An exploration of what stakeholders reveal about personality traits and associated behaviours of registered nurses working in older people's acute care settings.

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Abstract

Background

Concern around poor standards of nursing care for older people in hospital has been explored in relation to workload and operational pressures. What is less evident from existing literature in this field is an explanation as to why nurses behave differently under the same pressures within the same concrete situations. Notions of personality traits and associated behaviours as possible influencers on nursing care delivery are variables that require consideration.

Aim

To critically explore behaviours of registered nursing staff working in older people's acute care settings from perspectives gathered from key stakeholders, and to identify whether there are any distinguishing personality traits that influence effective care delivery for older people.

Methodology

Using a constructivist grounded theory methodology, semi structured interviews were conducted to gather data from 12 stakeholder participants. Representation was from patient governors, carers and others from a nursing or relevant professional background. Data was analysed through a process of initial, focussed and finally theoretical coding.

Findings

Analysis of data gathered from stakeholders identified a rubric, describing specific behaviours aligned with associated trait headings. A range of behaviours were identified spanning between two distinct types of nursing staff. One group of nurses who work with older people are perceived to have no real desire to do so and in turn their care behaviours

are perceived as 'cold' and task based. A second group of nurses are perceived as having a commitment to older people's wellbeing and their behaviours lead to the delivery of care that is perceived as being highly skilled and compassionate.

A theoretical framework was constructed from this data analysis that identifies four key personality traits related to nursing behaviours. These are referred to as: *conscientiousness*, *sociability*, *integrity* and *coping* under a core category heading of *'the authentic self'.* Whilst *authentic self* is identified as being a direct influencer on how care is delivered, defined as the *consequence*, the influence of *context* is also taken into account.

Conclusion

This research offers new insights into four key personality traits and associated behavious displayed by nurses working in the acute older people's healthcare setting and what effect these behaviours have on nursing care delivery, derived from perspectives of various older people's nursing key stakeholders. Implications for healthcare practice are presented, which includes potential for further research that can inform the development of educational and recruitment strategies for older people's nurses. This will ultimately have a positive impact on the quality of care older patients can expect to receive when in hospital.

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Glossary

FFM	**Five Factor Model** (McCrae and Costa, 1987; Goldberg, 1992).
HPI	**Hogan Personality Inventory**
NACE	**Narcissism Aloofness Confidence Empathy**
NHS	**National Health Service**
PCPI	**Person centred practice inventory** (Slater, McCance and McCormack, 2017)
PRF	**Personality Research Form**
TCI	**The Temperament and Character Inventory**
TIPI	**Ten Item Personality Inventory**
TOPNACS	**Trait based Older Person's Nursing in Acute Care Settings (TOPNACS)** (Day, 2019)

1 Introduction

1.1 *Personal Impetus: How we care for older people in the UK*

An interest in how older people are receiving health care in the UK originates from both a professional and personal capacity. As a granddaughter to my *Nanna,* I first witnessed how cold and dismissive professional carers can be with an older person, admitted on to an acute older people's ward, in a general hospital in England, which took place approximately 10 years ago (i.e. 2008). Recollections of that experience are outlined below:

The memories are still vivid, arriving on to the ward to find my Nanna, who had a specific type of oxygen mask on, most commonly used as a resuscitation device as it delivers high concentrations of oxygen. My nursing role at that time was in intensive care, which afforded me the knowledge that this mask was just wrong - it could actually cause significant harm to a patient with chronic pulmonary disease - as Nanna had.

I went to find a nurse, but was met with a blank look which immediately made me think that they did not even appear to care, which instilled a lack of confidence in the skills of the nursing staff. However, I explained my concerns, but the nurse abruptly said they did not understand, and that I would have to speak to the nurse in charge. I was left with the feeling she thought of me as an interfering 'smarty pants'. However, I didn't dwell on this as I thought 'Ok, skills can be learnt' but worse was yet to come.

A porter arrived to take Nanna for an ultrasound scan. Two staff came in to help as Nanna was weak and confused and could not get out of bed into the chair. Both staff were incredibly rough with Nanna. I had to ask them to stop hurting her as Nanna cried out in pain as they more or less flung her on to the porter's trolley. I sat down to wait by the bed and noticed that the bedsheets were wet. I presumed Nanna had been incontinent and wondered how long the sheets had been wet. I went to find a staff member to see if they could change the sheets before Nanna got back. I was told they were too busy. I asked if I could do it and one of them tutted and said 'I suppose so but you don't know where the sheets are', I said that I would find the linen room and I was left to get on with my task. Nanna was in hospital for 48 hours and the same staff were responsible for her two days in succession. Nanna's entire experience was one of uncaring and cold attitudes. I still wonder as to why this was the case.

Several years later I was Head of Nursing for Older People's Services within a large NHS Trust. I was specifically asked to take up this role after a series of serious incidents around poor care and abuse had been reported by two students via the Trust 'whistleblowing'[1] policy. The investigatory process revealed long-term physical and emotional abuse of patients. It resulted in custodial sentences for three staff. Whilst this case was concerned with extreme outliers at odds with the everyday practice of nurses, the key question I kept returning to, was; "*why do some staff behave so terribly to older people in our UK hospitals*?"

Personal interest, and being professionally involved in service improvements as a senior nurse meant I had to be familiar with many policy papers related to standards of care, many of which will be referred to throughout this thesis. However, I kept questioning if a missing contributory factor in these documents was the role of the professional carers' personality[2], and how that might affect care delivery. As I came to commence a Professional Doctorate, it was an obvious step to study my hunch further, through exploring any potential connection between personality and care delivery activities specifically for older people being cared for in acute care settings

1.2 ***Older People's Care in the UK***

[1] Whistleblowing is the term used when a worker passes on information concerning wrongdoing. The wrongdoing will typically (although not necessarily) be something they have witnessed at work.
[2] Personality is defined as; "the complex organisation of cognitions, affects and behaviours that gives direction and pattern (coherence) to the person's life" (Pervin, 2003 p447).

It is a general assumption that someone over 65 years of age is considered an 'older person', which is linked to UK state pensionable ages. However, a strict definition or age limit is not always clear cut, because people biologically age at different rates. Someone aged 75 may be deemed far healthier than someone much younger, at say aged 60. Simply using age range, therefore when considering someones health status has been over taken by use of the word 'frailty', a term that indicates likelihood that a person requires significant professional care and increased levels of support (NHS England, 2019).

Clegg *et al*. (2013, p752) defines frailty as "*a state of increased vulnerability to poor resolution of homoeostasis after a stressor event, which increases the risk of adverse outcomes, including falls, delirium and disability"*. Prevalence of frailty increases with age, with up to half of adults over the age of 85 estimated to be frail (Clegg *et al.,* 2013). It is now well reported that increasing frailty is important as a prognostic indicator, with frailty status being strongly associated with both quality of patient outcome and mortality. Assessing an older person with frailty who is acutely unwell is challenging and the practitioner must be alert to any serious underlying illness masquerading as a frailty syndrome and that frailty can also arise from over medicalisation of common problems, such as falls and dementia (British Geriatric Society, 2014). When hospitalised, older people are at high risk of negative outcomes and acute illness can increase frailty and compromise ability to perform activities of daily living. Therefore, older people require specialised care during hospitalisation (Dey, 2016).

Since 2006/07, the total number of hospital admissions across all English hospitals increased by 28.1%, reaching over 14 million in 2015/16. The number of admitted patients aged above 65 years increased by 46%, from 4 million in 2005/06 to just under 6 million in 2015/16 (The Health Foundation, 2018). In 2014-15, the percentage of older people admitted to hospital after attending A&E was 50%, compared to 16% for those aged under 65 and the complexity of their presenting conditions places has increased demands on the care system (Department of Health, 2016). An increasing older population is one of the biggest challenges facing the National Health Service (NHS) today.

The assessment of frailty before admission to hospital offers a simple approach to assessing the likelihood of recovery of frail older people, who are often acutely unwell. Identification of patients who are less likely to recover will allow appropriate care planning decisions to be made (Pocock and Sharp, 2017). Therefore, admission to an acute older person ward will be based on one or more of the contributory factors of age, comorbidity and frailty. Acute older person wards are the focus of this work, and 'older people' are loosely described as those over 65 plus or minus comorbidities plus or minus frailty who are considered the group most likely to make use of acute older people's health care services.

An acute older people's ward differs to an 'assessment unit', where length of stay is approximately 1-3 days and the priority of safe, early discharge is possible. Longer lengths of stay can be expected on an acute older people's ward and early discharge to usual place of residence (e.g. own home or a care home) remains a priority. However, for many older

people after hospitalisation, a period of rehabilitation may also be required which would not be provided on an acute ward (NHS England, 2019).

The decision to admit a person to a specialist acute older people's ward, would enable them to be seen by a gerontology specialist. Specialist services are made against a strict set of criteria. A decision for specialist gerontology input indicates the need for provision of specialist acute care, and often complex comorbidity related illness, associated with a significant decline in physical function.

1.3 *Standards of Care in hospital*

Age UK[3] (2013) report that poor standards of care are widely experienced amongst older people when in hospital, despite a continued focus on the need for compassion in professional care teams, further emphasised in the wake of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Lord Francis QC (Department of Health, 2013).

According to NHS England (2014) clinicians spend more time providing care to frail older people aged 75 years and over, than to any other age group, yet, older people with frailty are at the greatest risk of a poor experience or of suffering actual harm as part of their 'care'.

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3 Age UK is the country's largest charity dedicated to helping everyone make the most of later life.

Vizard and Burchardt (2015) analysed NHS Adult Inpatient Surveys for 2012-13 to provide a detailed picture of older people's self-reported experiences, focussing on dignity and nutrition during hospital stays. The report described how older hospital patients in England face a "widespread and systematic" pattern of inadequate care[4]. They estimated one million people in later life are affected by poor or inconsistent standards of dignity or help with eating in hospitals.

The Care Quality Commission (CQC), as the independent regulator of health and adult social care services in England, undertakes inspections of NHS care providers. The CQC reports on eight core aspects of service provision. One is specifically targeting quality of 'medical care including older people's care'. CQC utilise five lines of enquiry; i) safety ii) leadership, iii) responsive, iv) caring and v) effective. Ratings are allocated to each service then an overall rating is given to the Trust. Ratings are ranked between i) inadequate, ii) requires improvement, iii) good or iv) outstanding. From CQC Reports across England, undertaken in December 2016, over half of services inspected, (56%) identified as 'Medical care including older people's care' services were rated as *requires improvement* or *inadequate* . Only nine hospitals (4%) were rated as *outstanding* for medical care (Care Quality Commission, 2017).

[4] A summary of the Vizard and Burchardt (2015) findings are included as Appendix I.

The CQC rating for the hospital where I led the internal investigation, at that time was rated as *inadequate* overall and more specifically *inadequate* for medical care[5]. The CQC went as far as raising serious concerns about the care and treatment of older people as inpatients within that institution, including identification of a number of examples of poor care and avoidable harms, including how drinking water was placed out of reach of patients leading to dehydration and other complications of being frail and in hospital.

1.4 ***Explanations for poor standards of care for Older People***

This subsection is introduced with a summary of what is meant by the term 'caring', before consideration is given to some of the explanations considered as to why there is a consistent reporting of poor care for older people in the UK.

1.4.1 *Caring within the context of Health Care delivery*

Jean Watson's theory of human caring is widely used in health care, and focuses attention on the concept of caring as a transcendental interaction (Watson, 2008; 2012). Watson's theory is considered as part of a *caring science*, which includes aspects of the arts, sciences, and humanities. In so doing, human caring takes into consideration relationships by offering a view of human unity and includes consideration of a spiritual connection. Watson's theory (2008; 2012), expresses how a nurse helps the patient achieve a higher degree of harmony through the caring transactions, caring relationships and caring behaviours that occur

[5] This specific Organisation's CQC report is not referenced in order to protect and maintain anonymity

between the nurse and patient. Therefore, acts of caring are what creates and supports a caring relationship.

A number of researchers have attempted to capture the nature of caring behaviours, however caring behaviours in nursing are not clearly defined and may vary depending on speciality and patient need alongside the experience and personality of nurses (Merrill *et al.,* 2012). According to Merrill, *et al.* (2012) caring behaviours are those activities that indicate to a patient that the nurses care about them as a person. There is a variation however, between what patients and nurses perceive as important, in terms of caring, plus there is considerable variation taking place across various clinical settings.

1.4.2 *Explanations of poor care*

Research to date attempting to explain low standards and omissions of care have related, in the main, to high-pressured workload and low staffing levels (Kalisch *et al.,* 2006; Kalisch *et al.,* 2009; Ball *et al.,* 2014; Ball *et al.,* 2018). The apparent acceptance of low standards can be explained, in part, by the concepts of cognitive dissonance and emotional labour. Some examples of these explanations are now presented

1.4.2.1 Work pressures and staffing levels

Maben *et al*. (2012) performed a mixed methods study of nursing staff to examine any links between nursing experience of their work and older patient's experience of care. Maben *et al.* (2012) suggest that a) high demand/low control environment, b) poor staffing and c) poor leadership all interact to affect how nurses care for older patients. Staff tend to

alleviate the impact of such work pressures by prioritising care to those patients often considered as the nicest people (i.e. nicknamed as the 'poppets' as opposed to the 'difficult' patients). These 'poppets' are the older persons judged as being easier to get on with and therefore nicer and more rewarding to look after and more likely to appreciate care being given by the staff. However, other patients, those seen as 'difficult 'or 'demanding' can be more cognisant of their vulnerability and will seek to 'court favour' with staff and therefore seen to be manipulating or managing any caring relationships with a plethora of staff, all with different attitudes, perhaps in an attempt to get their needs met, but trying to gain good or better care for themselves over other people in close proximity (Maben *et al.*, 2012).

The limitation of focussing only on the relationships between staffing numbers, operational pressures and clinical outcomes is that they do not take into account the individual nurse's ability to deliver care within the context of considering their various personality traits. Nursing is generally discussed and presented as a very homogenous entity, mimicked in the press and media coverage as stereotypical, as either 'Angels' or 'Handmaidens'[6] . The question arises then; 'do all nurses deliver poor care when staffing levels are low and operational work pressures are high'?

1.4.2.2 Cognitive Dissonance

Cognitive dissonance theory may also be applied to understand poor standards of care (de Vries and Timmins, 2015). Dissonance research demonstrates that staff do not favour

[6] https://en.wikipedia.org/wiki/Nurse_stereotypes (accessed 29/1/2020)

changing their behaviours, over changing their perceptions. For example, if someone did something inconsistent with their own perceived values, they may reduce dissonance by convincing themselves they are not responsible or culpable, providing themselves with a valid justification, such as 'there was no time to do it' (de Vries and Timmins, 2015). Typically this leads staff to cutting corners in ways that are left undetected and the dissonance meant that poor care went "under the radar" (de Vries and Timmins, 2015).

The relationship of cognitive dissonance to 'care erosion' was described in the Francis Report (2013), which highlighted a gradual decline in the standards of nursing care delivered as a response to a misplaced focus on imposed managerial outcomes, such as target setting and discharge rates, rather than focusing attention and energy into the quality of care being delivered. Lack of clear leadership, empowering staff to challenge and inadequate staffing levels in clinical areas, including older peoples wards, are often reported in CQC inspection reports and the researcher's example of her own workplace referred to above was rated as of inadequate under the domain 'well led'.

Cognitive dissonance theory starts to address the psychological aspects of care delivery and goes some way to explain a rationale for poor care delivery, but does not acknowledge the role of an individual's personality. I am left therefore still speculating as to the role of personality and the individual nurse's potential to succumb to cognitive dissonance. For example, not all of the nurses involved in the Mid Staffordshire crisis, or indeed in my own workplace will accept nurses delivering poor standards of care to older people, or any patients.

1.4.2.3 Emotional Labour

The need to demonstrate caring behaviours becomes increasingly important in a fast paced, constantly changing healthcare environment. Diminishing devotion to nursing as a profession of caring may be observed in nurses who are emotionally exhausted, a phenomenon described as 'compassion fatigue' and first explored through the 'emotional labour' work of Smith (2012). Emotional labour is defined as a process of displaying outward emotion that may not match an internal emotional state (Smith, 2012). The associated dissonance this brings can be extremely stressful. A nurse will try and display caring emotions according to embedded social and cultural norms, rather than according to how they actually feel. Emotional labour refers to how changing or suppressing emotions at work, in order to comply with organisational expectations whilst still making sure patients feel any sense of being cared for, over time will result in a state of emotional exhaustion and compassion fatigue (Smith, 2012; Badolamenti *et al.,* 2017).

Compassion fatigue is a distressing state and, similar to cognitive dissonance, is linked with workplace stressors and operational work pressures. Compassion fatigue has also been linked to omissions of care and decisions to leave the profession (Elliot, 2017). However, in any given organisation, not all nurses succumb to compassion fatigue and whilst there are other factors such as age and experience, the researcher proposes that personality has been neglected as a potential contributor to the development of compassion fatigue.

Parke and Hunter (2014) suggest that healthcare professionals are influenced by a persistent social and cultural prejudice (such as ageism) and that notions of caring for older

people equates to something seen as being simple, in that caring for an older person requires common sense, rather than any taught technical ability or advanced practice know how. These cultural discourses are powerful, in that they may perpetuate, even promote harm to older people when exposed to health and social care services (King's College London, 2013).

1.5 ***Study rationale***

Attempts to improve standards of care may evolve from an academic perspective, for example, the development of the Person-Centred Care (PCC) model (McCormack *et al.*, 2011) or are politically focussed such as the 6Cs (Department of Health, 2012), or arise from increased regulatory scrutiny by the CQC who now perform a 'well led' inspection of every acute Trust annually, as focus shifts towards understanding the impact of effective leadership.

The PCC model (McCormack *et al.,* 2011) is often referred to in healthcare as the optimum approach to planning and delivering care by individual and teams, so is presented here as an benchmark of an improvement model to deliver high quality effective care. The PCC model includes prerequisites that health care staff should be able to demonstrate. The PCC model will be presented more within the Discussion Section, however, this model stops short of addressing personality types.

The Francis Report (Department of Health, 2013) recommended an increased focus on developing 'cultures of compassion' and caring in nurse recruitment, training and education. Compassionate care became and remains a political focus with large scale projects and conceptual models developed as the findings of Lord Francis QC unfolded, even before the final report was published. A key example is Compassion in Practice and the '6Cs': care, compassion, competence, communication, courage and commitment (Department of Health, 2012).

Validation projects relating to the 6Cs are limited at present, with emphasis based more on organisations 'signing up' to the concept of compassionate care rather than an evaluation of any outcomes. Dewar and Christley (2013) state that a model for creating caring and compassionate cultures, as set out in policy, is reductionist because it presents the six values as separate entities. Compassion should not be described as one of six elements as it is actually a core aspect of care, competence, communication, courage and commitment. Working from a reductionist approach may lead to organisations planning quick fixes for each of the six values, to satisfy external scrutiny, but not consider *context* issues, such as where care takes place or who is delivering the care (Dewar and Christley, 2013). Approaching compassionate care in this reductionist manner will not address the fundamentals of who nurses are and the effect of their personality on the level of care delivery as experienced by those in receipt of nursing care.

