident, taking physical biological measurements, recording findings in resident notes or charts and reporting information directly to the RN responsible for the delegation.

Assistive care workers interact and regularly engage and communicate both verbally and non-verbally with residents throughout their shift. These workers are often in a position where they can observe or compare changes in a resident’s condition, cognition or behaviour, and report noticeable differences directly to the RN on shift.

Literature reveals that in the midst of routine assistive care activities of daily living, nurses engage in four forms of personal interaction with residents (Carpiac-Claver & Levy-Storms, 2007). These involve ‘personal conversation; addressing the resident; checking in; and emotional support [or] praise’ (pp. 59–60). Aesthetic and personal knowledge is achieved through personal conversation. Resident engagement in personal conversation can be purposeful or esteem building. Purposeful interaction can include communication related to the meeting or identification of needs, specific instructions, personal acknowledgement, praise or reassurance.

Like Bridget, Alice called attention to her ‘prior experience; accurate assessment; policy and procedures; and relative or resident expectations’ as important considerations in making clinical decisions. Alice expressed her professional approach and experience of gathering data and managing care with the statement ‘there is no one suit that fits all’, adding ‘every clinical decision is made to suit the various co-morbidities and life experiences of the resident’. This suggests that Alice is empathetic, intuitive and analytical, with broad experience to ensure a strategic response to the differing needs of individual residents.

One employer adopted a model of RN practice that includes clinical decision-making (McDonald, 2006), which some RN participants were either not aware of or failed to apply to their practice. This indicated that the model was complex to refer to and follow in everyday practice. Many RNs preferred to rely on previous nursing experience, as did Alice. They applied knowledge or skills, or consulted with others before, during or after making clinical decisions. Those consulted include the resident, family, manager, multidisciplinary health care practitioners or the care team.

Some RNs adopted a multidisciplinary health care team approach to ensure continuity of PCC and realistic resident-focused outcomes. In 2004, Boon, Verhoef, O’Hara and Findlay (paragraph 14) discussed the need for an integrated health care team in which patients can holistically access ‘different practice models for different types of care, rather than focusing on a single model’. Such an approach would eliminate the ‘one size fits all’ care model, a concern raised by Alice, and fully address individualised resident needs through multidisciplinary collaboration and consultation with residents and families (McCormack & Dewing, 2010a).

4.2.2.2 Data informing practice.

Several RNs (Alice, Bridget and Sharni) indicated that decision-making is influenced by the quality, type and source of data used to make decisions. These participants individually acknowledged the importance of ‘accurate information from staff’, ‘observation of resident’, ‘objective not subjective measure’ and ‘accurate assessment’. Other RNs stated influences upon decision-making processes such as: ‘prior experience’ (of RNs), ‘quality of life’ (for the resident), ‘pain relief’, ‘palliation’ (resident imperative), ‘policy’, ‘procedure’, and many agreed upon the process of RN consultation with several different sources including the resident, family, medical practitioners, multidisciplinary teams and RNs, either before, during or after nursing decisions were made, depending on the situation.

According to Junnola et al. (2002) the nursing process consists of two phases. Phase one is known as the diagnostic stage, in which needs are identified and data collection occurs, in preparation for phase two. Phase two is the management stage, in which the collated data is used to guide decision-making, implementation and evaluation. Theoretically, the nursing process described by Junnola et al. (2002) is confined to nursing action dependent outcomes. However, contemporary aged care outcomes are dependent upon not only on the nursing process associated with diagnostics and management, but contextualised variables such as consultation with external decision-makers, and the competence of assistive care staff that can significantly alter expected nursing practice and clinical outcomes.

In the literature, the contribution of consultations relating to decision-making made by RN to RN, or RN to family, has been largely underestimated. In an aged care context, professional consultation protocols or networks, and resident or family advocacy, impact upon RN decision-making processes. In some cases RNs worked autonomously, without an opportunity to engage in consultation with another RNs throughout their shift. During the study, two RNs were observed working independently, with no opportunity to discuss nursing decisions with another RNs working inside the facility until the shift handover. At times, several RNs mentioned that they would access the after-hours aged care triage team or hospital triage nurses before transferring a resident to hospital via ambulance.

In one facility, Rosie was found to be working independently during a 10 hour day shift. Her role as onsite RN encompassed responsibilities across three different streams of care services on one site, including high care, low care and independent living residents. During the observation visit it was revealed that the organisation claimed to be unable to replace two sick RNs rostered for that shift, leaving Rosie to work alone. Astonishingly, in the first hour, Rosie made over 33 nursing decisions following assessments on the run, and approached aged care staff, residents, families and GPs to gather information and make clinical decisions to address resident needs and family wishes.

Several RNs (Penny, Marni, Bridgette and Sharni) asserted that ‘brainstorming’ and ‘discussion’ or consultation with GPs, physios and specialists occurred before clinical decisions were made or finalised. Moreover, the majority of RNs in the study stated or demonstrated that resident or family consultation occurred either before, during or after any clinical intervention, in addition to consulting with GPs in relation to hospital transfer and before personal care decisions were implemented or evaluated.

During the study, encounters with families with demanding expectations about care issues were observed to be challenging for nurses. Such encounters regularly posed ethical dilemmas, as clinical decisions are only enacted with family authority and cooperation (Ericson-Lidman, Norberg, Persson & Strandberg, 2012; Lindhardt, Hallberg & Poulsen, 2008). Some RNs were found to be emotionally or vocally expressive at times, either in private or when out of view of highly involved family members.

On several occasions, RNs were seen rolling their eyes or physically avoiding interactions with relatives by changing activity, direction or walking pace. Some RNs communicated to other staff during the shift or at handover their desire to avoid social contact with certain family members, and described their experiences with overly involved family members. During one observational visit, Debra repeatedly reminded herself during such encounters to ‘keep calm’, stating privately that she needed to ‘keep them happy’.

Observed RN interactions with family or others found that RNs adopt one of two options when faced with differing expectations of care arising from the consultation processes. Firstly, consultation is expected to validate RN autonomy and clinical expertise. Secondly, consultation is expected to offer RNs a strategy to arrive at an ethical compromise, whereby they could choose to forego professional autonomy by succumbing to family wishes and recording their acceptance of family decisions pertaining to residents’ quality of life, thus conforming to the version of person-centred protocols adopted by the organisation (Lindhardt, Hallberg & Poulsen, 2008; McCormack, 2004; Price, 2006).

4.2.2.3 RN management of clinical data and handover.

Several formats relating to data management and communication aides were identified during the study. These were informal social interactions, RN to-do lists, formal resident documents and organisational reports. Payne, Hardey and Coleman (2000) revealed that informal records, such as handover and social interactions, were far more effective in delivering nursing care than formal records. Just as in acute care settings, aged care RN clinical decisions are also dependent upon the quality of the nurse to nurse, nurse to medical practitioner and client relationship, to ensure effective communication or dialogue to produce satisfactory clinical outcomes (Peek et al., 2007).

During workplace observations, each participant RN had an opportunity to take part in clinical handover, either in person, as written summary notes, or as pre-recorded by a previous shift RN at the commencement of each shift. O'Rourke and White (2011) considered that a 'handover is an evidence-based, data-driven conversation which contains both the medical and nursing plans of care' (pp. 183–184). Handovers account for approximately eight per cent of verbal information transferred during the shift (Pelletier, Duffield & Donoghue, 2005, p. 41). In essence, the process is a transfer of responsibility for care from one health professional to another.

For several RNs, handover enabled collegial consultation before, during or after making clinical decisions. Sharni was observed taking notes at handover time, then reviewing non-computerised notes and care plan interventions for information to guide decisions or actions for the shift, but stated 'it is quicker to ask staff'. RN interactions with other health practitioners comprise almost 15 per cent of verbal clinical information disseminated during the shift (Pelletier, Duffield & Donoghue, 2005, p. 42).

During handovers, RNs were observed taking notes or adding to their existing handover notes and allocating priorities to tasks to be completed by themselves and assistive care staff during that shift. Debra emphasised: 'I do document a lot. I'm that kind of person. I even use highlighter'. Erika listened to handover, and was then observed reading resident notes and updating the shift to-do list. Similarly, Theresa, from a different facility, was observed writing brief notes and using coloured highlighters to prioritise care tasks and to audit resident observation charts completed by assistive staff.

In her interview, Erika explained that she simultaneously uses mental and written lists to ensure shift tasks are completed and residents are followed up. Literature reveals that the process of constant reallocation of work and ongoing priority based to-do lists involves a process called ‘stacking’ (Ebright, 2010). The concept of RN ‘stacking’ takes into account the coordination of a multi-occupational team approach by RNs, to meet resident needs, and the monitoring of changes in residents’ condition to ensure continuity of care.

In addition to RN stacking, aged care RNs experience what is termed ‘complexity compression’ (Krichbaum et al., 2007, p. 86). This occurs in situations where work-related challenges of time, additional professional responsibilities, personal factors, changing demands, altered resident condition, limited resources, increasing organisational, client or family related expectations and finite resources affect RNs in their delivery of clinical care.

Terry provided a realistic insight into an aged care RN experiencing complexity compression. Terry worked as the weekend morning shift RN in-charge on observation day. Over the first three hours, Terry was involved in the orientation and induction of a newly employed RN, completed routine and PRN, Latin meaning ‘when required’) medication rounds, reviewed and attended to wound care dressings, performed swallowing assessments and assisted two residents at risk of choking with meals, replaced sick staff on roster, supported two visiting medical practitioners, liaised with an unannounced audit team visit, arranged 11 care phone conferences with relatives for the forthcoming week on behalf of the site manager, conducted an assessment of a resident who had fallen, showered four male residents with dementia, monitored care staff duties, delegated tasks as required, and arranged and negotiated family consent for an urgent hospital transfer of an aggressive resident. At the same time, Terry coordinated the discharge of another resident at increasing risk of self-harm, responded to multiple resident family inquiries, coordinated care, pathology or other service requests, managed care delivery responsibilities or compliance and ensured the completion of nursing and resident documentation aligned to compulsory reporting of events and incidents.

RNs have expressed concerns about the volume of documentation they are required to provide, indicating that it is time-consuming (Payne, Hardey & Coleman, 2000). According to Pelletier, Duffield and Donoghue (2005), aged care RNs ‘devalue’ the process of completing documentation as it is ‘taking nurses away from their patients’ (pp. 42–45), revealing that up to 80 per cent of documentation undertaken by RNs is ‘indirect care’ documentation. Debra viewed documentation as a constructive and practical process that helped in managing care continuity. She explained:

> Because I want to be able to follow myself up. Before I hand over to the next person I’m doing as much as I can... nursing is 24 hours—I can’t do it in eight hours. I do as much as I can.

Examples of documentation revealed in this study include to-do task lists, administration reports, staff handover updates, operational safety data, risk management protocols, resident records (charts, forms, progress notes, care plans, resident appointments, clinical data and external medical results), funding based assessments, forms associated with ongoing identification, intervention and evaluation of needs, regulated compliance, continuous improvement and quality activities. Further, this study authenticated the findings of Pelletier et al. (2005), in which RNs were observed attending to documentation ‘whenever opportunities arose’, as they were ‘on call and frequently interrupted unlike acute care’ nurses (p. 44).

The impact of computers in informing aged care RN practice did not emerge until the observation and post-observation interviews. In facilities participating in the study it was apparent that RNs utilise computers with varying levels of hesitation, confidence and competence to gather, record or use data to inform decisions. One organisation continued to use paper based documentation systems, whereas another facility used both formats, as they were transitioning to partial computerised recordkeeping.

The introduction of computerised record keeping and data management in aged care settings was viewed by some RNs as an organisational influence that helped gather or store resident information to make clinical decisions, ensured compliance, gave transparency in nursing processes and evaluated outcomes. The emergence of technology in aged care demonstrates the importance of RNs becoming multi-literate professionals, thus adapting to differing sources of information in complex work environments.

RN uptake of technology and attitudes towards computers is dependent upon its relevance or application to the existing job function, ease in accessing required technology and age (Eley et al., 2009a; Yu, 2005). Nancy professed: ‘I would go back to paper based notes in a heartbeat’. Wendy stated: ‘I’m not very computer literate’, and emphasises: ‘I don’t like computer notes’, although she was observed referring to electronic records in following-up from the previous shift. Mary also showed some hesitation in using the computer, commenting during her interview that ‘just for the basics, I’m alright’. Eunice explained: ‘I am comfortable with what I know’, yet ‘I still rely on paper notes’.

A 2009 study revealed that approximately 25 per cent of RNs working with computers felt confident using computer applications (Eley et al., 2009b). According to

McDonald and Russell (2012), care staff who lack confidence using computers feel disempowered, with the belief they ‘had a negative impact on time savings’, whereas those who were ‘confident were empowered’, and realised the benefits computers offered (pp. 87–88). Alice, Sarina and Sharni demonstrated their ability and interest in using computer technology to inform decisions, creating lists to prioritise care, entering and retrieving electronic documentation or resident records. Bridget confidently demonstrated her computer skills by retrieving computerised data records to inform practice or prioritise assessments to be conducted during the shift.

Many RNs were observed obtaining information from multiple sources including staff, residents, families, GPs, managers and allied health professionals. Data collected during the shift by RNs was scrutinised for relevance, quality, accuracy, urgency and applicability, to make ongoing decisions in often demanding situations. Some RNs gathered information about residents and their care needs associated with either a need to know or need to act. This was demonstrated in the creation of to-do lists.

Eryn created both a written and mental to-do list. During routine RN care activities, such as medications, Eryn asked each resident ‘are you okay?’ or ‘do you want me to do something for you?’ According to Eryn, she mentally ‘ticked off ‘each person ‘as okay’, or they would be followed up for further action during the shift, either for assessment or intervention. Similarly, Jenny asked each resident ‘is there any pain?’ or approached relatives to inquire if everything, including the care from staff, was alright.

Clinical assessments of residents were triggered by changes in their condition or needs, with priority given to the urgency of responses, as data from various sources was used to construct a body of evidence for decision-making and action. Eight RNs were observed to gather and layer data obtained from formal assessments with input from residents and family members documented as clinical information and evidence for consideration of possible interventions.

Debra explained the layering process that occurs when assessing the ongoing needs of residents during the shift. Debra believes her training and experience enable her to assess residents effectively, stating:

> I dictate hospital training I did. I find it quite helpful. You do the first things first. So you get to the resident, look at the resident, how they appear, colour and consciousness. Those things, you can just use your eyes to assess. And then you do your vital signs—you’re getting deeper. You do your palpitations, so you’re getting deeper.

Lake, Moss and Duke (2009) revealed that nurses prioritising decisions in practice develop increasing professional confidence and expertise. Gardner (1983) identified key learning insights relevant to data acquisition and application, describing the following as forms of intelligence: language, logical reasoning and deduction, visual interpretation and recognition, interpersonal communication, kinaesthetic awareness (body movement and physical motion sensation), intrapersonal insight (reflective insight or self-awareness) and naturalistic determinations of recurring themes or concepts. By applying these intelligences to clinical nurse education programmes, Shoemaker and Smith (2012) deliberated that with training, nurses adapt readily to familiar situations with confidence, and can translate skills and knowledge to unfamiliar situations where there are varying degrees of urgency and competing demands.

Several RNs with less than three years of experience stated that they were relatively inexperienced in comparison to the level of expertise of peer RNs working on the same shift. Observably, most RNs reflected on their previous experience to acquire or confirm knowledge and amass professional self-confidence. As Shoemaker and Smith (2012) revealed, these reflected attributes were found to be useful when RNs were expected to work through unexpected and unfamiliar situations. Consequently, RNs were able to apply or integrate new practices, take up technology and manage changes to existing routines.

The National Competency Standards for RNs (ANMC, 2005) endorsed later by AHPRA, states that 'RNs must critically analyse and evaluate not only their own professional nursing practice but support or mentor other RNs to do the same' (p. 4). Marni asserted during her interview that she 'can't change what [she] did, but can in future', emphasising the existence and importance of critical reflection in improving or shaping future practice. Alice explained that she planned to 'use the knowledge gained from these scenarios and mould them to fit', thus conveying familiarity in reflecting upon new experiences for her own professional self-development.

Self-reflection by RNs to evaluate and routinely improve their practice and professional knowledge was evident from conversations between the researcher and RNs, observations of shift handovers, RN collegial consultations, care staff and GP interactions. Sarina reflected on the use of antipsychotic medications and their effectiveness for a particular resident with aggression and delusional behaviour. She considered the decision of other RNs to stop family visits to avoid resident and family distress, as well as to reduce risks to staff from potentially aggressive behaviour. The reflection simultaneously focused on the salient reduction of harm, while empathetically considering family and resident feelings of isolation or abandonment.

Further analysis revealed that many of the RNs reflected on improving their practice from the perspective of doing the right thing for residents and also their families. In some cases, RNs intentionally reflected on practice related to ethical dilemmas involving resident wishes or family demands, or situations when RN professional clinical decisions were ignored. Wendy recounted a situation in which the family member of an ill resident refused to agree to an RN intervention to transfer that resident to hospital for immediate treatment. Instead, they opted for the resident to stay in the facility and await the after-hours medical doctor's visit. However, the resident died before the review could be done. Wendy stated: 'she was very sick and I thought the quality of life had she received [hospital] care would have been better'. Moreover, Wendy explained that if a similar situation happened again, she would 'call the ambulance, and then the doctor' implying that she would not call the family until after the transfer to hospital, and inform the doctor of the transfer.

Similarly, Jacki agreed that if a resident 'needs it, give it', believing that she does what 'is best for the resident', and commented that this includes hospital admission, if necessary. Cris reflected on his role in mediating or working through ethical and care situations that can result in different nursing outcomes from those anticipated by others. In the post-observation interview, Cris provided the following insightful deliberation: 'people want to do what's best [for the resident] according to what their determination of best is. What I need to ask [myself and others] is, what are the benefits? Why there needs to be a decision … who is involved … and who benefits?'

This study revealed that RNs were often self-guided in reflecting on practice to ensure they did the right thing. Debra claimed to reflect 'a lot' on her practice, and emphasised:

> I need to know the policy … I just want to make sure what I'm doing is the right thing. In making decisions I need history of the resident, I need to know the wishes and speak with the family, or the nurses who are really doing the care.

Penny, on the other hand, was confused about what the right thing for RN practice in Australia is. Penny had trained overseas and worked in the UK, where RNs follow medical practitioner directives resulting from family consultation processes. By sharing her experience as an overseas-trained RN, Penny revealed that individual aged care service providers are solely responsible for the orientation and induction of overseas-trained RNs into Australian aged care. This is in contrast to overseas-trained RNs working in public hospitals, who are provided access to Commonwealth Government-funded orientation, induction and professional recognition programmes to familiarise them with Australian health care services and relevant legislation.

In wanting to do the right thing, aged care RNs were found to be ethically and professionally challenged by the differing expectations of residents, families, other health professionals and the employing organisation; competing work demands associated with clinical and administration related duties; and management operational activities and organisational compliance requirements. Scott (2003) identified that aged care RNs wanting to do the right thing face confrontation or situations in which they must yield.

Confrontation includes circumstances in which RNs assert their clinical decision-making autonomy to win over or work around residents and family expectations, in order to provide care according to best practice and affirming RN expertise. In one situation, Sachi acknowledged a resident’s right to choose for themselves, ‘but we can’t always follow them. When there are certain things to do, we can’t. We [RNs] have to make our own decisions’. However, many RNs in this study were observed yielding to the situation rather than asserting their expertise and authority to do what they considered right for the resident. RNs yielded by opting to avoid confrontation with families. Some RNs reassigned decision-making responsibility to others, either through compromising with family wishes or by referring to other professionals, such as managers or GPs.

In an attempt to avoid confrontation, RNs, including Jenny, Nancy and Erika, yielded to family directives, suggesting that their action followed organisational protocol associated with PCC, thus reassigning responsibility to management. This protocol aimed to keep ‘shareholders happy’ by actively involving residents and families in all care choices or clinical decisions, in the hope of averting professional conflict and family dissatisfaction. Similarly, Phyllis yielded control to certain families when she informed staff at handover that they must ensure that they meet the concerns and expectations raised by a particular resident’s family. In contrast, Amy, Wendy and Theresa separately yielded to situations when residents in their care requested that they exclude family from decision-making, in contravention of organisational protocol.

During the study, RNs also revealed the existence of culturally-acquired apathy. This was demonstrated by apathetic RN statements or affirmations, such as ‘if the family wishes to do it, we do it; it’s not really worth it to get into trouble … we have to be very careful’ (Jenny); ‘family influences care decisions’ (Louisa); and ‘families win’ (Penny and Amy). Nancy claimed residents ‘have too many choices’ and ‘admin bends over backwards’. RNs increasingly relied upon family directives, ACDs or verbal family directions rather than autonomously making nursing decisions.

Situations of confrontation or yielding were seen to create ethical uneasiness as RNs strived to do the right thing. This uneasiness arose when the professional expertise of RNs was discounted, coinciding with the loss in RN authority or autonomy as family-directed interventions dominated care decisions. These interventions often conflicted with expected RN professional practice and ethical values related to nursing care provision. Because of observation of practice and ethical incongruence early in the study, exploratory questioning of RNs revealed comparable feelings of being devalued and unsupported by management and employers. Factors such as a lack of confidence in RN leadership or job-related dissatisfaction, contributes to high RN turnover, and other work characteristics (King et al., 2012). Leadership is further explored in this chapter.

Aged Care RNs take on responsibility for their own professional development and continuous improvement by evaluating nursing practice through self-reflection; outcome analysis, acquisition of new knowledge from multiple and credible sources; application of intuitive and analytical data-gathering processes to develop, support and implementation of appropriate evidence-based interventions and effectiveness to meet goals of care or resident need. The aged care RN decision-making process is influenced by multiple stakeholder needs that contribute to RNs feeling unsupported in clinical practice situations due to experiencing ethical-clinical incongruence in their everyday practice.

4.2.2.4 Summary: Informed clinical decision-making threads of evidence.

RNs gather and use data from different sources, such as staff, residents, family and professional networks, among others. The quality or quantity of the data, or data management processes—whether verbal, paper based or electronic—have little influence on many resident or clinical care outcomes. The timing and urgency of events that bring about decision-making is influenced by data gathered through clinical observation and RN assessment and expertise, regardless of consultations with professional, multidisciplinary team members. The key finding is that the dominant influence on aged care RN clinical decision-making processes is the often informal but powerful authority of the family directing and demanding care. RNs realise that to deny or challenge the family’s wishes has implications for employment and career development, as well as professional and ethical consequences, despite RNs being confident that they are doing what they consider the right thing.

Overwhelmingly, general comment and Australian Government Aged Care Reforms assume an imbalance of power between nurses and residents, and therefore tend to emphasise the empowerment of residents and their families to self-direct care and endorse their responsibility to choose cost-effective services. Of concern is the lack of research or transparent discussion on the impact aged care reforms and models of service delivery will have on the professional role and efficacy of aged care RNs.

The Productivity Commission (Commonwealth Government, 2012b) inquiry into the needs of older Australians fails to address concerns involving the diminution of aged care RN autonomy and the sustainability of professional nursing involvement in aged care, under different models of practice. Regardless, the commission has been used to inform the Living Longer, Living Better (Australian Government, 2012b) aged care reforms. These target an increasing, ageing population, and expects them to partially financially contribute to their own care by choosing self-directed community and residential aged care programmes to lessen government fiscal obligations, as well as to reduce the demand for fully-funded residential aged care places. Similarly, the conservative national government of 2013 aims to restructure health care systems and continue the aged care service reforms initiated by the previous government. Whether these changes will affect access to professional nursing care and RN roles or not has been ignored in both major political parties' policy reform proposals.

With the change of government on 7 September 2013, the policies established under the previous government's reform agenda may be reviewed. In a climate of uncertainty, the active presence of nurses—the main health practitioners in the aged care sector—becomes even more important for the quality and safety of residential care for vulnerable older adults.

4.2.2.5 Evidence-based theme: RNs use informed clinical decision-making processes.

Clinical decision-making is influenced by interpersonal, environmental, professional, legal and ethical pressures arising from multiple stakeholder agendas. The information nurses rely on to make decisions is also shaped and censored by other stakeholders, undermining RN expertise, yet they are still held legally and professionally responsible for the clinical outcomes of decisions.

4.2.3 Decision to delegate tasks to professional and care assistive staff.

Sarina stated ‘Delegation is right people, right tasks to right standard’ (Sarina, 2012). Aged care RNs are responsible for the supervision of staff, monitor task allocations, evaluate and develop further knowledge and skills required by staff during the shift, ensure legal compliance requirements, standards and service obligations are met by providing resident care that meets all stakeholder expectations. This common clinical situation draws upon RN experiences, responsibilities and skill mix associated with the delegation of tasks to team members in aged care settings. Responsibility for delegating tasks, and RN involvement in ensuring care staff deliver services aligned to the expectations of residents, family, management, and government funding and accreditation bodies was established in questionnaire responses, observations and interviews. In delegating tasks to achieve appropriate quality resident care, RNs apply critical thinking, staff leadership, effective resource management, high-level social communication and overall clinical competence (Dwyer, 2011; Weydt, 2010).

4.2.3.1 Task delegation and assignment.

Rostering of care staff is a form of task assignment (Cohen, 2007; Weydt, 2010) and is related to managing workload. Staff are assigned tasks within their skill set and job description, to fulfil organisational service needs, as well as routines aligned to policies and procedures and the facilitation of quality care standards. Observed work assignments included assistive care routines, resident mobility, meal services, resident linen management, cleaning, waste removal, overseeing resident safety and supporting residents’ daily lifestyle activities.