In the UK, degree nurse training is currently university- based, aiming to ensure standards of academic attainment alongside clinical experiences and competency development. Yet,

limited attention is given to nurse's personal attributes and characteristics beyond initial values-based recruitment process, as specified by NHS Health Education England (2014) . However, this selection framework has been developed based on opinion, it is not used consistently and has not been rigorously evaluated nor does it take into account individual variables such as personality characteristics. De Vries and Timmins (2015) stipulate the need for greater emphasis on the teaching of structured reflection to counter potential decline in standards of nursing care. This suggests the question, 'why do nurses appear not to be applying psychological theory for resilience attainment, to help counter against potential lapses in compassionate nursing care?'

This introductory section has presented some explanations and potential rationale for poor care in older people's services in the UK Health care system. Policy and research has attempted to explain why this poor care occurs so frequently across the UK for older peoples services, and initiatives to improve care. Yet, each example has a limitation of not acknowledging the individuality of nurses in relation to their personality and, therefore has to date not explored the potential role of personality in how nursing care is being delivered.

It is evident that influences on how nursing care is delivered are undoubtedly multifactorial and include influences on caring behaviours, such as compassion fatigue and cognitive dissonance. However, despite the influences described above, not all nurses working in the same concrete work situation behave in the same way. One significant variable that has not been explored fully is therefore giving attention to the potential impact personality of nurses has on their care delivery. The concept of personality came to the fore because of

the harm that came to older aged patients I had personally witnessed, and outlined above, (in Section 1.1) that could not be explained by poor staffing levels or operational pressures alone.

The study aims to undertake a critical exploration of the behaviours of registered nursing staff working in older people's acute care settings, based on perceptions of key stakeholder opinion and experience. In other words, those closest to the situation of observing, or experiencing, service delivery to older people whilst inpatients on acute care wards in the UK. Using a grounded theory approach, it may be possible to identify whether there are any new theoretical insights into personality traits of nurses who care for older people. I can then work to ensure improvements can be initiated, through for example, recruitment processes based on personality trait identification, to achieve highly effective nursing care for older people, in acute care settings and across services focused on a deserving elderly population.

2 Literature review.

> *"We are not scientific observers who can dismiss scrutiny of our values by claiming scientific neutrality and authority. Neither observer nor observed come to a scene untouched by the world"* (Charmaz, 2014 p27).

2.1 *Introduction.*

A literature review is a process through which a researcher is able to analyse what literature already exists on a specified topic. Primary literature includes original research articles. However, also included in this literature review is other supporting, or secondary literature, that assist in positioning the literature review in the context of both personality theory and empirical studies around personality and healthcare. Using a wide inclusion criteria enables for a broad ranging approach to understanding of the research topic, supporting potential for new insights and theoretical development, particularly in areas that have not been previously been widely researched. For example, broader evidence accumulated and published from the field of psychology and specifically personality theory are included and considered .

2.2 *Sensitivity to bias using Grounded Theory approach*

Grounded theory (GT) is the chosen methodological framework for this study and will be discussed in more detail in Section 3. Glaser and Strauss (1967) advocated that literature reviews should be not undertaken until after data collection and data analysis had been achieved. This was to prevent evoking bias in how data is being perceived and interpreted as

the researcher has an initial understanding and opinion of the problem. Glaser and Strauss (1967, p253) suggested early literature review *"increases the probability of brutally destroying one's potentialities as a theorist".* However, a detailed literature review was undertaken as a mandatory component of my taught doctoral programme, hence it was achieved prior to undertaking the research itself.

Reading the literature and foregrounding my awareness of being a researcher with a professional nursing identity, background and interests in the subject will inevitably have an impact on the research process. I have included therefore, a level of reflexivity, as outlined in the Charmaz (2014) quotation above. I approached this reflection by asking myself repeatedly: "*Is my influence and opinion detracting and distracting me from what participants are telling me"?* Detailed accounts of how the findings remain true to what the research participants revealed are found in Sections 3.7 and 3.8.

McGhee *et al.* (2007) suggest that researchers should 'turn back' to previous experience and reading to appraise their effect. I commenced this project from a personal stance, and therefore acknowledge my prior knowledge, both as a professional nurse and as a granddaughter. I believe this prior knowledge brings its own potential to strengthen depth of understanding of materials under consideration by adding a layer of 'insider knowledge' (McGhee *et al.,* 2007). I utilise, weave, critically reflect upon and ground this prior knowledge within the data, as an authentic voice and stakeholder, in amongst the data gathered from other stakeholder representatives.

At the commencement of the literature review I had little knowledge of personality theory, and was unsure of its relationship to everyday behaviours and decision making. Therefore, the initial research questions at the point of the literature review being undertaken were to consider:

1) How are personality traits perceived in the literature relating to registered nurses caring for older people in the acute setting?
2) What effects do personality traits have on the nursing care behaviours of registered nurses caring for older people in the acute setting?

However, before attempting to review the literature to try and answer these two questions, the researcher thought it prudent to develop a theoretical grasp of the concept of *personality* to facilitate a deeper understanding of the subject when analysing personality related research articles. Therefore, the literature review is presented in two separate, but related parts;

- Part 1 provides an overview of the key theories of personality.
- Part 2 presents a critical review of empirical studies that relate to personality and considers research that specifically covers aspects of personality, nursing and care delivery. Undertaking a critical review of the literature aims to highlight gaps in existing knowledge around personality and the potential effect personality has on nursing care delivery.

2.3 *Literature review – Part 1. Purpose statements*

The purpose of Part 1 of the literature review process is to present an overview of the theoretical underpinnings of what constitutes human personality. Personality is a complex subject so the aim is not to offer a detailed critical analysis of personality theory but more to capture an overview that will then be used to help provide context from which to position the research and from which to explore the study aims.

2.4 *Literature review – Part 2. Purpose statement*

Part 2 of the literature review moves focus of attention on to exploration of any existing research that explores the relationship between nurses personality and nursing care delivery in the acute older people's setting. Therefore, the lens for this part of the literature review will be on nursing and personality, not aimed at achieving any further definitions of what nursing as caring is, or should be, within the context of older people's care delivery.

There is broad consensus on the science and art of nursing as described in Section 1.4.1 but the aim here is to understand the impact of personality on how nursing care practices are delivered. As presented in the introduction, there is much written about nursing as an act of caring. Yet, caring is a rather nebulous subject, with scholars approaching the subject of caring from a feminist perspective (Gilligan, 1990) or anthropological method (Wolf, 1988; Street, 1992) to name a few. There is broad consensus that nurses care, but the researcher would like to investigate how personality impacts on how nurses deliver aspects of care to older people within acute care settings.

2.5 ***Search method.***

Two separate searches were undertaken in order to complete a two phased literature review of personality theory and empirical research around personality in nursing, as outlined above. All papers were sought from online databases, covering a wide range of health, medical and psychology based literature.

2.5.1 *Search 1: Personality Theory*

Databases and search terms

An initial search was carried out in 2015, then further updated in 2017. Specialist psychiatric and psychology database *PsycINFO* and *PsychMED* were utilised. The main search term was 'personality theory' specified to be found in the article title. No other search terms were required as this term enabled a focussed search seeking to find articles that satisfied the aim of understanding the theory of personality. The search term was the exact phrase 'personality theory' as using the words separately would have resulted in a wide field of non-applicable articles and specialist research papers.

Inclusion criteria

- English language
- The time period of 1990-2017 was specified, ensuring most current publications were identified and maximising potential for including papers with applicability to the research aims. Search 1 was re-run in early in 2019 and revealed one additional article (the search was not re-run more frequently as theories are less likely to be published regularly, however studies testing the theory may have been revealed).

Exclusion criteria

- Publications in non-English language were excluded. Work published in English was considered sufficient to gain understanding of personality theory at the early stages of a grounded theory approach (as outlined above).

Results

- Two hundred and three (n= 203) articles were listed, which were divided into six sub classifications; 'personality theory'; 'personality traits and processes'; 'personality disorders'; 'personality psychology'; 'personality scales and inventories' and 'psychosocial and personality development'. 154 results for the sub categories: 'personality traits and processes'; 'personality disorders'; 'personality psychology'; 'personality scales and inventories' and 'psychosocial and personality development' were excluded. These articles were rejected, as the subcategories related to specific specialist areas of psychology that did not contribute to the researcher's aim to develop an understanding of personality theory.
- The articles within the sub classification of 'personality theory' (n=49) were chosen for review to meet the aim of 'scene setting' and assist in understanding both personality theory and empirical studies of personality. However, 43 of the 49 articles under the classification personality theory were subsequently rejected because they related to random subjects and were not of use to the researcher to aid understanding of personality theory. One example of such an article was; *"Why are women more religious than men: testing the explanatory power of personality theory among undergraduate students in Wales".*
- Following manual exclusion process as outlined above, the final list was six articles.

- From these six articles, a manual search of reference lists revealed another 12 relevant articles or older seminal work, a key example being McCrae and Costa (1987), therefore a total of 18 articles were reviewed.

Two key text books recommended to the researcher by a Consultant Psychologist were also used to assist the researcher's understanding of personality; Pervin (2003) and Mathews *et al.* (2009).

2.5.2 *Search 2: Personality and Nursing.*

Databases and search terms

The second search was first performed in 2015, specifically focused on research relating to *personality* and *nursing.* Search 2 has been re-run every three months during the research programme until December 2019 and a further four articles have been identified in these follow up searches and added to the literature review.

Whilst the research questions pertain specifically to older people's nursing, restricting the research terms to 'older people's nurses' may have led to missing other related and valuable articles on personality and nursing. Databases reviewed were *Medline, CINAHL, PsycINFO* and *PsychMED.*

Search terms specified to be found in the title were "personality" and "nurs*", using a truncation on nurs* to identify work using all variations of *nurse, nurses* and *nursing*. Using

the Boolean 'AND' prevented the research being limited to showing those documents containing just the keywords and would have resulted in a huge number of articles about nursing or personality but without the link between the two terms.

Inclusion criteria

- English language
- Publication date limit was added, restricted to the last 20 years (i.e. 1995-2015), to facilitate analysis of contemporary literature with the aim of finding works more likely to inform and be relevant to contemporary health and social care practice.

Exclusion criteria

- Non English language – As before, work published in English was considered sufficient to ascertain a current picture of existing research in this area.

Results

- This search yielded 319 articles which were listed and sub classified.
- 40 articles within the sub classification titled 'professional personal attitudes and characteristics' were the most focussed and relevant.
- For the remaining sub classifications, 279 articles were excluded that related, in the main, to nursing patients with personality disorders, health and mental health services, personality psychology and did not add significant value to the researcher's literature.

Further exclusions

- Grey literature, (e.g. data from conference proceedings, unpublished studies or opinion pieces) have not knowingly been used in this work although a wide variety has been read by the researcher to achieve as varied and detailed knowledge as possible.
- Additional exclusions: Articles about personality type. Personality types are seen as specific categories of people e.g. introvert or extravert, which is limiting whereas trait theorists measure extraversion/introversion on a sliding scale. Therefore, personality types are not discussed within major psychology texts e.g. Pervin (2003), Mathews *et al.* (2009) and are excluded from this review process.

2.5.3 *Validity testing*

To determine validity, as the key strengths and weaknesses of research articles being reviewed, a framework suggested by Coughlan *et al.* (2013) was utilised. This framework served to remind the researcher of the key components of a research article and the key questions to ask of these components whilst reading the articles to ensure validity and trustworthiness of the published data. Key questions sit under two main headings containing the research components: *Credibility/Believability* (for example, questions pertaining to the author and writing style) *and Integrity/Robustness* (for example questions pertaining to literature, theoretical framework, aims and objectives, sample, findings and ethics).

2.6 *Literature Review Part 1: Personality*

Personality is a complex subject and this section is introduced with the operational definition associated with personality followed by a summary review of some of the key theories associated with personality; trait, holistic and neurobiological theories, measuring personality and associated variables such as the impact of time and culture

2.6.1 *Introduction to personality*

What is meant by personality?

- Personality is defined as "*the complex organisation of cognitions, affects and behaviours that gives direction and pattern (coherence) to the person's life*" (Pervin, 2003 p447).

Ehrenreich (1997) described personality theory as concerned with the differences between individuals and the adaptation processes through which people interact with different life and circumstance conditions.

One way to explain key differences is that personality is 'who we are' and behaviours are 'what we do'. Trait theory, presented in more detail in Section 2.6.2 describes how there is the possibility to change 'what we do', at least for short periods of time but we are unlikely to be able to change 'who we are' and traits are thought to be enduring over time (Pervin, 2003). There are disagreements among contemporary psychologists about the meaning of personality. For example, Hogan (1992) suggested that personality has two meanings; the

first is a person's reputation, how an individual is perceived by others, and the second refers to the structures, processes and propensities that explains why an individual behaves in a certain way. These concepts will be explored in more detail throughout the literature review. The resulting articles from literature search 1. and supporting evidence have been reviewed and are used now to present an overview of personality theory.

2.6.2 *Trait theory*

Trait theory dominates the literature and influenced how the researcher presented the study findings. Therefore reviewing literature and performing research in the field of personality and traits require an understanding of what is actually meant by these and other related terms. Therefore, some working definitions are provided as an introduction to this section. Personality related terms are used interchangeably throughout this work. An understanding of these terms enables the researcher and readers of this work to successfully navigate through the literature and understand it's role in the subsequent research findings and discussion sections, ultimately contributing to research that will have an impact on patient care.

- [Personality] trait is defined as the predisposition to act in a particular way (Pervin, 2003).
- Facet is defined as a specific and unique aspect of a broader personality trait (McCrae and Costa, 1987).
- Characteristic is used interchangeably with trait but characteristics may reveal themselves only in specific circumstances, for example, honesty and require effort (Pervin, 2003).

- Behaviours may be described as the manifestation of traits and the facets (McCrae and Costa, 1987).

A reductionist approach to personality, trait theory, is the focus of most personality research, for example Mount *et al.* (2005) state that;

> *"Personality traits refer to the characteristics that are stable over time, provide the reasons for the person's behaviour and are psychological in nature. They reflect who we are and in aggregate determine our affective, behavioural and cognitive style"* (Mount *et al.*, 2005 p448).

A trait is an enduring characteristic which is thought to manifest in a consistent way even in a range of situations; a predisposition to respond in a particular way. Traits may be described as *cardinal*; a disposition that is so pervasive that every act is traceable to its influence and *central*; e.g. honesty and kindness, traits that are only seen in limited circumstances.

Traits are commonly measured using self-completed questionnaires, which most often involve the use of statistical measures (factor analysis) to establish association or correlation. Trait is widely accepted to be sufficient to describe the dimensions of personality and the best representation of trait structure is the Five Factor Model – 'FFM'; *conscientiousness, extraversion, emotional stability, openness, agreeableness* (McCrae and

Costa, 1987; Goldberg, 1992; Parks and Guay, 2009; Barrick *et al.,* 2013) - see Table 1. The FFM has undergone extensive construct validity published in multiple meta-analysis (Barrick and Mount 1993; Mount *et al.,* 1998; Mount *et al.,* 2005; Barrick *et al.,* 2013).

Five factor Domain	Description	Trait scales	High levels	Low levels
Extraversion	Characterised by excitability, *sociability*, talkativeness, assertiveness and high amounts of emotional expressiveness	Assesses quantity and intensity of intrapersonal interaction; activity level; need for stimulation; capacity for joy.	Outgoing and gain energy from social situations	Introverted - tend to be reserved and have to expend energy in social settings.
Agreeableness	Includes attributes such as trust, altruism, kindness, affection and other prosocial behaviours	Assesses quality of interpersonal orientation along a continuum from compassion to antagonism in thoughts and actions.	Cooperative	Competitive, manipulative, cold, uncooperative
Conscientiousness	Thoughtfulness, good impulse control and goal-directed behaviours	Assesses degree of organisation, persistence and motivation in goal directed behaviour.	Organised and mindful of details, compulsive perfectionists	Spontaneous, unreliable, sloppy lackadaisical
Neuroticism	Sadness, moodiness and emotional instability	Assesses adjustment Vs emotional instability (prone to stress, unrealistic ideas, cravings and maladaptive *coping* responses).	Mood swings, anxiety, moodiness, irritability and sadness	Emotionally resilient
Openness to experience	Imagination and insight	Assesses proactive seeking and appreciation of experience; toleration for and exploration of the unfamiliar.	Adventurous and creative.	Traditional and struggle with abstract thinking

Table 1 Summary of the Five Factor Model (FFM) traits (McCrae and Costa 1987)

2.6.3 *Measuring personality traits*

Assessing personality traits is, in the main achieved using one of a number of self-reporting questionnaire style tools. Most utilise key trait headings taken from the FFM; *conscientiousness, emotional stability, openness, agreeableness* and *extraversion* (McCrae and Costa, 1987). The questionnaire associated with the FFM is the NEO-PI Five Factor Inventory (McCrae and Costa, 1992) which consists of 300 items that enable questioning and identification of *facets* within the five traits. Modified tools are also available and these are summarised in Appendix II and referenced with corresponding studies critiqued in Part 2 of this literature review.

2.6.4 *Influence of time and culture.*

Traits are suggested to be stable in adult age and genetically influenced (McCrae and Costa, 1988; Goldberg 1992; Hogan, 1992; Smith, 1999) although Ardelt's (2000) meta-analysis of 206 personality stability coefficients could not demonstrate full support of personality stability theory. Ardelt (2000) describes a reciprocal relationship between personality, social environment and life experiences and states that personality characteristics may become more pronounced during times of stress or transition. This debate is of interest in nursing as an individual moves from being a novice practitioner to expert over time, experiencing and learning from multiple and diverse encounters with patients, families and colleagues (Benner, 2000).

Sackett and Walmsley (2014) describe 3 perspectives of personality; personality as disposition, as identity and as behaviour/reputation. Behaviour/reputation would be most

amenable to change and disposition least amenable to change. Sackett and Walmsley (2014) suggest that organisations would be indifferent if a pattern of behaviour is or is not consistent with a person's underlying disposition as long as the valued behaviour is exhibited. The notion is supported that whilst dispositions may be fixed, patterns of behaviour are changeable. For example, if a person is dispositionally not able to keep track of multiple and complex tasks they may be persuaded to start using a planner and diaries if there is a chance of reward and success.

The notion of displaying behaviours that may not be consistent with an underlying predisposition is potentially evident in healthcare organisations. The fundamental business of health care is one of caring. However, there will be situations where displaying 'desired' behaviours relating to caring is challenging; if, for example, an individual has higher or lower levels of particular personality traits. The key question would be around how sustainable a change in behaviour is and is it temporary or permanent? For example, can a nurse become more patient working with older people?

Cultural differences in trait exhibition are ruled out by mechanistic theorists (Goldberg 1981; McCrae and Costa 1988; Goldberg, 1992; McCrae and Costa 1997; Smith 1999; Triandis and Suh 2002). Goldberg (1992) states that the five trait domains are universal because each has survival qualities found in all cultures and humans are one species. However, these writers describe the effect of different levels of some traits across cultures as they will be affected by emic (culture specific) traits.

2.6.5 *Alternative views of personalit*

Ehrenheich (1997) suggests traditional trait theory is too linear in its approach and may neglect interactions crucial to understanding development of the individual over time in various situations. Smith (1999) describes trait theorists as *mechanistic* who treat personality as a collection of traits, skills and dispositions. More holistic theorists treat personality as a process, a system of interrelated structures and view trait as a purely descriptive concept (Epstein, 1994; Singer, 1996). The approach of holistic theorists involves a more systematic in depth study of the individual. This approach emphasises the constructs or ways of interpreting the world that people have and the problems created when they have maladapted constructs or apply their constructs in maladaptive ways. This approach does encourage subjective interpretation of data and involves exploring complex relations between variables (Pervin, 2003). The literature review did not reveal any studies of this type when searched in relation to nursing.

Humanistic and phenomenological theories of personality view self-actualisation and personal growth as a fundamental drive and therefore are at conflict with the trait stability theory as a developmental view is implied. This view was held by researchers such as Abraham Maslow (1943) and Carl Rogers (1946) although they still utilised trait theory to empirically investigate the concept of 'the self'.

Sigmund Freud's psychodynamic theory of personality (1961) describes the fixation of instinctual energy to psychological structures such as the *id, ego* and *superego* and the psychosexual stages of development. The pressure of objective reality and culture generate

conflict between these psychological structures. There has been some interest in matching Freudian structures to traits, e.g. *extraversion* to the expression of the *id*, however this work remains questionable and difficult to research through simple questionnaire design (Mathews *et al.,* 2009).

Cloninger (2008) describes how personality theory needs to be 'deep' enough to understand modular organisations of the brain's systems and their regulation over different time frames from milliseconds to a life span. Psychobiological theorists such as Eysenck (1967) use recording techniques to investigate the functioning of the brain, from which Eysenck's' arousal theory links *extraversion* to (low) arousability of the reticulo-cortical circuit and *neuroticism* to arousal of the limbic-cortical circuit with *psychoticism* to a fight/flight system. Hou *et al.* (2017) used magnetic resonance imaging (MRI)[7] and FFM testing to demonstrate the structural differences in the brain showing distinct associations with *compassion* and *politeness* (two sub dimensions of *agreeableness*). Compassion was positively correlated with grey mater volume in the bilateral anterior cingulate cortex, suggesting the two components have partially distinct neuroanatomical substrates.

Whilst some researchers believe that all trait psychology will eventually be able to be reduced to neuroscientific explanations, most see psychological explanations and physiological explanations as complementary to each other (Mathews *et al.,* 2009). Indeed

[7] MRI: type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Hans Eysenck believed that three main traits; *extraversion, psychoticism* and *neuroticism* are partially inherited and genetically determined and partially physiologically based.

Twenty one percent (21%) of the presentations given at the World Conference on Personality in 2016 focussed their work on the use of the FFM, however Kostromina and Grishina (2018) state that some of the scientific community are recognising the inherent weakness of the delineation of a person's traits and that the discussion around the interrelationship of situational and personality variables in the description of human behaviours continues.

2.6.6 *Combined trait and holistic approach*

Smith (1999) suggests that trait is easily reduced to a purely descriptive concept and a process approach would consider ontogenesis and adaptation. Smith (1999) states that despite clear advantages and disadvantages for both trait and the more holistic approaches, questionnaires for trait models still seem to be the preferred approach.

Singer (1996) appears to recommend a combined holistic and trait approach and summarises this by suggesting that, if interested in contextless dispositions then use trait measurement. But if interested in context specific behaviours then research should sample participant's lives and social competencies. Finally, if interest is in self-understanding and meaning, then this lends itself to the collection of lengthy narratives. Perhaps all three types of data would give the richest possible picture of a person.

At the point of care delivery, older people's nursing is a complex paradigm of influencers on patient expectation and outcome that can be associated with a multitude of ancillary causal questions, all linked to the central question of 'why do some nurses deliver poor care and why do some deliver better care'? Singer's (1996) approach aligns best to this exploration of nursing personality traits, as the research methodology will seek to gather data around stakeholder experiences and opinions of participants from which theory can then be generated and developed that may inform the meaning of personality traits of nurses and their impact on care delivery amongst the elderly population.

2.6.7 *Summary*

The dominant theory around personality indicates that personality trait and the trait facets are the predisposition to behave in a certain way. However, there is discussion around the stability of traits over time and therefore, influence of context and situation should not be dismissed. Some degree of adaptation, to adjust certain behaviours may be possible, although it is not possible at this stage to ascertain any potential degree of adaptation or whether adaptation is attainable in all trait facets. This degree of adaptability is of significance for this research, when the aim is to ascertain what trait facets are less desirable for older people's nurses and whether any clarification will be identified or revealed within this research.

Personality traits and their facets appear to be an accepted measurement of personality. However, limitations of such an approach are recognised. Quantitative research methodology is commonplace in healthcare and questionnaires are frequently used to gather data on a large scale to enable generalisable conclusions about a given subject. This

approach is appropriate as one method to measure personality, however the researcher is interested in more than just a measurement of personality in that there may be the potential to define personality traits that are more suited to the role of an older people's nurse. In order to do this a wider scope of research methodology may be required. That is, those that take into account potential influencers on the level of adaptability and of rather than relying on a simple measure of traits which may not give us a true understanding of the impact of personality on care delivery in older peoples' care.

The concept of traits may provide an appropriate lens for the researcher's work as the basis for theory development around the relationship between older people's nurses and care delivery, at the same time acknowledging that at the conclusion of Literature Review Part One, trait measurement alone may not provide an answer to the questions raised in relation to the impact of personality on care delivery.

2.7 *Literature Review: Part 2 – Empirical studies of personality and nursing.*

2.7.1 *Introduction*

The second phase of the literature search presents a selection of studies centred on personality and nursing in relation to caring, performance, managing stress and job satisfaction, leadership and the stability of traits over time. Reviewing research under these headings aims to provide a depiction of how care is delivered in relation to specific traits and what, if anything, can influence this.

They are presented one by one, to enable as clear an understanding of the study outputs as possible. Questions and critical reflection informed by literature search phase one, in relation to nursing and personality are raised simultaneously. Key personality traits and facet characteristics from the research analysed in the Literature Review part two are presented for convenience in Table 2, which provides a quick reference tool. This section ends with a summary of the identified themes and the gaps in the current literature. Subsequent to these findings, the study rationale is offered as a conclusion to the first, and second arm of the literature review.

	Trait or trait characteristics strongly evident and positively linked	**Trait or trait characteristics occasionally evident, not consistently mentioned and less positively linked**
Job satisfaction	• *Conscientiousness* • *Agreeableness*	• Adjustment • Likeability • Prudence • Emotionality • Honesty
Job performance (includes getting along with others engagement and proactivity)	• *Conscientiousness*	• *Agreeableness* (evident in jobs associated with 'getting along') • *Emotional stability* (low neuroticism) • Ambition • Self esteem • *Extraversion (*strongly evident in sales and management and associated with 'getting ahead') • *Openness* • Perseverance • Initiative

Table 2 Summary of traits and characteristics presented in the literature review

2.7.2 *Personality traits and caring in nursing*

Three studies specifically examined the relationship between nurse's personalities and caring, trying to define a relationship between specific traits and being caring. Williams *et al.* (2009) used the Ten Item Personality Inventory (TIPI) questionnaire to establish if there were higher levels of caring amongst female nurses than average individuals and demonstrated that the nurses score significantly higher than the female controls in *agreeableness.* Williams *et al*. (2009) described *agreeableness* as a tendency to be compassionate and considerate and so was used as a proxy for caring, although they acknowledge that this was based on stereotypes. Nurses also scored higher for *emotional stability* and positive capacity for coping, however, this was again based on stereotype and showed no evidence of impact on nursing outcomes

Williams *et al.* (2009) used case control design, descriptive research that involved comparing the characteristics of a sample group of female nurses (n=174) with a comparison or reference group (described as the general female population). A significant weakness of this study is that Williams *et al.* (2009) describes the control group as 'average female individuals'; however the control is a sample of female psychology students, who had previous involvement with the original TIPI research (Gosling *et al.,* 2003). Nurses are exposed to the aspects of caring every day in their work, as they have chosen to be in a caring profession, which is a similar description for a psychology student. Therefore the study is limited in that it is not in fact comparing nurses with a sample from the general population. In addition, the nurse participants were recruited by responding to questionnaires left in staff rooms, meaning that other staff groups may have submitted

data, not just female registered nurses. However, this first study does introduce an inference found in much of the literature, that traits are presumed to relate in some way to caring, and with *agreeableness*, which has been cited by Williams *et al*. (2009) as a proxy for caring. An obvious limitation here, is that there is no meaning applied to the results. The implication being that the meaning of *agreeableness*, as a personality trait is being merged with what behavioural aspects of care might look like, or even how it is experienced by the nurse and the patient.

Eley *et al.* (2012) undertook a mixed methods study on a purposeful sample of 12 registered nurses and 11 student nurses. Each was interviewed and completed a Temperament and Character Inventory (TCI) (Cloninger *et al.,* 1993). The research question under investigation in this study was "*are the reasons for entering nursing congruent with their general personality trait profile?*" Results revealed a higher rating in the students than average population norms of *reward dependence, persistence, self-directedness, cooperativeness* but lower than average for *self-transcendence*. Two dominant themes emerged from the qualitative interview data; 'opportunity for caring' and 'my vocation in life' were described by all participants in some way.

Whilst limitations of this study include it being only a small sample size, the self-selecting nature of the sample and the measuring of variables at only one point in time, it is still of interest. This study has tried to identify the link between the actual measurement of a trait and what the nurses say about themselves, which is a more holistic method of studying personality however there is no link made between personality and the standards or type of

care that that the nurses deliver. 'Opportunity for caring' relates to caring behaviours described in the introduction to this work, that is, a nurse finds satisfaction when they can deliver caring behaviours. However, whilst this intent of the nurses questioned is captured a key limitation with the work of Eley *et al.* (2012) , is again, a lack of meaning in terms of how care is delivered if nurses do have higher levels of *reward dependence, persistence, self-directedness, cooperativeness.* Results also indicated that lower levels of *persistence* seen in students rather than registered nurses was noted in both Eley *et al.* studies, suggesting *persistence* may increase with experience (Eley *at al.,* 2010; Eley *et al.,* 2012).

Catlett and Lovan (2011) investigated the qualities of 'being a good nurse' by asking 20 qualified nurses; 'A good nurse is one who is….', 'A good nurse is one who is not….' 'A nurse goes about doing the right things by….' and 'A nurse goes about not doing the right thing by…' An attempt was made to identify traits and attributes of a good nurse that could be defined as part of the personality of that person. Trait characteristics such as *caring, patient, selfless* and *honest* were described as positive and *dishonest* and *irresponsible* were cited as not being characteristics of a good nurse. Limitations of this study are that the findings were not analysed in relation to any key trait headings and the meaning of these traits in terms of what care delivery looks like in practice is not described. Catlett and Lovan (2011) introduced their work in relation to being morally virtuous and 'doing the right thing' but they were unable to bridge a gap in their findings between virtues and how 'doing the right thing' may be observed in relation to personality traits.

These first three articles presented a broad approach to understanding a relationship between personality and caring. Yet they do not provide meaningful data about what and how care will be delivered in relation to any given personality trait. This limitation aids direction of the researcher's study towards ascertaining meaning behind personality traits in relation to care delivery. The following sub section will present a more focused analysis of articles relating to personality and performance in order to continue to seek clarity.

2.7.3 *Personality and overall job performance in nursing*

The following six articles address the potential relationship between personality and job performance in nursing.

Louch *et al.* (2016) measured personality of 83 nurses, using a 50 item measure in the Five Factor tool (Goldberg, 1992). In addition, content taken from end of shift self-reported diaries over a working week (of three - five shifts) were analysed. Data was also collected on staffing levels and patient safety measures (perceptions of patient safety, ability to act as a safe practitioner and workplace cognitive failure). Nurses reported being able to achieve safe practice when the nurse to patient ratios were lower (i.e. fewer patients per nurse) and this also led to them experiencing less workplace cognitive failure. Key traits that emerged as moderators of association between staffing levels and patient safety were *conscientiousness* and *emotional stability* with many relationships differing at low and high levels of these factors. A key line of enquiry in the introduction of this work relates to the doubt that not all poor care can be explained by operational work pressures, as not all nurses behave in the same way in the same concrete situation. Therefore the work of Louch

et al. (2016) is of interest as it suggests staff respond to stressors in different ways depending on their personality.

Limitations of this study were acknowledged by Louch *et al.* (2016), including that nurses self-selected into the study. Perhaps a more effective approach would have been to recruit nurses from the same ward on the same shifts. The nurses are described as being from 3 acute trusts but the report fails to specify from what type of ward or department. Questions arise as to whether these results can be generalised, although it seems sensible to assume that *emotional stability,* (as a predisposition to being *calm*) is a necessary requirement if patient safety is truly in question, particularly when perceived safe staffing levels are compromised.

Drach-Zahavy and Srulovici (2018) explored relationships between missed nursing care, personal accountability and personality traits. In a multi centre cross sectional study, personality of a sample of 290 nurses was tested using a 44 item FFM inventory. Personal accountability was assessed using a self-report 9 item Likert scale tool developed by Drach-Zahavy and Srulovici (2018) that included statements such as; "*willingness to stand up for every clinical decision you have made*". Missed care was assessed using a 22 item MISSCARE survey (Kalisch and Williams, 2009) that allows nurses to self-assess missed care on a 4 point Likert scale (ranging from 'rarely missed' to 'always missed'). Statistical correlations demonstrated that high levels of *conscientiousness, openness* and *agreeableness* and low levels of neuroticism were associated with higher levels of personal accountability, (Drach-

Zahavy and Srulovici, 2018). High personal accountability was associated with lower frequency of missed care.

Obvious limitation of this work is the use of self report tools and the risk of bias. Drach-Zahavy and Srulovici (2018) suggest that a future study to assess missed care by direct observations could be useful to further support their findings. This study does not address other influencing variables on missed care such as availability of resources. The strength of this study is that it starts to add meaning to a personality trait such as conscientiousness, linking this to how missed care is less likely. However, the study is about the completion or omission of tasks and does not imply *how* care is delivered, or the manner in which it is delivered.

Regts and Molleman (2016) described how a*greeableness, conscientiousness* and *openness* are widely accepted as desirable traits. Their study focused on the interaction of traits such as *emotional stability* and *extraversion*, with benefits of social networks and the effect on job performance, a concept known as 'network centrality'. Regts and Molleman (2016) stated that employees who are embedded in social networks at work allow access to resource and peer support that enhanced individuals and subsequent organisational performance. Regts and Molleman (2016) introduced their study with a useful summary of these traits in relation to their expectations around social interaction:

- Extraverted emotionally stable individuals are confident and easy going and view themselves and their social world as positive and approach their social environment in a positive way.
- Extraverted neurotic individuals are volatile, impulsive and moody. They will be socially active but view their social environment as negative. They lack listening skills and are more likely to be intrusive in their communication with colleagues.
- Neurotic introverts are shy, self-critical and fearful. Their negative attitude only pertains to themselves and they may still view their social environment positively but be fearful of disapproval within it.
- Emotionally stable introverts are sedate and unassuming and may gain less benefit from engaging in social networks.

Using questionnaires, from a sample of (n=299) nurses from orthopaedic and medical wards provided ratings about their co-workers and themselves in relation to advice and mutual liking and job satisfaction, in addition to completing a self-assessment of *emotional stability* and *extraversion*. Supervisors also rated the participants in regards to job performance.

Statistical regression demonstrated a positive relationship between 'network centrality', and job satisfaction for employees scoring high on *neuroticism,* low on *extraversion,* and similar for low *neuroticism* and high *extraversion* (Regts and Molleman, 2016). There was no significant relationship for employees scoring high on both *neuroticism* and *extraversion.* There were some variables: For those scoring high in *neuroticism* and low in *extraversion*, perhaps not surprisingly, more job satisfaction was gained if they were more central within

their network. Job performance was increased when there was a positive relationship between high *neuroticism,* low *extraversion* and 'network centrality'*.*

Regts and Molleman (2016) suggested individuals differ in how much they benefit from social network positions depending on their personality. Social networks demonstrated benefit for employees and organisational performance, therefore personality traits such as *emotional stability* and *extraversion s*hould be taken into consideration at recruitment or during staff development. The level of *extraversion* was found to be critical as too high a level may be detrimental to relationships and performance. Similarly, whilst high levels of *neuroticism* tend to pertain to the individuals' view of themselves they may require more input and support from those around to enable them to feel more central to the social network (Regts and Molleman, 2016). This study provides useful direction for employers, particularly around the benefit of creating a sense of social network and paying attention to potentially socially isolated employees. However, limitations of the work highlighted by Regts and Molleman (2016) include a lack of conclusion about the direction of causality between constructs by using a cross sectional design. A longitudinal design would perhaps have been more effective. Limitations are that, once again, this study does not infer the quality of care that would be delivered, although it does identify a correlation between organisational performance and personality. Yet, the participants were from orthopaedic and medical wards with no specific reference to older people.

Kennedy *et al.* (2014b) analysed the personality traits from a sample of (n=72) emergency department nurses using the FFM. The sample size was small but did demonstrate higher

than population norms of *extraversion* and *openness to experience* and in 12 facets including *excitement seeking.* Kennedy *et al.* (2014b) suggests that the profile of high levels of extraversion and openness are more likely to have the ability to function in a stressful, high pace environment. It is of interest to note high levels of *extraversion* in this Emergency Department sample. If this trait may not be as high in other nursing sub specialties, what does it's presence enable in emergency department nurses?

Ellershaw *et al.* (2016) explore a sample of (n=393) nurses, tested for the relationship between nursing performance indicators and traits. An online survey assessing work role performance and *conscientiousness, openness to experience* and *extraversion* were measured using the FFM. Work role performance was measured using the Griffin *et al.* (2007) measure which consists of nine subscale that assess behaviours at an individual, team and organisational levels in terms of; *proficiency, adaptivity* and *proactivity*. Each subscale consists of three items asking participants to indicate how often then had carried out each of the behaviours over the last month. Results revealed that *conscientiousness* is significantly linked with all work performance indicators. However, a second hypothesis - that predicted *openness to experience* would positively relate to organisational and individual productivity - was not supported however was linked to team proficiency. *Extraversion* was positively related to organisational proficiency but less to team indicators. Ellershaw *et al.* (2016) point out that a longitudinal study would be more beneficial to further explore cause and affect relationships. Ellershaw *et al.* (2016) has come closer to actually describing the relationship between traits and quality of care, for example *conscientiousness* was particularly strongly related to individual task proficiency. However,

care delivery- if not just about tasks completion- are these measures of personlaity linked to how care is delivered? The sample consisted of nurses from across whole organisation so specifics about older people's care cannot be ascertained.

The FFM was utilised by Baldacchino and Galea (2012a; 2012b) to assess a sample (n=116) cohort of 3rd year nursing and midwifery students. No significant differences were found in all five personality traits between diploma and degree nursing and midwifery students apart from a wider variation in response around *agreeableness* demonstrating a statistically insignificant higher rate of agreeableness in the diploma group. Positive findings were high levels of *agreeableness* and *conscientiousness*. There were low scores on neuroticism and only moderate scores on *openness.*

Baldacchino and Galea (2012b) compared their work to other studies and find some consistencies between results. For example, Bradham *et al.* (1990) found no significant differences in personality traits between degree and diploma students. Baldacchino and Galea (2012b) acknowledge that comparing their work to other studies may limit validity as other studies used different tools to measure personality and have different definitions of 'low' and 'high' scores. A further limitation is that this study does not indicate what traits are associated with effective care, what that care may look like, or what levels of traits are associated with impact on standards of care. However, Baldacchino and Galea (2012b) have gone some way in trying to infer impact and consequence of trait on behaviours, which may be associated with specific traits in relation to nursing. For example, a relationship between *agreeableness* and facilitating reciprocal relationships, *openness* to receiving constructive

criticism or a lack of willingness to change, *extraversion* and positivity and *conscientiousness* and diligence.