Delegation is the assignment of tasks drawn from the RN’s professional scope of practice and expertise, to meet resident needs and coordinate clinical interventions to care staff and other nurses (Cohen, 2007; Weydt, 2010). RNs accept responsibility for delegated tasks’ competent and safe performance (AMNC, 2006; Weydt, 2010). During this research, the delegation of RNs tasks to care assistive staff was observed, in addition to the responses of care staff undertaking these tasks. Care staff were delegated medication administration, tasks associated with pain management, wound care, the recording of cognitive, physical and clinical observations, as well as care interventions.

In this study, aged care RNs identified their roles as clinical managers or team leaders responsible for continuity of clinical care in residential aged care facilities. As managers, RNs are responsible for meeting operational service expectations, including staffing allocations, regulatory compliance, quality care delivery and fiscal efficacy (Courtney & Minichello, 1997; Dwyer, 2011; Hodgkinson, Haesler, Nay, O’Donnell & McAuliffe, 2011). As team leaders, RNs guide and oversee delegations, then work closely with assistive care workers to meet residents’ specific needs and care expectations.

Alice works as a clinical manager of an independent dementia unit, and is involved in staff recruitment, rosters, mentorship and team delegation. Additionally, Alice emphasises the ‘need to delegate to CSEs or physio, to ensure positive outcomes for residents’ and ensure that delegated tasks are known by staff. To achieve this, ‘handover sheets’ that ‘list their duties’, with clear instructions for staff to ‘know they must report when they do not carry them out’. Hence, Alice fosters and expects ‘team work’, ‘respect for each other’, ‘positive thinking’, ‘open communication’ and ‘multi-tasking’ flexibility, in an attempt to create and maintain a cohesive, self-supportive dementia care team.

Bridget works in a dual role as part-time clinical manager as well as shift RN team leader, several times a week. Unlike Alice, Bridget is not involved in recruitment, and staff delegations are rostered by the organisation, based on the residents’ needs that have been approved for government subsidy payments. Through self-reflection, Bridget pondered ‘how to get best outcome, to work as a team’ and meet the ‘needs of residents’, finding that the answer was to ‘delegate to staff as much as possible’, ‘involve others’ and ‘give responsibility to others’. With competing clinical demands for time, complex resident co-morbidity and high resident and employer service expectations, Bridget felt duty-bound to review and redesign the delegation tasks according to rostered staff skill mix and resident needs, while adhering to existing budget and staff coverage constraints.

Task delegation implies having significant trust in the competence of the person to perform the task. Observably, RN clinical managers and team leaders closely monitor staff, undertaking delegations as well as assigned staff tasks as listed in their job descriptions, to ensure resident care outcomes at an acceptable standard. Jenny shared her insights about the obligation of RNs to watch, guide and supervise care staff who were delegated tasks, until ‘I see they are quite competent to do it on their own … otherwise, I would be the one in trouble if something happens’.

In situations in which rosters are organised by a third party, such as the employer, some RNs expressed a degree of moral and professional concern. These concerns involve resident and staff safety and practice during the shift; in particular, the level of skill and competence of the assigned or delegated staff member to meet the specific needs of residents. For instance, in situations where the RN or staff members are unfamiliar with the assigned or delegated task, activity routine, needs of residents, the work area or co-workers on shift. This unfamiliarity or uncertainty generates mistrust or doubt in staff abilities to work effectively and competently (Erlen, Mellors & Koren, 1996), necessitating RNs to frequently monitor staff, evaluate their practice and ensure tasks are completed to expectations.

Bridget asserted her role as manager and team leader by following-up on tasks ‘all the time’ while ensuring that effective team work, resident safety and quality resident care were in place. Sharni echoed similar sentiments shared by other RNs, stating that ‘following-up is sometimes more time-consuming than doing it yourself’. Communication issues were raised by Phyllis, Jacki and Sharni. They described difficulties in staff communication, particularly the delegation and assignment of tasks to linguistically and culturally diverse staff, employed in increasing numbers as casual or part-time workers within aged care (King et al., 2013).

Debra emphasised the importance of clear communication when delegating tasks, and uses the perspective of the resident to inspire and motivate care staff to do the right thing for the resident and their family. During the period of research observation, Debra delegated tasks during handover, or as necessary on shift, and then acknowledged their completion or, if required, reasserted that staff had a responsibility to complete tasks delegated to them.

As a team leader with no direct control over rosters or delegation during the shift, Sharni expressed that ‘delegation is about funding dollars’, and that it is ‘hard enough to fill the roster let alone meet resident needs’, implying that staffing numbers and skill levels are inadequate. Nancy reported that replacing rostered staff is ‘a nightmare’. Observations revealed that some RNs responsible for roster management outside of office hours spent time replacing sick or otherwise absent staff. In one instance, Theresa was seen confirming staff on the roster for the approaching afternoon shift and the following morning’s shift.

The organisational responsibility for replacing staff involves RNs personally contacting casual staff, one by one, until the shift roster is filled. At times, this activity delays RNs from completing their own clinical and leadership tasks, necessitating additional delegation or rescheduling of tasks. David and Sharni recounted similar experiences, in which organisational policy dictates that rostered ‘staff may not come in or leave early’ without appropriate notice, thus creating shortages until replacements or alternatives are found.

4.2.3.2 Staff adequacy.

In separate observations, one organisation was found to be actively benchmarking different facilities according to staff ratios aligned to resident need assessments and government funding subsidies, under the ACFI. This prompted an exploration of staffing protocols to establish the numbers of assistive care workers assigned to a RN during a shift, and the number of residents for which RNs might be responsible.

Although this study did not purposefully investigate aged care staff-to-resident ratios, this divergent analysis raises support for future research, and in particular, promotes generalised discussion about workload disparities between aged care and acute care nursing. The analysis revealed differing numbers of RNs to care staff working in high care facilities across three work shifts, identified as morning, afternoon and nightshift. These results established the following variances per shift:

1. Morning shift:
2. One RN overseeing 10 assistive care staff, with responsibility for 176 care residents.
3. One RN overseeing six assistive care staff, with responsibility for 30 residents.
4. Afternoon shift:
5. Two RNs overseeing seven assistive care staff, with responsibility for 96 residents.
6. One RN overseeing six assistive care staff, with responsibility for 36 residents.
7. Night shift:
8. One RN overseeing six assistive care staff, with responsibility for 97 residents.

These observations demonstrate the variability and inconsistent staffing and resident loads for RNs encountering simultaneous workload compression factors, including oversight of RN task delegation activities and roster allocations. Several RNs were further responsible for residents with increasing chronicity, and working with staff without the necessary skills to meet resident needs and family expectations for care. Some RNs shared similar experiences, explaining that variable levels in staff adequacy pose significant risks to resident care delivery, safety, service reputation and employee job satisfaction. Several RNs acknowledged their expectations that staffing levels planned for prior to the shift would often be different from what was rostered upon shift commencement. To compensate for this staffing uncertainty, RNs find they need to reprioritise work activities, redirect task allocations and oversee delegations, as well as resolve day-to-day service needs and customer issues.

In one instance, Eunice recounted that her daily preparation for the upcoming shift often involved planning staff allocations and task delegation around the existing facility routine. Following handover, the day’s activities were regularly reprioritised around resident health status or requests from the resident, family or employer. However, during the workplace observation, Eunice found her planning required an urgent rethink as an electricity and water outage impacted upon the safety of residents in secure dementia units, particularly regarding personal hygiene, nutrition and hydration, certain clinical and medical interventions, mobility and access around the facility, as well as resident activities.

4.2.3.3 RN delegation experiences.

Bridget explained that her working hours involve working part-time in a dementia unit as team leader, with the remaining hours in the office engaged in management duties. Bridget's responsibilities include continuity of care and team leadership, dependent 'on the team called in', including the RN replacing her in the care unit with the suggestion that RN replacement 'may upset residents with dementia', as they may become unsettled by changing staff. Sharni considered difficulties in her team leader role, and the time spent on increasing administration duties, stating 'the more admin I have to do, the more clinical [work] I have to delegate'.

RNs working in aged care acquire, understand and apply human resource skills, financial and funding responsibilities, operational and compliance requirements related ongoing accreditation (Cooper & Mitchell, 2006), as well as ongoing clinical nursing competence. Management-related responsibilities result in increased monitoring of staff to ensure delegated tasks are completed in a safe, appropriate manner to the standard expected by residents, families, the organisation and government regulation. RNs find themselves constrained by time, which necessitates additional delegation of clinical tasks that they would have undertaken.

Aged care RNs engaged simultaneously in administration or management duties and nursing care activities. Differences in the time RNs spent completing the two types of work were noticeable. Some RNs affirmed their primary clinical responsibilities, opting to transfer or refer management and administration tasks to a more experienced RN working in another unit onsite. Experienced RNs skilfully negotiated the dual role.

In separate instances, the roles and responsibilities of two aged care RNs engaged in clinical and management activities employed by different organisations were found to diverge widely. Researcher observations reveal the range of skills, clinical expertise and managerial responsibilities required by RNs in different aged care work settings.

Workplace one required the shift RN in-charge (Wendy) to undertake extended duties and responsibilities, including on-call responsibility for 122 village residents living onsite, acting as the maintenance issue responder and working as a clinician in the nursing home. Wendy was also responsible for ordering stock, equipment and food supplies and undertaking financial administration associated with invoices, receipt fees or other service payments from village and nursing home residents. Additionally, Wendy was responsible for promoting services to potential client families and residents, replacing rostered staff, coordinating resident allied health referrals and appointments, coordinating cleaning and laundry workers, reception activities, delegating tasks and overseeing clinical care of residents.

In workplace two, Eunice was observed undertaking management responsibilities, such as recruitment, roster replacement, ordering equipment, wound products and continence aids, undertaking infection surveillance audits, continuous improvement activities and office administration and reception duties. Eunice was also engaged in cleaning resident areas, assisting resident toileting, showering and feeding, as well as completing clinical tasks such as medication management and follow-up delegation of other staff tasks.

In the post-observation interview, Eunice from organisation two justified activities that take time away from RN duties—such as medication administration and liaising with medical practitioners—stating: ‘I see that as part of my role … I sort of see my role merging with either side [assistive care assigned tasks] … but I’m getting better [at saying no], I am getting there’. This statement ‘I am getting there’ reveals the dilemma faced by some RNs as they transition from traditional clinicians to being team leader and manager. Eunice voices the inevitable acceptance of self-limit clinical care activities when constrained by workload complexities and an ever changing, dynamic yet expansive management and supervisory role expected from employers.

Four RNs shared similar dilemmas of prioritising RN duties with assistive care duties. Unlike Eunice, other RNs (including Jacki, Lois, Thelma and Marni) had previously worked as assistive care workers in aged care settings. At times, these RNs were hesitant in task delegation to assistive care workers, and often required guidance from, or intervention by, the senior RN on shift or an experienced assistive care team member.

During one observation, Jacki was approached by two assistive staff members to request an immediate change of roster favouring one staff member for a particular shift. These two staff members demanded that Jacki notify the other rostered worker not to come to work the next day, as the shift would be replaced by the other staff member who was a friend, thereby enabling the two members to work together the next day. This loud conversation took place at the nurses’ station and lasted several minutes, until the matter was referred to the senior RN in-charge on shift. Later, Jacki discussed the incident with the senior RN, who affirmed that rostered shifts are not interchangeable.

At another site, upon shift commencement Marni was informed by several care staff members of their preferred assignments and delegations. Additionally, some staff members manipulated rosters by negotiating their own shift replacements and changing unfavourable shifts or co-worker allocations. Debra stated that ‘some staff don’t like being told’, and attempted to negotiate shift work on their terms. This was observed by the researcher, as staff responded only to certain resident call buzzers and prioritised resident requests during the shift. To ensure resident needs were met during the shift, Debbie explained to staff the importance of responding to buzzers and viewing resident needs from the resident’s perspective. This approach was effective in getting care assistants to respond to all buzzers and to meet resident needs during the remainder of that shift.

Erika worked as a casual RN on weekends, and it was observed that staff ignored her when she attempted to delegate and assign tasks during the shift. Care assistants would suggest alternative staff to do the tasks and refuse requests made by Erika. This resulted in the RN in-charge having to intervene and allocate tasks on Erika’s behalf. The incident and staff involved was reported to facility management. Later, Erika explained that recent roster changes were affecting staff morale and participation. She tolerated their behaviour, stating ‘it is okay’ until rostered staff refuse to undertake tasks requested of them.

4.2.3.4 Team leadership observations.

RNs in this research demonstrated a range of team leadership qualities and various levels of delegation effectiveness. Bittner (2009) found that ‘successful delegation was dependent on the relationship between the RN and the UAP [untrained assistive care person], communication, system support, and nursing leadership’ (p. 143). During the research observation, RNs’ communication approaches and effectiveness at delegation differed, irrespective of professional experience. Leadership attributes are learned or evolve through professional development, and are successfully applied in different contexts (Saccomano & Pinto-Zipp, 2011).

Characteristics for effective leadership include effective communication and establishment of clear work roles and responsibilities for team members (Perry, Carpenter, Challis & Hope, 2003). Several RNs exhibited strong leadership abilities in situations where it was necessary to clarify team roles, make delegations and allocate assignments during the clinical handover and throughout the shift, to ensure team work and continuity of resident care. Some RNs were observed working in situations where their team leadership status was not overtly supported or recognised by care team members. Moreover, some RNs were unable to confidently articulate their leadership authority to care teams, especially in situations where the work tasks of RNs and assistive staff were allocated and delegated through organisational rosters prepared by executive managers. As a result, RN access to development through experience, task delegation, team communication and leadership is either restricted or enhanced by the employing organisation.

RNs working as clinical managers and team leaders in residential aged care settings can often feel unsupported by employers, managers, medical and other health practitioners. Noreen recalled her experience of being instructed to ‘do what I say or you are on your own’, and being told: ‘I didn’t tell you to do this, so I won’t support you’ by two different employing managers. Debra and Nancy shared similar experiences of inadequate support from employing organisations, whose priority was for staff to ‘keep residents and families happy’. Dwyer (2011) reports a dearth of positive attitudes to aged care, inadequate understanding or support of residential services, and insufficient professional nursing development, especially in clinical leadership and aged care management (pp.388-402).

By supporting aged care RNs in areas of leadership and professional development, employing organisations and professional colleagues can influence job satisfaction, RN employment retention, high standards of resident care, positive working culture and reduce costs associated with high staff turnover (Honeyfield, 2008; Jeon, Merlyn & Chenoweth, 2010). Moreover, developing aged care RN clinical leadership abilities and improving cohesive support processes and management skills can result in effective delegation for continuity of care and care services coordination.

4.2.3.5 Effect of work routines.

‘Routines are dominated by staff. Routine care dominates over resident choice’, said Jacki. Aged care work routines were observed in different facilities, yet all followed similar activity schedules established by executive managers to efficiently manage costs, staffing ratios and time to meet perceived resident needs. Routines are ‘historical nursing behaviours and traditional structures [that] contribute to an environment that inhibits the delivery of patient-centred care’ (Tonuma & Winbolt, 2000, p. 215). In practice, facility routines develop around resident waking time, showers, breakfasts, mobility limitations, toileting and scheduling of meals in between recreational activities, until bedtime.

David believed that some staff do not like delegation or assignments as they change their routine, explaining that ‘some staff are able to change with the routine, but some are hard to get focused on that, and some [staff] you have to check out to make sure they do showers … and some good ones go with the flow’. On reflection, David later recalled some situations in which facility routines were changed to accommodate resident preferences. These included waking later in the morning, eating outside of facility meal service schedules and showering in the afternoons or not taking morning showers.

Overall routines can be deeply entrenched in staff attitudes and work practices, and changes in policies that affect practice may sometimes be ignored (Sandvoll, Kristoffersen & Hauge, 2012). Routinised practice—known as the ‘habitus of caring’ (Sandvoll et al., p. 7)—fully engages staff in habit forming practices, requiring intensive training with continual monitoring by supervisors until the new practice is adopted.

During the current study, several participants were inflexible and unyielding in their routine work practices. In separate instances, Thelma and Bridgette persevered with facility routines despite incidents occurring that required staff to vary scheduled activities, such as hygiene assistance, meals and delegations. Similarly, Louise maintained work routines, adamant that she would not change routines. Further, Louise refused to incorporate resident preferences into care activities while transitioning several residents into a new dementia unit, stating ‘we always do it this way’. Several other RNs exhibited similar unyielding adherence to existing facility routines. This was consistent with findings by Harnett (2010), who established that staff perceive routine changes as disruptions, disturbances or good matches, if suited to staff circumstances or an organisation’s PCC goals.

Cris was particularly open about implementing changes in practices and routines to introduce PCC into the facility. His post-observation interview explored the role of RNs and care assistants in advocating for resident wishes, setting goals to attain positive outcomes and driving improvements related to resident quality of life. The discussion with Cris included strategies for empowering RNs to change routines, adopt PCC approaches, document ACDs and to be flexible in implementing new models of care. Cris reflected on the employing organisations’ current practice of routinised task-oriented care, compared to a previous employer that implemented PCC in a purpose-built facility. During the observation, Cris shared with management his vision of progressing PCC, later acknowledging that ‘the staff mindset is a challenge … I can’t change the structure of the building, but, I can pretty it. [And] having staff designated to areas and getting rid of that task-orientated thought process’.

4.2.3.6 RN consultation processes.

Consensus was established among the RN participants regarding consultation with other RNs, including in-charge RNs. Bridget explained that another RN is sometimes asked ‘before, for their ideas, during and after, to assess outcome’. Similarly, Alice highlighted that ‘if unsure, then I always ask others for their opinion’. Alice stated that consultation is resident driven: ‘before starting, [we] keep them in the loop, and look at other options for collaboration with them’ as well as ‘afterwards [to] discuss outcome and other options’.

Sharni reported that she consults with another RN ‘during’ the decision-making process. Several RNs remained fairly autonomous and did not engage with other RNs on the shift. However, Cari and Rosie, in two separate observations, worked alone with no onsite access to another RN for consultation.

4.2.3.7 Influences on delegation options: Aged care RN availability.

In 2007, 11 per cent of Australian RNs worked in residential aged care, representing 21 per cent of the total aged care workforce (NILS, 2008). From 2007 to 2012, the number of RNs decreased six per cent to almost 15 per cent of the aged care workforce. Similarly, the numbers of direct care workers (including RNs and ENs) in residential aged care has declined by three per cent, to about 73 per cent of the workforce (King et al., 2012).

Buchan and Calman (2005) identified that ‘whilst there is no universal definition of a nursing shortage, there is increasing evidence of nurse supply/demand imbalances in many countries’ (p.5). In Australia, as well as New Zealand, evidence indicates that government ‘funding shortfalls can create shortages which are not necessarily related to nurse availability’ (Honeyfield, 2008, p. 23). These ‘shortfalls’ affect employment opportunities for RNs and positions available for nursing graduates from university programmes. This then influences the availability of educators, further limiting the number of RNs trained over time (Buchan & Calman, 2005). Further, increasing rates of job dissatisfaction, low wages, lack of organisational support and increasing care workloads have contributed to a reduction in RNs seeking work in the aged care sector (AHWAC, 2004b).

King, Wei and Howe (2013) have referred to the RN shortage in Australia as a shortage of RNs wishing to work in aged care. They surmised that ‘residential [aged care] facilities are decreasing their reliance on RNs to provide direct care to residents’ (p. 9), substituting RNs with care assistants. At the same time as RN and care worker roles are changing, there are noticeably increasing demands upon all direct care staff to safely and adequately care for older people living in residential aged care contexts (King, Wei & Howe, 2013).

During the study, several RNs suggested that additional RNs and care staff are required to meet an increased demand in complex clinical care needs, and to meet high service expectations. Cris explained: ‘I believe we need other staff. I’m not saying we are understaffed, but, I did a review of our residents and they’re high active [funding] claims’. He indicated that over 85 per cent of residents at the time were assessed to have very high care needs, yet they were being serviced by low care staff numbers on the roster because the residents had aged while in the facility. Louisa and Jacki, working in different organisations, agreed that additional RNs and care staff are required to meet increased demand in complex clinical care needs and service expectations of RNs’ administrative workload.

The ageing Australian population will increase significantly by 2047, when it is estimated that one in four Australians will be over 65 (p. 34), with comparably fewer tax payers contributing to aged care funding in the future. As increasing numbers of Australians live longer, aged care services face changes in client demographics, chronic care needs and care service delivery provisions. This is due to increasing frailty and complex care needs through the ‘prevalence of co-morbidity (people living with two or more diseases at the same time)’ (Productivity Commission, 2008, p. 44).

Complex care needs arise from chronic diseases such as cancer, cirrhosis, cardiovascular conditions, kidney disease, functional impairment and physical disability, neurodegenerative diseases (including Alzheimer’s disease, dementia and Parkinson’s), depression, osteoarthritis, osteoporosis, pulmonary disease, as well as acute infection or injury. The number of people with progressive and debilitating dementia requiring supervised care and high care services and accommodation is expected to increase from 220,000 to over 730,000 between 2007 and 2050’ (p. 45).

The focus of the Productivity Commission (2011) upon ageing Australians and aged care services also raised the profile of aged care RNs and care staff. Moreover, it highlighted the differences between RNs working in aged care and acute health care services. In 2010, the National Aged Care Nursing Roundtable ([NACNR] 2010) established that general health care RNs believed that aged care nurses had less expertise than acute care RNs, and reaffirmed that ‘wages and conditions of service, staffing mix and staffing levels impact on aged care workforce participation and satisfaction levels’. Further, NACNR members considered aged care RNs to be specialist nurses in the care of ageing populations, and that aged care staff had high job satisfaction rates, except in the area of wages, while acute nurses required additional training in dementia and the care of older people with chronic co-morbidities (NACNR, 2010; Mellor, Chew & Greenhill, 2007).

Experiences of indifference by acute health services personnel towards aged care RNs were recounted during interviews. In several encounters, RNs were openly interrogated and challenged by ambulance officers as well as by triage RNs in hospitals, regarding the transfer of, or need to refer, ill, elderly residents to other health services. These experiences influence the quality of professional consultation or collaborative processes between hospital-based RNs and aged care RNs, which can affect resident care, safety and access to adequate medical treatment. These issues are discussed later in this chapter.

4.2.3.8 Delegation processes.

RNs working in the aged care workforce face situations of complexity compression (Krichbaum et al., 2007) and are required to delegate tasks in order to meet resident and family needs. This increases the possibility of risks arising from inappropriate assignments and delegations allocated by an organisational manager, without input from the RN team leader, or by RNs under pressure from low staffing levels to ensure clinical care continuity, regulatory compliance and service outcomes that satisfy the resident, family and organisation. In the USA, nurses collaborated on a safe task delegation framework that acknowledged the five rights of delegation for nurses to consider when delegating to others (NCSBNANA, 2006). These five rights are task, circumstance, person (delegated to), direction or communication, and supervision (by RN).

In Australia, the Nurses and Midwives Registration Board ([NMRB], 2006) adopted the ANMC (2006) National Competency Standards for the RN, which affirms that:

> The registered nurse practices independently and interdependently assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care (p. 1).

Within the 2006 RN competency standards are several key elements involving delegation:

> Standard 2.5: Understands and practises within own scope of practice and raises concerns about inappropriate delegation with the appropriate registered nurse. (p. 5)
>
> Standard 2.7: Recognises the differences in accountability and responsibility between registered nurses, enrolled nurses and unlicensed care workers. (p. 5)
>
> Standard 7.5: Delegates aspects of care to others according to their competence and scope of practice. (p. 10)

During participant observations, delegations aligned to the above standards were noted. Tasks were allocated to specifically trained care assistants familiar with residents and routines, who understood the importance of reporting back to the RN any variation in resident condition and their concerns, and who were aware that they were to inform RNs when the delegated task was completed or not within the specified timeframe.

Jenny stated: ‘I don’t delegate things to staff [if] I don’t think [they] can handle it.’ She further explained: ‘I observe, I teach them and if I see they are quite competent to do it on their own, I let them.’ Mary had ‘no worries, no problems’ with delegating tasks, although routine practice is to follow-up on delegated staff tasks, including the giving of medications and resident care during the shift. Mary explains that staff ‘will ask me and I’ll answer –if they are having a problem, I’ll go with them and deal with it, sort it out’.

Increased service expectations and task delegations have modified RN workloads from self-completion of tasks to that of ongoing monitoring and following-up of staff assignments, as well as delegated duties to ensure care standards and resident needs are met. Through their experience, RNs believe that they ensure tasks are conducted according to regulatory guidelines and organisational protocols. In particular, Sharni and Theresa share concerns about assistive staff not completing their tasks to the standard required.

A proportion of RNs reported that normal routines are often ‘messed up’ with phone calls, information requests, family wishes, resident condition changes, roster replacements, pharmacy deliveries, senior manager interruptions, GP visits and ‘searching for stock’ if there are no supplies onsite (Debra). Noreen rationalised: ‘do what you can, with what you got’.

Thelma acknowledged that ‘residents didn’t follow routine’. Similar views to those expressed by Nancy in relation to the planning of shift routines and to-do lists were revealed, concluding with checks that staff had completed set tasks. Terry professed: ‘I got my list … but it don’t work here, too busy’, affirming the changing complexities and demanding workloads experienced by RNs.

4.2.3.9 Summary: Evidence of influences on RN delegation decision-making.

In this study, RNs delegated nursing and care tasks with a consideration of workload distribution, staff skills, competence and the demands of resident-influenced routines. RNs who demonstrated confidence as team leaders were responsive to organisational service obligations, and used strong interpersonal communication skills to inspire staff, achieve work outcomes and ensure resident safety and continuity of care.

It also emerged that RNs who lacked confidence or encountered difficulty in communicating with care staff found it difficult to lead their teams and satisfy the care needs of residents. In some situations, RNs were not supported by their employing organisation, RN peers or care staff in their delegation role. These are all factors known to influence care continuity and resident safety. Therefore, RNs need to access and develop team leadership skills and obtain support from their employing organisations, to create cohesive assistive care teams responsible for continuity of resident care.