There have been no articles found, in this search, relating to older people's nursing and job performance. This leads to the question of whether there are desired personality traits that can be deemed generic across the nursing profession. In addition, articles reviewed thus far have been largely descriptive of self-reporting questionnaires. Such an approach cannot capture the essence and quality of nursing care that would be delivered in relation to the presence of any given personality trait, as for many their personality traits and associated behaviours are not something they would be fully conscious or particularly self-aware of. These limitations enable the researcher to focus on the potential need to address how effectively care is delivered in the presence of specific personality traits.

2.7.4 *Personality and managing stress in nursing*

Two articles are presented in this subsection in relation to personality and the management of stress. Barr (2018) explored the relationship between personality and the effect of work stress. The personality of a sample of neonatal nurses (n=140) was tested using the FFM and work stress was self-reported using a 27 item Likert scale tool addressing role ambiguity, role conflict and role overload. Linear regression statistical analysis demonstrated that high levels of neuroticism and low agreeableness were associated with burnout; although work stress did not seem to make a significant contribution to the variance in compassion satisfaction. Extraversion made the only unique positive relationship with compassion satisfaction. In a similar way to the work of Louch *et al*. (2016), the work of

Barr (2018) also links personality with the susceptibility to stress and burnout. However Barr's (2018) specifically looks at neonatal nurses and therefore cannot be easily generalised to other nursing specialisms. For example does the level of *neuroticism* noted in the neonatal nurse sample need to be higher, the same or lower in other speciality groups to be associated with stress or burnout? A methodological limitation of this study includes the self reporting nature of the data collection.

Burgess *et al.* (2010) specifically looked at the personality traits of intensive care unit (ICU) nurses in relation to stress and *coping* to address the anecdote that ICU nurses are *tougher*. Personality was measured using the FFM in addition to two other instruments: The Nurse Stress Index (Endacott, 1996), a 30 item questionnaire using Likert scales to measure perceptions of workplace stress. Coping was measured using the COPE questionnaire, an inventory of 14 dimensions (Carver, 1997). Whilst the sample (n=46) was relatively small, there were some useful correlations to indicate the need for further research. The participants did not perceive ICU as stressful suggesting that some traits buffer the effect of workplace stress. Time pressure and workload were associated with lower stress levels in those nurses who reported higher levels of *conscientiousness,* whilst *openness* was associated with more problem solving and *coping*.

Significance arising from the Burgess *et al.* (2010) study is the statement that the need for highly skilled and technically able staff means it is imperative to plan for the recruitment of effective ICU nurses. This is particularly relevant as demand for ICU services continues to increase in response to an increasing aged population with complex health care needs

together with the rapid pace of technological advances for health care treatment options. However each speciality may argue that they face recruitment challenges that require effective planning including older people's nursing.

Burgess *et al*. (2010); Kennedy *et al*. (2014b) and Barr (2018) introduce the concept that there are desired traits in specific nursing specialties. As with caring for older people, any subspeciality of nursing will have its own reason to ensure that nurses with optimum personality types for these specific roles are recruited to the work based on perception and experience. For example, Burgess *et al.* (2010) describe the perception of ICU nurses as 'tougher'.

At this point there are still no articles describing the perceptions of what is required in older people's nurses. Management of stress is of particular interest as a research enquiry in older people's care as described in the introduction to this thesis, older people's care is described in relation to high operational pressure and low staffing.

2.7.5 *Personality and job satisfaction in nursing*

One article was found that looked specifically at the relationship between personality and perceptions of job satisfaction. Aslan and Yildirim (2017) state that employees who demonstrate determination and succeed at difficult tasks gain credibility and importance over those employees with less patience or those who cause problems for the employer. In addition, employees who are inclined towards teamwork, helping each other and are

committed to organisational rules, increase the *dynamicism* of an organisation. Aslan and Yildirim (2017) define job satisfaction as one's positive or negative value judgment regarding his or her employment status. They assume a theoretical basis for the measurement of patient care and performance when there is a distinction between tasks and contextual performance. Contextual performance, is described by Aslan and Yildirim (2017) in terms of employees who show performance over and above what is necessary for the role.

The study sample consisted of 500 nurses across varying clinical areas, exploring the relationship between the FFM, a job satisfaction scale (Weiss *et al.,* 1967) and a contextual performance scale developed by the authors. Statistical analysis of the data demonstrated that nurses had less job satisfaction with environment factors such as policies and working conditions and more job satisfaction in relation to factors around the quality of the job; success, approval and responsibility and the personality traits that correlated with this were *conscientiousness* and *agreeability*. Higher levels of contextual performance were observed in those scoring higher in agreeableness.

Aslan and Yildirim (2017) conclude their study by suggesting that contextual performance can be increased by checking personality traits on application; then job satisfaction can be increased during employment and this would be the role of the employer. These findings imply the role of the employer is to acknowledge and implement initiatives and staff support to ensure success or succession planning, demonstrate approval of the employee and increase levels of responsibility. This finding is of value in that, personality of nursing staff will not be the only variable to influence job satisfaction, and subsequently

performance. This is addressed in the Findings Section 4 and Discussion Section 5. The limitations of this study are that the tools used for data collection are self reporting tools and may be open to reporter bias. In addition, the sample consisted of nurses from a variety of clinical settings making it difficult to generalise about the relationship between personality and job satisfaction or apply the findings to an older people's setting. .

2.7.6 *Issues of personality traits and nursing leadership*

Nursing leadership is generally accepted as linked with nursing performance. Yeh *et al.* (2016) state that the relationship between personality and leadership in nursing is an area under represented in research studies.

Based on existing research Yeh *et al.* (2016) offered 6 hypotheses in relation to leadership:

Hypothesis 1: *Conscientiousness* will be positively associated with job performance

Hypothesis 2: *Extraversion* will be positively associated with job performance

Hypothesis 3: Agreeableness will be negatively associated with job performance

Hypothesis 4: *Openness to experience* will be positively associated with job performance

Hypothesis 5: *Neuroticism* will be negatively associated with job performance

Hypothesis 6: Leadership will moderate the relationship between personality and job performance.

Yeh *et al.* (2016) recruited a sample of (n=135) nurse managers (taken from 1,353 nurse participants) in their study. The nurse managers completed a self-assessment FFM questionnaire and the nurses completed a Leadership Behaviour Description Questionnaire (LBDQ), scored on a Likert scale about their manager under two key style headings of; 'initiating structure' and 'consideration'. Consideration is the extent to which a leader exhibits concern for the welfare of the members of the group. 'Initiating Structure' is the extent to which a leader defines leader and group member roles, initiates actions, organises a group and defines how tasks are to be accomplished by the group. This leadership style is task-oriented.

Yeh *et al*. (2016) used statistical regression analysis, which demonstrated that *neuroticism* is associated with lower efficiency under the initiating leadership style. However, those high in *extraversion* performed well if the head nurses had an initiating structure style. Conversely, introverted head nurses were more efficient when associated with a low initiating structure style. Highly agreeable leaders were more efficient when associated with a high initiating structure style. Highly agreeable leaders struggled to delegate tasks and enforce regulations and may require a high initiating structure to function effectively. There was no direct relationship between *openness* and *efficiency*.

The hypotheses outcomes were that:

1. *Conscientiousness* was positively related to efficiency in nurse leaders.
2. *Extraversion* had no statistical relationship with efficiency.

3. High *agreeableness* scores were reflected in compassion and cooperation rather than conflict but no statistical relationship with efficiency.
4. No significant relationship between *openness* and efficiency.
5. Higher levels of *neuroticism* were associated with lower efficiency.

Yeh *et al*. (2016) report that *neuroticism* was associated with lower efficiency, although those higher in *neuroticism* and working in a low initiating structure style will be more efficient than those working under a high initiating structure style. Initiating structure is less concerned with nurse's wellbeing and would lend itself well to individuals who would demonstrate stress and anxiety in a high task focused style. Findings indicated that high *conscientiousness,* high *extraversion,* high *agreeableness,* high *openness* and low *neuroticism* were associated with greater efficiency, particularly under the initiating structure style.

The work of Yeh *et al.* (2016) provides many prompts for discussion around what is required in a senior nurse leader and what traits may improve efficiency. However limitations include, potential bias in the use of self-reporting tools, in addition to the reliability or bias effect of nurses reporting on their own managers who might also be appraising their work. Whilst this research project is studying older people's nurses, nursing leadership may also become an integral part of the research findings. Therefore, the relevance of this article is potentially significant if it is considered necessary to analyse leadership and junior nurses as having differing roles and thus associated personality traits effected by job and role experiences over time.

2.7.7 *Adapting nursing behaviour over time*

Bradham *et al.* (1990) measured personality traits defined in the Personality Research Form (PRF) (Jackson, 1974). A sample of (n=90) participants completed self-administered tests at the beginning and on completion of their nursing programme to ascertain the personality traits at two points and how traits changed over time. The students were a mix of both associate degree and baccalaureate level. In addition to measuring personality using the PRF, the participants were also asked to indicate the degree to which behaviours should be present to promote the delivery of high quality care.

Participants described desirable and expected traits, for example, good levels of *endurance* and high levels of *harm avoidance*, *resilience* and safety and low levels of *impulsivity*. However, whilst the participants stated what the desired level of each trait should be this did not always match the measurements of their own traits; for example, endurance was rated highly but scored low on exit from training and *succorance* was rated as low desirability but score were moderate.

Personality change over time was suggested by Bradham *et al.* (1990), as there were increases in levels from entry to exit in *aggression* (although scores remained low), dominance (higher in baccalaureate students) *exhibition, play, succorance* and *understanding* and decreases in *endurance*

Bradham *et al.* (1990) suggest their study strengthens the argument for personality screening at recruitment stage. However, the limitation of this recommendation is that there is nothing to confirm what traits are undesirable, as there is no evidence on the impact on care - only evidence of nurses' opinions of what traits should be present.

Eley *et al.* (2010) used the Temperament and Character Inventory (TCI) (Cloninger *et al*., 1993) to describe the profiles of nursing groups from a mixed sample, n=451, student and registered nurses. The *character* component of the tool reflected personal goals and values that may develop in response to life experiences and consist of *self directedness*, *cooperativeness* and *self transcendence*. *Temperament* refers to emotional, automatic responses to experience, which are probably inheritable and stable, and consist of four dimensions; novelty seeking, harm avoidance, reward dependence, and persistence.

Eley *et al.* (2010) found that student nurses show higher levels of *novelty seeking*, *reward dependency* and *persistence,* and are more open to trying new things than registered nurses. The results also demonstrated that younger nurses were less persistent and more unreliable suggesting that qualified nurses develop persistence over time. Howvere younger nurses were also more open and curious. The key limitation of this study was that the entire sample was female. Gender may or may not be of relevance, for example higher *narcissism* scores were observed in male nursing staff according to Munro *et al.'s* (2005) and Pitt *et al.*'s (2014) work.

The work of Bradham *et al.* (1990) and Eley *et al.* (2010) suggests that a degree of adaptability of personality trait facets may be possible over time. However it is not known what facets may truly be adaptable and if the ability to adapt itself relates to the presence of a specific trait, for example, higher levels of *openness*.

2.7.8 *Potentially less desirable personality traits in nursing*

Pitt *et al.* (2014) carried out a longitudinal study utilising a personal qualities assessment, which includes a *narcissism, aloofness, confidence* and *empathy* scale (NACE) (Munro *et al.*, 2005), an interpersonal value questionnaire (Bore *et al.,* 2005) and a self-appraisal inventory (Munro *et al.,* 2008) with the aim to provide a description of the qualities of a sample of 139 nursing students. Higher *narcissism* scores were observed in male student nursing staff, however this number was small. A quarter of students recorded extreme scores which may be associated with psychiatric morbidity. Pitt *et al.* (2014) also described consistent results over time when traits were re-measured 3 years on. A limitation of this study is that convenience sampling resulted in a relatively small sample, which limits generalisability. However, individuals with higher scores for *narcissism* may be described as self-centered, having a lack of individual/patient focus, and an inability to differentiate personal values and morals from professional ones.

Field and Pearson (2010) identified *power* as a prominent subtext in their discursive construction work around the murder of patients by nurses, although concluded that there was no stereotypical profile of the characteristics of nurses who murdered patients. Field and Pearson's (2010) work has the limitation of being a discourse analysis and provides little

empirical data as to the personality profile of nurses who harm or murder patients with intent.

McLaughlin *et al.* (2007) were interested in personality as a predictor of success in academic performance and a link to attrition. A convenience sample, n=384, of nursing students completed an occupational self-efficacy questionnaire and an academic self-efficacy questionnaire in order to determine self-ratings in regards to confidence in performing a job and confidence in completion of relevant educational programs. In addition the students completed a revised 48 item Eysenck questionnaire with 12 item subscales of *extraversion, neuroticism* and *psychoticism* [8]. Multivariate analysis of this longitudinal research revealed that students who scored higher on a psychoticism scale were more likely to withdraw from the training, and *extraversion* was also shown to be a negative predictor of academic performance. *Psychoticism* tends to be displayed as aggression, apathy, antisocial and impulsive behaviour. A key limitation of this study was that attrition probably cannot be explained by one variable such as personality and may benefit from some qualitative work to support findings.

2.7.9 *Personality and job performance in other professions*

The researcher also performed a review of articles of interest noted in the search results and reference lists of articles in both Literature search 1 and search 2 that relate to personality and other professions not specific to nursing. A review of these articles can be

[8] Psychoticism is a personality pattern typified by aggressiveness and interpersonal hostility (Mathews *et al.,* 2009)

found in Appendix III, however in summary, higher levels of conscientiousness and agreeableness were repeatedly linked to job performance. Of interest extraversion was inconsistently linked with job performance unless the job role was associated with customer service type occupations and there was a need to 'get ahead' rather than 'get along'.

2.8 *Summary – personality traits and nursing care delivery*

Original research has demonstrated that personality measures can go some way in predicting job satisfaction and performance in nursing and there are three studies that have identified personality traits linked to the abilty to manage stress (Burgess 2010; Louch *et al.,* 2016; Barr 2018). *Conscientiousness* appears widely as a positive influence on performance across many studies. *Agreeableness* and *openness* are also generally seen as having a positive relationship although not as strong as *conscientiousness*. Low levels of *emotional stability* and *agreeableness* may be associated with a lower ability to cope with stress and be more susceptible to burnout.

A personality trait profile is starting to emerge that may be perceived as desired in the nursing profession. However, the weakness that remains in the literature is a lack of meaning of these traits in the effectiveness of and experience of care delivery for patients and staff. Two articles have looked at specific specialties within nursing but no articles have been found that discuss personality traits and older people's nurses.

The literature reviewed revealed some useful correlations between certain personality traits and job performance, although many were not specific to nursing and none specific to older people's nursing. *Conscientiousness* and *agreeableness* were most often presented as desirable traits and results in some studies demonstrate high levels in the nursing population. *Extraversion* is discussed extensively and appears to be a personality trait that may be more difficult to assess in terms of what levels are appropriate to what roles. Many limitations were found with the research studies in this area, therefore there is still a need for further research into optimum personality traits in nurses. For example, whilst some studies describe levels of personality traits that provide a *guess* at being appropriate for a given nursing specialty, there is no evidence to explain specific traits in relation to how care is delivered, nor how personality traits have an influence on the care experiences.

There is debate over the effectiveness of defining personality by only looking at traits, and although the trait research approach remains popular amongst experts in the field, trait theory may not provide a holistic picture of how nurse's personality and associated behaviours effect how they deliver care. Linked to this is debate around stability of traits over time, which would not take into account the professional development of an individual as simply as development as time passes, or within their workplace context (moving from medical to surgical specialism and adaptability for example). A small number of studies suggest that personality may change over time (Bradham 2010; Eley *et al.,* 2010; Eley *et al*., 2012) however this may be adaptivity of a behaviour rather than a change in trait predisposition. Yet, most trait research does demonstrate that traits do not change significantly over time, which would make trait measurement a useful tool for recruitment if

the researcher can develop the theoretical meaning of each trait in nurses. Perhaps the debate over trait or holistic theory is less of a priorty when considering how little is known about personality traits in nursing, and the actual effect on quality of care delivered.

There is, perhaps, a need to move away from describing personality traits to a more theoretical based understanding of traits and how this can be applied to different settings. Utilising personality testing to inform nursing strategy can only be done after describing optimum personality traits and associated facets for nurses. For example, to determine what traits really are a proxy for caring behaviour and what are the behavioral indicators of traits. At what level do some traits become detrimental to care? When working in teams, what traits are desirable to maximise positive outcomes? What traits are required for different level of nursing roles? This research cannot answer these questions but can start to propose some meaning around traits that may be desirable in older people's nurses.

The current research reviewed here does not imply what traits are desirable, if there are any distinguishing personality traits for older people's nurses, at what levels some traits may become undesirable or if traits are stable over time. Such an inherent weakness in the literature in this area has led to the development of this research proposal. There almost needs to be a step backwards, to utilise participants' experiences of nursing care in order to gain understanding of how older people's nurses may display personality traits and their facets through their care delivery behaviours. In conclusion, little is known about how personality characteristics influences nurses' behaviour within care settings and disappointing is that there is nothing published about personality and older people's nursing

specifically. In relation to nursing, Eley *et al.* (2010) suggest that focus of future research should be around what personality traits are more or less suitable in various life situations and professions rather than finding the 'ideal nurse profile'.

Charmaz (2014) describes *sensitising concepts* as a place to start inquiry. The concept of personality is evident as a key sensitising concept for the researcher and on completion of the literature review trait theory has emerged as the specific sensitising concept which provides a general sense of reference and guidance for this work (outlined in section 3.4.2) and the following research aims have been further refined.

2.9 ***Research Aims and Objectives.***

The purpose of this study is to explore whether registered nursing staff's personality traits and associated behaviours affect care delivery for older people within acute care settings. Data will be gathered from stakeholders, as those people who have experience of how older people's acute care is delivered.

2.9.1 *Research aims*

The primary research aim is to critically explore behaviours of registered nursing staff working in older people's acute care settings from the perspectives of key stakeholders; those closest to the situation of observing, or experiencing service delivery to older people whilst inpatients on acute care wards in the UK. The secondary aim is to identify whether there are any distinguishing personality traits that influence effective care delivery for older people in acute care settings.

Further exploration will be considered through research objectives that allow deeper understanding of the implications arising from the study aims, these are outlined below.

2.9.2 *Research Objectives*

1. To gather stakeholder perceptions of registered nurses behaviours when caring for older people in acute care settings and to consider how different behaviours as an output of their personality might impact on nursing care delivery.

2. To undertake conceptual clarification of whether registered nurses working with older people have specific personality traits which relate to behaviours exhibited whilst delivering care that may inform an older people's workforce strategy.

3. To propose a theoretical framework of how registered nurses' personality traits related to behaviours that could sustain quality care delivery across older people's care services.

3 Methodology

3.1 *Introduction*

Constructivist grounded theory (GT) methodology was used (Charmaz, 2014) with an interpretivist epistemology (Mason, 2002) to critically consider the overarching research aim. The overarching research aim was to critically explore registered nursing staff's personality traits and associated behaviours within acute care settings gathered from key stakeholder participants to identify insight into whether there are any distinguishing traits that influence effective care delivery for older people.