4.2.3.10 Evidence-based theme statement: Stakeholders determine delegation.

The ascendency of stakeholder influence on professional roles and decision options is supported socially, and through a growing body of regulation. Proficiency in care task delegation requires RNs to draw upon their experience, skills and self-confidence in negotiating with employers, residents, families and staff.

4.3 Participant Decision-making on PRN Medication Administration.

In this study, opportunities arose for RNs to be observed during clinical decision-making processes around the giving of PRN medications, as well as how RN delegation occurs in such situations and the practice of evaluating the effectiveness of administered PRN medications (Australian Government, 2012d, p. 23). PRN medications are controlled, with instructions as to the purpose or ‘circumstances specified by the prescriber’ (Australian Government, 2012d, p. 36).

4.3.1.1 PRN medication administration in an aged care context.

Residential aged care service organisations have a statutory responsibility to ensure the safe administration of medication to residents. The development, implementation and maintenance of a quality, safety-driven medication management system can ensure this responsibility is met. Aged care RNs work within a scope of practice that includes team and clinical management, as well as being legally responsible for supervising delegated medication administration duties and accountable for the performance of competent medication administration (ANMC, 2006).

In Australian aged care, medication management processes must align to the following regulatory and competent practice requirements:

1. guiding principles for medication management in residential aged care facilities (Australian Government, 2012d);
2. guidelines for delegation by RNs and midwives (ANMC, 2006) endorsed by NMBA (2012);
3. national competency standards for the RN (ANMC, 2006), endorsed by the NMBA (2012).

Medication management systems are chosen by organisations that determine policies, procedures, staff training, medication competency assessment, medication delivery systems and equipment, to enable safe medication provision. In practice, an employer-selected medication management system must be used by RNs, who are also responsible for the performance of care staff working under employer delegation to administer medications. Employers are also responsible for recruitment, selection and retention of staff they believe capable of using the organisation's medication management and administration systems.

Mary, Noreen, Eunice, Debra, Amy, Louisa, Sachi and Wendy were responsible for medication administration when on shift. In these facilities, care staff were assigned the tasks of clinical monitoring of blood pressure, pulse, respirations, pulse and routine activities of resident care. However, in other facilities, care staff were delegated the administration of medications after they had been trained to follow the medication management system of their employer.

RNs are legally accountable for their own medication administration and other delegations, and must ‘follow-up and monitor delegated responsibilities of non-clinical [care] staff’ (ANMC, 2006, p. 3). Care staff work in aged care settings to implement care plans devised by RNs, and are routinely delegated medication administration duties, except for PRNs, which remain the responsibility of RNs as it involves clinical assessment and judgement. When discussing her experiences in monitoring delegated staff tasks, Bridget declared that ‘PRN medication is not always given appropriately’.

In the first instance, Bridget questions the administration of PRN medications by trained care staff or other RNs, asking ‘is it necessary and why? Are there alternatives?’ Bridget instructs care staff-delegated medication administration tasks by managers, and states that she would ‘usually prefer regular medication orders, which are more reliable than subjective decision-making’ when opting to administer PRN medications. In this situation, regular medication orders or alternative strategies to PRN medication administration can reduce workload pressures and time taken to clinically assess each resident or intervene with medications. The National Ageing Research Institute (2010) conducted aged care education programmes encouraging facilities to review the ‘use of pain medication on a regular, rather than PRN, basis’ (Masso et al., 2011, p.110) where appropriate, ‘rather than [administer] on a PRN (as required) basis’ and adopt other methods to address symptoms, such as pain and sleeplessness, through evidence-based practice strategies.

In clinical practice, Bridget’s decisions to give PRN medications are influenced by the resident’s ‘medical history’, ‘current needs or symptoms’, ‘knowledge and experience’, ‘input from other health professional’, ‘recent health issues’ and medication history, by ascertaining ‘if used before, was it effective?’ More importantly, the major influence for consideration associated with PRN medications includes ‘resident choice’. Bridget emphasised that her role involves ensuring ‘PRN medications are discussed with the resident and family’, to keep them ‘informed’, ‘to discuss if they may prefer another course of action’ and ensure that the ‘GP is kept informed’.

Alice acknowledged that several resident factors influence her PRN medication decision-making processes. Resident assessments and specific clinical interventions would be prioritised in instances of ‘pain, discomfort, infection, and SOB [shortness of breath]’. In ensuring PRN medications are safely targeting specific residents’ needs, Alice confirmed that her workplace ‘only has Panadol, Mylanta and Coloxyl as PRN medications and pain relief, if palliative, as needed’.

Many RNs confirmed similar medications, with some adding that psychotropic medications were also prescribed as PRN options and used by RNs in situations of aggressive behaviour or extreme agitation. The most common PRN medications in Australian aged care facilities include ‘analgesics, laxatives and psychotropics’ (Elliott, 2006, p. 58) along with inappropriate prescribing and ‘polypharmacy’, in which more than eight medications are prescribed for the one person.

Alice remarked that ‘there is a tendency to use medication, rather than treat the symptoms by a kind word or understanding’. Her decisions concerning PRN medications are influenced by her clinical experiences, and she is strongly of the view that ‘medication can often do more harm than good in the elderly’. Alice declares: ‘I do not support the use of psychotropic drugs’ or ‘sleeping medications for the elderly’ by staff (including other RNs). In each instance, she believes that the professional judgement of experienced RNs should focus on the welfare of the resident, and be person-centred.

Concerns about inappropriate use of PRN medications were raised by Stokes, Purdie and Roberts (2004), who found that the use and practice of prescribing PRN psychotropic drugs was determined not by resident factors but by organisational policies and procedures. Morris (2013) explains that psychotropic medications can be used as a chemical restraint, and are used for ‘behavioural control’. The effect of chemical restraint is to limit the aggressive behaviour, or to subdue the person (Victoria Government, 2006). The use of both physical and chemical restraints is closely regulated, requires permission and is used for short periods (DOHA, 2012a).

In Australia, 28 per cent of residents assessed as aggressive are administered psychotropic medications to chemically restrain them (Morris, 2013), whereas, 34 per cent of similarly assessed aggressive elderly residents in the US are chemically restrained (Agens, 2010). This suggests that Australian aged care facilities use less psychotropic medication for chemical restraint of aggressive residents than US elder care facilities. However, at least one in four Australian residents may be placed under chemical control.

Residents may be prescribed regular therapeutic psychotropic medications for the management of conditions such as anxiety, depression or bipolar disorder (NAMI, 2013). Residents with a dementia-causing illness or psychiatric conditions characterised by agitation, anxiety or aggression may also require episodic interventions of prescribed PRN psychotropic medication. Infection, constipation and pain or discomfort are well-known causes of changes in elderly resident behaviour, and it is important that each person be fully assessed to identify causes of problems and to ensure the most appropriate clinical intervention is employed.

During study observations, RN perceptions of immediate risk of harm to self, others or property posed by resident aggression were managed clinically as a matter of urgency. In separate instances, Wendy, Jacki, Thelma, Lois, Terry and Nancy assessed residents exhibiting aggressive behaviour towards staff and other residents. Each situation necessitated the administration of PRN psychotropic medication to reduce the risk of further aggression and possible harm to self, residents, staff or others. Nancy explained the legal requirement of clinically assessing residents for chemical restraint.

Following assessment, the medical practitioner is informed, and based on the information provided, determines the resident’s need for restraint, before giving authority and providing a prescription. Further approval for psychotropic medication administration must be obtained from the resident’s family formally nominated as guardian, or otherwise responsible. This person is informed of the need for the medication, and must sign consent for chemical restraint to be given as prescribed when needed. The resident is then closely monitored during the restraint intervention, to ensure their safety.

The most commonly observed administered medication in this study involved pain relief or analgesia. Mary, Theresa, Noreen, Eryn and Marni responded to resident or family requests on behalf of their resident for pain relief. Residents and family members were observed asking for pain relief after approaching the RN or other staff members. Proactively, Thelma, Sarina, Debra, Erika and Eunice examined the resident and gathered details of the occurrence, type and level of pain experienced. In some cases, this information was charted and used later to determine the ongoing effectiveness of pain relief, by using a similar approach to rating the pain level 30 minutes after medication administration. The effectiveness of pain medications was followed up through three RN observations on three occasions, by Rosie, Sarina and Theresa.

Resident attributes, behaviour or personal moods can change with the onset or increasing severity of pain or discomfort and/or an alteration in physical condition. In one particular instance, Jenny intuitively used non-verbal cues to identify pain or discomfort in residents experiencing dementia symptoms, who were unable to vocalise their pain or discomfort. Several RNs explained that residents were often observed exhibiting pain-related behaviours, including 'aggression' (Jacki), agitation or being unsettled' (Erika), 'crying' (Amy) or 'wincing or groaning' (Penny).

Studies estimate between 26 per cent and 80 per cent of residents in aged care facilities experience pain on a regular basis (Commonwealth Government, 2007). According to the Australian Pain Society, 40 per cent of ageing high care residents with a degree of cognitive impairment are 'unable to report pain' (APS, 2005, p. 4). Of those residents, many were not prescribed pain relief by their medical practitioner, or were not administered RN authorised (nurse-initiated) analgesia for relief of non-verbalised or symptomatic pain. McAuliffe, Nay, and Fetherstonhaugh (2009) claimed that pain is not always identified by aged care residents or staff. They established that for resident discomfort to be identified, staff must know the resident intuitively and perceptively. In addition, McAuliffe et al. (2009) held that staff education on pain identification and management for people living with dementia or cognitive impairment is necessary, and adequate tools are required to assess or measure pain and determine the effectiveness of pain relief.

During clinical handover between shifts, RNs in the research study instructed care staff to watch for and report signs of resident discomfort and non-verbalised incidents of pain. RN and assistive care staff engaging in-facility-based, PCC practice are well placed to readily distinguish pain-related changes in resident behaviour and mood differences, and to observe for difficulties in bodily movements when assisting residents in activities of daily living. As a result, PCC approaches help to empower and advocate the needs of residents living with chronic pain (Howarth, Warne & Haigh, 2013) who are able to gain access to responsive interventions, such as PRN medications.

Erika commented that she ‘would like everyone on PRN pain relief’, to ensure resident pain is adequately managed from admission, and to lessen the need for administering ‘nurse-initiated’ medications on multiple occasions for chronic or medically undiagnosed causes of pain. Nurse-initiated medications include those approved by the DOHA, and are endorsed by the aged care organisation’s Medication Advisory Committee. The Committee monitors the organisation’s medication management system, so nurse-initiated and PRN medication administration follows clinical assessment by the RN (Commonwealth of Australia, 2012a; Quality of Care Principles, 1998). Jacki, Theresa and several other RNs administered nurse-initiated medications, and remarked that their use would result in a referral to a medical or nurse practitioner.

Alice identified the following resident needs that influence nurse-initiated and PRN medication decision-making processes. These include ‘pain’ or ‘infection’, ‘quality of life’ and the need for ‘palliation’. Moreover, Alice considered organisations to support RN considerations and outcomes through ‘policies and procedures’ to ensure ‘quality outcomes’ for ‘reduction of pain’ and ‘treatment if infection’, as well as access ‘to multidisciplinary health and treatments’.

Sharni revealed that clinical and medication decisions are guided by looking ‘at the whole picture’ of the resident, including relevant history, condition and staff actions. Staff report signs, symptoms or observations of residents, and relay requests for PRN medication to RNs. In seeking clarification from medication delegated staff, Sharni, despite the information being available in the residents' case files, was observed to ask medication administering care staff directly about when the last PRN was given. She did this to identify patterns of PRN usage, as well as to ensure that medication administration staff 'do not go over total dose [allowable] for 24 hours'.

In some organisations, managers delegate PRN authority to care staff, who are empowered by their employers to act without reference to RNs. During RN observations, several incidents of PRN medication errors by rostered medication administering care staff were identified. In separate instances, Phyllis, Sharni and Theresa established that a lack of consultation of care staff and RNs on shift regarding PRN medication needs had resulted in errors of repeated administration. To reduce the incidence of such errors, Theresa instructed care staff not to give PRN medications, and to inform the RN in all instances. This is to ensure that each 'resident is followed up from previous medication administration' for safety reasons, and to evaluate the effectiveness of the medication. Alternatively, Sarina insisted that two delegated staff were to undertake all medication administration, in an attempt to reduce further errors. RNs asserting their legal responsibility for the oversight of safe medication administration can also generate tension with organisation managers, who believe their decisions to delegate PRN authority to care staff should not be challenged by nurses.

Medication errors are consequences of human error, or are in conjunction with inadequate procedures or limited training (Zimmerman et al., 2011). To avoid similar situations, Sharni applies 'a strict rule to discuss PRN medication with RN before giving'. This implies the need for adequate RN-staff-resident consultation. Moreover, Sharni emphasised the need for employers to allocate additional RN time for supervision of staff tasks, especially PRN and routine medication administration. Without this it becomes difficult to ensure safer administration practices or provide opportunities for RNs to assess residents and follow-up or coordinate medical or nurse practitioner review.

To emphasise the importance of such a ‘rule’, Sharni describes the following situation, in which ‘a resident in low care’ informed the medication administering care worker that they had a ‘headache’. Sharni explained the organisation’s current medication administration policy, practice and clinical experience to demonstrate that the resident would be administered PRN pain relief without RN consultation. Sharni’s concern for the resident drew from her clinical expertise, as a headache, if experienced by a resident with a history of hypertension, can be an indication of ‘increased blood pressure’, potentially causing a life-threatening situation, such as a stroke. However, if the RN is notified of the headache by the medication administering care worker, a clinical assessment was immediately follow, as would blood pressure measurement, and the resident would be clinically managed by the RN.

In PRN medication administration situations, participants reflected on the practice of other RNs as well as themselves. The study explored communication and consultation processes. Professional consultation and collaboration in clinical decision-making was evident from three RN questionnaires. These stated that they would talk to another RN at some time either before, during or after making such a clinical decision.

Bridget clearly stated that consultation with another RN was undertaken ‘before, during and after’. She sought RN consultation ‘before, for input in decision-making, ‘during’, to involve RNs in decision-making, and ‘after’, during handover, to report whether medication was effective or if ongoing evaluation of effectiveness was required. Alice indicated that she would talk to another RN ‘before, if they are the ones wanting to use PRN for behavioural problems’; however, ‘if the PRN is for pain, I support this'. To a lesser degree, Sharni advised that she would talk to another RN 'sometimes during' the decision-making process involving PRN medications.

In addition to monitoring delegated staff and RN duties, Sharni described her situation, which involved extended RN responsibilities expected by the employing organisation. These included supporting independent living village clients when rostered as RN in-charge for the high care facility. In her written responses she mentioned that there is 'no general rule in the village for PRN' medication administration by RNs according to organisational policy. In such a situation, RNs are expected—by different stakeholders, including village or nursing home residents and employers—to ensure responsive clinical care, as well as manage aged care service quality and safety.

Aged care assistive staff may or may not hold an accredited qualification in which medication assistance competency is undertaken (Scott-Cawiezell et al., 2007) such as Certificate III or IV in aged care work. In residential aged care facilities, organisations take responsibility for staff training and ensuring ongoing competence of medication administration staff, including RNs. This responsibility is aligned to aged care service approved provider requirements (under the *Aged Care Act* 1997) as having a safe organisational medication management system in place.

Bridget explained that in the facility in which she worked, medication administration tasks were delegated by managers via organisational rosters compiled centrally by executive managers. Staff to whom these tasks are delegated are deemed competent by the person completing the roster, according to organisational, 'protocol' and 'education' factors. Alice, who worked in another organisation, shared a similar view that PRN medication administration is controlled by organisational 'policy and procedure', and highlights concerns raised by other RNs about the executive delegation of medication administration roles through the staff rosters.

In recent years, aged care organisations have acknowledged their responsibility for safe medication management systems and procedures. Care staff are trained to give medications, and their competence is assessed routinely by the organisation. However, research suggests that a system of medication management is only sufficient to eliminate or reduce medications errors in circumstances where influences on direct practice are effectively managed. These influences include a workforce culture that involves self-reporting errors, quality assurance activities and frequent medication relevant training and adequate supervision (Kohn et al., 2000; Leape & Berwick, 2005; McDonald, 2010).

Observations revealed that RNs customarily monitored care staff-delegated medication tasks. Post-observation RN interviews exposed the concerns of those RNs about resident safety, appropriate medication administration and evaluation of medication effectiveness. RNs are professionally and legally responsible for ensuring that only appropriate and competent staff are delegated tasks. RNs are further accountable for supervising tasks they delegate, in accordance with medication administration delegation competencies (ANMC, 2006), Quality of Care Principles (1998), government residential aged care medication management guidelines, and facility Medication Advisory Committee policies (Australian Government, 2012d, pp. 13–18; Australian Nursing and Midwifery Federation [ANMF] 2013).

In 2013, the ANMF released nursing guidelines for medication management in residential aged care facilities, clarifying the responsibilities of aged care providers and RNs. These guidelines state that aged care service provider responsibilities include 'employing registered nurses and appropriately qualified enrolled nurses to safely undertake the management, administration and (where appropriate) review of medicines' (p. 8). This is to ensure the safe use of medications, as RNs 'use clinical judgement to assess whether medicines should be administered or withheld with regard to the consumer's health and family history, diagnosis, co-morbidities and health status' (ANMF, 2013, p. 13).

Additionally, RNs are duty-bound to follow-up and evaluate the effectiveness of all medication administration, as part of their obligation to ensure the continuity of safe resident care. However, as observed in this study, where they have little or no input into management delegations of nursing roles and procedures, RNs have no authority but full responsibility and accountability for core outcomes from organisational processes they cannot influence.

The role of RNs beyond 2014 is yet to be fully defined, as planned government aged care reforms could significantly affect the role of the aged care workforce. It is expected that the reforms will affect the distribution of organisational quality and safety responsibilities. These reforms involve the implementation of consumer-directed care (Australian Government, 2012a, 2012b, 2012c; DOHA, 2010) and the requirement that resident needs be assessed by health practitioners registered under the National Law (AHPRA, 2009) and acting within their scope of practice.

By 2014, the Australian Government Aged Care Reforms could dictate changes to known models of clinically coordinated aged care, residential aged care, service delivery mechanisms and aged care staff practice. Changes and amendments to regulations under the *Aged Care Act* 1997 (such as aged care standards, funding processes, related medicine management or health and ageing government guidelines) could further redistribute responsibility for tasks currently identified within RN scopes of practice. They could clarify professional competence requirements and establish regulatory responsibilities associated with medication management, clinical care coordination, administration and aged care service models.

4.3.1.2 Summary: Evidence around influences on PRN medication administration decisions.

In Australian health and aged care settings, the reduction of RN participation levels in the aged care workforce is accelerated by decreasing numbers of RNs in clinical roles. As care team leaders, RNs face increasing administrative and managerial role responsibilities, which necessitates management delegate to care assistants some tasks usually located within the RNs practice, such as medication administration. Delegations, whether by executive decisions via organisational rosters or RN substitution strategies, require RN clinical supervision to be preserved to ensure that safe and appropriate medication management practices can be maintained.

4.3.1.3 Evidence-based theme: RN substitution raises concerns for medication safety.

RNs are obliged to monitor the effectiveness of PRN medications, evaluate the frequency or appropriate need for PRN administration and assess residents, to evaluate or reconsider interventions and, if the need arises, refer a resident for medical or nurse practitioner review of medication. Management decisions to substitute RNs with care assistants in clinical roles, coupled with concomitant increases in RN management activities, is perceived by nurses to be placing residents at greater risk of life-threatening clinical errors.

4.4 Participant Referral or Transfer of Residents to Specialist or Emergency Service Providers

The reasons and influences on RN decision-making processes related to resident transfers or referrals to specialist or emergency service providers were explored in this study. Much of the debate and submissions by individuals, aged care service providers and hospitals to the Productivity Commission’s inquiry, Caring for Older Australians (Productivity Commission, 2011), highlights issues regarding the high numbers of residents being transferred from aged care facilities to emergency centres. Some submissions considered many instances preventable, while others acknowledged the difficulties residents faced receiving adequate and timely treatment from medical practitioners in residential aged care settings, necessitating transfer to emergency departments or other acute hospital services.

4.4.1.1 Contextual issues around resident access to health care services.

Research has identified that around 31 per cent of transfers from residential aged care facilities to hospitals are potentially avoidable (AIHW, 2011; Australian Government, 2010; Karmel, Hales & Lloyd, 2007; Nelson, 2011). According to the peak industrial body for nurses known as the Australian Nurses Federation (ANF, 2011) reductions in the number of aged care facility transfers to hospital, acute patient bed days utilised from falls and infections are possible if the aged care staff skill mix is right (2011). Furthermore, the ANF suggests that acquiring an appropriate mix and skill set for aged care would include employing qualified aged care RNs with increases in funding from the ACFI to support a ratio of one RN to 30 residents; stopping RNs being relegated to multidisciplinary management roles by rostering RNs to direct aged care roles to assess clinical needs allowing RNs to determine and deliver clinical care; increasing RN pay to improve retention rates and job satisfaction (ANF, 2011).

In the current study, data on staff ratios or adequacy was not deliberately collected; however, observations of the variability in staffing skill mix is relevant to decisions to transfer residents. Submissions to the Productivity Commission inquiry into the Care for older Australians (2011) revealed that several peak organisations share similar views to the ANF (2011). Two of these were National Seniors Australia (Access

Economics, 2010), an aged care consumer group, and the Aged and Community Services Australia (ACSA, 2010), a peak association servicing managers of aged care organisations. These submissions recognised increasing workload and work compression factors on RNs, including complex resident co-morbidities, administration, management, aged care-specific clinical expertise and ethical considerations. Moreover, these bodies suggested improvements in aged care staff retention, through future government policy changes, including aged care funding.

This Productivity Commission inquiry (2011) did not address staffing concerns, opting instead to consider the impact of an ageing population on existing aged care and primary or acute care service delivery models. This focus explores workforce components comprising: staff expertise, aged care service delivery, primary care resources used, predicted utilisation by aged care residents and multi-level approaches used to contain increasing costs of care and services, involving access to community-based care options and residential care.

It was established by the Productivity Commission inquiry (2011) ‘that more intensive sub-acute and medical care is not the direct responsibility of the aged care system’ (p.19). The Productivity Commission’s Caring for Older Australians (2011) offered recommendations that aimed to improve ‘access by aged care recipients to services provided through the wider system, including potentially supporting an expanded role for aged care providers in health care provision’ (p. 20). The Commission identified training and access for health care professionals, and the responsibility of aged care services for providing professional development for staff, especially to manage complex co-morbidities, including dementia. In addition, and without presenting any research evidence in support, it took the view that older Australians preferred in-home care and community services packages to residential care, and considered the possible use of aged care nurse practitioners who would work closely with medical practitioners and aged care services to meet this growing need.

The Australian Government Response to the Productivity Commission's Caring for Older Australians Report (Commonwealth of Australia, 2012b) outlines the following key strategies: improved access to practitioners specialising in mental health; behavioural or dementia-specific care and treatment; primary allied health care professionals; mobile palliative and chronic care specialists; mobile allied multidisciplinary and acute care teams; greater medical practitioner involvement in residential aged care services; nurse practitioners; and outreach or mobile medical treatment services.

These strategies informed the Australian Government's Living Longer, Living Better Aged Care Reforms (Australian Government, 2013) which claims to address current gaps and future care needs of older Australians. However, the implementation of the 2013 reform agenda is undergoing review following the change of Federal government in September 2013.

RNs participating in the study shared concerns about the referral or transfer of ill residents to hospital when requiring urgent access to medical practitioners and multidisciplinary health professionals for acute clinical-based interventions. They also expressed the desire to respect the wishes of the resident to remain in their own home or provide safe familiar surroundings, for those experiencing dementia. Planned policy reform is targeted to provide aged care services with improved acute care management resources and training to both hospital and aged care staff.

4.4.1.2 Perspectives on the need to refer or transfer residents.

When managing situations in which they were faced with the decision of whether to refer or transfer residents to medical services, Alice and Sharni purposely considered in the first instance, to avoid sending residents to hospital emergency departments. These RNs, from separate facilities, questioned the need to refer residents to an external specialist, or to transfer them to an emergency service provider. For Sharni, the consideration of whether the situation could be managed in her facility was imperative.

When discussing situations related to transferring residents to hospital or a medical specialist, Bridget explained that she first questioned if the decision to transfer a resident, made by another RN, was appropriate. In her practice, Bridget quickly establishes who the ‘most appropriate person or health professional to manage an issue’ is, and stated that she would ‘refer a problem to the person with relevant expertise’. On reflection, Bridget affirmed that she would ‘refer to allied health professionals frequently’.

The RN decision to send a resident to hospital, according to Alice, is undertaken ‘only when the resident cannot be managed in the facility’, and only if this ‘is the best outcome for the resident, depending on the situation’. Alice explained that ‘hospital trips are usually avoided’, unless it is an emergency, as ‘specialists do home (facility) visits for me’. She stated that there are X-ray and specialist clinic services in the vicinity under contract to the organisation, with a service agreement with medical practitioners, residents and their families. Referral or emergency transfer of a resident is dependent upon a set of criteria aligned to the capacity of the external clinic, and the determination of medical or nurse practitioners concerning issues such as ‘quality of life for resident, pain and fractures requiring repair, excessive bleeding and infection status’ (Alice). Additionally, Alice describes several decision-making influences, including ‘relative or resident wishes’, and ‘expectations’ of management and others.

Other RNs also provided clear guidelines that would be significant determinants for them in the decision to transfer or refer residents. Louisa indicated that resident transfers are for palliative assessments and suspected fractures following falls. Lois and Terry emphasised that transfer is also necessary when there are risks to resident safety, wellbeing and possible harm, resulting from behavioural and psychiatric conditions. These elements of decision-making are consistent among participants in other study locations.

From 2010, RNs working in different organisations along the eastern coast of NSW revealed similar issues and processes surrounding hospital transfers. Further, deliberate questions in subsequent interviews with RNs identified and explored how RNs identify and interpret contributing factors to transfer as a last resort option for urgent medical treatment. Analysis revealed situation-specific themes, as well as an initial theory common to all five situations.

One theme identified in the decision to transfer or refer involves situations in which medical practitioners, or their preferred after-hours medical services, were not available. In many instances, timeframes from referral to consultation extended beyond eight hours, from the initial notification by the RN of significant changes in resident condition. This time lapse poses a risk to resident safety, and necessitates transfer to acute care services for urgent medical review and treatment. Further, this investigation found that RNs taking such a decision do so to fulfil a professional duty of care, or to act as an advocate for the resident’s right to access medical treatment, respond to acute illness or trauma, improve or maintain quality of life by access to palliation, among many other possibilities.

Another theme revealed dilemmas faced by RNs who decide to transfer a seriously ill or clinically compromised resident to hospital, but is subsequently directed to withhold or delay the transfer. Different views from the resident, family members, organisational managers, medical practitioners or paramedical services can place the RN in an ethical and professional dilemma. Several RNs explained that it seems that previously documented ACDs, signed by residents some time before, can be spontaneously overruled or changed by family members, who may be consulted in an emergency. RNs also described situations in which other health or medical professionals or executive managers influenced RN decision-making processes, despite the resident's condition necessitating referral or transfer to hospital.

A few RNs in this study encountered opposition from other health professionals, who questioned their clinical competence to make the decision to transfer ill and suffering residents. Questions about clinical competence to manage chronically ill residents were directed at aged care RNs by hospital-based aged care triage staff and ambulance service officers. This suggests that hospital-based clinicians and others hold a belief that aged care RNs are inadequately skilled, or have poor assessment and care interventions, as well as limited decision-making ability in relation to transferring residents.

The Australian College of Ambulance Professionals (ACAP) submission to the Productivity Commission into Australia's Health Workforce (2005) revealed their view on the poor utilisation of highly trained personnel and equipped ambulances when responding to the increasing needs of an older population, mental health patients, and impacts arising from inadequate medical practitioner coverage in primary health care. ACAP believes that paramedical officers and their resources could be more effectively utilised, as currently 'the ambulance service and the emergency departments become the de-facto GP service', and 'the inability of some GP practices to service their patients … only exacerbates after hours with limited access to GPs' (Australian Government, 2005,

p. 5). Ambulances are often ‘reduced to being very expensive taxis even when the patient does not require any actual or potential ambulance interventions during transport’ (Australian Government, 2005, p. 6). RNs participating in this study revealed similar difficulties in accessing medical practitioners, necessitating the calling of an ambulance to transport residents to hospital for urgent medical treatment.

The decision to transfer residents is further complicated by the realisation that hospitals are not safe places for older people. In some cases, experiences revealed that:

> older people are apparently regarded as being less worthy than young people in accessing hospital services … This culture of resentment towards older people who are being admitted to hospital in their 80-90s with conditions that a few decades ago caused hospital admission in their 60-70s, has hampered medical and nursing clinicians in their skill development to meet the growing demand for astute diagnosis and treatment of reversible conditions. Hospital managers also have some case to answer in terms of the performance measures they set for clinicians such as ‘preventing admissions of older people’ and staff viewing them as ‘bed blockers’ (McDonald, 2008, p. 6).

Studies reveal that residents transferred from aged care services are more likely to experience adverse health outcomes (Ingarfield et al., 2009; Mudge, Denaro & Rourke, 2012), which may reflect the demographics of residents who are chronically complex and frail as well as elderly. It is also possible that acute hospital clinicians and managers may believe that residents transferring to emergency departments place an unnecessary burden on health care resources. An alternative would be to increase professional nurse participation in aged care clinical roles, and to establish clinical outreach from hospitals to work with RNs to manage resident health care appropriately. However, for such an arrangement to occur there needs to be a realistic range of skills among aged care staff, and RN workloads recalculated to allow for assessment and timely clinical intervention and evaluation of residents.

A study conducted by Mudge, Denaro and Rourke (2012) found that the model of standardised care adopted by emergency care teams and hospital staff does not adequately meet the needs of patients with dementia, or those with ageing chronic complex care needs. This study explored the differences between standard health care team management of ageing residents from residential aged care facilities accessing hospital care services, to those from the ageing community with similar chronicity receiving care from a specific multidisciplinary team with interventions appropriate to the management and specific needs of such patients. A control cohort receiving a standard model of hospital care was included.

The results of the Mudge et al. (2012) study established that the hospital multidisciplinary team care approach improved health care outcomes, as well as the patients' quality of life and mortality by six months or more. This study found that ageing patients admitted from residential aged care are similarly responsive to ageing populations in the community who access emergency and acute care services provided with community team models of care. Mudge et al. (2012) found 'high mortality rates may reflect the model of care rather than just baseline vulnerability' (pp. 672–673). This suggests that medical ward care fails to address the complexities of an older person, and is unable to effectively manage 'acute reversible deterioration' unless timely interdisciplinary interventions are used, as they were for younger or older patients from the community.

The subjugation in health care rights for people aged 78 or above was evident in the literature. In determining cost effectiveness, WA and NSW hospitals calculate risk factors such as obesity, lung and heart diseases, diabetes and renal impairment, age and fitness of patients when measuring their health care service-related performance. Further, Australian hospital statistics record and comparatively analyse health and quality outcome indicators in terms of ‘years of potential life lost to measure premature mortality for deaths occurring between the ages of 1 year and 78 years inclusive’, by tallying the numbers of years of potential life lost against causes of death to their measure performance (ABS, 2006, para. 15). Therefore, the demand management strategy of hospital administrators of reducing hospital emergency department presentations and admissions of older people aged above 78, significantly improves hospital efficiency and quality performance indicators.

4.4.2 Contextualised influences on RN clinical decisions to refer.

Alice proclaimed that influences on RN decision-making processes depend on the level of RN ‘knowledge or experience of similar situations’ and ‘resident wishes’. Many RNs were observed consulting with other RNs on shift in the same facility. Alice further acknowledged that consultation with other RNs ‘before, during and after’ making decisions was important to ‘ensure we are on the same page’. Alice works in a facility in which managers support RNs to make clinical decisions that aim to ensure residents’ ‘quality of life [is] optimal’ or that align care to the organisation’s mission and vision statements where possible.

RNs in aged care are responsible for coordinating a multi-skilled workforce (ranging from care workers to visiting health practitioners), as well as ensuring continuity of care. By doing this, resident needs are met to the standard expected by residents, families and the aged care accreditation standards as outlined in the *Aged Care Act* 1997. According to this study’s data, clinical decision-making considerations for hospital transfer or referral of residents by RNs are linked to competent clinical assessment of resident needs; accessing appropriate RN expertise; the capacity and resources of the aged care facility to manage a situation effectively; access to medical, nursing or allied health practitioners; and importantly, the opportunity to ascertain the wishes or expectations of the resident or their representative and balance any competing priorities and agendas of family members, managers and other health professionals.

Noreen recalled a situation in which a resident was transferred to hospital for an intervention because the facility was ill equipped to conduct it. Although RN expertise and skill using the required equipment was available, the facility did not stock the equipment necessary to perform the intervention within the required timeframe. As such, the facility manager directed Noreen to transfer the resident to the emergency department so that clinical interventions could be undertaken using appropriate equipment. In such circumstances, the resident is able to access appropriate clinical interventions through transfer to a hospital emergency department, receive the intervention and later return to the residential aged care service following medical review. Organisations such as Noreen’s adopt policies that restrict access to clinical interventions, thereby creating the need for transfer of residents to acute primary care or emergency services for most assessments and minor treatments, as well as outreach clinical interventions for serious conditions.

Assessing and transferring residents to external health care services is well within the RN scope of practice and competence (ANMC, 2006). Moreover, RNs enable residents living in residential care facilities to gain equitable access to the level of primary health care resources that is available to the wider ageing community. In NSW, residential aged care facilities are encouraged by the NSW Ministry of Health to consult with a 24-hour Aged Care Emergency Triage (ACET) service before transferring residents to emergency departments. This service aims to support RNs in aged care who are considering referral or transfer of residents to an emergency department or to other allied clinical centres such as acute mental health units. As some RNs revealed during their interview, in practice, there is a lack of awareness about this service or the option of calling on professional outreach multidisciplinary teams that can provide a range of outreach services to the aged care facility. Other RNs who knew about the triage services typically responded ‘if after-hours [medical services] can’t handle it, we transfer out’ (Sachi).

Alice recalled a situation in which the resident preferred medical practitioner was unable to review a residents’ long-term deteriorating wound. Advocating for the resident to receive a timely medical review, Alice considered pain treatment, attending to ongoing discomfort and viewed the clinical wound treatment could not be delayed by waiting for the after-hours locum medical service to arrive. As a result, Alice decided to send the resident to the emergency department for specialist medical wound review rather than contact the ACET service for referral to their outreach team, which would have involved scheduling a visit for the following week.

Wendy explained why she does not use the ACET service despite being ‘aware that there is an ACET aged care emergency team’, ‘I don’t bother with that. ACET don’t know the people. I don’t think it is their place to say whether I send them or not. I’ll ring the doctor in A&E [accident and emergency] and tell them what is happening. They usually always say send them in’. Wendy was observed discussing clinical interventions with other RNs or telephoning the manager about transferring one resident for an urgent medical review. Debra also used other RNs including, on occasion, aged care triage services, stating ‘it all depends and is always an advantage when you work as a team, if I need someone’s help [to] make a decision’.

4.4.3 RN experiences associated with resident transfers.

Observations during this study revealed that RNs make decisions to refer or transfer residents according to situational priorities and urgency. Events that are considered of priority or urgency include breathing difficulties, infections, chest pain, falls or fractures, and behavioural aggression or anxiety. As this study progressed, RNs were found to transfer residents more frequently to emergency departments when medical practitioners were unavailable to review seriously ill residents or those whose clinical condition had rapidly changed or deteriorated.

In some situations, RN autonomy in making referral decisions was found to be the result of an ethical stance involving stakeholders influencing RN decisions, rather than a straightforward clinical intervention by RNs assessing and meeting resident needs. RNs described their ongoing difficultly in securing medical treatment for their ill and ageing residents. They believed this was due to the frequently encountered attitude of ambulance officers who challenge RNs' decisions or their perception of urgency in seeking medical treatment for residents. By expressing challenging RNs' decisions and assessments, paramedical and other professionals cast doubt on the assessment competence of RNs and their ability to provide resident care. The implication of such challenges is that sending residents to emergency means that RNs are poor managers of primary health care resources.

Both Cari and Eryn described similar but independent situations in which they were asked by paramedic or ambulance officers responding to their transfer request to reconsider transferring gravely ill residents to their local emergency department. Eryn stated that she defended her decision to transfer a resident to emergency by informing the ambulance officers about the lack of after-hours medical resources attending the facility and problems with overdue medical practitioner reviews. Further, she asserted her professional responsibility and competence to perform any necessary clinical interventions within her scope of practice and duty of care, including accessing urgent medical treatment for residents in her care.

Cari recounted an ambulance officer’s reluctance to transfer a resident because she was aged in her nineties and in his view, too old to receive his services. Upon arrival, the officer instantly began dismissing the urgency of the need for medical intervention or transfer to the emergency department. During her post-observation interview, Cari also described helpful and positive encounters with other ambulance officers attending resident care and transfer needs, including the insertion of sutures to lacerations or careful transfer to hospital after falling.

4.4.4 Influences exerted by medical practitioners.

The literature validates the difficulty noted by the RNs participating in this study in obtaining medical services for residents after business hours or for urgent resident consultations (Productivity Commission, 2005, 2008, 2009, 2011). It seems that medical practitioners aged 45 years of age or older are more likely to have visited at least one residential aged care facility to consult on residents aged 75 years or older, than medical practitioners younger than 45 years of age (O’Halloran, Britt & Valenti, 2007).

The quality of medical services provided to aged care residents is affected by the increased workload of the few medical practitioners willing to service increasing numbers of aged care residents. In 2008, less than 50 per cent of Australian aged care residents had a comprehensive medical assessment (CMA) completed by their medical practitioner (Georgiou & Westbrook, 2012; Westbrook, Georgiou, Black & Hordern, 2011). A CMA is a government-funded CMA voluntarily undertaken by the resident in which the resident’s attending medical practitioner assesses their health, and physical and psychological function, either following admission or annually (Medicare Australia, 2013).

From 2010 to 2011, medical practitioner services to aged care residents living in residential care were seen to increase approximately 20 per cent (Taylor et al., 2013). However, issues regarding the availability of medical practitioners to provide continuity of care, including after-hours services, were raised in the Productivity Commission report (2011, pp. 185–188) and strategically acknowledged; however, these issues remain unresolved. It is hoped that future aged care policy reforms will go some way to addressing the shortage of doctors willing to treat patients in residential care.

In 2004–2005, 48 per cent of emergency presentations were by people aged 65 years or older (AIHW, 2006a). Of these, 22 per cent were aged care residents who had been transferred to hospital after a fall (AIHW, 2006a). Approximately 11 per cent of residents who have fallen are admitted to hospital for approximately 10 days (AIHW, 2006a). Other emergency presentations included problems associated with circulation (including cardiac); neoplasms; digestion; injury, poisoning or external causes; and respiration, with additional co-morbidities such as arthritis, dementia and eye or vision disorders.

By 2009–2010, people aged 65 or older presenting to emergency from all referral sources accounted for 60 per cent of admissions to hospital (Arendts & Howard, 2010). This age group included people living in the community and aged care residents. Overall, approximately 10 per cent of all hospital stays involved people aged 65 or older who had suffered an injurious fall (AIHW, 2013).

The effect on primary health care resources of older people presenting to emergency departments has been identified and reported in several Australian Government and Productivity Commission inquiries. These include the *Productivity*

Commission into Australia's Health Workforce, Research Report (Productivity Commission, 2005); *The Productivity Commission, Future Demand for Aged Care Services* (Productivity Commission, 2008), *The Productivity Commission, Performance of Public and Private Hospital Systems* (Productivity Commission, 2009); and, *Caring for Older Australians* (Productivity Commission, 2011). Each of the Productivity Commission reports revealed different perspectives of individuals and organisations affected by an ageing population with several submissions advocating for residents or staff working in aged care services. Some submissions speculated on the clinical competence of aged care RNs to undertake early assessment of resident conditions and implement timely interventions to manage unstable conditions. Recommended strategies arising from the Productivity Commission reports include training aged care RNs and staff, as well as improving access to medical or clinical interventions by establishing outreach teams with medical and nurse practitioners. Few submissions acknowledge the difficulty faced by residential aged care RNs in accessing timely and effective medical practitioner services from clinically competent doctors.

The current study identified that participating RNs clinically assess the residents' condition and will transfer in situations of increasing resident deterioration, where medical interventions would improve their quality of life, treat infection or alleviate discomfort. Delays in the availability to residential aged care services for medical practitioner consultation creates the need for transfer to hospital. Moreover, direct orders from family members or managers add further complications for RNs and may limit access by older people to essential services and dismiss their right to access medical treatment or ignore their right to refuse it.

In some situations this may foster an 'ageist' culture that supports limiting resident choice or access to timely healthcare and medical services. Health care professionals who have an ageist perspective in resolving the problem of the rising demand for medical services for the aged and funding shortfalls often use their authority to restrict access by ageing patients to emergency services and acute health care interventions. In so doing, these health care professionals contravene the Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Health Care, 2008).

Several studies considered the role of medical practitioners in developing and improving primary care intervention services to meet the medical needs of residents living in residential care facilities (Arendts & Howard, 2010; Holland, Allen & Cooper, 2012). This study reveals the adequate capacity of RNs and aged care services to manage appropriately and effectively changing conditions of resident health, a service that is central to reducing the demand for ageing people living in residential care to be transferred to hospital emergency departments.

The development of improved care pathways within residential-based care by adapting or modifying outreach or mobile primary care services is a possible solution to enabling access by older Australians living within aged care facilities to optimum healthcare services. Training in acute care skills for aged care RNs, as well as training in age-related morbidity and dementia for primary or acute care RNs could also resolve some of these issues. Moreover, strategies to decrease the demand for emergency and acute care services coincide with ageing and chronically ill people being encouraged to develop ACDs with aged care RNs and resident preferred medical practitioners. If such strategies are implemented, it is expected that ageing and frail people, or family members holding decision-making authority, will be able to choose their level of care, as well as decide on options such as hospital-based interventions or little or no intervention, in which case RNs considering transferring residents to emergency departments would have some clear guidance in their decision-making (Productivity Commission, 2011; Sharpe, 2013; Willoughby, Marr &Wendell-Smith, 2013).

RNs face an ethical dilemma in some situations involving resident or family wishes that can oppose or dismiss RN clinical decisions to provide access to clinical or medical interventions. Ethical debates from community and professional groups such as Alzheimer’s Australia and Doctors for Voluntary Euthanasia Choice aim to facilitate open discussions and enable older Australians with the right to refuse or choose treatment through a national euthanasia strategy similar to those in the Netherlands, Belgium, Luxembourg and Switzerland, rather than support multi-jurisdictional legislation.

In the United States, Oregon passed the *Death with Dignity Act* in 2000, which continues to generate ethical debate from inter-jurisdictional governments or individual lobbyists about ‘physician-assisted suicide’ or ‘physician-assisted homicide’ (Durante, 2009; Lindsay, 2009) who express concerns about abuse or religious sacrilege, and assert moral objections. In Australia, the Rights of the Terminally Ill Bill (May 2013) (Sharpe, 2013) was presented to the jurisdiction of Tasmania, raising ethical debate about affirming the needs of ageing and chronically ill individuals to self-determine not only their quality of life but their pathway in palliative approaches, including death with dignity.

Current debate in Australia encompasses health care rights for ageing patients, enabling personal autonomy and self-determination over life and death decisions such as the right to equitable health care or to die with dignity. The debate also includes discussion on implementing pathways for better palliative care, with potential solutions for shortages of residential aged care medical practitioners and RNs. In addition, there exists the opportunity for more effective management of the ageing population presenting to hospital emergency departments. Australian aged care RNs work within an ethically charged environment in which the resident's condition, right to self-determination and autonomy, family directives and professional autonomy influence RNs' clinical decision-making processes and resident outcomes.

4.4.5 Influences affecting RN clinical autonomy.

Bridget stated 'as the person responsible for duty of care to the resident, it is my decision as to whether or not to transfer to an emergency provider'. Similarly, other RNs asserted their autonomy to make clinical decisions. Interestingly, Erika stated 'it's my decision', yet, she further explained 'we ring the relative—the person responsible, then notify the doctor'. Upon exploring these characteristics of decision-making processes, Erika was asked the following question: 'what if you assessed the resident and decided to not transfer to hospital but the family requested the transfer?' Erika responded, 'I go to the advanced CDs and follow that [to transfer or not.] I transfer on the urgency of care'.

The significance of resident CDs overriding RN clinical decision-making processes and outcomes was confirmed again in the post-observation interview. During this interview, Erika was asked the following question: 'what is a clinical decision?' She replied, 'one that is in writing, very important like transfer to hospital'. This indicates that RNs are influenced by ACDs and incorporate the person's wishes in their decision-making. Other RNs were observed not only to check the ACDs, but also to seek approval from relatives, GPs or RNs and management for permission to refer or transfer residents in urgent cases or emergencies. A possible explanation is that nursing is a consultative activity and therefore, communication with all stakeholders is standard practice. By adopting PCC to guide decision-making activities, RNs consult with residents and appointed guardians to authorise resident transfer to an emergency department or to approve specialist referrals.

In any care situation, it is expected that RNs, family or guardians, multidisciplinary team members and managers would act in the best interests of the patient or resident. Wendy reflected on a situation in which she advocated for hospital transfer to improve a resident's quality of life, yet was overruled by family members and the resident's medical practitioner. 'She was very sick, and I thought the quality of life had she have received care [via approval from family to transfer to an emergency department] would have been better'. The resident later died. When Wendy was asked 'what would you have done differently in that situation', she replied, 'I would call the ambulance and then try the doctor', that is, she would have transferred the resident to hospital in the first instance, even against family and medical preferences, highlighting the dilemma for RNs concerning resident benefits, ethics and loss of authority as a RN.

Wendy further stated, 'we have a few' ACDs, 'we usually speak to the family about them on admission but sometimes no one wants to make a decision'. Sharni mentioned difficulty in gaining GPs permission for a resident transfer to hospital. On occasions, there were times when it was 'difficult to contact the [resident-preferred] GP to ask permission for referral or to send [the resident to an emergency department]'. As a result of her experiences, Sharni asserted that documentation such as advance care plans would elucidate 'residents wishes to have full treatment or palliative' care and would eliminate the dilemma encountered by RNs in such situations.

The Living Longer, Living Better reforms (Australian Government, 2012b) emphasise the importance of ACDs, as well as self-directed or consumer-directed care. This provides ageing people with increased choices and control over the manner in which their care and interventions are provided. If the reforms are implemented as planned, aged care clients will be able to select and prioritise elements of care that are negotiated with providers according to assessed funding eligibility or capacity to contribute their own funding to achieve their expectations of care. Community-based consumer-directed (aged) care packages began in July 2013. Residential aged care consumer-directed care services are scheduled to begin in July, 2014 despite policy uncertainty arising from the change in federal government from September 2013.

4.4.6 ACDs and care plan influences on decision-making.

Resident care plans document individually assessed personal and clinical needs, detail interventions designed to meet specific goals or objectives to progress outcomes through consultation or negotiation with residents, families, multidisciplinary and allied health care professionals. Care plans are aligned to resident or family-determined CDs or preferences of activities associated with daily living, recreation, hygiene, physical comfort, emotional or mental strategies and more.

Resident ACDs are formal, legally binding documents. These specify interventions discussed, acknowledged and agreed on by residents, family representatives, medical practitioners and RNs. ACDs were observed during this study to be the most influential factor on RN clinical decisions to refer residents to other services or transfer residents to hospital. Many RNs shared similar experiences, confirming that a family member ‘usually decides for them [residents]’ (Marnie), and nurses are expected to ‘always listen to family’ (Sharni).

In contrast, Amy, Debra and Penny recalled experiences in which residents were referred to other services (including mental health-intervention clinics) or transferred to emergency departments, and which resulted in the ‘family not happy if [the resident was] sent against CDs’ (Debra). Other RNs also mentioned that they would be ‘in trouble’ if they failed to follow family or ACDs. Several RNs described strategies to avoid such conflict. In some instances, RNs would notify the family while the resident was en route via ambulance to an emergency department for an urgent medical assessment.

Sarina revealed that on some occasions she experienced ethical uneasiness in situations where person-centred palliative care needs would sometimes conflict with rehabilitation or independence goals associated with longer term quality of life. This included situations in which RNs were following or varying ACDs. To resolve or avoid conflict, several RNs revealed the need to consult with other RNs, medical practitioners or managers to help resolve ethical and moral dilemmas.

In some instances, RNs felt that families were empowered to such a degree that to ignore the ACDs or oppose family wishes would result in their lodging a formal complaint against the RN or the facility, which would need to be dealt with through formal grievance proceedings. Such actions by residents and families can undermine the RN's professional reputation by inferring incompetence or lack of professional credibility in exercising professional judgement related to ensuring high standards of care. By imputation, complaints processes can affect an organisations' reputation for care standards because they are delivered by the staff they employ and direct.

During the post-observation interview, Cris reflected on a situation in which a family was removed by the guardianship tribunal as the resident's advocate. Individuals within this family had differing views of care for their aged parent, which created conflict for the aged care service, RNs and members of the resident's family. The tribunal established an independent guardian to oversee the resident's care and finances and requested that important medical or clinical decisions be made by the resident's medical practitioner.

Wendy described an experience in which a resident’s advance care directive clearly stated that transferring the resident to hospital in a particular circumstance was not to occur. Wendy telephoned the preferred medical practitioner with an urgent request to review the resident for an acute severe infection, which was reversible with prompt antibiotic treatment. However, the medical practitioner did not return the telephone call. The resident’s condition quickly deteriorated, however, the family insisted that the RN must not transfer the resident to hospital and choose to wait for the medical practitioner to telephone back. The facility manager *on-call* supported the family wishes and did not agree with the RN’s recommendation to transfer the resident to hospital emergency for urgent medical review and treatment. The resident died later the next day, while still awaiting a response from the preferred after-hours medical practitioner service. Wendy reflected on this situation, she stated that next time she would not follow family or guardian directives and assert her clinical responsibility to care for the resident by ‘calling the ambulance first’, ‘then the doctor’ and finally notify the family and manager that the resident was en route to emergency treatment.

To avoid family conflict situations, several RNs indicated that decisions to transfer residents contrary to family or advance care directives required obtaining approval from the resident, facility manager or the resident’s medical practitioner. Noreen described seeking and following the facility manager’s directive to transfer a resident, believing that as an RN she ‘does what’s best for the resident’. Marni, Terry, Lois and Jacki were observed consulting with the residents’ medical practitioners to inform relatives about referring to allied and medical specialists or transferring residents to emergency departments.

In one situation in which an advance care directive was in place, Cari contacted the medical practitioner after-hours service so that the medical practitioner could ‘convince the family to take them [the resident] to hospital for an operation’. The medical practitioner successfully convinced the family to reconsider their position on transferring the resident to emergency as soon as possible. If the RN had followed the advance care directive without question, the resident would have had a shortened lifespan, difficulty mobilising, and would now have to endure a significantly poor quality of life with increased pain and suffering.