3.2 *Epistemology*

Epistemology is the theory of knowledge and relates to the principles around deciding how social phenomena can be known, and how knowledge can be demonstrated (Mason, 2002). Internal consistency should be demonstrated between the methodological approach, and epistemological and ontological assumptions (Carter and Little, 2007).

Two main philosophies underpinning research approaches are the positivist and interpretivist approaches. Positivist philosophy is associated with the assumption of an objective world that can be characterised and measured. A positivist epistemology is associated with deductive research to discover causal relationships and is concerned with the testing of empirical hypotheses (Urquhart, 2013).

An interpretivist epistemology in social science is associated with respecting the cultural differences between people and requires the researcher to grasp the subjectivity of the meaning of social action. In this way the researcher is part of the world being studied, is influenced by their own social and cultural background, and therefore influences how research is conducted and how data is interpreted (Mason 2002; Grix, 2010). This study aim was to gain understanding of stakeholders' experiences of older people's care and develop interpretations of this care in relation to behaviours and personality characteristics, therefore the underpinning epistemology for this was interpretivist.

3.3 *Ontology - Social constructionism*

Ontology is concerned with the form and nature of reality and a specific theoretical orientation relating to interpretivism is social constructionism. This approach is based on the concept of idea of multiple realities and cautions us to be suspicious of our assumptions about how the world appears to be (Burr, 2015).

Constructivist grounded theory was proffered by Charmaz (2014) as an alternative to classic (Glaser, 1998) and Straussian grounded theory (Corbin and Strauss, 2015). This variant of grounded theory developed by Charmaz (2014) promotes a social constructivist approach, grounded in symbolic interactionism, which is a branch of interpretivism. Constructivism thus challenges the belief that there is an objective truth that can be measured or captured through research enquiry. Grounded theory can be entirely consistent with an interpretive, social constructivist approach. From a constructivist perspective, meaning does not lie

dormant within objects waiting to be discovered, but is rather created as individuals interact with and interpret these objects (Charmaz, 2014). Symbolic Interactionism (SI) is a dynamic theoretical perspective that views human actions as constructing society, self and situation (McCann and Clark, 2003; Charmaz, 2014).

SI was introduced by Blumer (1969) and places emphasis on understanding the way meaning is derived in social situations. In the case of the proposed research, the intention is to gain understanding about the effect of personality traits in nurses on their standards of care delivery. Social relationships and human interaction and communication are key to the development of the person when coming from an SI perspective. The likely effects of an individual's actions on others can be imagined and acted upon accordingly because of a shared (socially constructed) system of meaning. For example, language and gestures have the same meaning in certain cultures, whilst for others it can provide alternative meaning for the individual who is outside of this cultural norm (Burr, 2015).

Burr (2015) describes how moral behaviour cannot simply be determined by pre-existent social rules that have been internalised by the force of social structures. Burr (2015) identifies a *self* to be what contains personality (and therefore individuality) which can be explained (and therefore investigated) in social constructivism through study of prevailing discourses. Burr (2015) suggests that the self-concept arises out of an ability for reflection and is present in all social interactions and is a positive moral asset. Are nurses, then, morally responsible for delivering effective and compassionate care? Will they be

unconsciously, subconsciously, or consciously reflecting on their social interactions whilst endeavouring to do this?

This study aligns with an interpretivist epistemology and social constructivist ontology. The research questions are exploratory, and understanding of experiences is sought rather than testing an existing theory. This approach means not seeking objectivity and findings are context-dependent, provisional and open to contest. The researcher has pre-existing ideas and opinions and reflexivity must be practiced to acknowledge and understand the influence of these on the research process.

3.4 *Grounded Theory*

GT aims to develop theory from data. The aim of the researcher is to approach the data without any preconceived categories or codes and not to start out with any hypotheses but develop them after collecting initial data. However the role of the researcher is paramount and the knowledge and experiences that the researcher brings to the research process in constructivist grounded theory is an integral thread throughout data analysis and theory formation. Therefore, a short informal biography forms the introduction to this section, outlining the researcher's professional background and personal professional values. The conclusion to this research will include a reflection on how the researcher's thoughts and values may or may not have been impacted by the research findings.

3.4.1 *Researcher biography*

My nursing career has spanned 30 years thus far. On qualifying as a registered general nurse (RGN) in the North East of England, I started work on a paediatric ward and was able to complete my registered sick children's nurse training (RSCN). As a newly qualified nurse the patients I enjoyed looking after most were children with profound special needs, both physically and mentally disabled. On reflection, this was when I was subconsciously developing a protective interest in the most vulnerable of patient or client groups. After just three years I moved to London and continued to work in paediatrics but moved into paediatric critical care, being promoted quickly and commencing my academic career, gaining a BSc in Child Health and started to publish a few review articles. Gaining an MSc. Advanced Nurse Practitioner award saw me take up this role in a leading London teaching hospital, implementing the country's first paediatric critical care outreach service and publishing a book about paediatric high dependency nursing. Again, on reflection I was passionate about preventable harm/non recognition of deterioration and wanted to support nurses on wards to develop these skills. However, it was the behavioural aspects of care delivery that interested me and my MSc. thesis was a phenomenological study looking at the lived experience of ward nurses looking after children who were deteriorating.

After 10 years I made a decision not to be a career paediatric nurse and moved to work in Her Majesty's Prison Service as a senior manager and practitioner in a high security male prison. I took this job as I was invited to have a look round and I was offered a job after I asked questions about governance, human rights and improving healthcare in prison. I was appalled at the quality of care these clients received for acute and chronic illness, for example ignoring requests for help and assistance from offenders with the belief they were lying or trying to attract attention. A specific example of this was staff stepping over an inmate who was slumped against the wall in the queue for methadone distribution. He had been complaining of abdominal pain but was not examined. When I asked for him to be moved so I could look at him it was clear he was very unwell and an ambulance had to be called. He was in septic shock from a burst appendix. I wanted to 'make a difference.' Here was another vulnerable group with deprivation of civil rights.

After two years in the prison service I took up a post as Head of Care for technology dependent children and adults in the community, a high risk population of clients where lone workers were responsible for care delivery 24 hours a day. It was in this role that I also witnessed poor standards of care by agency staff who lied about their qualifications and caused significant and long-lasting harm to a patient. At this juncture I was asking myself how and why nurses could behave in such a way.

On moving back into the acute care sector I held several roles including Matron in paediatrics then senior nursing roles in renal and older people's services. As mentioned in the introduction of this work, this was the key driver for this research. Since leaving that role I have held two senior corporate roles and I still continue to take a specific interest in the quality of care delivered to this patient group.

My values as a junior nurse reflected the enthusiasm of being a young nurse, doing one's best and trying not to make a mistake. My focus was on the feeling of satisfaction on delivering good care but at the earlier stage in my career I was not analysing the origin of that job satisfaction. My personal value system now incorporates the belief that care that is delivered without kindness is abhorrent to me. Skills can be learnt but being kind in the delivery of care is a decision that is an active process on the part of the nurse. Preparing for the professional doctorate and performing the literature view necessitates questioning any disconnect between the values I state and my own personality and care delivery. I feel that my values are associated with a strong bias towards focussing in on negative aspects of care delivery in older peoples nursing and puts me at risk of confirmation bias emphasising the need for robust reflexivity. Perhaps having strong views are related to an aspect of my personality. Reflecting on whether I think my personality has changed over time, I would say not but behaviours associated with having strong views have definitely modified over time, that is, with experience comes knowing the 'right time and place' and how to express an opinion that will influnce others. I have not had a formal personality profile performed, only those associated with professional and leadership development. It is almost fun to 'guess' at what my profile would be however this takes an internal strength and honesty. I am committed and conscientious but I am fixated on holistic care and speak often to nurses about the 'tick box culture' we have in healthcare which, whilst promotes safety, does little to reinforce a holistic approach to care and reduces care to the tasks we are trying to avoid.

3.4.2 *Sensitising concepts*

Sensitising concepts give the researcher a general sense of reference and guidance in approaching empirical instances. Social researchers tend to view sensitising concepts as interpretive devices and as a starting point for a qualitative study. Sensitising concepts offer ways of seeing, organising, and understanding, they provide starting points for building analysis, not ending points for evading it (Charmaz, 2014). In the case of the researcher's work, the key sensitising concept is that of personality trait theory which is evident as the thread through the literature review, research findings, data analysis and theory development.

3.4.3 *Theory development*

Abstract theory can be inductively and abductively derived from the data because it is grounded in the data (Grix, 2010). Two types of theory can be developed: formal theory, which is general and deals with a conceptual area such as illness experience or organisational learning, and substantive theory, which concentrates on specific social processes within a specific context. Multiple substantive theories may result in a formal theory (Glaser and Strauss, 1967). The output of the proposed research is substantive and will describe theory relating to nursing care delivery as a social process.

The constructivist approach of Charmaz (2014) places more emphasis on views, beliefs, values and assumptions of individuals than on the methods and the complex systematic approaches of Corbin and Strauss (2015). Charmaz (2014) suggests that many researchers claiming to use GT engage in data collection and analysis, draw on data and develop

inductive abstract categories but stop short of true theory construction and do not acknowledge how the researcher's preconceptions can shape analysis and theory construction; a concept known as theoretical sensitivity. Viewing the research as constructed rather than discovered will encourage researchers' reflexivity about their actions and opinions. Abductive reasoning, which distinguishes constructivist GT, is the process that leads researchers beyond induction, where researchers can pay attention to data that does not fit, re-examine it and perhaps gather more data as a consequence to further investigate any anomalies.

Lo (2014) suggests that this evolution of GT methodology is inevitable, given the lack of philosophical discussion in Glaser and Strauss's original work (1967). Healthcare is complex and the flexibility to choose an evolved approach to GT may be beneficial, the key is to justify the approach and stay true to the philosophical underpinnings.

3.5 *Relevance and choice of GT for this research*

GT falls under the broad umbrella term of 'qualitative research methodology'. Data collection, in the main, takes the form of observational work and/or interviews that generally involve the use of open-ended questions that can evoke responses that are meaningful and significant to the participant, unexpected to the researcher and rich and illustrative in nature.

An advantage of qualitative methods is that they allow the researcher the opportunity to respond in order to clarify the response given by the participant. Specifically, GT allows direct examination of the area of study through engagement with those who are best placed to comment on the research topic. Therefore, the stakeholder participants for this study were those with a direct interest or experience of nursing in older people settings: nurses, governors, ex-patients and/or carers.

GT is considered useful for studies where little is formally known about the area, there are few existing theories or those that do exist do not capture the complexity of the issue (Glaser and Strauss, 1967). In this case, little is known about the impact of personality on nursing care delivery. Consideration of other methodologies is summarised in Table 3.

For the purpose of this work the research process is laid out in a logical order. However, consistent with GT, the research process was not a linear one and constant movement back and forth between the different elements of the process was required.

Alternative methodology	**Rationale for not using**
Phenomenology	Phenomenology in its broadest sense, enables understanding of a phenomenon through the specific human experience of the phenomenon (Creswell, 2013). Participants explore and describe profound experiences which may have been of value for this work. However, the goal is to answer a specific research question about the experiences of the participants and at this point the researcher does not have a specific phenomenon to ask the participants about at this stage therefore the researcher's aim is to generate theory.
Ethnography	Ethnography is generally associated with the study of culture and of group values and traditions (Creswell, 2013). Observational studies are the most common method of data collection and could be a suitable methodological approach for this research. A mixture of observations and interviews would be required. However, the researcher has opted for GT in the first instance as there is little or no research in this area and there would be no meaningful guide as to what to observe for.
Quantitative methodology	Quantitative approaches are generally associated with testing a hypothesis and would not allow the depth of exploration required to give meaning to personality. In addition, there is little to 'test' before theory is developed. Quantitative approaches can be rigid with data collection methods such as surveys and questionnaires meaning that researchers ask participants the same questions in the same order. The responses from which participants may choose are often closed-ended or predetermined. There is less opportunity to ask questions that follow up on key lines of enquiry with individuals as this builds unwanted variation in to the sample and data collection.

Table 3 Research methodologies considered for this work

3.6 ***Methods***

3.6.1 *Sample*

The sample consisted of stakeholders, as people who have the ability, experience, willingness and/or knowledge to talk in detail around the subject of nursing in older people's acute care settings.

Twelve participants were recruited and are summarised in Table 4 below. All participant names are pseudonyms, used to ensure anonymity and confidentiality. The last two participants in the table (identified as Amy and Jo), were interviewed after initial data analysis and coding in line with the spirit of theoretical sampling in GT (Glaser, 1998; Charmaz, 2014). This enabled a pursuit of key lines of enquiry, as revealed in the initial interviews.

(pseudo)Name	Stakeholder representative group	Additional information
Joan	Governor	Elderly father had died in hospital on an older people's ward. Joan has also been an inpatient but not on an older people's ward.
Sarah	Public Governor	Elderly mother had died in hospital on an older people's ward
Betty	Patient Governor	Betty was herself an inpatient on an older people's ward. Elderly brother died in hospital on an older person's ward.
Helen	Band 6 Junior Sister	Qualified less than 10 years. Moved to older people's ward from a respiratory ward.
Deborah	Band 5 Staff Nurse	Worked on older people's wards for > 25 years.
Chloe	Band 5 staff nurse	Qualified for one year; Three months on intensive care then moved to older people's ward.
Louise	Lead Nurse – Frailty & dementia	Qualified for 20 years, background acute care then moved into older people's care 10 years ago.
Kay	Director of Nursing	Qualified for >25 years, corporate roles for 8 years. Clinical background is cardiac nursing.
Elaine	Lecturer in Adult Nursing,	Specific interest in older people's care.
John	Head of Education & Organisational Development	No clinical background, extensive experience in team and individual staff development.
Amy	Associate Director of Nursing – Community Division	Qualified > 25 years. Community Division includes Care of the Elderly, medicine and associated ambulatory specialities.
Jo	Matron – Elderly Care	Qualified 15 years. No background in elderly care until this post, commenced 2017.

Table 4 ***Study Participant Details***

3.6.2 *Sampling stages*

Purposive sampling was used to enable a secure process for acquiring research participants with a particular characteristic (Bowling, 2014). Purposive sampling enabled the recruitment of stakeholder participants who were able to talk extensively about their experience of older people's care, as either a healthcare professional or someone who has received care or witnessed care as a relative.

Sampling then progressed to 'theoretical sampling', which pertains to conceptual and theoretical development, not to the representation of a group or population. Early data analysis and the increased understanding of an emerging theory starts to direct the sampling. Participants are asked more focused questions adding to the existing data set about a particular concept or category (Bryant and Charmaz, 2007; Charmaz, 2014).

The iterative nature of GT, abductive reasoning and theoretical sampling means that the researcher may return to participants or indeed interview with new participants. Sample size is of less importance than the focus on revision of interview questions to enable deeper understanding of emergent issues. Increasing the number of interviews in response to findings and the construct of complex conceptual analyses allows for improved ability to obtain theoretical precision. Charmaz (2014) states that the researcher should retrace their steps or take a new direction when tentative categories are emerging in order to collect more data and aim to saturate the properties of that category.

An additional two participants were approached after a period of initial categorisation of data. Key lines of enquiry, which the researcher wanted to explore further, were elements of *coping*. This enabled the researcher to definitively identify *coping* and *conscientiousness* as two separate major categories as part of the *authentic self*.

Obtaining access to stakeholder participants and obtaining their ethical consent to participate can be time consuming and challenging. The process is detailed in Table 5. Access to patients or carers of relatives who had recently been in hospital was attempted via Age UK, by attending their meetings but this was unsuccessful. Although the attendees at the meetings were happy to chat about experiences in their open forum perhaps they did not feel engaged enough with the research to undertake an interview and recall their experiences.

One governor that was recruited fitted the patient category criteria as she had recently been an inpatient on an acute older people's ward. All three governors had experience of their relatives being cared for on older people's wards.

	Rationale	Inclusion criteria	Exclusion criteria	Recruitment method	No. recruited	Challenges/comments
Patients/ Carers	First-hand experience of nursing care. AGE UK was chosen to try and ensure willingness and ability to discuss a complex topic rather than approaching current inpatients who would be vulnerable and may be less willing to talk about such a sensitive subject.	Willingness and ability to discuss a complex topic. Recent (within 12 months) experience of an older people's ward.	Current inpatients - the researcher considers inpatients to be vulnerable and knows from experience that many patients do not like to comment on what they perceive as their care in case this effects the care given. In addition, the researcher did not want to interfere in any way with treatment progression or interventions.	An initial approach was made via email to AGE UK requesting advice in terms of recruitment (Appendix IV). Attendance at a coffee morning (AGE UK) – North Yorkshire & an associated Ladies Healthy Living Group), meant the researcher was able to present the research proposal and leave participant information sheets and contact instructions.	0	The attendance at 2 meetings was challenging as attendees were very keen to talk within the group which snowballed into vociferous regaling of negative experiences of healthcare and is summarised in the researcher's reflective diary and field notes (Appendix VI)
Patient/ governors[9]	It is paramount that the patient's views are obtained for this research and patient governors by virtue of their role as the patients advocate and challenging the	Active patient governors with an interest in the care of older people.	Not a current inpatient (vulnerable and may be less willing or able to talk).	Presentation at the Council of Governors regular meeting in September 2017 followed up by direct email (Appendix IV) resulted in the recruitment of three	3 (1 x patient and 2 x carers)	Nil

[9] NHS foundation trust governors are recruited from the local population, patient or staff groups. Governors hold NHS foundation trust's non-executive directors to account for the performance of the board and represent the interests of members and the public.

	hospital Board around quality of care are well placed to discuss care of the older person.			patient governors.		
Nursing lecturers	Experience of care and educational delivery relating to care of older people.	Specialist interest in care of older people.	No interest in older people's care.	Direct email (Appendix IV)	1	Nil
Senior nurses, Band 7 and above working in the field of adult nursing and familiar with older peoples nursing.	Experience of care delivery and managing nurses.	Working in the field of older people's nursing.	Not working in the field of older people's nursing.	Direct email (Appendix IV)	4	Nil
Band 5 or 6 older people's ward nurses	Experience in the delivery of care to older people.	Qualified longer than 6 months to allow development of experience, opinion and knowledge that will enable more effective participation in the interview.	Qualified less than 6 months	Poster/voluntary (Appendix V).	3	The plan if there were more volunteers from the ward area than were required was to select the names randomly and those who were not required would be emailed and thanked and put on a reserve list. This was not necessary. The poster was put up with some participant information sheets, 'post its' and envelopes to return for expression of interest but after 4 weeks no one had volunteered. There were potential concerns around junior nurses feeling coerced into participating or feeling like they have to say 'the right thing' by virtue of the seniority of the researcher's position

						in the organisation. However the researcher found that by informally visiting the wards, and talking about the research, staff then came forward as they felt they knew more than they did from the poster alone, particularly about the type of interviews and not being asked lots of questions. The researcher put emphasis on a voluntary approach to being interviewed and confidentiality aspects of the participation and the opportunity to discontinue with an interview or indeed participation in the research at any time.
Head of Organisational Development (OD)	Expert in the nurturing and development of staff in order to drive change in an organisation.	Not applicable	Not applicable	Opportunistic	1	The decision to interview the Head of Organisation Development for the host site, was made opportunistically at work during a professional discussion about team dynamics within the researcher's older people's services. Whilst this participant may not 'fit' accurately under the criteria of '*Selection of research participants who have first-hand experience that fits the research topic*', there was a realisation that, although much of this participant's contribution may be theoretical, it would also be based on extensive experience in human behaviour and observations in the chosen clinical setting.