In a different workplace, a poignant encounter between one participating RN and a relative returning from hospital with the resident was observed. The relative thanked the RN for insisting on transferring the resident against the relative’s wishes. The relative had previously instructed RNs to dismiss the residents’ behaviour in the weeks leading up to the transfer as ‘attention seeking’. The resident frequently asked staff to be sent to hospital because of weight loss, not eating and feeling unwell. Following transfer by this RN, the resident had emergency surgery for an acute life-threatening condition, unrelated to existing co-morbidities or perceived resident attention-seeking behaviour.

4.4.7 Summary: Evidence related to RN referral of residents to specialists or emergency services.

RN decisions on clinical emergencies are influenced by their assessment of the resident’s condition; resident and family wishes (including ACDs and medical practitioner availability and involvement); emergency personnel and hospital staff perceptions about older people accessing care; facility resources and policies; as well as their own ethical position, professional experience and competence.

Ongoing data analysis of this situation incorporates reports such as the Productivity Commission (2011) report and recommendations and the Australian Government Aged Care Reforms (Australian Government, 2013) to provide contextual depth. Investigations by the Productivity Commission (2011) generated widespread awareness of the demands and growing needs of an ageing population, in particular, those living in residential aged care facilities with complex co-morbidities, who need to access health care services for medical treatment and interventions for reversible conditions. The aged care-reform documentation contains strategies to reduce the need to transfer ageing residents with complex co-morbidities from residential care services to emergency departments by promoting a service system that can provide timely in-home or in-facility care and clinical intervention.

During this study, RNs emphasised the importance of checking an individual resident’s advance care directive. ACDs from the resident or families guide RN decisions and actions in relation to referring or transferring residents to other services. In other situations, RNs assert their clinical autonomy by making decisions that are sometimes counter to the wishes of residents or family members, justifying their actions on the basis of the urgency for accessing efficacious medical treatment.

In such situations, ethical circumstances were also explored, revealing strategies by which RNs avoid conflict when opposing ACDs and family wishes. The strategies include RNs liaising with and forming alliances with medical practitioners; consulting with other RNs or managers to increase the authority of the decision prior to transferring the resident to an emergency department; and to notify substitute (family) decision-makers while the resident was en route, which would mean it is late for the transfer decision to be overruled.

4.4.8 Evidence-based thematic statement: RN ethical–professional duty.

Aged care RNs are aware of their ethical and professional duty to advocate for patients in their care, and take personal risks to ensure the safety and wellbeing of residents, as well as insist that the residents’ right to access hospital and medical services when necessary is upheld.

4.5 Participant Decisions Related to Facilitating Resident Choice in Their Own Care

Residents and relatives have the right to choose their path—we do not (Alice)

The role of RNs and their decision-making processes in facilitating resident choice in aged care situations were also explored in this study. RNs reported that resident preferences and choices influence the circumstances in which care and clinical decisions are made. Instances in which such situations arose were observed in practice, as well as documented as ACDs or in care plans. Resident choice within a person-centred approach is empowering for residents and families yet, in some instances, these frameworks can present challenges for RNs seeking to advocate for residents and ensure that acceptable practice and expected outcomes are achieved because at times, the best interests of the residents do not seem to be a priority to the family or facility managers.

4.5.1 Resident choice.

This study suggests that that the concept of resident choice within aged care is subject to different interpretations and perspectives from RNs who sometimes differ on *what* resident choice is and *when* resident choice is to be respected and followed. In addition, early observations and analysis in this study identified two opposing influences experienced by participating RNs. The first is the knowledge that residents have a fundamental human right to be self-determining and to decide on care or outcomes, and that these decisions need to be heard and heeded. The second involves working with a substitute decision-maker who may dismiss or reject the resident’s decisions on care, even where the resident understands the nature and consequences of their choice, which constitutes dismissing their human rights.

In some instances, RNs were found to be immersed in negotiations or mediation activity due to these two paradigms operating simultaneously. RNs were observed advocating respectfully the resident’s right to determine their care and to make choices involving daily activities or preferences. Conversely, RNs were engaged in deciding whether to follow the direction of substitute decision-makers such as family members, peer RNs, medical practitioners and managers. This study established that communicative processes exist within aged care organisations that inform staff about resident wishes, identify substitute decision-makers, and document preferences for care and treatment to advocate resident choice.

Alice and Sharni described methods and approaches through which resident choices are identified, discussed and formally documented. Activities include ‘verbal case conferences’, organisational procedures require ‘case conference with resident, family, GP, allied health professional on admission’ and records such as ‘care plans’ or ‘worksheets’ (Sharni). Phyllis and Noreen highlight the importance of having an effective team communication system in place, so staff are informed of ‘resident needs’, ‘preferences’ and ‘wishes’. Like many of the RNs who participated in this study, they ensure and expect the involvement, feedback and consultation of the residential aged care assistive staff in many aspects of daily living and clinical decision-making to enable resident choice.

Analysis of questionnaire responses, observations and interviews demonstrated that ‘resident or family choice’, ‘relative or resident expectations’ and ‘family wishes’ strongly influence RN interventions. Some RNs acknowledged the importance and advantages of formally documenting resident or family wishes through advance care plans or ACDs. These documents guide future RN practice and care provision for an individual resident in specified foreseeable circumstances.

In certain situations, RNs were observed negotiating or mediating variations of previously determined ACDs, particularly when trying to ensure appropriate resident care and treatment goals or outcomes. In other situations, RNs found it necessary to assert their authority by making clinical care decisions that varied from the expectations or directives of other stakeholders who desired to assert their control over the situation. As a result, RNs experienced difficult and ethically conflicting situations involved in the resident’s quality of life, multidisciplinary team interventions, palliation and dying issues, which often involved the resident, family or medical practitioner. Sharni confirmed such experiences involving conflict arising from simultaneous and differing views about care choices from residents, family, other RNs and facility managers.

Mary raised the issue of family-preferred ACDs and the need to discuss care decisions with family. Nancy highlighted the importance of family cooperation and flexibility in ensuring choices are in accordance with the resident’s preferences. Nancy described a common situation in which the resident chose not to shower one morning. The decision was respected by staff caring for the resident who was offered a wash basin, which was accepted and assistance was provided in bathing. However, the situation of the ‘resident not showering, upset the family more than the resident having the right to choose’ and could result in the residents’ choice being denied to avoid family complaints. In such circumstances, Nancy explains that RNs can become ‘social workers or counsellors, as well as nurses’ and will act as the resident’s advocate by initiating choice or promoting independence in activities.

4.5.2 Resident choice and resident rights.

Other RNs also develop individualised, goal-oriented outcomes associated with ‘resident rights’ to express their ‘own wishes’ by acknowledging and supporting an individual’s efforts to achieve ‘comfort’ and ‘quality of life’. Alice explained that her organisation influences and supports the facilitation of resident choice with the ‘expectation that quality of life be maintained at optimal level’. This embraces the

Australian Aged Care Charter of Residents Rights and Responsibilities embedded in the Aged Care Act (Australian Government, 1997), Kitwood's (1997) person-centred approach adopted within dementia and residential aged care (McCormack, 2003), and specific RN competencies to ensure 'optimal health outcomes' (ANMC, 2006, p. 3). The Charter of Residents Rights and Responsibilities (Australian Government, 1997), affirms the right for residents to determine care, activities and to access treatment options. Of particular importance are the rights and responsibilities such as full and effective use of the resident personal, civil and legal consumer rights. Other rights include the right to access to quality care appropriate to the resident's needs; obtain full information about their own state of health and about available treatments; live in a safe, secure and homelike environment; and move freely both within and outside the residential care service without undue restriction. In addition, residents have the right to be treated and accepted as an individual, and to have their individual preferences considered and treated with respect; have access to advocacy; and maintain control over (and to continue make decisions about) the personal aspects of their daily life, financial affairs and possessions. This study found that the participating RNs endeavoured to find solutions for residents that are compatible with their requirements and advocate resident rights.

4.5.3 Influences of resident factors.

Sharni considered resident's choice making choices in their care as evidence of asserting resident rights, which vary depending on the degree of the resident's cognition and capacity for decision-making. As a result, Sharni prioritised resident choice before the choices of others to ensure advocacy and beneficial outcomes for the resident. In contrast, Bridget considered whether it was 'appropriate for residents to make choices' and expected 'family and health professionals to be 'part of that process' through 'case conferencing'. This raises the issue of resident cognition and capacity to make their own choices. According to NSW Young Lawyers (2010), determining capacity is not about doing tasks competently or undergoing capacity tests. Individuals are considered to 'have capacity' by being 'capable of understanding the nature of the decision … and the effects that that decision will have' (p. 11) on themselves or others, irrespective of any other stakeholder's opinions about the decision.

In aged care, RNs and GPs need to be certain that a resident has the 'ability to understand the nature and consequences of a specific decision' to be considered 'capable' (NSW Young Lawyers, 2010, pp. 11–12). This has led to the increasing practice of ensuring that resident wishes are known by relatives or nominated decision-makers and documented in care records. Formalising preferred care options and wishes is achieved by developing ACDs and advance care plans. Several RNs reported this was usually executed when the resident was admitted to the care facility.

In this study, several aged care RNs acknowledged difficulty meeting the increased service responsibilities including operational management, competing workload and care expectations held by residents and their families. This difficulty is in conjunction with increasing workloads related to caring for residents with complex co-morbidities, inadequate staffing levels and a lack of skill sets of staff for the case mix of residents admitted by managers for care. Erika admitted that care had become 'more demanding' because of 'family, lifting, equipment, computer systems [...] resident dementia and unrealistic expectations from family in guilt of them [resident] being here'. The issue of guilt felt by families who decide to admit their relative to a facility often correlates with the perceived views and fears by families of poor resident care, which negatively affect staff–family interaction (Haesler, Bauer & Nay, 2006).

Family members can often feel guilt after the resident's admission because the person was no longer able to stay at home because of safety or physical reasons, and the family feels they have failed to support them at home. However, resident admission can often promote acceptance by the family carer that they would not have been able to continue to provide adequate care and that admission was the option of last resort. Admission to care can represent a broken promise to the resident or the family, which can cause significant emotional outcomes, including anger or embarrassment (Alzheimer's Australia, 2012).

Residents entering and living in residential care may feel social isolation, family abandonment, loneliness or fear (Tuckett, 2007), which can also coincide with families feeling guilt or other emotions involved in admitting the resident into care. In response, RNs were observed allaying the anxiety of residents and family members, and were clearly conflicted when other priorities took them away from residents when 'holding their hand or sitting with them' (Nancy) or spend time 'talking softly' (Wendy) to soothe them or 'talk to calm them' (Theresa) and making themselves available to individual family members who frequently telephone to speak with the RN about their relative or spouse.

In some instances, older and frail residents fear ageist comments or reprisal from people who lack understanding or are quick dismiss their needs. Residents express fear and anxiety from apathy, increasing co-morbidity or loss of independence and autonomy (Brownie & Horstmanshof, 2012, p. 777), as well as eventual death (Tuckett, 2007). Ageist views held by others, including care staff or other health care professionals can influence the effectiveness of responses to resident co-morbidities, wellbeing, engagement in community activities, access to medical treatment, or appropriate and timely care; therefore, affecting the residents' health and self-esteem. In some cases, anxiety or stress from thoughts, feelings or experiences can reduce lifespan and lower the resident's quality of life and service-related satisfaction. RNs participating in this study were observed advocating for and readily empathising with residents. Such care provision could explain or contribute to the fact that in Australian residential aged care facilities, the average length of stay for permanent residents is 34 months until death (Brownie & Horstmanshof, 2012). This is longer than aged care residents in the United States, who live for approximately 27 months, and those in the Netherlands, who stay for approximately 16 months in residential aged care facilities (Brownie & Horstmanshof, 2012, p. 778).

Through progressive analysis, observed RNs were found to be actively engaged in facilitating PCC by advocating resident rights or choices, and communicating family-preferred care, which was evaluated daily through resident and family feedback about satisfaction with the care and services provided. Facilitating resident choice and resident rights has resulted in residents experiencing greater service satisfaction and improved health outcomes (Access Economics, 2010). Overall, aged care residents are encouraged by RNs and others to engage with life, have a sense of purpose, derive meaning from social participation in activities and be involved in the community (Haesler, Bauer & Nay, 2010).

RNs find themselves in a dual role as clinical practitioners and caring custodians. First, RNs are competent clinical practitioners and multidisciplinary care coordinators employed by a service provider to assess needs, plan and deliver expected standards of care, oversee compliance, and implement Quality Care Principles (Commonwealth Government, 2013). In their secondary role as caring custodians, RNs ensure resident safety, advocacy, offer family counselling, and persevere to fulfil their responsibility to ensure that residents in in the aged care community enjoy ‘a good life’ (Bower et al., 2009) and the right to ‘actively age’ (United Nations, 2011).

4.5.4 Resident choice and PCC verses work routine.

RNs provided varying explanations about the meaning of ‘resident choice’. David referred to activities of daily living and assistance such as ‘clothing, meals and preference’ for activities. He proclaimed that PCC is ‘priority number one’, adding that ‘We can pretty much do everything for the person … and give them choices’. Upon reflection, David clarified that although the ‘meal times are set, we can always go to the kitchen and ask them to make something … clothing we give at least two choices … easy stuff like that’. Eryn, provided similar explanations and references to PCC approaches as ‘they got [resident] rights’ and resident choice to ‘eat in their rooms’, ‘stay in bed’ or ‘choose from the food menu’. However, she reflected that ‘they don’t always get it’ [choice].

In this study, connecting PCC with resident rights, wishes, preferences and choices led to specific questions about what RNs know or understand about PCC. This provided a rich and diverse series of responses that revealed an ethical impasse involving constraints in RN time availability and routinised care activities. In separate instances, Theresa, Erika and Eryn portrayed PCC as ensuring resident rights by engaging in activities such as ‘sitting’ or ‘talking’ with residents, ‘holding their hand’ or singing, but stated they ‘do not have time’ or have ‘differing priorities’ or ‘constant interruptions’ which takes them away from these activities. Several RNs explained that they would like to give residents more choice and consult with them about all aspects of their care and daily living activities, yet they ‘don’t have the time’ (Jacki) or ‘enough staff’ (Nancy) to do it.

Although Thelma believes that PCC acknowledges resident preferences, she insists that residents must conform to the facility routine. She said that ‘We ask the family what is their [resident] routine. We have routines here, but, if it doesn’t suit the resident, then we do explain to them that they have to follow our routine to some extent. But, we will try to fit them in’ (Thelma). Sachi agreed that ‘they got the right […] and get what they want, but we can’t always follow them’, suggesting that resident preferences and wishes are respected but not always accommodated due to the routinised models of care.

When asked whether the RNs thought PCC had empowered people, Noreen retorted, ‘who is being empowered, people like residents or the family members?’ She continued, ‘most of the residents don’t feel that empowerment, only the ones who are new to the facility [and] who have not been institutionalised. These [people] would be empowered to ask for, and become more needy, and they see their needs. They see they are paying this amount of money, so I should be getting this’ (Noreen).

Nancy works in an organisation that aligns residential aged care services to business customer service principles by actively encouraging staff to offer ‘value for money’ services to their shareholders, which are the residents and families. Sharni also works in a facility in which the ‘family expects [that] our job is to care for them [family needs]’. In a separate observation, Alice explained, ‘what they want, we will help them out to have what they want’. By adhering to a customer service approach, age-care providers will be able to smoothly transition to consumer-directed care, which is a feature of the Living Longer, Living Better (Australian Government, 2012b) aged care reforms where services will be coordinated within a fee-for-service arrangement dependent on consumer-assessed needs, service availability and choice.

As a result of the customer service focus, Jenny was observed ensuring that the residents and families were happy with care. In her approach, Jenny directly asked whether their needs were met, and offered encouragement for the family to become involved in the care and understand the different aspects of care. Jenny described PCC as a ‘holistic approach to residents’ that ‘involves the whole family’, recalling instances in which family and staff work together to walk, assist with meals or spend time with residents. RNs working in different facilities were observed checking and evaluating care through residents’ and relatives’ feedback during their shift. In particular, RNs asked residents or their families whether the care provided during the shift had matched their expectations (Debra & Jenny). This evaluation process confirms the influence that families have on directing care and influencing resident outcomes, as well as the professional approach nurses have to service provision.

4.5.5 Influences of resident choice and family wishes on RN decision-making processes.

During this study, RNs were frequently observed consulting with the residents or their families before making clinical decisions and undertaking interventions. RNs explained the practice of ensuring that ‘resident relatives’ wants come first’ (Debra). This sentiment was reiterated by Alice who stated that ‘residents and relatives have the right to choose their path—we do not’.

On several occasions, Bridget, Alice and Sharni commented that resident choice is achieved by meeting ‘resident and relatives’, ‘expectation’ or ‘wishes’. Resident and relative wishes were evident in ACDs and care plan consultation processes. In particular for Sharni, achieving resident-family wishes was considered a ‘quality outcome’ measured by resident or family satisfaction that the care services provided met the standards they expected.

In January, 2014, the Australian Aged Care Quality Agency commenced operations following enactment of the Australian Aged Care Quality Agency Act, 2013 (Australian Government, 2013a). This agency ensures aged care services maintain quality aged care standards of the Aged Care Act 1997. The Residential Care Manual (Australian Government, 2014) views that accreditation will ensure ‘the civil, human and legal rights of older people living in subsidised aged care services are protected’ (p. 175) and that providers ‘must have in place systems, services and staff that respect the rights of residents’ (p. 176) in addition to meeting statutory and legislative requirements.

The Residential Care Manual (Australian Government, 2014, pp. 184-188) upholds that resolving complaints within an aged care service in the first instance can achieve timely and sustainable solutions that lead to improved aged care services for older Australians. The Complaints Principles 2011 and Quality Agency Principles 2013 (Australian Government, 2014, p. 187) help establish guidelines to deal with aged care consumer complaints as they identify gaps that indicate where resident rights need to be protected or service expectations addressed (Australian Government, 2013b). An aged care facility is considered quality if it is compliant with aged care standards, quality of care principles, relevant legislation, and ensures transparent processes of continuous improvement that include best practice and meet service delivery expectations.

RNs in this study were observed frequently checking resident needs, levels of resident or family satisfaction with the service provision, as well as undertaking service-risk assessments and mitigating potential or actual complaints to avoid ‘trouble’ (Debra) and meet stakeholders’ service expectations. Stakeholders in aged care include families, government, accreditation and standards bodies, multidisciplinary health care teams and employers. De Bellis (2006) established that in aged care ‘persons and agencies outside of the nursing profession constructed nursing care' and that 'nursing and nurses have been silenced and the dominant discourses are eroding the value, as well as the reputation of nursing' (pp. 297–298). The RNs in this study shared similar experiences to those described by Debra about intense stakeholder scrutiny posing risks to professional standing and career prospects.

Aged care RNs are responsible as team leaders and clinical managers to ensure organisational compliance with accreditation standards, continuity of care protocols and the maintenance of stakeholder satisfaction. Quality of life is viewed as a measure of resident comfort, lifestyle engagement and self-determination leading to satisfaction with the standards expected of the delivery of aged care services (Penney, 2006). For some aged care providers and government agencies, quality involves scientific measures of specific clinical indicators such as the number of wounds, infections, psychotropic medications use. For others, it is the non-clinical indicators of the residents' quality of life. These providers align quality of life indicators with evaluations of PCC services that deviate from routinised care to models involving resident-focused decisions and self-preferred routines in care and service.

Higgs and Jones (2000) describe the shift from traditional clinical models of decision-making to that of 'nurse-client facilitation' viewed as 'clinical reasoning' (p. 4). Within this shift, care is facilitated within a framework of understanding, involving communication between the client or resident and the care staff to ensure resident self-determination of care activities and negotiating personalised outcomes that are advocated and supported by staff. This decision-making paradigm changes the professional role of the RN from an autonomous clinical decision-maker to a partner and coordinator of multidisciplinary team-managed care within a holistic person-centred approach of service provision, which is aimed to result in positive outcomes for the resident and the care team.

In aged care, RNs focus on a holistic view of quality care managed within a legislated framework and evaluated by a mandated accreditation process. A quality resident outcome depends on the skills, knowledge, expertise and resources of care staff to ‘ensure that the treatment or care is effective in that it achieves the intended outcome […and is] effective in that it “works” for this person with these co-morbidities, in this context, at this time and it is what the person chooses’ (McAuliffe et al., 2010, p. 26).

McCormack (2003) states that person centeredness is the alliance of patient values, nurse’s values and expertise, and the context of care. Evidence from his study suggests that within the context of Australian aged care, resident values or dominating family values can sometimes be at odds with each other, and therefore compromise PCC principles, organisational reputation and undermine the values and expertise of professional nurses.

During the observation, Jenny was seen working through a situation in which a long-term palliative care resident was transferred to hospital as a result of expressed family wishes, which overrode the choice the resident made when she was cognitively aware to remain in familiar surroundings, and die with dignity in her own room. The resident’s wishes were widely known and thoroughly documented in the weeks prior to this event through an advance care directive negotiated with the gravely ill resident, present family members, and managers. The organisation’s policy aligns to PCC, so by completing an advance care directive, the residents’ right to make such decisions and have their wishes respected should be asserted. As the RN on duty, Jenny urged all involved to respect the dying resident’s wishes to stay in the facility until death but this was overruled by a family member. Therefore, while nurses and other staff supported the resident’s choice not to be transferred to hospital, the transfer occurred because certain family members insisted their right to decide take precedence over the resident’s right to decide.

Clearly, in this situation, as the reality of the resident’s imminent death approached, the previously documented decision was being viewed differently by the family when confronted by the likelihood of losing their relative. The previous decision of the resident was replaced by the family’s revised wishes, prompting a variation of the resident’s care directive by the son who was acting as the person responsible (legal guardian). As a result, the organisation was required to respect the authority of the person responsible to make the final decision. The son asked that the resident be transferred to an emergency department as soon as possible because he was dying. The son was not emotionally prepared for the finality of his father’s death. Moreover, he could not reconcile his grief and was overcompensating by trying to save his father’s life, rather than accepting his father’s fragility and impending death.

Jenny was observed to support the father’s wishes to die in familiar homely surroundings with respectful staff caring for him. Jenny advocated resident wishes in an attempt to uphold ethically and clinically the residents’ choice for palliative care until death, until eventually the executive manager of the organisation overruled Jenny and agreed to the transfer to an emergency department. During her interview, Jenny explained she quickly had to concede when she was reminded of the theoretical risk of a complaint and grievance proceedings against the facility that would arise by delaying the son’s request to transfer the resident to hospital before the resident could die in the facility as he had wished.

Many RNs in this study acknowledged ‘family consult and control care’ (Wendy). This reveals the influence that families have on resident outcomes by asserting that they are making resident choices and preferences through substitute decision-making processes. Wendy raises the issue that clinical care decisions are sometimes at odds with the residents' choices and their rights. On reflection, Wendy confirmed her resolve to advocate and meet the wishes of residents in her care with the following empathetic analogy: 'If it was my mother or father, I would be really making sure they were heard and things were done their way'.

Although RNs attempt to advocate for the resident, their professional judgement or rationale is often discounted by or subjugated to the resident's right to self-determination. In situations such as these, the family can successfully overturn a resident's dying wishes by proxy of the resident's right to self-determination. Other instances arose over the course of this study that demonstrated the dominating effect of family members on the manner in which residents live their lives, including choices about their diet, clothing, engaging in community activities and social functions or, in some cases, opting not to engage.

Participating RNs confirmed that they had experienced situations within practice in which resident's wishes and choices were dismissed, along with the expertise and advice of the RN. In several instances, resident choice was rejected by family members who had differing perspectives about care and asserted their legal authority to make decisions about care. This study found that some participating RNs do not believe they are in a position to advocate for residents against family members who have competing views about ageing, quality of life or quality of death. Part of the RN assessment of such situations includes estimating the ability of residents' families to deal with personal grief and accept familial loss, and their capacity to understand the complexities of ageing processes.

In such circumstances, RNs were found to experience ethical dilemmas or were forced by their employers to accept the authority of substitute decision-makers. Conversely, several RNs advocated on behalf of the resident with varying results that reflected well on RN or organisational credibility and resident wellbeing. As team leaders, RNs were observed to empower residents, inspire staff and reflect on practices. Such characteristics are deemed important in the implementation of PCC (Brownie & Horstmanshof, 2012, pp.782–783).

4.5.6 Summary: Evidence of informed clinical decision-making.

Observation of aged care RNs in their practice context and conducting the follow-up interviews afforded an opportunity to identify meaningful and purposeful situations of resident choice, acts of associated critical thinking, RN interactions with others and actively reflect on events. From the onset of data gathering and through progressive analysis, five unique characteristics of care were identified in which RNs experienced conflict or were influenced by others in their decision-making. The five characteristics increasingly evident within clinical decision-making situations are the RNs’ own ethical stance; resident advocacy; substitute decision-maker influences (expectations); organisational policy; and the assertion of clinical authority to provide continuity of resident care.

Upon analysis, person-centred aged care can be described as a dichotomy of opposing and comparable values that can significantly influence decisions, continuity of care and resident outcomes. The values consist of ethical and moral perspectives, and clinical decisions that in certain situations require the RN to assert one view or yield to another. This study has identified a number of conflicting perspectives within aged care policies, procedures and practice.

Policies can include government and organisational statements of endorsement of certain actions and procedures to provide instructive guidance for those enacting the policy. In aged care, the policy and procedure for person-centred practice is aligned with the espoused values of the organisation, public or government policy and community expectations. During an observation in a facility that adopts PCC values, one RN ceased advocating for her resident who had expressed the wish to stay in the facility to die in her room with dignity. Her wishes were documented in an advance care directive completed previously with the manager. However, conflict arose when the family opted to transfer the resident to hospital. Anticipating a complaint from the family or grievance processes from management, the RN reluctantly conceded to the family's wishes and manager 'advice', thereby failing to advocate or respectfully meet the resident's wishes.