Table 5 Participant recruitment process summary

3.6.3 *Choice and limits of the sample.*

The final sample size consisted of 12 participants drawn from across a diverse range of stakeholder experiences of older people's care in acute settings. In qualitative research the intent is not to generalise but to collect extensive detail about the individuals being studied (Creswell, 2013) and Charmaz (2014) states that "*a very small sample can produce an in depth interview study of lasting significance".* The researcher was guided by the data that emerged from each interview and simultaneous analysis and was satisfied that 12 interviews were sufficient.

The decision was taken not to interview members of other allied health and medical professional groups because of specific sub cultures and training backgrounds that may influence their responses about attitudes and observations of nursing care delivery. The *context* for them may also be more around their own interaction with nurses, rather than focusing on nursing care delivery to the older person as an acute care patient.

No inpatients were recruited to the study to be interviewed. The researcher made an informed and considered decision that current inpatients were potentially vulnerable and from a professional clinical experience many inpatients do not like to comment on what they perceive as their live, in patient care experience, particularly if there is any risk that providing negative feedback might further negatively impact the care they are receiving. In addition, the researcher did not want to interfere in any way with treatment progression or interventions which also influenced the decision not to interview patients in the outpatient

setting. 'Vulnerability in research' is well recognised and may relate to feelings of subordination in the participant, fear of negative consequences if participation is declined or failure to enroll will deny them effective treatment (Biros, 2018) .

3.6.4 *Research setting*

The study site was a large NHS Trust in the North East of England and the study participants lived locally to the main hospital site. The Trust provides secondary healthcare services to a large population within both inner city/town and a large geographical rural area. The population demographics are typical of the UK in that there is a rising aging population and there are health discrepancies between the more rural or suburban areas, where life expectancy is higher and general health is better than for those living in inner city, less affluent areas. Although deprived areas can be found in all regions of England, there is a higher concentration of more deprived authorities in the north. In addition, life expectancy in local authorities within the same deprivation group is generally lower among authorities in the north than those in the south (Public Health England, 2017). The demographic narrative is included for completeness but does not relate to or effect the findings or analysis.

3.6.5 *Data collection – Interviews and field notes*

Semi structured Interviews were designed and implemented to gain as much data as possible from individuals about their experiences and perspectives. Brinkmann and Kvale (2015) describe the interviewer either as a *miner*, discovering and collecting data that

already exist, or a *traveller*, talking to people on their journey and constructing data through conversation.

The researcher's rationale for using qualitative interviews to gather data relates to how interviewing can provide a rounded knowledge about our conversational realties. In relation to the metaphors, the researcher is the *traveller*, more interested in travelling around the territory, which may be unknown, and in the conversation and accounts to produce knowledge, than the m*iner* who would be looking for reports to reflect the facts of the interviewee. The interviews produce data from which knowledge is constructed and the meaning is derived from within social situations, in keeping with the symbolic interactionist epistemological approach taken by the researcher (Blumer, 1969).

The constructivist approach means that the interviewer does not attempt to 'vet' what people say, experience is embedded in a web of interpretation and reinterpretation (Silverman, 2011). An intensive interview technique was used (Charmaz, 2014) and the key characteristics of this technique are summarised below:

Intensive interviewing:

- Selection of research participants who have first-hand experience that fits the research topic.
- In depth exploration of participants' experiences and situations.

- Reliance on open-ended questions, with the objective of obtaining detailed responses.
- Emphasis on understanding the participant's perspective, meanings and experiences.
- Practice of follow up on unanticipated areas of inquiry, hints and implicit views and accounts of actions.

Charmaz (2014) stipulates devising broad open-ended questions, and then focusing the interview questions to invite detailed discussion of the topic and/or an interview guide of a list of topics to be covered in the interview. The researcher developed an initial guide, then specific questions were developed and added in subsequent interviews as key lines of enquiry started to emerge (Appendix VII). In reality, the interviews became less structured than planned. The researcher rarely glanced at the guide as the simple act of asking a participant to talk about their own experience or thoughts initiated easy conversation which the participant could dominate whilst the researcher used reflective prompts and gentle guidance (if required) or asked specific questions.

The questions were initially an attempt by the researcher to gain understanding about how personality characteristics are exhibited in care delivery, rather than just accounts of experiences. However, it was evident after just one interview that it was the accounts of experiences and opinions that are vital to enable the researcher to enable reflexive thinking and early theorising about the exhibition of personality in care delivery. The skill of the

researcher is to create a balance between asking significant questions and not forcing responses, and how to link and utilise the participants' experiences to guide the participants from description to a theoretical level of response (Charmaz, 2014).

The iterative process of GT and theoretical sampling led to interviews with two new participants. These participants were senior nurses. As tentative categories developed from first interview data analysis, the researcher needed to interview well informed participants to assist in bringing greater clarity to the conditions under the category which "*illuminates the empirical wor*ld" (Charmaz, 2014 p103). After similar opening and general questions offered to the previous participants, the researcher presented questions that were still open in style but addressed very specific matters that had arisen in previous interviews such as;

> *Can you tell me your thoughts about the need for high levels of patience in older people's nurses? Relate this to experience and examples if that helps*

In this way participants were encouraged to focus on specific characteristics but still within the context of real examples of nursing care, continuing to support the reflexive process.

3.6.6 *Interview logistics.*

Interviews took place in private rooms and were audio recorded. All data was, and remains, password protected on the researcher's private computer. Of the 12 interviews, two were

held in participants' own homes, by their own choice, and the remaining 10 at the researcher's workplace. The researcher was mindful that, for the junior nurses, they needed to be able to concentrate and not be distracted by thinking about work, therefore the researcher ensured cover for the duration of the interview so they could leave the ward and not feel guilty. This was also to mitigate the researcher's own feeling of discomfort as, had they asked them to be interviewed on a day off or before or after a shift, this would be very intrusive to their own time. The researcher also provided coffee and cake to the junior nurses in a further attempt to humanise the setting and put them at ease.

The participants were asked if they had any questions about the participant information sheet and were asked to read through the consent form, then the researcher clarified each question and the participant was asked to sign the form unless they had any questions. No additional questions were asked at this time.

The interviews lasted between 40-60 minutes. The length of the interviews was dictated by the researcher recognising that narrative was coming to a natural conclusion or end point. The level of control over the interview process is discussed by Brinkmann and Kvale (2015) who describe this as 'power asymmetry' and that the researcher should not presume open and free dialogues between egalitarian partners. The researcher initiates interviews, asks the questions, closes the interview and manages the data. However, the participant ultimately remains in control of what they say and taking part in research may be driven by a wide range of reasons, for example, eliciting sympathy and relieving boredom. In this

work, the participants all agreed to be interviewed and/or volunteered. The time of the day was also chosen by all participants. These elements of control contributed to reducing the 'power asymmetry'.

The interviews were audio recorded, uploaded onto a computer and sent to a professional transcriber. Transcriptions are constructions from oral to written text and must be considered in terms of reliability and validity (Brinkmann and Kvale, 2015). To ensure reliability, the researcher listened to all interviews whilst reading the transcriptions to add in specific intonations, pauses and to ensure insertion of commas and periods that accurately conveyed the spoken word as it is imperative in GT to have full content and context. Validity of transcriptions is more challenging and Brinkmann and Kvale (2015) state that asking the question "what is a useful transcription for my purposes?" is a useful approach. The professional transcriber used by the researcher provided high quality and accurate transcription, which the researcher has validated by listening to the audio tapes again whilst reading the transcriptions and ensuring, for example, that any distress or changes in tone of voice are noted.

A field diary was maintained – collecting data that may contain some conceptualisation and thoughts about these. Field notes are different to memos, which often include more in depth thinking about a subject and often represent analysis (Appendix VI). Field notes were written immediately after each interview so as not to appear disinterested by making notes

during the interview. The notes captured details of the setting and thoughts of how the interview progressed, as well as initial analysis ideas.

In GT, data is collected to advance theoretical analysis and interviewing gives more control over generating data than other forms of data collection. Iterative data collection and analysis are intertwined. In the 'interviewing' chapter of her book, Charmaz (2014) describes theory construction in relation to four theoretical concerns that assist progression through data collection and analysis:

1. Treat recurring statements as **theoretically plausible**
2. **I**dentify **theoretical direction after** developing initial tentative categories.
3. **Theoretical centrality** of certain ideas and lines of enquiry leads the researcher to pursue them.
4. Later interviews included questions that helped assess the **theoretical adequacy** of the categories.

3.7 *Data Analysis*

3.7.1 *Introduction*

The act of data collection and data analysis occurs simultaneously and is the iterative process associated with grounded theory. As each interview was analysed, codes, categories and theoretical ideas emerged that identified the need for further interviews to allow these

ideas to be challenged or developed. Analysis is only achieved with effective constant comparative analysis. This refers to the act of examining one piece of data against another within and between documents (Glaser and Strauss, 1967). Similar data can be grouped together under a conceptual label and essentially data collection and analysis is occurring simultaneously. Charmaz (2014) makes suggestions of how researchers might use comparative analysis, such as comparing data in earlier and later interviews or compare observations of events at different times and places, suggesting that perhaps the rigidity of stages of comparative analysis are not required. Comparison makes it more likely that variations will be uncovered as well as general patterns.

Comparison also helps suggest further interview questions and counters the tendency to focus on a single case by taking analysis to a more abstract level. The inductive researcher will want to see how the data functions, how the researcher is positioned and how many varieties of the data there are (Miles and Huberman, 1994). This is the 'grounded' approach originally advocated by Glaser and Strauss (1967). Constant comparison continues throughout the coding and theory generating process.

Coding enables the researcher to look at data differently from the participant's interpretations and analysis leads the researcher to look at statements in a way that would not naturally occur to them. The words 'codes' and 'categories' are used in varying ways and interchangeably. The researcher defines codes for this work as 'labels' given to lines or sections of the interview narrative and categories refers to grouping together of these codes

following multiple comparisons. Categories are presented at varying levels of detail, dependent on context and stage of analysis.

3.8 ***Coding and categorising the data***

This section is presented as three distinct phases but in reality the phases were not linear and there was much overlap as categories developed and substantive codes were constantly re-examined.

3.8.1 *Initial coding*

Interview transcripts and field notes were initially coded line by line. Constructed codes then developed into categories that crystallised participants' experiences. Constant comparison of the incidents or experiences started to generate the theoretical properties of the category. Similar meanings in codes were clustered together into categories and labelled with more abstract concepts. Charmaz (2014, p133) states that a "*study fits the empirical word when constructed codes have been developed into categories that crystallise participants experiences".*

Line by line analysis and the assigning of initial codes serve as symbolic markers of the participant's meanings and speech. Such codes anchor the researcher's analysis in the participant's world, which also assist in reflexivity as coding by incident or theme increases the likelihood of the researcher imposing pre conceived ideas. Whilst initial codes were vague or incomplete, repetitions and patterns and asking the questions: 'what's

interesting?' Then, 'why is it interesting?' led to a descriptive or constructed analytical code or a note in the margin, labels and then, 'why am I interested in that?' which helped progress to a more conceptual and abstract level.

Charmaz (2014) suggests that trying to see actions in data segments rather than applying pre-existing categories to the data and attempting to code with words that reflect action will reduce the risk of focussing on types of people rather than what is happening in the data. Glaser (1998) suggests coding with gerunds will assist this process e.g. describing not description, leading versus leader etc. Examples of initial coding can be seen in extracts of transcripts in Appendix VIII. The codes stay close to the data and the researcher endeavoured to identify concerns and thoughts of the participants rather than treat narratives as a series of statements.

The analytical or constructed codes were developed by the researcher or occasionally 'in vivo codes' were used, using the words of the participant. In vivo codes are participants' 'special terms' that will preserve participants' meanings of their views or actions. For example, describing a nurse as *slapdash* is a very accurate way to describe someone who does not pay attention to detail or the patient's needs. The most commonly used in vivo code was "*going the extra mile"*, a description of a nurse that was perceived to do more than was necessary in their role.

3.8.2 *Focused Coding*

Focused coding is the second phase where codes were used to sift and synthesise large amounts of data. Focused coding is more conceptual than the initial stage and gives theoretical direction to the work. Decisions were made about which initial codes made analytical sense in order to categorise the data. Although of note, Charmaz (2014) states that researchers must not believe that codes need to reappear often to become a focused code.

The researcher's approach to focussed coding

Logistically, the researcher copied and pasted all of the initial codes or 'labels' from the margins of the transcripts onto separate documents to enable ease of cutting them up into individual pieces of paper containing the codes. Each code also had a reference, which enabled the researcher to be able to go back to the exact point in the transcript when required, to ensure the original meanings of the codes were not lost. For example, 'P1 pg 37' meant the code came from Participant One and originated from page 37 of the transcript. The researcher had not assigned pseudonyms at that point so the participants were numbered. The researcher had purchased several pieces of A1 card that provided a convenient medium to place the codes, read them, and move them around into categories. The researcher took a photograph of one of these A1 cards as part of a reflective log (APPENDIX IX).

Initial categorising of over 200 codes led the researcher to think about 3 very broad category headings, 'behaviours', 'quality of care' and 'other stuff'. These headings actually reflected the success of the data gathered at interview. The aim was to gain understanding of what was meant by terms like *caring, approachable* or *nice* etc and each time a participant used these type of terms the researcher asked them to describe what a nurse looked and sounded like when they had these qualities and how they delivered care. The response then became about behaviours, what nurses actually did and the end result of this was of course, a description of the quality and type of care that was delivered.

The two large categories of 'behaviours' and 'quality of care' were then broken down to approximately 15 very broad categories which at this point still had very simplistic headings such as 'good care', 'poor care', or 'communication'. The focussed codes within these broad categories were re-examined and grouped into more abstract category headings. At each point when codes were moved between categories the transcripts were re-examined again to ensure the codes had not been moved out of context and the categories did indeed summarise the data. The data under these abstract headings will be presented in detail in the Findings Section (page 123). This clustering technique was facilitated by diagramming the emerging categories and a photographic version of this can be seen in APPENDIX IX, a visual representation of 'flip flopping' codes between categories - constant comparison allowing for the richest and genuine meaning of the final categories and emerging theory.

A key reflexive point at this stage of data analysis was that the researcher had a relatively small group of codes to one side under the heading of 'other stuff'. The temptation was to leave these codes out of any further data analysis. However, the participants had chosen, consciously or otherwise to talk about other factors that they perceived to influence care delivery and whist the researcher was focussing on behaviours and personality, it was apparent that personality and subsequent behaviours may be influenced by other factors. These codes then fell under their own category heading of *Context* which will be described in detail in the Findings Section (page 193). The researcher at this point was mindful of earlier literature around personality theory, that addressing traits alone may not provide adequate explanation of behaviours and would not be in keeping with the epistemological underpinning of this research. The extent, if any, to which contextual factors influence the exhibition of personality behaviours started to become of interest.

The researcher chose not to use an electronic analysis tool for qualitative data such as 'Nvivo'. Bazeley (2013) states that it is ideal to have both the benefit of being able to see all the data pertaining to one code or a combination of codes in one place. The above method adopted by the researcher allowed this and provided an easy and deeply interactive way to be grounded in the data. This style suited the personality and visual approach of the researcher. GT methodology is not about counting or tallying up the number of times a word appears, which would be a significant benefit of using electronic software. The main caution offered by Bazeley (2013) is to ensure care in how you record what you are noticing

and thinking as you code, which the researcher has done and demonstrated in the associated memos, reflections and the final writing up of the findings in Section 4.

3.8.3 *Theoretical coding*

Theoretical coding is the process of bringing together the constituent parts into one conceptual *whole.* At this stage the researcher is theorising and new ways of thinking are fostered as theorising about relationships and concepts occurs (Charmaz, 2014).

As mentioned above, this process was facilitated by 'diagramming' (Charmaz, 2014), visually mapping out the categories and relationships, which was useful to identify the relationships between categories. Diagramming offered a concrete image of ideas and Charmaz (2014) states that, through mapping situations, social worlds and researcher positions, GT will preserve realities and complexities without reverting to reductionist analyses. The analytical categories described by Glaser (1998) also proved useful, particularly *causes, conditions*, *context* and *consequence* and relate directly to the researcher's category headings. The conditions and *context* relate to what else may influence how nurses deliver care apart from personality. The causes are around the personality traits themselves and the *consequence* is the outcome of the effect of the traits on care delivery.

From approximately 15 categories, a core category was identified during theoretical coding: t*he authentic self*. This was underpinned by four categories relating to personality:

conscientiousness, sociability, *integrity* and *coping*, and related to two categories identified as *consequence* and *context*. The theory constructed during data analysis is presented in detail in Chapter 4, Findings.

The complexity of the conceptual relationships between categories and within a core category reflect a model of multiple realities, not of causal linear relationships, that was built by interpreting and analysing both implicit and explicit meanings in the data. The researcher ensured that the views of all of the participants had been captured by reflecting on whether the view of each participant had been captured, to a lesser or greater, degree within the framework. This process was facilitated by writing memos aligning the framework headings against the original transcripts of some of the participants asking "*can I see this theory in the original data*"?

The majority of the codes identified within the data related to the characteristics of nurses and how the associated behaviours were enacted in care delivery. Therefore, the category of *context* did not appear to relate to the research question and objectives, nor to the questions asked of the participants. The category itself is small and the codes within it are much smaller in numbers than the other categories. However, given the variables that could be called into question when discussing how nursing care is delivered, the researcher thought it prudent to reflect the importance of *context* as a concept that may moderate the behaviours of a nurse when delivering care and how that *context* is responded to dependent on the characteristics of the nurse.

3.8.4 *Theoretical memos*

Memoing occurred throughout the research process. This enabled the researcher to pause, make notes and develop ideas about codes in any and every way. Analysis started early and fulfilled a key aspect of GT, which is the simultaneous collection and analysis of data so nothing is missed or dismissed (Charmaz, 2014). Glaser (1998) describes memo writing for 'moment capture', to capture meanings and ideas for the researcher's growing theory at the time they occur and still far from ready to show others.

An example memo can be found below, which relates to early initial coding. Further examples are in Appendix X. The memo content is woven into data analysis by assigning each memo to its relevant category and underpinned by researcher reflexivity. Example;

> *Much has been said about the right type of nurse being patient and compassionate and the desire to spend time with patients, which reinforces the stereotype of the 'perfect' older persons' nurse. Equally, much has been said about the pace of work, older people's nurses like a slower pace, nurses who have worked there a long time complain more about change and 'busyness' and blame lack of staff. Do we have recruitment completely wrong? Should we move away from the image of the young hand holding the old hand? Should we focus more on the acuity which is actually the reality? Do RNs need to focus on skills and utilise different staff to spend the time with the patient – will it be a group of staff that meet all the needs of the patient not a homogenous group of RNs? Do we need to free RNs of guilt about not being able to*

spend a lot of time with the patient in an acute setting? We do this in reality by utilising low grades and volunteers yet still pursue the 'traditional' qualities in older people's nurses and portray the image that RNs have all these qualities. Do RNs need the 'traditional' characteristics AND the ability to cope if they can't spend a lot of time with a patient?

This memo became relevant as the researcher wrote up the findings and revealed a clear category entitled *Coping* and an incongruence between the characteristics required and the characteristics which some nurses have that do not enable *coping*.

3.8.5 *Theoretical Sufficiency*

Glaser (1998) stated that data should be collected and analysed until 'theoretical saturation' is achieved. He suggested that when comparing more incidents yields no more properties of the category and it is verified, saturation is achieved and that stopping coding and collecting on a saturated category is almost automatic. "*The category has earned its way into the theory and it becomes boring to keep comparing incidents. Memos keep track of what is emerging"* (Glaser, 1998 p141)

However, it is challenging to assess when saturation is achieved, therefore codes and categories were compared until what is described by Dey (1999) as 'theoretical sufficiency' is achieved, thus avoiding the trap of assuming categories are 'saturated' when they may

not be. Charmaz (2014) emphasises the iterative nature of GT, therefore saturation is contradictory to this concept.

The researcher collected enough data to allow meaningful analysis after 12 interviews (10 initial and two post initial analysis and categorisation). The two later interviews did not fundamentally change the direction of the analysis but added to the existing categories. The researcher is confident that the theory generated is based on credible interpretations of the data as the process for analysis has been described in detail, however, even at completion of this thesis the researcher remains open to challenge and further analysis.

It was challenging to differentiate between stakeholder's positive statements (about what is) and their prescriptive statements (about what ought to be) as the participants moved fluidly between talking about their personal experiences of nursing care, and describing those they had observed, compared with expression of their own thoughts about what effective nursing care should or could look like. However, the study participants were specifically chosen as informed stakeholders around the subject of older people's nursing. Therefore the 'is' or the 'ought' became of less important distinction in terms of data accuracy, rather the focus is on a collective expression of stakeholder opinions, merged to form a new understanding of how older people's nursing is effected by an individual nurses personality traits, demonstrated through their behavioural characteristics whilst undertaking their nursing duties in acute care settings.

3.9 ***Ethical issues and approval***

Protection of the safety of human participants is the paramount concern in research and much of the writing about ethics in research concerns the principle of not harming the participant (Denicolo and Becker 2012; Gorard 2013).

Iphofen (2009) states that some commentators suggest social science research does not need the ethical scrutiny of biomedical research as it does not cause as much *harm*, however that means trading the *effects* of physical harm against emotional or psychological harm. Iphofen (2009) argues it is obvious that harm could be caused, and indeed has been caused, by social research, and scrutiny of research intentions is of paramount importance.

3.9.1 *Ethical concerns related to this research*

Firstly, the potential situation of having to breach confidentiality of the participants. This was explained to participants by assuring them that all information gathered would be kept confidential unless something was disclosed that must be investigated. This would be highly unusual and only if not doing so posed a danger to the public and indeed, did not occur.

Secondly, some topics may be considered controversial, for example, poor care or treatment of patients. The researcher's proposal to study personality in nursing may have revealed perceptions of negative characteristics in nursing and consideration was given to this when presenting the research proposal to the relevant ethical committee and to a

wider audience. The findings of the Francis Report (Department of Health, 2013) are still widely talked about in healthcare and the nursing profession continues to attract media attention. Research such as this, that potentially describes negative experiences of care by participants, needs to be presented and published proactively and honestly but with sensitivity. Of interest, the participants did not appear to be reserved in their opinions of what they perceived to be negative effects of personality on nursing care.

One nursing participant did stand out as having more negative views of older people's nursing. For example, high level of complaining amongst the nursing staff about workload or having to be 'politically correct'. This exploration within the research interview did not reach the level of raising sufficient concerns about current practice, which for the researcher, as a professional nurse and working within the study site, meant there was no presenting risk, for the need to take any further action, as outlined in the Participant Information Sheet. There were no professional conduct or performance issues identified that needed to be addressed further through 'whistleblowing' or 'safeguarding' procedures available to me.

3.9.2 *Ensuring ethical approval*

Behaving ethically in research requires the researcher to "*plan a route through a moral maze*" (Iphofen, 2009 p6) and the following were put in place to enable an ethically sound research study:

- The research proposal has come under the scrutiny of, and approval for research was awarded by:

    - London South Bank University Ethics Committees – October 2017 (APPENDIX XI)
    - NHS Research and Development Committee. The local NHS Research and Development Committee did not recognise this work as research it fell in to the category of 'service evaluation' and, as such, did not require a full ethics application. – July 2017 (APPENDIX XI)

- The researcher sought additional assurance that a full ethics application submission was not required by the Health Research Authority (HRA). The research details were submitted into the Health Research Authority online assessment tool firstly in 2017 and again in April 2018 following some changes in HRA regulations, which did confirm that a full ethics application was not required (APPENDIX XI).

- Voluntary informed consent was obtained and included assurance of confidentiality to anyone other than the researcher (Appendix XII). Explanation was given to participants as stated in the Participant Information Sheet, in that confidentiality may need to be broken if anything was disclosed that related to current patient risk or harm that had not been managed appropriately. This was not required to be actioned at any stage of the project. For the Head of OD, confidentiality to him related more to speaking about nursing behaviours he had witnessed or disclosing

conversations he had with nursing staff. As for any participant, any names were redacted from the transcripts and nothing was disclosed to the researcher that required action.

- Robust participant information sheets were provided for all participants taking part, which reinforced that the participant could withdraw at any time. There were two sheets with slightly different wording, one for the nurses and one for the patient/governor/carer participants that acknowledge how they could contribute, i.e. using nursing experience or personal experience. The information sheets are enclosed as Appendix XIII.

- The need to potentially conduct a second interview with some participants was explained in the patient information sheet. In reality, no participants were interviewed twice.

3.10 ***Trustworthiness***

3.10.1 *Introduction*

Achieving rigour in GT research has been open to criticism (Cooney, 2011). There are several ways to gain assurance as to the quality of qualitative research. Glaser (1998) describes the concept of trust in GT and four criteria for the evaluation of the emerging theory:

- Fit – another word for validity meaning the concepts represent the data which will be achieved with effective constant comparison.

- Relevance – the emergent concepts relate to true issues for the participants, gaining understanding of what is really going on.
- Work – a core category can start to be identified that accounts for most of the variation. The concepts and their theoretical coding are tightly related – they work! The researcher can apply a theory.
- Modifiability – the theory does not miss anything that cannot be incorporated into it by modifying through constant comparison. The theory does not force the data but is modified by it.

However, these evaluative criteria are focused on the theory constructed as the 'end product' of the research and exclude the role for the researcher throughout the research process. Therefore, the researcher applied the test of trust using the four criteria for 'trustworthiness' published by Lincoln and Guba (1985); credibility, transferability, dependability and confirmability**.**

3.10.2 *Credibility.*

Establishes confidence in the 'truth' of the findings. Multiple ways to ensure truth were utilised by the researcher:

- Reflexivity. Reflexivity is the extent and manner in which the researcher presents themselves as embedded in the research process and situation. Reflexivity has been optimised as the researcher's position has been made explicit throughout. The researcher is aware that that they themselves shaped the writing that has emerged

and this influence was inevitable, given the background to this research described in the introduction to this work. The researcher kept reflective logs to maintain a record of methodological dilemmas, direction and attempted to capture moods and thoughts of the researcher and any potential effect of these on data analysis. Charmaz (2014) cautions not to try and reframe participants' statements to fit a language of intention and forcing data into preconceived categories. Full explanation of the analytical process is provided and rigour is enhanced by being open about the researcher's position in the memo and report writings.

- Fieldwork. Fieldwork took place during the months of October 2017 to May 2018 when interviews were held. Whilst each participant only had one interview there were multiple contacts to arrange visits, which included checking to ensure the participants were still happy to be interviewed. This was of importance when the researcher visited two participants in their own homes. This pre interview dialogue enabled a relationship to develop and established a degree of trust in each other. After each interview the researcher analysed the data before moving onto the next interview so no opportunities were missed to pick up key lines of enquiry or amend the interview approach if required.

- Triangulation. Triangulation usually refers to the use of different data collection methods and sources. However, whilst the researcher used interviews as the primary data collection method, field notes and analytical memos were also part of the data. The participants were from varying backgrounds and were of varying ages.

All were of the same ethnicity but ages varied from people in their 20s to 80s. The key difference between participants was that they were either a healthcare professional or had been a patient or relative of patient in an older person's ward. Despite the differences between the participants the data did not reveal any discrepancies or significant differences in the data collected from professionals and patients. The key differences between the participants was that the professional participants related their experience and opinions of colleagues and to themselves and the giving of care whilst the patients/carer participants related their thoughts to the experience and observation of receiving nursing care. The subsequent codes did not need to be differentiated by participant to enable the development of the theoretical framework underpinned by the rich experiences of a wide range of participants.

- Member checking. Member checking can be described as participant validation and can be achieved in a number of ways. Member checking was not done with each participant, rather it was achieved by following key lines of enquiry in each subsequent interview, thus ensuring whether emerging codes were of relevance and remained credible.

- Peer review. The researcher relocated to the North East of England from London at commencement of the third year of the Professional Doctorate programme, making attendance at London South Bank University (LSBU) support groups challenging. The researcher sought to find academic colleagues in the local university who specialised

in GT and Social Sciences. A colleague did make contact and made some really useful suggestions, which the researcher responded to and integrated into the work. The researcher's colleague questioned the use of academics being interviewed and this did enable the researcher to reflect on their 'real' experience in older people's care and wonder if academic colleagues' contributions would be purely theoretical. The question was, 'did it matter'? The answer was 'no' as academic colleagues are still privy to extensive sources of experiences, opinions, research, healthcare feedback and can therefore provide meaningful data. A suggestion was made to reframe the initial interview question so, if someone could not describe what a characteristic looked like in a nurse, the researcher should ask him or her to think of someone with that characteristic and ask him or her to describe them. The researcher could also ask if they had encountered any situation where personality played a part. This advice was invaluable in the conduct and success of the interviews.

A further meeting occurred to allow the researcher's colleague to read and then affirm the initial coding and lines of enquiry. The researcher also sought reassurance that achievement of adequate understanding and subsequent presentation in the literature review of personality theory had been achieved as this is a highly specialised and complex area. The researcher made contact with psychiatric colleagues in the neighbouring mental health organisation and met twice with a Consultant Psychologist specialising in personality who confirmed the researcher had demonstrated understanding and applied the theory in the appropriate context.

The researcher also had regular email contact with LSBU supervisors. However, all parties preferred face-to-face contact so three-monthly meetings also took place at the LSBU campus.

Having seen an item of interest on Twitter posted by a Head of Research at the Royal College of Nursing, the researcher requested an informal meeting whilst visiting London to discuss research progress. There was no feedback to weave in to the data analysis but this colleague confirmed that the section on personality demonstrated the researcher's understandin, that the aims and objectives of the research were clear, the data from the first 10 interviews had been coded and categorised in a sensible and meaningful way and initial interpretations appeared robust –there was no difference of opinion.

Finally, in accordance with LSBU regulations, regular progress reports were submitted for formal review by LSBU staff and the subsequent feedback allowed for ongoing refinement of the study and testing of credibility.

- Researcher background. The role of the researcher in establishing credibility of the research can be demonstrated in several ways. The researcher has demonstrable academic achievements thus far in the completion of the first three years of the doctoral programme and developed robust research skills. The researcher holds a senior position in a large NHS organisation and has previously held the role of Head of Nursing for Older People's services, as described in the introduction to this work.

This has led to a sustained interest, familiarity and responsibility for this speciality. The researcher has remained true to the epistemology and methodology of GT and demonstrated consistency with the research aim and objectives.

3.10.3 *Transferability*

Transferability relates to demonstrating that findings have applicability in other contexts.

- Transferability can be discussed in two ways (Lincoln and Guba, 1985). First, in relation to the uniqueness of any given situation and multiple realities, therefore generalising and subsequent transferability may not be directly valid. Second, that it is up to the reader to assess if findings can be considered applicable to another setting. The focus of this research is around older people's nurses in the acute setting. However, given that a theoretical framework of nurse's characteristics is being developed, transferability may be possible to other nursing groups caring for older people and perhaps other nursing specialities. The researcher cannot affirm that findings from a small purposeful sample would be the same in a larger random population. However, findings should be transferable. A detailed depiction, 'dense description', of the sample and setting has been provided therefore findings could be expected to occur in similar individuals in a similar setting. Dense description is the presentation of the detailed information about the participants and, in addition to the inclusion and exclusion criteria, will allow transferability of findings to another study context (Lincoln and Guba, 1985).

3.10.4 *Dependability*

Dependability relates to demonstrating the constancy of findings and accounting for variability. Dense description and audit provide ways to ensure dependability by the researcher:

- Dense description. In this context, dense description applies to the methodology utilised for the research and this is provided in Section 3, which details relevant rationale and decision making.

- Audit. An audit trail should enable another researcher to follow the process and decisions throughout the research. GT is iterative and analysis involves a 'flip flop' approach during constant comparisons of the data, and data was coded more than once and moved between categories more than once. However, the coding phases can be followed by reviewing the transcripts, memos and field notes to identify the decisions taken by the researcher to pursue certain lines of enquiry.

3.10.5 *Confirmability*

Confirmability relates to the extent to which the findings of a study are shaped by the respondents and not researcher bias or preconception. Reflexivity was the main method employed to promote confirmability.

- Reflexivity. Bryant and Charmaz (2007) state that the use of language as a central element in the organisation of human experience has led to a greater sensitivity to

the ‘authoritative’ role of the researcher in the production of evidence. Interpretive reading of the data involves the researcher constructing a version of what the researcher thinks the data means (Mason, 2002). The researcher needs to be able to monitor and present the critical steps in the development of the analysis, including, what may be perceived as problems, so that these can be followed by the reader (Bryant and Charmaz, 2007).

- A reflective log was kept by the researcher to facilitate reflexivity. The researcher combined field notes and reflection to ensure the richest accounts of the researcher experience. An example around participant recruitment follows which, although an early reflection, had the potential to influence data analysis:

I was slightly taken aback when I arrived to be shown in to a run-down front room of an old house. Why had I thought it would be fancier? After all, it’s still a charity.

It was clear there was a mixture of people in the room, approx. ten, ranging from the educated and stereotypical ‘middle class’, a couple of folk who were a little confused and one lady who appeared to be hard of hearing but was enjoying the company. Two ladies had taken charge of the kitchen and were making tea and coffee and had brought home made scones and cakes, which they ironically displayed next to the British Heart Foundation healthy eating freebie jigsaws!

I was made very welcome and sat down next to 2 other 'guests' who introduced themselves to me as Patient Public Involvement Lead and the Deputy Chief Operating Officer of the CCG. They were asked to speak first and their topic was about mental health services. Interestingly it wasn't long before someone asked about proposed changes to provision in a local hospital which is part of the Trust I work for and the local people are 'up in arms' about reduced services! I thought 'oh no, what if they just want to ask me about that'?! When it was my turn I introduced myself by name and said I was a registered nurse but I did not state my role or workplace and emphasised the fact I was a student doing a doctorate!

I described some of my background and how I had become interested in the care of older people and I described in very simple terms the development of my proposal and research question, how interviews could take place, and tried to offer as relaxed a scenario as I could. What happened next?! At least half of the room all started telling me they would know people who would be interviewed and started talking very enthusiastically about the state of the NHS and how nurses aren't what they used to be, not caring, and don't talk to you anymore! Two people described how poor their recent care experiences had been. My immediate thoughts were – interviews will be hard with any of these folk! My second thoughts were, yes the interview will be hard but they have a lot of interesting things to say. I left some PISs, response forms and some pre-paid envelopes…..several folk laughed and said they could put a sticker over the address and use the envelope! They may have been serious as I have not received any replies!

Several people wanted to talk about negative experiences, which immediately led me to think about poor nursing care without considering other factors. I am aware that I associate poor care with a set of characteristics of nurses who should not be working with older people and need to consider that this may affect subsequent data analysis.

3.10.6 *Summary*

This chapter presented the methodology in terms of ontology, epistemology, methodology and methods that addressed the research question: 'what do stakeholders reveal about the personality traits and associated behaviours of registered nurses who work in older people's acute care settings'?

Social constructionist grounded theory methodology was chosen (Glaser, 1998; Charmaz, 2014). Grounded theory enables an interpretive approach that focuses on the experiences of the participants but more importantly recognises the central role of the researcher throughout the research process and in theory construction. Participants were recruited in a number of ways and, whilst they were from a mixture of backgrounds and held different roles, including nursing and patient governors, all participants were chosen purposefully because of their ability to speak about personal experiences of nursing care delivery to older patients.

Data was collected using semi-structured interviews in the hospital setting or in participants' own homes. Data collection and data analysis occurred simultaneously. Initial, focussed and

theoretical coding occurred as an iterative process going back and forth between the steps and was supported with theoretical memos that led to the development of theoretical ideas. Theoretical sufficiency was achieved after 12 interviews as recurring themes were evident and no new key lines of enquiry were emerging.

Trustworthiness of the data was established using the four criteria described by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability. Methods to promote trustworthiness included extended fieldwork, memos, audit trails, peer review and reflexivity. The findings of the study are presented in the next chapter.

4 Findings

4.1 *Introduction*

The data is presented in this Findings Chapter under category headings chosen and assigned as personality traits of older people nurses The headings have been assigned by the researcher and used within the narrative, so were not specifically used by the participants. However, each category has emerged from expert stakeholder opinion, their experiences and rigorous analysis of the collective data.

Use of direct quotations from study participants, as key stakeholders of older people's nursing, ensures any interpretation of findings is backed up and verified, as these interpretations should remain grounded in the primary data sources. This ensures any of my own practitioner-researcher based interpretations can be isolated, or further verified when firmly grounded and anchored in the actual experiences of the study participants, in what they have observed, as key stakeholders of older people's nursing practices.

This chapter presents inductively coded data, supported and grounded by direct quotations from study participants relating to their perceptions and experience of the behaviour of nursing staff working with older people. The data was analysed to propose a theoretical framework that aims to depict the complex relationship between older people nursing behaviours and personality traits, within the context of older people's nursing taking place in acute care settings.

Each personality trait as it is identified, is then summarised with an accompanying table of the trait facets. Each identified trait facet is presented as a range of desirable and less desirable facet behaviours. This analysis developed from within the data demonstrates nursing characteristics as perceived by the study participants ranging between desired and undesired.

Tables are used as a convenient way to present the range of traits and associated facets but does not suggest that an individual does or does not possess a trait, simply that an individual nurse will be somewhere on a proposed scale and may have the potential to move up or down on that scale, influenced by internal and external contextual factors.

External factors that may also influence how older people's nursing behaviours' manifest and are presented are identified as context variables. These are acknowledged by using an image of a wraparound, which offers a representation of workplace *context*. This is further represented in the identified theoretical framework, as shown in Figure 1 (below).

4.2 ***Demonstrating the 'authentic self' in effective older people's nursing across acute care settings.***

A key finding, evident very early into the data collection and analysis process, was that the study participants perceived the same behaviours, as those required to be an effective older people's nurse. This can be seen as a verification of their stakeholder status. These

behaviours reflect a value base, which all of the stakeholder participants could readily discuss. However, how these behaviours are displayed as nursing activities is discussed as further influenced by an underlying personality trait disposition. Therefore, a core category that emerged quickly, was that of working from a basis of *authentic self.*

This core category represents a person's inherent nature or disposition; in this context, *authentic self* relates to an older people's nurse's true nature. In other words, how an older person's nurse's values and beliefs are expressed through their behaviours as a result of their personality, which in turn has a direct impact on how nursing care is being delivered and received.