As a result of such risk management processes, neither the RN nor the manager applied the values of PCC. Furthermore, they did not adequately communicate these values to the family enforcing their demands. As a result, the PCC values of upholding resident self-determination, ensuring resident advocacy, ensure respect by acceptance of resident wishes to remain in her own room, maintain resident self-dignity and her right to a peaceful death in her own room with those who care for her were ignored and unheeded.

Practice is the action that occurs that may or may not reflect policy or procedure. In several observations, RNs implementing PCC were able to change policy, procedures and practice from institutionalised or routinised care, resulting in advocacy of resident choice with positive effects on resident outcomes. According to Brownie and Nancarrow (2013), implementation of practice of PCC improves staff attitudes and satisfaction, as well as resident or family satisfaction with care services.

Debra emphasised the following in ensuring she execute PCC: ‘I need to know the policy […,] I just want to make sure, what I’m doing is the right thing [...]. In making decisions, I need history of the resident. I need to know the wishes, and speak with the family, or the nurses who is really doing the care’. This aligns to Scott’s (2010) concept of RNs positioning themselves according to the particular situation to do ‘things right’ (p. 89). Ethical tension is likely when confronting and advocating care interventions or yielding to the wishes of others in directing care.

4.5.7 Evidence-based thematic statement: RN socio-ethical conflict in decision-making.

RNs can experience socioethical conflict when making decisions to attempt to ensure resident choice or when implementing person-centred models of practice that could compromise resident clinical outcomes or wellbeing. Similar conflict occurs in situations in which RNs assert their autonomy as health practitioners and clinicians to defend resident choices against management and family influences that would deny them such choices. Throughout the above discussion, issues of power and influence emerge as key factors in shaping the role of RNs in the aged care context, as well as their clinical decision-making and professional role performance. Therefore, it is important to examine these situations to illuminate the processes involved.

4.6 Theoretical Discourse Analysis: Applying George Herbert Mead’s Developmental Social Psychology Actor’s Theory

In the *a priori* situations used to focus data collection, RN decision-making processes were found to be influenced by resident or family preferences that were incorporated into care planning and used to direct care. Adoption of differing versions of approaches to PCC across Australian aged care settings has affected RNs’ authority as professionally competent coordinators of clinical care. An increasingly ageing population and diminishing aged care RN workforce feature within proposed consumer-directed aged care reforms, that is, Living Longer, Living Better (Australian Government, 2012b), which further compromises the role of RNs, service delivery and aged care work practices.

As coordinators of consumer-directed care with responsibilities for service-related compliance, RNs will increasingly encounter clinical–ethical dilemmas associated with operational responsibilities and desired outcomes for residents by the various stakeholders. These dilemmas are explored and described using Mead's actors' theory (1934, 1938). Grounded theorists Corbin and Strauss (2008) use the interpretive symbolic interactionism of Dewy (1929), the perspective reflexivity of Blumer (1934, 1969), and Mead (1938) to analyse the data from the perspectives of RNs immersed in a complex working environment that is distinctly different from the work environment of mainstream health care services. The use of Mead's theoretical principles (1938) in this analysis enables the reconstruction of meaningful interpretations of qualitative data obtained through observations, texts and interviews.

Corbin and Strauss (2008) found that 'knowledge arises through the acting and interacting of reflective social beings […] precipitated by a problematic situation, where one can't just act automatically or habitually […] and where the behaviour is the resolution of the problem' (pp. 2–3). This is of particular relevance to the current study investigating clinical decision-making influences on RNs working in aged care.

Glaser and Strauss (1967) held that grounded theory has two theoretical paradigms: pragmatism and symbolic interactionism that are exemplified in Mead's work (1938) and are relevant to this study. Pragmatism involves rationalising and metacognitive analysis 'to resolute or explain' qualitative data collected (Jirojwong, Johnson & Welch, 2011, p. 119). Whereas, symbolic interactionism involves 'meaning, language and thought' (Carlson, 2013, pp. 458–459) in which 'the relationship between individuals and society' (Schreiber & Stern, 2001, p. 178) is composed of symbolically constructed objects that are meaningfully interpreted or differentiated and negotiated according to their functionality or purpose.

By adopting the analytical process of Mead's (1925, 1934,1938) actor's theory, this study describes aged care RNs and key stakeholders in aged care through their social interactions, either as individual entities known as 'selves', contextualised objects, or as a group known as 'collective selves' interacting with others or objects filled with agency or purpose.

4.7 RN Perspectives Discourse

By using RN perspectives identified in this study, it is possible to obtain an understanding of the RN as an individual identity termed a 'self' or acting as a working tool of the organisation responsible for care services. Exploring the working context of RNs by adopting this analytical approach, various independent and dependent relationships encountered by RNs were obtained (Perdue, 1986; Woolf, 1998). Each relationship requires RNs to communicate with others that are also an individual self or in a group collectively called selves who are filled with their own agency or purpose and desire to achieve an expected outcome from the encounter between them and the RN.

The aged care RN is viewed with detachment using Mead's (1925) theoretical paradigm. This facilitates a descriptive form of objective analysis of RNs in an aged care context, their sense of purpose (or agency) when acting to cure or comfort, or meet resident and family wishes, constrained by constructs of their circumstance, which include management and clinical functions, legal responsibilities, staff skill availability, resources, physical surroundings and organisational support. The rationale in using

Mead’s (1925, 1934) actor’s theory is more than inviting an empathetic reflection of the views of RNs working in aged care. Application of developmental social psychology works to deconstruct objectively circumstances, events and perspectives associated with RN decision-making processes and resident outcomes related to such decisions.

In many situations, RNs perform the social act of engaging and interacting with people who have multiple individual points of view of their role and that of others around them, and all these points of view influence RN decision-making processes. RN considerations and encounters involve the following: resident and risk assessments of varying degrees; interpretations of resident needs; and the navigation of political, societal and familial agendas. Throughout this study, RNs were observed demonstrating an ability to conform or respond to diverse and unique attitudes in others and in the self; apply ongoing reflection of their practice; ensure the implementation of policy and procedural elements in their practice; and provide evidence-based service provision of clinical and non-clinical nursing care.

Through the use of the five study situations (see Appendices A,B, C and D), seven RN functional characteristics associated with their scope of practice were identified and symbolically interpreted using Mead’s (1925) theoretical concepts. These included RNs operating in the following roles:

1. business managers responsible for the delivery of aged care service
2. coordinators of clinical care
3. facilitators of PCC
4. practice innovators
5. not engaging in practice
6. maintaining routinised or institutionalised services
7. consultative or non-consultative professionals.

4.7.1 RNs as business managers responsible for the delivery of aged care services.

RNs experience changes in functionality depending on their current role, which can include being an operational manager of care service delivery, a clinical professional, empathetic grief and loss counsellor or assertive advocate, as well as other roles involved in their nursing responsibilities. By applying Mead's (1925) theory, cognitive descriptions of social and action-related encounters of RNs can be highlighted. For example, in aged care, RNs working in the role of manager can be characterised as an instrument or tool of the organisation. That is, they can be viewed as an object to effect care services. Therefore, they act accordingly in that role to perform their duties to ensure operational requirements are met and services are delivered as planned.

As an object of care, the RN interacts professionally with organisational (or other) collective selves (Mead, 1925, 1934). These selves have their own sense of agency or purpose by which they construct and uniquely imply intent of actions or achievement of expectations from the relationship they have created with the RN to produce anticipated outcomes. The outcome of the interaction when the RN is an object is that the RN must either act or yield during the interaction. An example, in the aged care setting can involve the interaction by the director of nursing operating as an object during an accreditation visit or food-safety inspection communicating with the auditor selves, that is, individuals with different perspectives from a legally authorised organisation tasked to inspect the service for compliance with legislation.

Alternatively, the RN as a self in a management role through effective communication and prevailing agency can assign tasks to other selves, such as staff, who in turn view the RN as an object of the organisation and not as a self, like themselves. Staff selves are required to act or yield to produce a directed or optimal outcome from the interaction with the RN. In practice, an optimal outcome may result when negotiating staff rosters or delegating nursing tasks.

4.7.2 RNs as coordinators of clinical care for residents.

A report of the operation of the *Aged Care Act* 1997 (DOHA, 2010) confirms that in aged care ‘Nursing care is combined with accommodation; support services (cleaning, laundry and meals); personal care services (help with dressing, eating, toileting, bathing and moving around); and allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry)’ (DOHA, 2010, Section 5.1). As clinical coordinators, RNs use their clinical skills and expertise as tools of the organisation engaged in the business of providing aged care services to residents viewed as service objects.

As an object in the position to coordinate care for residents, the RN is at the same time an individual self with agency to provide cure or comfort for residents that are viewed as objects to which care is to be applied. From this perspective, the RN’s aim is to meet resident needs as effectively as possible, and in a timely manner to achieve the best clinical outcomes. To achieve this, the RN self must interact with the residents (the objects of care) to establish a construct in which care is to be delivered. This delivery of care is individualised, negotiated and aligned to resident expectations through effective coordination of care elements available from a multidisciplinary team, which is also subject to financial constraints imposed by the organisation. Residents are termed the collective selves with the expectation that the object (care) is satisfactorily provided by employing competent tools (staff).

4.7.3 RNs as facilitators of PCC.

In PCC, an RN self will interact with a resident self with the object being care. This creates a shift in the dynamics of the relationship between the RN as an instrument to deliver care and the resident as the object receiving care, although care is constructed through the interactions of the RN self and resident self. By communicating their perspectives and intentions in setting expectations and achieving care goals, the outcome benefits each self.

Through this approach, members in multidisciplinary care teams are also selves as the residents are also ‘themselves’ with care being the object. Complexity arises for resident selves, RN selves and team selves when additional selves of resident families, organisational selves and compliance-responsible selves are established. Each self and the collective (group) selves have their own sense of agency or purpose and the intent to contribute through their interactions to the construct in which care is to be delivered. In many situations, there are multiple selves emphasising agency and intent on the team selves, in particular, the RN, who is now positioned within a dual role of both self and object. In such situations, all selves engage in negotiation and compromise to influence the object of care provided by other selves and thus, the quality of care delivered can be changed.

For some of the participating RNs in this study, the experience of encountering such situations on a daily basis affected their level of engagement with their work, and their ability to be flexible or innovative. In the milieu of person-centred residential aged care services, RNs who act naively as a ‘selfless self’ by seeking to help others using only compassion and knowledge, can find themselves in roles involving facility management and regulatory compliance risk management coordination. RNs may become objects through which care is coordinated and delivered via methods that are constrained by conflicting and multiple demands or expectations. Consequently, when viewed as an object, the RN responsible for care services is subject to intense scrutiny by stakeholders seeking resolution or reassurance about meeting their own needs.

Through an ethical and clinical lens, RNs reflect on their performance as objects to deliver care. This process of reflection by participant RNs was found to be a cause of tension between feelings about professional competence and personal failure.

Eunice revealed the conflict she experienced. For Eunice, the dual role of coordinator of care and direct caregiver was problematic. In her interview, she explained that in addition to her RN role with medication administration responsibilities, she found herself doing other care tasks such as cleaning up or toileting residents. However, she said, ‘but I see that also as part of my role, but I sort of see my role merging with either side’. Eunice reflected that she found it difficult to say ‘no’ to someone requiring her attention when she is busily involved in meeting another resident’s immediate needs. She stated, ‘but, I’m getting there—I am getting there’, implying a role-related conflict and acceptance of her limitations in satisfying the multiple demands of others.

Mills, Francis and Bonner (2007) established that nurses have ‘different perspectives of self’ framed by their ‘culture, politics and practice’, which can create situations of ‘professional compromise’ (p. 16). Eunice revealed both professional and personal conflicts when hesitating to assist a resident with toileting. Mead’s (1925) theory helps to interpret the situation that confronted Eunice by exploring the unique individual perspectives that abound within the context of aged care RN experiences.

Eunice hesitated as she was engaged as an object of aged care services when requested by a resident operating as an individual self to assist with a need to be toileted. The *act* of toileting is a function performed by non-regulated care attendants (collectively termed the ‘generalised other’). Care attendants are employed by organisations (also a generalised other) as objects or tools to convey care that is clinically designed and coordinated by RNs working as an independent and clinical professional self who is also viewed a tool of the organisation.

By saying ‘no’ to toileting the resident, Eunice responded as the clinical professional self who considered the professional effect of the act. The act creates an ethical–clinical dilemma as the choice either conflicts with her personal empathetic self or competes with her RN tasks or leads to possible consequences from care attendants who maintain traditional and specific cultural norms in their work role. Eunice resolved the dilemma by delegating a carer self to act after denying the resident request due to workload priorities.

4.7.4 RNs engaged in innovative practice.

This study identified situations in which RNs were influenced in their levels of engagement in care activities and responsibilities through their professional commitment, experiences and relationships involving their employing organisation, managers, peers, residents, families and other stakeholders. Levels of engagement were identified through the actions of some RNs who desired to develop as clinicians in an evolving specialist area in aged care and to demonstrate commitment to improving their own practice.

When analysed, data from observations and interviews revealed several RNs exhibiting examples of action-based research or demonstrated them using evidence-based practices and employing reflection of their own practice and the practice of others to improve care and treatment processes, and resident outcomes. In contrast, two RNs with more than two years of aged care experience were observed avoiding innovative, reflective or responsive aged care practice and consequently, intervention or support from another RN on duty was required to guide and oversee their practice outcomes. The varying levels of engagement that influence RN decision-making processes were categorised as working attributes of RNs operating as innovators or engaged; RNs not engaged; RNs working to institutionalised routines; RNs working consultatively; and RNs working non-consultatively.

Phyllis demonstrated her engagement in practice during her observation. In her role, Phyllis was responsible for following-up on resident care, including medication administration delegated via rosters to non-clinical staff. She was also responsible for coordinating daily activities of the multidisciplinary team members including GPs and physiotherapists. Engagement in her practice moved Phyllis through the roles of coordinator of care, resident advocate and direct carer with the expectation that she executed these roles effectively.

Two RNs in particular were found to be highly innovative and engaged in nursing, as well as in improving their practice. Alice claimed that she had ‘resolved long-term chronic skin wounds and conditions’ of residents by self-focused research, applying evidenced-based practice, evaluating wounds and reflecting on their outcomes. Likewise, Louisa said she had updated clinical skills in wound care through external postgraduate studies and used ‘common sense’ in choosing cost-effective wound-dressing regimes. Alice and Louisa worked in different organisations and were observed to be enthusiastically engaged in their work as selfless selves driven by a commitment to continuous improvement to achieve best practice in wound care, which is the object gained through their actions.

4.7.5 RNs not engaged in practice.

Conversely, Wendy did not appear to want to be engaged in certain activities such as medication administration or working with a resident experiencing dementia-related unsettled behaviour. In an example indicating non-engagement, Wendy accepted information from the delegated medication administration staff member that pain relieving PRN medications had been requested by a resident during the past week and had been administering the medication on a regular basis for that resident. In practice, such a situation would have prompted a pain assessment by an RN or GPs review and perhaps would have resulted in changing a prescription to more regular administration. However, Wendy did not act on the information given by the resident until requested by another RN to act.

In another situation, Wendy avoided confrontation with a cognitively impaired resident who was exhibiting escalating unsettled behaviour. Other staff were called by Wendy to calm the resident, stating the she ‘didn’t like upsetting anyone’, thus, avoiding the tension associated with conflict. Wendy acted not as a professional self but as an individual protecting the self by not engaging in the object of care with a person acting as an unpredictable self.

4.7.6 RNs as maintainers of routinised or institutionalised services.

Eunice, who has been an RN for 42 years organises her routine by creating a mental list of daily activities. Eunice explained, ‘That is the thing I start thinking about when I get up, but I never do it. I do have a plan, sometimes it happens, but not very often, though. Today, we had a black out!’ Eunice reflected, ‘that’s what I mean about distractions. There’s always something always happening—it throws me out. But I accept that it’s part of the job’. By creating a mental list, Eunice provides herself with a structured traditional and methodical routine and she is able to ‘tick off’ items on the mental list as tasks are completed.

During her interview, Eunice claimed, ‘Well every day I come in and I plan things in my head—I’ll have my pills done by such and such a time. The first thing I do when I come in is I get all my medications ready. Then, I’m going to do my residents of the day follow-up after handover. Then, give out my medications, do my treatments, come back to the computer and do some assessments’. The problems of relying on a mental list to provide care as the object of service delivery became further evident in Eunice’s interview. Eunice claimed that ‘if I ask them [residents] and they tell me they are okay, then I can go onto the next person and I can forget about them, so I can then concentrate on the next person in my head. But, I’m still aware of them, and if they said they want to go to the toilet, then I can go back to help them … maybe that’s my training’. Eunice’s task-oriented thinking enables her to maintain focus and regain control when ‘distractions’ such as a blackout occur. For Eunice, ticking off tasks provides a quantitative measure of work achieved or completed during her shift in which she works as a tool of the organisation. Through reflection, Eunice asserts that the written list gives her a sense of doing the right thing at that time and the satisfaction of knowing that she did her best while thinking about improving outcomes for the future, again becoming a selfless self.

4.7.7 RNs in consultative or non-consultative practice.

The process of consultation on clinical decisions was found to depend on the availability of another RN with whom the RNs could discuss considerations, decision-making options, interventions or evaluation strategies. Several RNs were observed working independently in leading their non-RN care teams. In addition, these RNs were also responsible for operational management decisions as required if on duty outside administration office hours. Contact with other RN staff was observed in situations of emergency or unforeseen circumstances, at which time a supervising RN would be notified and attend the care unit.

In situations in which RNs were available to consult with each other, they did so to varying degrees, engaging as collective selves working for the benefit of the resident. In some cases, as previously described, RNs would consult each other either before, during and/or after decisions were made. In these circumstances, the RNs valued being able to consult with another RN and being able to receive collegial support as required. However, consultation was observed to have been initiated by RNs on an individual case-by-case basis, and not executed routinely. The literature supported this finding and established that RN decisions-making processes involve situations in which experience or intuition combines with new data to enable clinical reasoning and development of interventions in their context (Scott, 2003).

4.8 Significance of Findings in Understanding RN Perspectives

Considering the literature related to job satisfaction, it could be argued that different levels of engagement are indicative of RN job satisfaction. Aged care nurses in this study often had poor levels of job satisfaction that could be related to inadequate professional recognition or organisational support, a finding that is consistent with earlier studies (Al-Hussami, 2006; Scott, 2003).

This lack of acknowledgement of their nursing input, posed risks to their continued relationship with employing organisations impacting on their level of job satisfaction while they attempt to maintain their duty of care and sense of professional obligation to care for residents. In some situations, failing to acknowledge nursing input could be misinterpreted by the organisation as professional commitment. Such an attitude in an organisation indicates that the organisation lacks commitment to quality and safety in resident care.

4.9 Conclusion

There is evidence to suggest that some RNs in this study were dissatisfied with their work or with their organisation, and that this influenced their level of commitment. Further investigation into RN levels of engagement and job satisfaction needs to be undertaken to identify both systemic and personal causal factors in declining rates of RN participation in the aged care context.

Chapter 5: **Emergent Theory**

5.1 Introduction

This chapter discusses emergent theory and the mapping of the effect on aged care RN decision-making of clinical–ethical, and legislative and employer influences. Recommendations for further investigations into aged care RN practice influenced by government policy and stakeholder expectations are listed to address gaps in knowledge and promote discussion regarding policy to RN practice implications.

5.2 Aged Care RN Decision-making Processes

The process of making an informed or competent decision requires an understanding of the manner in which knowledge is acquired, applied and linked to elements in the RN competencies or expertise that are necessary to produce resident beneficial or positive clinical outcomes (Benner, 1984; Cooper & Mitchell, 2006; Dwyer, 2011). The quality of RN decision-making is influenced by the context of practice and the RN's communicative competence in social and interactive skills, personal attitudes, expertise, cognitive proficiency, and reflective practices, as well as the resident's capacity to make informed decisions (Duff-Cloutier, Duncan & Hill-Bailey, 2007; Pelletier, Duffield & Donoghue, 2005). Moreover, outcomes are measured on 'success […] realized from the client's perspective' (Higgs & Jones, 2008, p. 8).

This study analysed data collected from 28 RN participants working in different aged care services and from research on other sources of RN decision-related influences such as guidelines, models and clinical decision characteristics. Two government policy influences on aged care nursing practice and two RN decision-making guidelines or models were identified as relevant during this study, as well as six emergent themes to explain specific context-related influences on RN decision-making. These policy influences were evident in one or more of the commonly occurring clinical decision-making situations that focused on influences being exerted on aged care RNs.

By adopting grounded theory coding processes to evidenced-based themes and literature, a series of significant elements were sorted into categories to reveal four specific domains of influence on aged care RN decision-making processes and their effect on resident outcomes. The domains are the following: scopes of practice, care expectations, employer-delegated decisional authority, and prevailing regulations. These four domains are differentiated into two distinct spheres of influence within which RNs operate. Figure 5.1 depicts two operational or functional domains that are found to operate both independently or simultaneously to influence clinical decisional pathways or nursing practice in accordance with the individual RN's professional ethical–moral position.

The top two cells of the diagram describe the RN's operational domain. This is characterised by the RN's scope of professional and individual practice and prevailing regulation or legislative compliance including health care and resident rights requirements to provide competent care to ensure clinical–ethical outcomes that benefit residents. The bottom two cells describe the employer's operational domain that involves the management of care expectations and delivery of services aligned to regulatory-compliant services.

The findings reveal that in addition to fulfilling their clinical professional obligations (depicted in the top section), employers (depicted in the bottom section) also expect and direct RNs to maintain operational administration and service-related compliance. In managing residential services and related human resources such as staff allocation, employers assume authority to delegate specific RN tasks to care service employees (assistive care staff) and allocate operation-related tasks to RNs. Both stakeholder domains are characterised by family and resident care expectations on one side and employer obligations on the other.

These influences combine with emergent theory and analysis of aged care decision-making guidelines and policies that influence concepts of practice in several types of Australian aged care settings. The resulting Australian Model of Nursing Practice in contemporary aged care RN clinical decision-making reveals two aged care operational levels working simultaneously. The first level indicates RNs’ claim to be operating according to their scope of professional and individual practice within the constraints of their legal responsibilities to implement safe and effective clinical care. The second level demonstrates that employers were found to operate according to their own expectations and those of stakeholders, resulting in the delegation of clinical tasks and nursing work to increase the efficiency of service delivery and through that process, limiting RN professional authority.

RN Scope of Practice	**Prevailing RN Regulations**
Individual scope of practice involves contexts and settings in which practice is applied, including model of practice. Professional scope of practice involves meeting a specified level of competence.	These include the *Aged Care Act* 1997 and Quality of Care Principles and the Charter of Resident Rights and Responsibilities, as well as other legal requirements, government policy directives and aged care industry reforms (Australian Government, 2012b; Coalition Policy, 2013). **RN Operational Domain Employer**
Care Expectations	**Operational Domain:** **Employer-delegated Decisional Authority**
Stakeholders include RNs, government, residents, families, allied health professionals, medical practitioners, managers and employers.	This includes delegating RN tasks, ACDs, care intervention approval, leadership approach, level of support for RNs, and resource management.

Figure 5.1 Operational domains.

The results of this study indicate that participating RNs work and acquire skills according to their scope of practice in professional care and their aged care experience, which facilitate the development of their expertise. Their experience and practice are enhanced by a holistic assessment of individual residents that supports the application of a care plan that meets the clinical and quality of life needs of the resident. Expectations of RNs align to competency standards in individual nursing practice first established by the ANMC (2007a). These standards were highlighted by Higgs and Jones (2008) as key influences on nurses’ clinical reasoning.

Following legislative restructure in 2010, state-based professional nurse registration and professional authorities were replaced by the *Health Practitioner Regulation National Law Act* 2009 (AHPRA, 2009). Consequently, the ANMC was renamed the Australian Nursing and Midwifery Accreditation Council (ANMAC) and held core responsibilities for creating RN tertiary accreditation standards. In 2012, the NMBA adopted the ANMC’s (2007b) ideas about individual nursing practice and the influences placed in such practice by contexts of practice; consumers’ health needs; the nurse’s level of competence, education, qualifications and experience; the service provider’s policy, quality and risk management framework; and the organisational culture (ANMC, 2007a, 2007b, pp. 22–23). By identifying these influences on individual nursing practice, the NMBA revised the ANMC (2007) decision-making flowchart to guide nurses and midwives in making decisions about everyday practice and changes to practice over time to meet the health needs of their clients. The revised decision-making guidelines are featured within the NMBA’s (2013) national framework for the development of decision-making tools.

There are four RN decision-making principles in the NMBA (2013) flowchart, one of which affirms the ‘joint responsibility’ (p. 8) for care of RNs and employers/managers. Principle four highlights the collaborative measures RNs and organisations or managers must undertake to maintain the work environment and ensure evidence-based practice is supported to the ‘full extent of the scope of nursing practice’ (NMBA, 2013, p. 8).

For some RNs, expectations of support to fulfil their scope of practice and continuity of care may be impeded by managers (employers) who do not have professional health qualifications and can lack sufficient clinical understanding to provide appropriate support for RN clinical decisions. Managers may also use policy for clinical outcomes to dominate their decisions to try to ensure they meet stakeholder expectations. In such circumstances, RNs feel unsupported by the manager and feel constrained as decisions that are financial or related to case management can affect their professional practice and undermine continuity of care, resident quality of life, and the achievement of safe and effective outcomes for residents.

5.2.1 Influences: Aged care decision-related flowcharts and models.

McDonald’s (2007, 2011) aged care-specific model of practice emphasises considerations for resident choices in comparison to the broad generalised NMBA (2013) flowchart for nursing decision-making processes (ANMC, 2007). McDonald (2007, 2011) acknowledges the influences of PCC or consumer-directed care on decision-making processes in nursing. The NMBA (2013) flowchart follows a decisional pathway towards a beneficial health outcome for the patient, rather than an improved quality of life outcome, which is often the overriding priority in aged care. This priority is evidenced in this research study that demonstrates that RN ethical considerations are sometimes overridden by unrealistic curative or life-prolonging expectations of family members, despite the pain and suffering their interventions cause on their relative (the resident).

This study's analysis of these two decision-making approaches revealed similar influences on clinical reasoning that were identified by Higgs and Jones (2008), and which they claim are influenced by the following six elements:

1. 'personal context' (of the resident)
2. 'clinical problem' (and clinical complexity of the resident)
3. 'context of care' (where resident and their carers' negotiate care according to the situation in which care is provided)
4. 'health care environment' (aligned to staff culture, organisational support, as well as the availability of physical and other resources)
5. 'clinical problem solving expertise' (referring to the skill mix and staff capacity to manage resident care needs, as well as resources to intervene or manage)
6. 'personal and professional framework' (which permits the RN to assert autonomy or consult with others on options best suited to the resident needs and wishes).

This study revealed that individual RNs dealt differently with day-to-day clinical decision-making situations and almost all RNs sought to ensure their decisions were aligned as far as possible to the best clinical, ethical or moral practices for individualised clinical nursing practice. When evaluating their own professional practice, RNs consider two frames of reference or perspectives. First, RNs reflect on nursing processes leading to practice development and knowledge acquisition. The second perspective focuses on resident outcomes, in particular, resident beneficence aligned to clinical needs, resident wishes or stakeholder preferences. For some RNs, the perceptions of other stakeholders and their involvement in deciding resident outcomes causes ethical dilemmas.

Significant influences to aged care RN practice stem from recent government and public-policy initiatives that seek to maximise and validate older people's right to make decisions on the type of care they receive and the delivery of that care. First, PCC principles modify or compete with routinised care practice models of residential care and aged care services to ensure individual resident needs and preferences are collaboratively negotiated and agreed. The PCC ethos arises from a movement by consumer organisations to empower consumers of aged care services to be able to assume care and monetary responsibility where possible. Consequently, person-centred planning has been widely adopted in aged care to facilitate consumer-directed care, which is 'a strategy to improve individual outcomes and cost efficiencies' (Laragy & Naughtin, 2009, p. 1). Individual consumers negotiate the specific goals of assistance necessary to ensure living in their community of choice, with as much autonomy or independence as safely possible.

5.3 Evidence of Influences on Aged Care RN Scope of Practice

In this study, the aged care RNs' scope of practice and achievable resident outcomes were largely influenced by resident self-determination and choices about their care, or decisions made by a person authorised to represent them, as well as by employers or managers implementing decisions about care. The participating RNs believed that they were responsible for implementing clinical interventions decided by others, rather than implementing the interventions they would have chosen as a result of clinical reasoning based on a nursing assessment of the resident.

Significant contributing factors that influence resident outcomes were identified in this study. These include residents and families being empowered by government and organisational policy to make care decisions; the role and authority of PCC models of practice; the implementation of consumer-directed care; the interpretation of quality of care and resident outcomes that are measured by employers using consumer-satisfaction surveys and assessing the frequency and management of resident complaints.

In many instances, RNs experience a loss of clinical authority and loss of control over their role when some interventions, tasks and clinical decision-making activities are removed from their role and allocated by managers or employers to care assistants. In some situations, a manager acts on behalf of family members seeking to ensure that their preferences for care and treatment are undertaken and maintained. Family members also influence decisional processes via ACDs or preferences associated with clinical and care interventions, as well as activities of daily living. Family preferences are generally encouraged and welcomed; however, these can override RN decisions and planned care strategies based on their professional assessment of a resident’s care needs.

On several occasions, the RN participants claimed that such decisions or directives contradicted clinical best practice. Some felt that their RN ethical values about resident advocacy had been dismissed, and their professional duty to implement clinical interventions for resident beneficence was ignored. RNs were observed to assert their clinical authority on the basis that their evidence-based clinical judgements aligned with professional, clinically based decision-making processes essential to meeting resident needs and ethical considerations.

5.4 Emergence of Substantive Theory as a Model of Aged Care RN Practice

Following the comparative analysis, a model of Australian aged care RN decision-making practice emerged that can theoretically guide or validate contemporary aged care RN decision-making practice. This model is composed of influences from the aged care context, including data from this study, the *Aged Care Act* 1997 and *Quality of Care Principles* 1998 (Australian Government, 2012c); PCC (Kitwood, 1997;

McCormack & Dewing, 2010b), consumer-directed care Living Longer, Living Better (Australian Government, 2012b); considerations of the RN scope of practice; as well as the two decision-making guidelines from the NMBA (2013) and McDonald (2007, 2011).

Ethical–moral congruence involves aligning RN professional values to resident rights to fulfil their responsibility to advocate for resident choice and incorporate family-endorsed PCC into their practice. These ethical–clinical elements influence decision-making processes and autonomy among aged care RNs, and affect continuity of care and the achievement of intended resident outcomes.

5.5 Emergent Theories

The following two emergent theories describe the influential factors most likely to affect aged care RN clinical decision-making processes, nursing practice and resident outcomes:

1. The RNs in this study believe that their professional autonomy and clinical authority is conditional on attitudes held by employers and families about the value of nursing and nurses' ability to deliver resident care.
2. PCC modifies or competes with routinised care practice models of residential care, as aged care services must ensure that individual resident needs and preferences, as well as those of their families are collaboratively negotiated and agreed.

The two emergent theories, which arose from thematic analysis interrelate characteristics of aged care RN nursing practice describe the dominant influences on RNs' clinical decision-making processes in aged care. The six primary themes arising from theoretical sampling of the data reflect five commonly occurring clinical decision-making situations that focused the analysis to produce an integrated Australian Aged

Care Model of Nursing Practice. When applied, the model fits into situations of clinical nursing and PCC; it utilises observed characteristics from the study, and aligns existing frameworks or approaches to aged care practice to explain the factors that influence aged care RNs in the clinical decision-making processes that must occur prior to implementing care and treatment geared to achieving individualised resident outcomes.

5.6 Emergent Theoretical Model of Aged Care Nursing Practice

This Australian Aged Care Model of Nursing Practice incorporates legislated requirements for Australian aged care RN practice and aligns with the principles of PCC and consumer-directed aged care services while endorsing RN professional authority. The model draws on the findings of this study to describe functional processes wherein individualised nursing care practice becomes possible, as does the mitigation of the effect of policy-driven aged care on RNs' autonomy and ability to assert their authority to practice in accordance with their professional scope of practice.

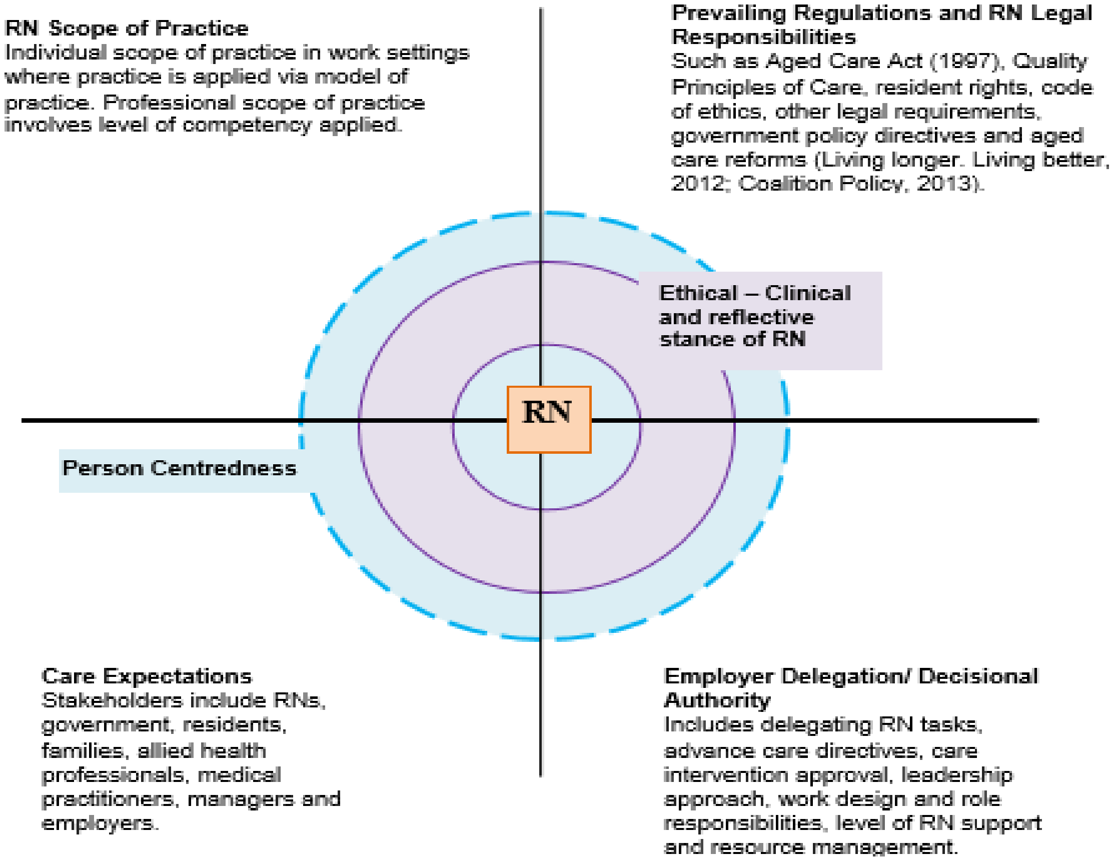
The model of aged care RN practice acknowledges the following:

1. RN professional accountability and legal obligations to deliver and coordinate safe and effective care
2. contextualised application of individual and professional scope of nursing practice
3. influences of employers/managers/others involved in task delegation and management authority
4. expectations of care influenced by consumer choice/preferences or the preferences of other stakeholders who advocate for and negotiate services and care approaches
5. RN clinical reflective approaches for person-centred, evidence-based and ethical practice.

Evidence threads that build to theoretical themes about influences on RN clinical decision-making options are more clearly understood when depicted graphically. To this end, a decision-making practice map that combines the emergent theory with analysis of aged care decision-making guidelines and policies that influence practice in Australian aged care settings has been developed based on the findings of this research. The maps present the Australian contemporary aged care RN clinical decision-making Model of Nursing Practice with the two aged care operational levels working simultaneously. However, these operational levels can be distorted according to the dominant influences at play.

The first level indicates RNs’ claim to be operating according to their scope of professional and individual practice within the constraints of their legal responsibilities to implement safe and effective clinical care. The second level demonstrates that employers were found to operate according to their own expectations and those of stakeholders. Such practice results in the delegation of clinical tasks and nursing work to increase efficiency of service delivery but such a process limits RN professional authority.

Figure 5.2 presents a diagrammatic view of emergent decisional influences on RN decision-making, including ethical–clinical and person-centred-care considerations in balance with care expectations and obligations of employer service delivery.


RN Scope of Practice
Individual scope of practice in work settings where practice is applied via model of practice. Professional scope of practice involves level of competency applied.
Prevailing Regulations and RN Legal Responsibilities
Such as Aged Care Act (1997), Quality Principles of Care, resident rights, code of ethics, other legal requirements, government policy directives and aged care reforms (Living longer. Living better, 2012; Coalition Policy, 2013).
Ethical – Clinical and reflective stance of RN
RN
Person Centredness
Care Expectations
Stakeholders include RNs, government, residents, families, allied health professionals, medical practitioners, managers and employers.
Employer Delegation/ Decisional Authority
Includes delegating RN tasks, advance care directives, care intervention approval, leadership approach, work design and role responsibilities, level of RN support and resource management.

Note: RN (centred) is fortified by ethical – clinical reflective perspectives encircled by the degree of person centredness and remains vigilant of domain influences which comprise the RN operational paradigm (top section) and employer operational paradigm (lower section). Changes in the balance of these influences were found to create an ethical dilemma which affects practice and resident outcomes.

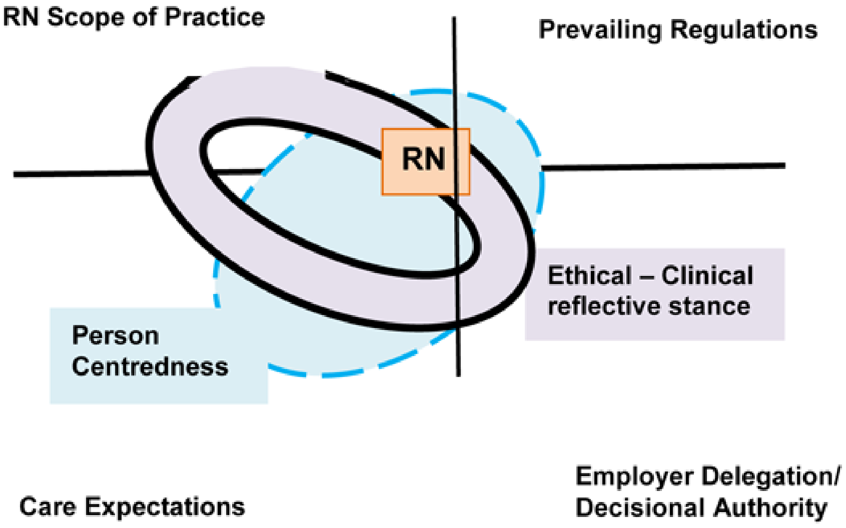
Figure 5.2 Emergent decisional influences. Scopes of practice.

According to ANMC (2007), ‘The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession’. The National Framework for Decision-making by Nurses and Midwives on Scopes of Practice (ANMC, 2010; adopted by NMBA, 2010) states that the RN scope of practice is predicated on the achievement of national competency standards for registration to practice nursing that includes knowledge, and Australian codes of ethics and professional conduct (ANMC, 2008; adopted NMBA, 2010). Moreover, the RN scope of practice involves application of contemporary professional practice within individual contexts, settings and circumstances at a standard expected from a health professional registered under the Health Practitioner Regulation National Law Act 2009 (AHPRA, 2009).

Figure 5.2 outlines the professional context of RN practice that includes work conditions, settings and locations for various organisations servicing diverse care-recipient characteristics to meet their needs. Context of practice also involves health promotion; nursing-related evidence-based research; clinical or care service management; practice complexity; availability of resources and practice support by the employing organisation, other health or medical professionals; and the degree of clinical autonomy available (ANMC, 2009).

This study reveals that RNs work within their specific scope of practice as health professionals, and according to the work role designed by their employers. Some RNs in this study were entrenched in routinised practice and worked strictly to their designed work role. RNs working within this context of practice experienced ethical dilemmas involving employer delegation of RN tasks to assistant care workers, changes to care and treatment routines or the adaptation of person-centred-care approaches that exclude nursing input (see Figure 5.3). Professional nurses are employed by aged care services and settings to care for ageing people with varying care needs that arise from co-morbidities and socioeconomic complexities.

This study confirmed that the extensive role of aged care RNs extends beyond that of clinicians to include management, education, research, and adapting to other roles and functions deemed necessary by the employer. Figure 5.3 illustrates competing priorities of professional responsibilities, management influences and stakeholder expectations that create an ethical-clinical imbalance which influences the RNs scope of practice.


RN Scope of Practice
Prevailing Regulations
RN
Ethical – Clinical reflective stance
Person Centredness
Care Expectations
Employer Delegation/ Decisional Authority

Note: This figure depicts the clinical authority in which aged care RNs experience including those maintaining traditional or routinised practices or aligned to ethical-clinical perspectives, RN scope of practice, increasing stakeholder care expectations as well as adoption of a version of person centred care that excludes nursing input due to employer delegation/decisional authority.

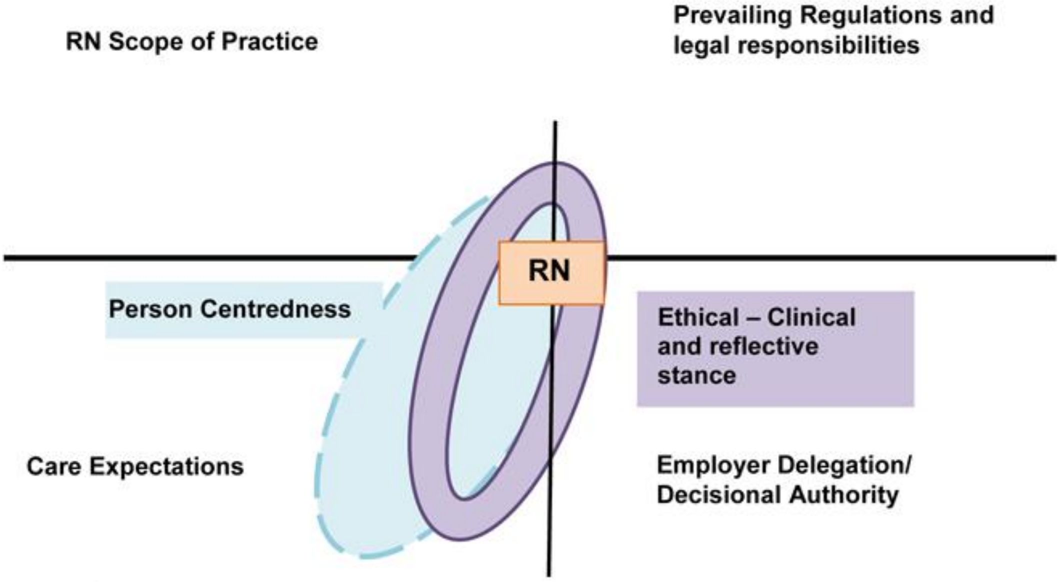
Figure 5.3 RNs influenced by routinised practice, professional responsibilities and accountabilities.

The level of support or autonomy for professional RNs to practise within their individual practice setting often depends on the availability of organisational resources or access to health care teams, as well as compliance with jurisdictional and organisational policies. Practice contexts and location within urban, and rural and remote areas also shape the role and authority of aged care RNs’ care expectations.

This study revealed that stakeholders such as residents, families, care workers, RNs, managers, employers, government agencies have unique expectations in upholding resident rights, curative interventions and quality of life issues, as well as the RN focus on resident advocacy and clinical nursing autonomy. Many RNs revealed experiences in which ‘families direct care’. Further, the RN participants indicated that some families have unrealistic expectations for rehabilitation or recovery of an elderly relative suffering from complex co-morbidities and insist their care preferences be implemented against the advice of nurses and other stakeholders.

Several RNs described situations in which families were unsatisfied with RN or nurse-led services. Such situations can result in the family creating a power imbalance by involving, or threatening to involve, formal complaint mechanisms. In some situations, such actions force RNs to compromise their professional responsibilities. As a result, RNs experience ethical dilemmas with concerns about the continuity of care provided to residents who require RN advocacy to ensure their rights for self-determination and choice are respected and upheld. This study reveals that managers frequently monitor family satisfaction with the levels of service and personal interactions with staff, including RNs, and can initiate disciplinary action if a resident or family is not happy with a member of staff, in cases where either family and/or resident preferences differ from RN clinical decisions and advice.

Figure 5.4 presents the imbalance that can be created through PCC practice in which employers and RNs compromise their standards to meet family or resident demands. Although in such situations, the RN is following the demands of the family or resident, RNs remain accountable to their employers for compliance with aged care legislation and policy that reduces the control they should have as professionals over their scope of practice and autonomy as specified under their health practitioner registration.


RN Scope of Practice
Prevailing Regulations and legal responsibilities
RN
Person Centredness
Ethical – Clinical and reflective stance
Care Expectations
Employer Delegation/ Decisional Authority

Note: Influences of person centred or consumer directed care approaches expected by families and residents are supported by employer delegation of nursing work and decisional authority which creates ethical-clinical tension for RNs by undermining their professional autonomy while person centred care dominates care practice.

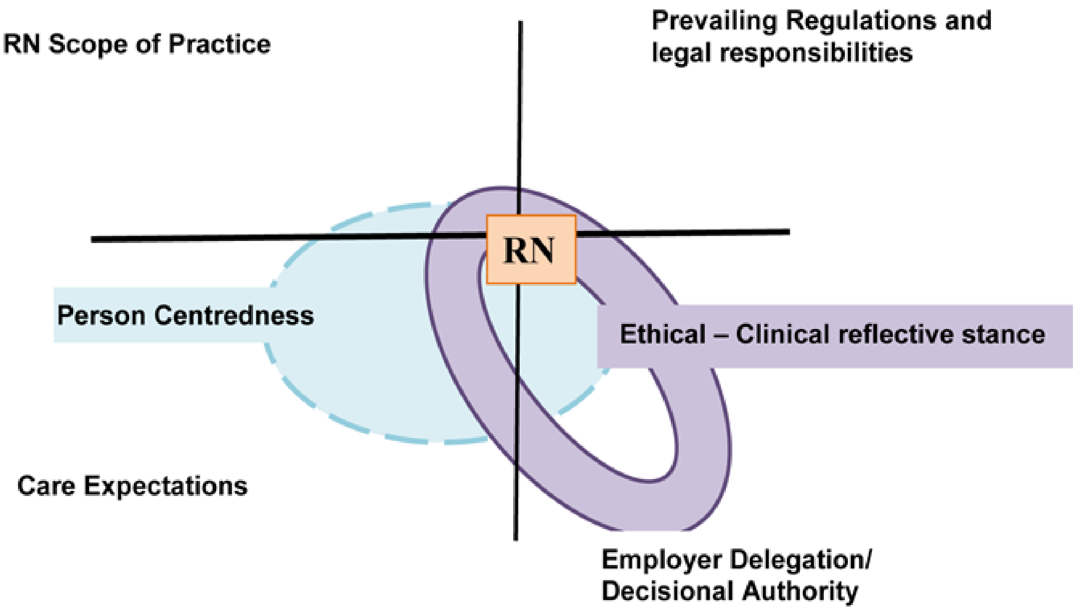
Figure 5.4 Influences of person-centred approaches, employer authority and stakeholder care expectations.

5.6.1 Employer-delegated decisional authority.

Aged care RN have legal authority to supervise and direct nursing care, as well as accountability for all operational aspects of care and strategies to cater for people with special needs. RNs must be able to engage skilled staff, multidisciplinary expertise, access referral and collaborative networks and use equipment to deliver health care interventions needed to meet assessed resident care and treatment requirements. This includes having access to competent staff who can accept delegations and collaborative opportunities with other professionals to provide professional, responsive and safe care.

The RNs in this study expressed concerns in relation to tasks within their scope of practice, for example, medication administration, pain management and wound care being delegated by managers and employers to care assistants. Several RNs reported having little opportunity to oversee all delegated tasks on their shift or ensure appropriate delegation to competent staff. However, some employers were found to be supportive of RNs in matters of delegation, and conditionally allowed RNs to provide supervision and oversight in altering certain delegated RN tasks. Often RNs found that the task of supervising delegated staff was made more difficult by employer delegation to them of managerial tasks, which invariably necessitated further delegation of nursing work to care assistants, over whom effective supervision was very difficult.

In such situations, RNs consider their scope of professional practice is diminished and that their adherence to prevailing legal responsibilities are risked through manager delegation and decisional authority to dictate RN workload factors. Figure 5.5 demonstrates the role conflict RNs experience in situations in which employer delegation and decision-making authority is used to approve or direct care in accordance to family wishes and financial constraints, rather than in accordance with care or clinical needs. RNs encounter ethical–clinical tensions in attempting to convince employers and families of the benefit of resident preferences involving health, wellbeing or quality of life. Employer and family dominance reduce RNs’ ability to function effectively within their professional scope of practice, as well as their ability to comply with their ethical and legal responsibilities as nurses.


RN Scope of Practice
Prevailing Regulations and legal responsibilities
RN
Person Centredness
Ethical – Clinical reflective stance
Care Expectations
Employer Delegation/ Decisional Authority

Note: In situations where employers dominate decision-making processes and delegation authority, RNs experience loss of autonomy as their scope of practice is diminished and prevailing legislation requirements are at risk. Person centredness maintains focus upon stakeholder care expectations creating incongruence and ethical-clinical tension as RNs are forced to assert their clinical authority, or yield to employer authority, or to stakeholder influences.

Figure 5.5 Employer delegation and decisional authority influences increase RN ethical-clinical and reflective stance.

5.6.2 Prevailing regulations and legislative responsibilities.

Regulations control the provision of quality aged care services, they outline the manner in which services are delivered, and guide RN practice priorities. Employers control the availability of RNs to provide direct care and to oversee care delegated or allocated to other care staff. The Australian *Aged Care Act* 1997; Aged Care Principles (1998) and Quality of Care Principles (Australian Government, 2012c) obliges approved providers of aged care to provide 24-hour professional nursing to aged care recipients assessed as requiring high levels of nursing and health care. A report of the operation of the Aged Care Act 1997 (DOHA, 2010) confirms that ‘Nursing care is combined with accommodation; support services (cleaning, laundry and meals);

personal care services (help with dressing, eating, toileting, bathing and moving around); and allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry)' (DOHA, 2010, para. 4). These elements may be replaced as part of the reform agenda to reflect nursing services as the planning and management of care for residents executed by an RN. These services should include palliative care and complex clinical care executed by an RN or where appropriate, another qualified health professional registered under the Health Practitioner Regulation National Law Act 2009 (AHPRA, 2009) (e.g. an enrolled nurse) or another registration scheme (for some therapists) in accordance with their scope of practice.

Currently, RNs inform their practice through collaborative interactions with colleagues, training and participation in aged care networks, as well as through reflective processes and consultation with residents and families. RNs follow legislation that stipulates requirements for their professional registration and they work to ensure the provision of safe, quality residential aged care services as determined by their employment contracts.

As part of the anticipated aged care legislative reforms of Living Longer, Living Better (Australian Government, 2012b) being implemented over the next 10 years, nurses as health practitioners will play a central role in assessing the needs of residents, and delivering or coordinating health or nursing care to the burgeoning population of ageing Australians. This will place further strain on the existing aged care RN workforce. Moreover, these legislative changes have initiated discussions related to identifying the aspects and scope of aged care practice, RNs' role in service delivery, implementing PCC with future responsibilities in overseeing consumer-negotiated plans of care, as well as ensuring continuity in maintaining accreditation standards and compliance (Victorian Government, 2012, p. 11). Additionally, the Coalition Policy

[The Liberal Party of Australia] (Australian Government (2013), *Healthy Life, Better Ageing* will create further changes in the delivery of aged care services that will undoubtedly influence RN practice.

The increasing dominance of PCC encountered by RNs who collaboratively negotiate and advocate for resident preferences in depicted in Figure 5.4. As this study has found, within a PCC framework, resident and family wishes can be at odds with RN scope of practice and care considerations for optimising quality of life and health outcomes. For aged care RNs, PCC is traditionally a part of a nursing approach to care considered from ethical and clinical positions; however, the current version of PCC means employers have a great deal of influence over nursing decisions about the type and quality of care interventions that may be offered or provided according to stakeholder expectations.

Consultation with stakeholders such as health professionals (including medical practitioners, nurse colleagues, allied health professional) and facility managers was regarded by the RN participants as being pivotal to the formulation of care and treatment plans and interventions. RN professional skills and consultative ability were found to be fundamental to informing residents and families about the rationale for proposed interventions and options for care. Equally, informed discussions about the coordination of care involving a multidisciplinary team were held with families and colleagues so that interventions supported by evidence and could be implemented and lead to positive outcomes.

This study has helped to identify significant influences on current aged care RN decision-making within Australian residential aged care contexts. Analysis of the findings from this study and those of existing frameworks or decision-making approaches has revealed two emergent theories that pertain to influences on RN clinical decision-making processes in the aged care practice environment.

5.7 Conclusion

What began as a theoretical investigation into influences involved in aged care RN clinical decision-making processes and professional competence evolved into a set of findings sufficient to establish a model of RN nursing care practice for the aged care context that has relevance to philosophical influences that guide RN practice and ensures harmonious person-centred (consumer-directed) and stakeholder outcomes. The initial considerations involving RN competence in clinical decision-making processes involving resident assessments, knowledge acquisition, knowledge transfer, experiential reflection and evolving expertise as a clinical practitioner were ultimately found to be secondary to the significantly important influences derived from social and policy influences identified within this study.

Person-centred-care approaches as interpreted by care organisations influence clinical and non-clinical decisions in RN practice and affect care outcomes. At times, resident care, stakeholder expectations, interventions and outcomes can vary from situation to situation and may lead to assumptions being made about RN competence.

5.7.1 Recommendations for further research into the effect of aged care reforms on RN practice.

This study has identified the potential effects of different interpretations of PCC and current clinical decision-making practices that influence stakeholder expectations and the quality of clinical outcomes. Evidence revealed that RN roles may change as a result of legislation; service and organisational reform; altered RN workload, work priorities and professional authority; and the increasing demands and complex health and lifestyle needs of residents. This area will require a great deal of further research to ensure that the balance is found between implementing sound aged care policy and ensuring that aged care RNs are able to make decisions in accordance with their professional knowledge, experience and scope of practice. Therefore, the following recommendations for research should be considered:

1. research to consider the value of reflective aged care practice case studies to enhance person-centred aged care RN clinical decision-making and knowledge development, which can then inform aged care nursing curricula in undergraduate nursing programmes
2. investigation of employer understanding of the aged care RN scope of practice and clinical autonomy as it relates to person-centred and consumer-directed care strategies, as well as employer support of RN models of clinical practice involving the full scope of professional nursing practice
3. examination of the effect on job satisfaction of aged care RNs of changes to Australian models of aged care RN practice and service delivery, including delegation practices for a comparative analysis of resident outcomes using indicators for quality of life and quality of care since the introduction of PCC, ACDs and consumer-directed care.

5.8 Study Limitations

The study findings aim to address the scant knowledge in clinical decision-making processes of RNs working in aged care. Several major limitations of this study have arisen during analysis and findings review. Firstly, the study timeframe and researcher employment limited the recruitment of RNs to NSW geographical areas during the two year data collection period from 2010 to 2012. Exploration of aged care RN decision-making in other jurisdictions would enable further comparative analysis to establish a national model of aged care RN practice. Secondly, the issue encountered by aged care RNs may reflect similar challenges to RN models of care in other practice contexts as this study focus is on aged care, replication of this research to include other settings is warranted.

The final limitation is the narrow exploration of influences of aged care RN clinical decision-making where the RN scope of practice and model of care is heavily influenced by stakeholder expectations and government policy. An investigation incorporating input from employers, government policy makers and consumers into RN decision-making authority and scopes of practice in different settings would enrich understanding of the factors influencing nursing contribution to care quality and safety.

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Appendix A

Data-collection Instrument: Initial Participant Data Form

✂

Name:

Home/Mobile Phone:

Work Address:

Clinical Decision Making Project: Initial Participant Data Form

Interviewer Commentary:

This is the first component of this study.

This data will provide a group profile of participants involved in the survey.

Please complete this questionnaire prior to arranging the time, date and site for your workplace observation with the researcher.

Your name, workplace details and contact phone numbers must be confined to the triangle information field on this form.

This data field will be removed and destroyed at the conclusion of the project period.

Please do not identify yourself on this form in any other way.

A special identification code will also be assigned to you by the researcher during the project.

This code is to ensure confidentiality and anonymity within the privacy and ethical requirements operating during the study.

I appreciate your time and participation.

Researcher task

Assign de-identification code to observation documentation _____________

Ensure observation date is confirmed.

Secure all records as confidential information for record keeping and further analysis.

AUSTRALIAN CATHOLIC UNIVERSITY

Data-collection Instrument: Questionnaires

Professional Data	Research Question
1. Nursing-related education qualifications (Tick appropriate box or boxes) ☐ Hospital Certificate ☐ Post Graduate Certificate or higher ☐ University Degree ☐ Other ______________________________	In your opinion: What is a clinical decision?
(Please state) Qualifications gained from ☐ Overseas ☐ Australia Are you currently studying? ☐ Yes ☐ No If so, what? ______________________________ 2. How long have you been a registered nurse? _______ years 3. How long have you worked in aged care? _______ years 4. Are you a facility manager or supervisor of registered nursing staff? ☐ Yes ☐ No 5. If yes, how long have you worked in this position? _________ years 6. Are you ☐ Male ☐ Female 7. Indicate your age group (tick appropriate box) ☐ 20–29 years ☐ 30–39 years ☐ 40–49 years ☐ 50–59 years ☐ 60–65 years ☐ 65 or more years	What are important considerations for registered nurses working in aged care when making clinical decisions about resident care? Please rank them in order of importance.

Clinical decision-making situation consideration.

Using data, methods or tools to inform clinical decision-making.

Please answer the following questions related to this situation.

Describe your professional experience in managing this clinical decision-making situation.

What were your thoughts in the first instance for action regarding this clinical decision-making situation?

What influences your clinical decision-making in practice?

Do you talk to other registered nurses regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?

Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.

Does your employing organisation influence your thinking when making decisions? If so, how?

Delegation of tasks to staff in a multidisciplinary team.

Please answer the following questions related to this situation.

Describe your professional experience in managing this clinical decision-making situation.

What were your thoughts in the first instance for action regarding this clinical decision-making situation?

What influences your clinical decision-making in practice?

Do you talk to other registered nurses regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?

Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.

Does your employing organisation influence your thinking when making decisions? If so, how?

PRN medication administration.

Please answer the following questions related to this situation.

Describe your professional experience in managing this clinical decision-making situation.

What were your thoughts in the first instance for action regarding this clinical decision-making situation?

What influences your clinical decision-making in practice?

Do you talk to other registered nurses regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?

Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.

Does your employing organisation influence your thinking when making decisions? If so, how?

Referring residents to a specialist or emergency service provider.

Please answer the following questions related to this situation.

Describe your professional experience in managing this clinical decision-making situation.

What were your thoughts in the first instance for action regarding this clinical decision-making situation?

What influences your clinical decision-making in practice?

Do you talk to other registered nurses regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?

Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.

Does your employing organisation influence your thinking when making decisions? If so, how?

Facilitating resident choice in care decisions.

Please answer the following questions related to this situation.

Describe your professional experience in managing this clinical decision-making situation.

What were your thoughts in the first instance for action regarding this clinical decision-making situation?

What influences your clinical decision-making in practice?

Do you talk to other registered nurses regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?

Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.

Does your employing organisation influence your thinking when making decisions? If so, how?

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Appendix B

Field Observation Documents

Observation guidelines and data form.

OBSERVATION GUIDELINES AND DATA FORM

Participant Code ID:

Other details:

The triangle field is to be used for this information and removed after data analysis.

Researcher task

Assign de-identification code to interview documentation.

Ensure interview date, time and venue is confirmed.

Debrief observation; briefly note any participant reflections or comments in field notes.

Researcher post-observation reflection—complete memo and field notes.

Attach observation data form for interviewer information to guide interview.

Secure all records as confidential information for record keeping and further analysis.

Interviewer protocol: Observe not participate approach

These questions are prompts only to supplement the observations. Scenario questions can be asked if not observed as the response given may be in consideration of the workplace context and practice of the time of observation. Encourage subject thinking aloud.

Interviewer commentary

Thank you for participating in the project to explore clinical decision-making processes of registered nurses working in aged-care facilities. This is the observation component of this study using a think-aloud technique where possible without breaching confidentiality or privacy obligations.

Each of the five commonly occurring clinical situations is explored separately for data collection.

A debrief interview is yet to be arranged with you. If you have any difficulty during this observation, please let me know as soon as possible. I appreciate your time and value your input.

Data-collection instrument: Observation data form.

Clinical situation: Using data, methods or tools to inform clinical decision making.

Thoughts and Ideas	**Observation Prompts or Protocol**	**Coding Family or Data**
Observer considerations remain neutral yet supportive in practice situations.		
	Professional experience observed Thoughts in first instance Influences in practice Consult with other RNs—when? Observed resident influences Organisational influences *Reflection in action observations* Why did you do things in the way you did? If the situation occurred again, what would you do differently Are there any other influences or reasons for your professional actions and thinking?	**Example**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Clinical situation: Delegation of tasks to staff in a multidisciplinary team.

Thoughts and Ideas	**Observation Prompts or Protocol**	**Coding Family or Data**
Observer considerations remain neutral yet supportive in practice situations.		
	Professional experience observed Thoughts in first instance Influences in practice Consult with other RNs—when? Observed resident influences Organisational influences *Reflection in action observations* Why did you do things in the way you did? If the situation occurred again, what would you do differently Are there any other influences or reasons for your professional actions and thinking?	**Example**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Clinical situation: PRN medication administration.

Thoughts and Ideas	**Observation Prompts or Protocol**	**Coding Family or Data**
Observer considerations remain neutral yet supportive in practice situations.		
	Professional experience observed Thoughts in first instance Influences in practice Consult with other RNs—when? Observed resident influences Organisational influences *Reflection in action observations* Why did you do things in the way you did? If the situation occurred again, what would you do differently Are there any other influences or reasons for your professional actions and thinking?	**Example**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Clinical situation: Referring residents to specialist or emergency service provider.

Thoughts and Ideas Observer considerations remain neutral yet supportive in practice situations.	**Observation Prompts or Protocol**	**Coding Family or Data**
	Professional experience observed Thoughts in first instance Influences in practice Consult with other RNs—when? Observed resident influences Organisational influences *Reflection in action observations* Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Clinical situation: Facilitating resident choice in care decisions.

Thoughts and Ideas	**Observation Prompts or Protocol**	**Coding Family or Data**
Observer considerations remain neutral yet supportive in practice situations.		
	Professional experience observed Thoughts in first instance Influences in practice Consult with other RNs—when? Observed resident influences Organisational influences *Reflection in action observations* Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Appendix C

Participant Interview Records

Data collection: Post-observation reflection participant interview record.

DATA-COLLECTION INSTRUMENT: ✂ **Participant**
POST-OBSERVATION REFLECTION PARTICIPANT **Code ID:**
INTERVIEW RECORD

Interviewer commentary

Thank you for participating in the project. This is the debrief interview. A transcription of what we talk about in this interview will be made for clarification or validation purposes. I would like to remind you that the research objective(s) for this project is to explore clinical decision-making processes of registered nurses working in aged-care facilities and your contribution will fill a knowledge gap in this area.

Each of the five scenarios is explored separately for data collection.

I appreciate your time and value your input.

Researcher task

Assign de-identification code to documentation.

Discuss observation and attach observation data form for interviewer information to guide this interview.

Post-interview—complete memo and field notes.

Complete interview transcription for coding and analysis.

Secure all records as confidential information for record keeping and further analysis.

Using data, methods or tools to inform clinical decision-making.

Thoughts and Ideas Observer considerations remain neutral yet supportive in practice situations	**Observation Prompts or Protocol**	**Coding Family or Data**
	Can you reflect on: Your professional experience in managing this situation What were your thoughts in the first instance for action? What influences your clinical decision-making in practice? Did you talk to other registered nurses regarding clinical decisions? If so, did you talk to them before, during or after you made a decision? Were there any resident factors that influenced your clinical decisions? If yes, in what order did you prioritise them? Did your employing organisation influence your thinking when making a decision? Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example:**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Delegation of tasks to staff in a multidisciplinary team.

Thoughts and Ideas Observer considerations remain neutral yet supportive in practice situations	**Observation Prompts or Protocol**	**Coding Family or Data**
	Can you reflect on: Your professional experience in managing this clinical situation What were your thoughts in the first instance for action? What influences your clinical decision-making in practice? Did you talk to other registered nurses regarding clinical decisions? If so, did you talk to them before, during or after you made a decision? Were there any resident factors that influenced your clinical decisions? If yes, in what order did you prioritise them? Did your employing organisation influence your thinking when making a decision? Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example:**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

PRN medication administration.

Thoughts and Ideas	Observation Prompts or Protocol	Coding Family or Data
Observer considerations remain neutral yet supportive in practice situations		
	Can you reflect on: Your professional experience in managing this situation What were your thoughts in the first instance for action? What influences your clinical decision-making in practice? Did you talk to other registered nurses regarding clinical decisions? If so, did you talk to them before, during or after you made a decision? Were there any resident factors that influenced your clinical decisions? If yes, in what order did you prioritise them? Did your employing organisation influence your thinking when making a decision? Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example:**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Referring residents to specialist or emergency service provider.

Thoughts and Ideas Observer considerations remain neutral yet supportive in practice situations	**Observation Prompts or Protocol**	**Coding Family or Data**
	Can you reflect on: Your professional experience in managing this clinical situation What were your thoughts in the first instance for action? What influences your clinical decision-making in practice? Did you talk to other registered nurses regarding clinical decisions? If so, did you talk to them before, during or after you made a decision? Were there any resident factors that influenced your clinical decisions? If yes, in what order did you prioritise them? Did your employing organisation influence your thinking when making a decision? Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example:**

ADDITIONAL RESEARCHER DATA OR MEMOS OVER PAGE

Facilitating resident choice in care decisions.

Thoughts and Ideas Observer considerations remain neutral yet supportive in practice situations	**Observation Prompts or Protocol**	**Coding Family or Data**
	Can you reflect on: Your professional experience in managing this clinical situation What were your thoughts in the first instance for action? What influences your clinical decision-making in practice? Did you talk to other registered nurses regarding clinical decisions? If so, did you talk to them before, during or after you made a decision? Were there any resident factors that influenced your clinical decisions? If yes, in what order did you prioritise them? Did your employing organisation influence your thinking when making a decision? Why did you do things in the way you did? If the situation occurred again, what would you do differently? Are there any other influences or reasons for your professional actions and thinking?	**Example:**

ADDITIONAL RESEARCHER DATA OR MEMOS

Appendix D

Pilot Tool to Test Scenarios and Questions

Participant pilot-tool letter.

This pilot involves testing the commonly occurring clinical situations and the questions within a Master of Philosophy program (MPhil.). The results of this Pilot will be used to re-develop the questions and or scenarios where necessary in preparation for a Doctorate of Philosophy (PhD) study into clinical decision-making by RNs within aged care.

The PhD study involves RNs working in aged care to undertake a questionnaire, workplace observation, and reflection interview that focuses on feedback using the five situations developed from the literature review in clinical decision making.

This pilot tool asks for any constructive feedback regarding the suitability of the five situations, the questions (and wording) developed to focus or prompt participant responses during self-reflection conducted before the workplace observation, the workplace observation, and the post-reflective interview after the observation.

A summary copy of all the data-collection tools are provided to participants in this Pilot with a Yes or No box to tick if the scenario or tool is clear and suitable for RNs to respond with space to provide additional suggestion or comments.

Please assist in completing all the questions, including the last set that is designed to identify any potential conflicts of interest due to the peer researcher working in the same organisation as the intended RN participants.

Pilot project: Scenarios.

Please respond to each scenario.

Clinical Decision-making—Situation Consideration	**Is this scenario suitable for RNs in aged care?**	**Do you have any comments?**
1. Using data, methods or tools to inform clinical decision-making	☐ YES ☐ NO	
2. Delegation of tasks to staff in a multidisciplinary team	☐ YES ☐ NO	
3. PRN medication administration	☐ YES ☐ NO	
4. Referring residents to specialist or emergency service provider	☐ YES ☐ NO	
5. Facilitating resident choice in care decisions	☐ YES ☐ NO	

Questions used within three data-collection tools to focus on each clinical decision-making situation.

Questions Posed to RNs For Each Clinical Situation	**Is this question suitable for RNs in aged care?**	**Do you have any comments?**
Describe your professional experience in managing this situation.	☐ YES ☐ NO	
What were your thoughts in the first instance for action regarding this situation?	☐ YES ☐ NO	
What influences your clinical decision making in practice?	☐ YES ☐ NO	
Do you talk to other registered nurses regarding your clinical decisions? If yes, would you prefer to talk to them before, during or after you have made a decision?	☐ YES ☐ NO	
Are there client or resident factors that influence your clinical decisions? If yes, please list them in priority order.	☐ YES ☐ NO	
Does your employing organisation influence your thinking when making decisions? If so, how?	☐ YES ☐ NO	

Participant pilot questions.

Ethical considerations—Peer researcher

Pilot participants are asked to rate responses by *circling* the most appropriate number that best describes your level of difficulty or ease in participation in this pilot.

a) Rate from 1–5 how *difficult* it was for you to participate in this part of the study.

Responses:

1. Not difficult for me
2. A little difficult for me
3. Difficult for me
4. Very difficult for me
5. Extremely difficult for me.

b) Rate from 1–5 the level of *ease* you feel in working with a researcher from management support unit?

1. Feel strongly uneasy
2. Feel somewhat uneasy
3. Feel a little uneasy
4. Feel at ease
5. Feel very at ease.

Thank you for participating in the project. I appreciate your time and value your input.

Appendix E

Ethics Approval Documents

Ethics information letter.

Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Professor Tracey McDonald Nth Sydney Campus
Co-Investigators:
Student Researcher: Ms Marina LoMonaco Nth Sydney Campus

Ethics approval has been granted for the following project:
An investigation into the uptake by registered nurses working in aged care, of clinical decision-making frameworks. (Investigating clinical decision-making of registered nurses in aged care settings
for the period: 2 August 2010 to 31 December 2011
Human Research Ethics Committee (HREC) Register Number: N2010 37

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (2007) apply:

(i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:

- security of records
- compliance with approved consent procedures and documentation
- compliance with special conditions, and

(ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:

* proposed changes to the protocol
* unforeseen circumstances or events
* adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than low risk. There will also be random audits of a sample of projects considered to be of negligible risk and low risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

K. Pashley.

Signed: .....Date: 02.08.2010

(Research Services Officer, McAuley Campus)

Confirmation Email regarding Ethics Approval N2010 37 – Extension period to 31/12/12

From: Kylie Pashley
Sent: Friday, 2 December 2011 2:18:25 PM (UTC+10:00) Canberra, Melbourne, Sydney
To: Tracey McDonald
Cc: Kylie Pashley; Marina Lo Monaco
Subject: N2010 37 Extension approved

Dear Tracey and Marina,

Thank you for returning the Ethics Progress Report for your project N2010_37 An investigation into the uptake by registered nurses working in aged care, of clinical decision-making frameworks. (Investigating clinical decision-making of registered nurses in aged care settings

The Deputy Chair of the Human Research Ethics Committee has approved your request to extend the period of data collection. The new expiry date for data collection is the 31/12/2012

We wish you well in this ongoing project.

Kind regards,
Kylie Pashley

Ethics Officer | Research Services
Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
PO Box 456, Virginia, QLD, 4014
T: 07 3623 7429 F: 07 3623 7328

ACU National
Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

INFORMATION LETTER TO PARTICIPANTS

TITLE OF PROJECT: Investigating clinical decision-making of registered nurses in aged care settings

NAME OF PRINCIPAL INVESTIGATOR or SUPERVISOR: Professor Tracey McDonald

NAME OF STUDENT RESEARCHER: Marina LoMonaco

PROGRAMME IN WHICH ENROLLED: Doctorate of Philosophy

Dear Participant,

You are invited to participate in a research project. The purpose of the study is to explore clinical decision making processes of registered nurses working in low and high care residential aged care facilities. The study will involve observation of up to ten participants in their workplace, a personal interview and a questionnaire to be conducted.

This study aims to examine factors that determine and influence decision-making practices in an environment of competing priorities and expectations. Factors associated with the clinical decision-making processes in the workplace (residential aged care facilities) need to be known and reviewed. The data will be useful in industry discussions, exploring competencies, developing education programs or initiating public debates surrounding future clinical practice, management interventions and policy related to a potential clinical decision-making model arising from the study.

The student researcher will observe and interview registered nurses responsible for making clinical decisions in an aged care setting. There are no foreseeable risks in conducting this project within the workplace. However, the researcher will offer privacy and planned observations and interviews. The study is designed to identify the elements involved in common workplace scenarios so that data will improve knowledge and resources regarding aged care specific decision-making processes for experienced registered nurses working in an aged care setting.

Following recruitment participants in the project will be required to complete one pre-observational questionnaire, participate in an observation of practice and attend an interview session (post observation). The time expected to complete the pre-observational questionnaire is 30 minutes with up to 2 hours allocated by the researcher to observe each participant in the workplace concluding with a 30 minute reflective interview outside work time. A project exit session will be available for participants to provide an overview of the project if requested. The questionnaire will seek responses related to five decision-making scenarios within aged care, researcher observations will record thinking processes, feelings and practices associated with the clinical decision-making scenarios. A document similar to the questionnaire will be used to focus and record data related to the five commonly occurring clinical situations developed for this study. To ensure continuity in scenario data collection, the post-observation interview documentation will record a reflective or debriefing process for the participant and will assist in clarification or validation of the data collected in the study related to the five situations. Total time invested by participants in this research study is approximately 4 hours over a 18 month period.

You are able to refuse consent and, or involvement in this research study without having to justify that decision. Therefore, you can choose to withdraw consent and discontinue participation in the study prior to the observation period or at any time without giving a reason and without prejudice.

Data gathered in the form of observations, interviews or survey responses will be treated within the provisions of the Commonwealth Privacy Act (1988), Privacy Amendment (Private Sector) Act (2000) and National Statement on Ethics in Research involving Humans (1999) and remain confidential. Participants private and personal information will not be disclosed to any parties other than supervisors of the project who are bound by ethical conduct and privacy obligations as is the researcher. Confidentiality will be maintained in project documentation, written reports or publications. Where necessary non-descriptive codes will be used so as not to identify participants involved in the study or its stages of analysis.

Should participants have any concerns or questions regarding the study or it implementation please contact the researcher directly or contact the project supervisors.

Researcher: Marina Lucia LoMonaco m_lomonaco@bigpond.com.au

Principal Supervisor: Professor Tracey McDonald tracey.mcdonald@acu.edu.au

A post study feedback session will be available to participants when the research findings are finalised. The project is due for completion in 2012 therefore arrangements will be made in that year.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University in 2010.

If during the project you have any question, concern, complaint or issue regarding the manner that you have been treated while participating in this study and, or the researcher or supervisors have not be able to satisfactorily address your concerns you can write to the Chair of the Human Research Ethics Committee. Concerns or complaints treated confidentially and are fully investigated with feedback provided directly to the complainant.

Chair, HREC
C/o Research Services
Australian Catholic University
Strathfield Campus
Locked Bag 2002
STRATHFIELD NSW 2135
Tel: 02 9701 4093
Fax: 02 9701 4350

You should sign both copies of the consent form provided if agreeing to participate in this project. Both copies are also signed by the researcher with one copy retained by the participant and the other copy returned to the student researcher or principle investigator.

Principal Supervisor:

Student Researcher:

Date:

ACU National
Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

North Sydney Campus (McKillop)
ACU National, Faculty of Health Sciences
40 Edward Street, North Sydney NSW 2059
PO Box 968, North Sydney NSW 2059
Telephone: 02 9739 2280 / 02 9548 0101
Facsimile: 02 9739 2009
www.acu.edu.au

CONSENT FORM

TITLE OF PROJECT: Investigating clinical decision-making of registered nurses in aged care settings

NAME OF PRINCIPAL INVESTIGATOR or SUPERVISOR: Professor Tracey McDonald

NAME OF STUDENT RESEARCHER: Marina LoMonaco

I .... *(the participant)* have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this research project from 30 June 2010 to 30 December 2012 and the activities of questionnaire, observation and interview (with audio-taping), realising that I can withdraw my consent at any time without prejudice or penalty to studies or relationships with university or researchers in the future. I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: ....

SIGNATURE ....DATE ....

SIGNATURE OF PRINCIPAL INVESTIGATOR (or SUPERVISOR): ....

DATE: … … … … … … … … … ..

(and, if applicable)

SIGNATURE OF STUDENT RESEARCHER:..

DATE: .... … … .