Being *authentic* to one's *self* reflects a complex relationship between desired traits of an older people's nurse and how these may or may not be displayed through behaviours (i.e. nursing practice). The *self* should be considered as an individual person and the object of his or her own reflective consciousness. *Consequence* is described here as *how* care is experienced, as being delivered, plus how that is, in turn, effected by the individual nurse's traits and associated behaviours. Therefore the two are interlinked and co-existing.

Findings indicate that four key traits comprise the substance of *authentic self* in relation to older people's nurses, which the researcher has labelled *conscientiousness, integrity, coping* and *sociability.* Each has a direct effect on how care is delivered.

As previously mentioned, c*ontext* variables may also effect behaviour and therefore impact the *consequence* of how care is delivered. *Figure 1* below proposes a graphic representation of how each of the different elements identified as core findings thus interact and are effected by the other. Figure 1 then is identified as representing an ideal of how personality traits interact, and interplay with providing effective/authentic older people's care delivery in acute health care service settings.

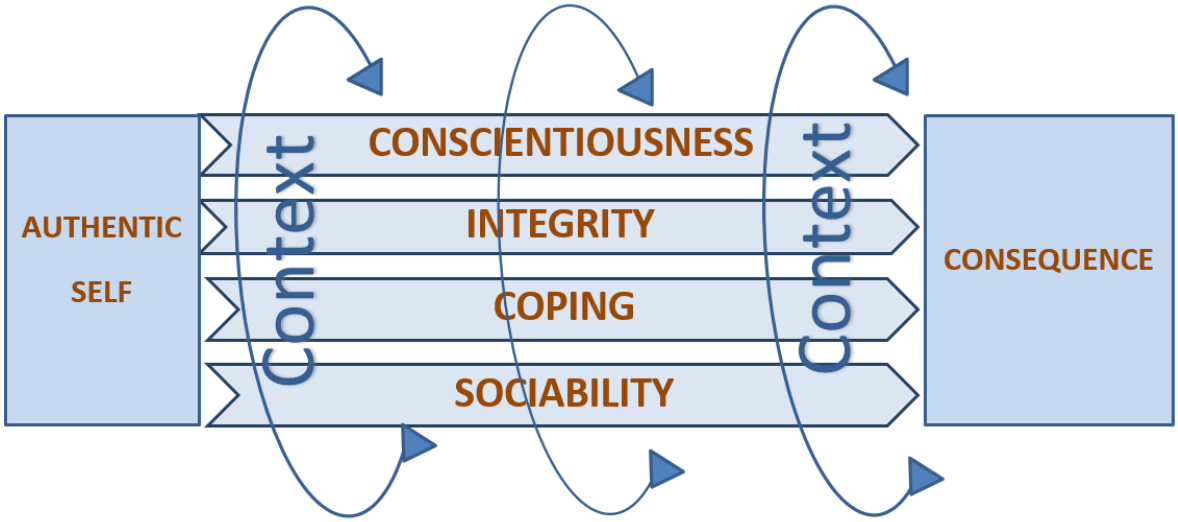

Figure 1: A theoretical framework representing effect of key personality traits on the care of older people - Trait based Older Person's Nursing in Acute Care Settings (TOPNACS) (Day, 2019)

This next section will describe how the *Authentic Self* category as a key finding has been used to underpin the identification of the facets under the personality trait heading *conscientiousness*.

4.3 ***Conscientiousness: "that patient's mine and I'd like to see what I can do for them"***

Joan makes aspects of nursing conscientiousness clear in her statement: "that patient's mine and I'd like to see what I can do for them". The participant's experience, particularly the nursing participants (as identified in the above quotation), reflects that an ability to be conscientious appears to be preceded by a strong sense of responsibility in nursing staff to deliver good care to the patient, as an extension of their authentic self, and as a desire to achieve the best for that person, as they would like to be treated themselves, or see care delivered to one of their loved ones. This desire appears to be inherently natural (i.e. authentic) and a selfless act, rather than associated with any need for reward. With this, comes a professional sense of responsibility.

4.3.1 *Sense of responsibility*

John stated:

> *….that individual is defenceless. So, you- you have to recognise the responsibility that you're taking on your shoulders.*

The older person, as a patient, is seen as being at risk of feeling defenceless and therefore, nursing staff need to recognise the level of responsibility that goes with this level of vulnerability through to assessing aspects of frailty. Within the context of acute care settings, this might not appear to some nurses, as the focus of their clinical skills and

attentions. Whereas, those nurses with a conscientiousness for older people, this is an added aspect of their nursing responsibilities:

Chloe explains:

> *And I just think it's a privilege to b- you know, to look after people in such difficult conditions. And, you know, when- when they're so – I think everybody's vulnerable but obviously, if people are palliative, I think they are more vul- well, they can be more vulnerable. And I think it's such a privilege.*

At the positive/authentic end of the conscientiousness spectrum, having a sense of responsibility for the older person, brings with it a sense of 'ownership' of the patient. Whereas, not to be *conscientious* is viewed (particularly by some of the nursing participants) as a purposeful act of dismissal, neglect almost. A lack of *conscientiousness* is understood as a nurse not having the ability, or wherewithal to be diligent and recognise the needs of the older person, within the busy context of an acute setting. Nursing participants particularly expressed concern around why some nurses simply walk away from certain situations and do not appear to want to help. Louise stated:

You just think, 'how could they go- how could you have said that?' Or, 'how could you have walked away from that situation?' Or, 'how could you have not done something? How could you have not felt responsibility to…'

This was discussed as being even more evident when having to deal with the more *challenging* elderly patients. Perhaps at the less desirable end of *conscientiousness*, participants identified a strong sense that any omissions in care delivery, represented poor and ineffective nursing care. For example, Louise stated:

They do turn a blind eye, they don't- they're not diligent, they- they walk away when things aren't finished. So, they don't shave the person or they don't ask if they want to be shaved. They're not bothered about the fact that the bed's still wet or it's got a stain on it … Or that they're wearing a gown rather than their own clothes.

Some staff participants recognised a need to be proactive in their approach to ensure that all relevant tasks are completed in good time during their shift. As such, their conscience would be troubled if a number or certain tasks were not complete. This was evident in the accounts around the extent to which nursing staff would remain late at work, to ensure they had the time to complete on tasks, even if these were not all done during their allocated shift hours.

Chloe and Helen revealed how they even continued to think about their patients after their shift had ended, and this continued over time, even whilst busy at home. Helen stated:

> *We're there – sometimes the ones that are not that passionate wouldn't- wouldn't go above and beyond the role. Cos I think as nurses, you do sometimes. You do things that are out of your- sometime- you finish at twenty to eight. You sometimes don't get off the ward 'til twenty past ten at night……Like, you go home, you think about, 'oh god, that poor patient. Didn't have anybody-' you know?*

Deborah expressing being more frustrated at the pace of work in acute care settings meant she could not do everything she wanted to get done and felt guilty if having left over aspects of her work for other colleagues taking over from her on the incoming shift:

> *Oh yeah, the pace has changed……Really – er, when I was really – so- I mean, some days you do, you- you go home and you're so frustrated … You know, we don't shut down at seven o'clock or anything like that, but you- nobody wants to go home and think, 'oh, I didn't put that up and I didn't do that, and I didn't do that. And the poor night staff have got to do that.' It's- it's that.*

Having a *conscience* about their work was seen by most participants as a necessary value that would lead a nurse to being diligent and thoughtful. However, Jo (a nurse participant)

exercised a level of caution and suggested that going home and worrying about work is not the same as going home and just worrying, but rather to be reflecting about situations for improved learning:

> *…and they're not able to solve problems, I think you know, I- I see nurses that really struggle….. But I'm not convinced that they reflect…Erm, and I think if things are so busy they can get home, they can think, right, I forgot to do this. And you know, quite often I would have staff ringing back up and saying, you know, if staff had been on nights and they've gone to bed and at ten o'clock in the morning going, oh I've forgotten to- to sign for the drugs there*

However, from the data, this sense of responsibility is associated with strong feelings of guilt, particularly if care is incomplete. Some participants described how nurses are uncomfortable if they are aware of another nurse's omission or observe poor standards of care. For example, Chloe described feeling *saddened* when she observes nurse who:

> '*Can't be bothered*': "*it was quite- quite sad to see. Erm – yeah, she just didn't really want to be involved and she didn't go – I think – yeah, she just didn't do her job properly".*

4.3.2 *Preparedness and completion of care*

P*reparedness* appears to be a key component of *conscientiousness* and is described in the context of being thoughtful about the patient and relatives' needs. *Preparedness,* was discussed as the ability to be organised, analyse and collate multiple pieces of information from the multidisciplinary healthcare team, and assimilate this with the patient or their relatives/carers.

Joan describes how *preparedness* could prevent poor care and communication with relatives and gives one example of a nurse delivering care to her elderly father. She administered eye drops into both eyes and did not notice, and was not aware, he had one false eye. As a relative, Joan wondered why the nurse had not found out, why she had not read his records and why this had not been communicated:

> *Yes, it is. Yeah. Er, I was up one day giving him some breakfast and, erm, the nurse come in with medication. And he had a false eye. And she said, 'oh, would you like your, er, eyedrops in?' And he used to just say 'yes' to everything. And she put one in his good eye and then one in his- the- where there wasn't an eye actually, it was just a false eye. And I said, er, 'why did you do that?' And she said, er, 'because he asked for them.' So, I said, 'but actually, there's no eye there.' A-and then she went, 'yeah, but he asked for them.' I said, 'yes, but he doesn't understand you.' You know, I said, 'he doesn't understand at all.' I said to her, 'I'm asking you please not to do that.' And I said, 'that's not good enough,' you know? I said, 'you know, I've told you*

there's no eye there. It's been- it's documented in his notes.' I would make it my business to actually go and have a look in my notes and think, 'right, I'll just have a little read up about them before I go in' …

Two words which imply opposition are used to describe care delivery by participants; *basic* and *complex* nursing. The concept of effective basic care, is described as activities like offering comfort, washing, shaving and toileting, and how these, for some nurses, are considered the most important aspect of older people's nursing care. However, some of the professional participants also discussed nurses also requiring complex problem solving skills, which is perhaps particularly prevalent in acute care settings where clinical decision making has to take place rapidly. There was a duality within the nursing role, one that was viewed by the professional participants as ensuring that effective nursing care encompasses high quality basic care alongside the ability to manage complex care. This was seen as the coordination of ongoing basic care alongside working with the complexities of a patient's multiple comorbidities:

Deborah states:

*It's quite complex now as well, isn't it? Yes, because – [sighs] er, and it sounds really obvious – but years ago, especially, like, **** Hospital {community hospital now closed} it was more like a nursing home. And it was – you know, they were in there and they all used to go and sit in the day room and then used to go around with your medicines. Where, now we can't do that…*

Louise states:

> *Where I think older people's nursing is so busy and so complex … And [the nurse] is able to, kind of – gets the compel-complexity of it. And in fact, that actually, this affects that, and that affects that, and actually you- you can't just be one disease focused. You need to … that is an example of somebody who I think is a modern older people's nurse. She probably doesn't think of herself as an older people's nurse…. good care from somebody li-like her is compassionate and includes the person. So, is very much person, you know, holistically based on that individual.*

The participant's experiences reflect what is key to good older people's nursing appears to be rooted in the desire to 'do the right thing'. If a nurse is not that bothered about what they are doing, or just wants to do the minimum for a patient, just to get by, then the ability to be both basic and complex, as a process of effective clinical conscientiousness, including aspects of preparedness, knowing the patient's needs, will not be evident. As a consequence, even the basic care will not be provided effectively. Nurses might just walk away.

Study participants also recognised that sometimes aspects of basic care could not be delivered within the context of an acute care setting. Yet, this still formed part of *conscientiousness,* when associated with proactive acts that ensured effective care is still

being delivered. An example came from Helen, who described how she managed to call ahead and ask a family member to come and assist feeding a patient who was getting highly distressed with nursing staff's attempts to feed them:

> *There's no point arguing with them…. You know, it's about supporting them, nurturing, reassuring them …I- yeah, I always ask them, 'do you know who I am? Do you know what I am? Do you know where you are?' Cos I know they know I'm a nurse, I'm not gonna poison them… Sometimes you ca- you- you- you simply can't. So, then sometimes I- I would ring the family… And just say, 'they're getting really distressed.' Familiarity sometimes…*

A lack of *conscientiousness* not only meant older people's care needs were not being met. A nuanced characteristic here is that participants described nurses who are not conscientious as viewing the fact that incomplete care is then seen as unimportant. Perhaps, this is a conscious act of re-aligning care needs, placing them as unimportant, which allows the nurse to then move onto other activities they might see as more worthy of their time, attention and skill set. Therefore, a nurse might still be working to align their clinical choices with their sense of importance, interest or undertaking activities that gives them more close alignment to their authentic self. However, for those who cannot align their authentic self to clinical choices, this can cause inner turmoil. For example, Chloe (a nurse participant) described an example of not being able to deliver care in the context of operational

pressures and the distressing effect it had on her personally, in raising negative emotional impact even whilst away from work:

> *Over the winter, you know, the winter time, you just don't feel like you are doing your job as you should be. It makes you feel like rubbish. And then you go home and you- you feel so guilty. But you know that you've done everything you can that shift.*

Interestingly, one of the patient participants, Betty, described her move from an acute ward, where her experience was not all positive, to a rehabilitation ward which she described, in contrast, as *"marvellous"*. It was only on this specialist rehabilitation ward that staff started to address her physical symptoms and residual pain; symptoms that had been overlooked, neglected even, whilst she was on the acute ward setting. Betty's interpretation was that staff were either too busy or came across as if they did not care:

> *I would say the majority of the nurses were very good. And, er, they sort of – if you were – or if you – if they liked you, you were alright. Because there was, maybes – there was a lot in the ward…. And I thought, well, how the hell do they cope with all this? Put it that way. Mister [….] came in and he said, 'oh, erm, I'd like you to know that we're moving you tomorrow into a- another ward. We're gonna really sort everything out.' So, I went to ward twelve and that was it And they got- they were marvellous….And they got you up … Walked you aro- you see, now, on that other*

ward, they didn't get you up… Because I couldn't- I always felt as if I was walking on sand…and I couldn't hold a pen. So, I- they got- started doing treatment on my hands and my feet. They- they were – well, I think – the atmosphere was different….They weren't racing around. Whereas on the other ward, they never asked you if you had any pain.

Betty's experience introduces a level of complexity in the relationship between *conscientiousness* and *preparedness*, and ability to *cope* with working at pace in acute care settings, whilst balancing the need to deliver good basic care to frail and vulnerable elderly people.

4.3.3 *'Going the extra mile'*

The most commonly described concept by the majority of participants within conscientiousness was that of nurses; 'going the extra mile'. What this meant in terms of behaviour was how the nurse would still be able to deliver more than what would be normally expected within the hectic environment of an acute ward setting. The data suggests that a fundamental part of personality is the ability to 'go the extra mile' and not even realise you are doing it, whereas other staff will be willing just to do the minimum possible. Sarah described one particular nurse 'going the extra mile' when caring for her mother as simply: "*She couldn't have done any more. I don't think you can be taught that".*

Louise, a senior nurse, stated that a good nurse is:

> *"Somebody with high standards. So, somebody who didn't compromise, somebody who didn't, kind of, turn a blind eye to things"*.

Helen, (a nurse participant) described an example of this in her practice:

> *Yeah. We all know- what we- we need to do in our role, but some nurses just do what they need to do. Like, for instance, I was fixing somebody's glasses. I brought a kit in from home and I fixed the gla- I brought it in the next day and I fixed their glasses for them. They thought I was the best thing since sliced bread. It was about their glasses. They've got a sensory impairment their glasses were their lifeline. If they didn't have their glasses, they couldn't see where they were going, they couldn't see the nurse looking after them.*

Chloe, a nurse participant described her own personal experience of taking a food thickener to a nursing home, whilst travelling on her way home from work, as it had been forgotten to be handed on to the patient on discharge from the ward. For Chloe, she said that; "*I just had to do it*". However, she added she; "*wouldn't expect everyone to do it and that is ok":*

[The extra mile is] like, compassion. Erm, it's making sure that jobs get done, kind of, going, you know, making sure that if they're not done …. You know, just making sure that it does get done. Erm, it's if – [sighs] – for example, erm, one of m-my patients, when they were discharged, the doctors forgot to prescribe some sof- erm, softener? Some thickener, erm, for the patient….I actually took it on my way home to the care home… Erm, but I think it's just things like that, you- you l- really want to make sure everything gets done correct … And you will go out of your way to make that happen.

These 'going the extra mile' examples of behaviour reinforce earlier findings around the desire from the older people's nurses to 'do the right thing' as conscientious acts, and have a feeling of responsibility for *their* patients. If the patient did not have the food thickener, it would have had a negative impact on her ability to swallow, and eat, and therefore increase risk of malnutrition, hindering her rehabilitation prospects. The nurse not only understood this as an important element to the patient's short term rehabilitation and longer term impact for sustaining her recovery, but also found the notion of any delay as unacceptable.

John asked:

How do people that are trained in the same way and yet execute the same things completely differently? You know, that- that ultimately is about care and thoughtfulness and attention, in my mind. Which is, you know, do I have respect for

that individual? Do I want to help that individual continue to cope and manage and have comforting experience?

Amy states that the 'extra mile' is not necessarily required and relates back to taking responsibility for the patient, as their own responsibility to achieve the best for that person:

…….it is about actually people taking responsibility for their own actions as well….in describing that- that good nurse. Erm, and not necessarily going the extra mile, just going the right mile.

The desire to 'go the extra mile' is demonstrated by staff putting patient needs (for example taking food thickener to a care home after work has finished for the nurse) before their own (for example going home) and, again, strongly links to a sense of *responsibility, conscientiousness*, and a *willingness* to see beyond the basic care needs despite time or contextual constraints.

It is at this point that recognition is noted of potential differences between generational issues in nurses in terms of when they trained; in other words, a difference between those who are described as 'the older generation' and a 'newer' generation of nurses who appear to be more able and/or willing to put patient needs before their own starts to emerge. For example Sarah describes some of these staff: "*No, they had no drive. It was just a bit of a*

job, like, let's just do a bit of sneaking off'". Elaine also identified this and stated: *"I think that maybe historically, you know, you couldn't cope with the acute stuff so, you- you shuffled off to elderly".*

Going the 'extra mile' may also disrupt the planned activities or expectations of the shift for the nursing staff. Helen stated *"You know, I would always go that extra mile, even if it puts me back doing my jobs. I can cope with my workload. I can get that done".* Therefore, the desire to 'go the extra mile' is also linked with the ability to *cope,* which will be discussed further in Section 4.6.

4.3.4 *Generation differences: Longevity in the role and conscientiousness*

The participant findings do not identify a differential between the generations of nurses, in portraying older nurses as being not good as acute care nurses. However several participants described the tendency for less desirable characteristics to be demonstrated are often by some nurses who have worked in older people's care for more than 15-20 years.

Louise stated:

But I think where we've got problems is that we've equally got a number of staff who've been moved into that area [i.e. elderly care] … Because either they didn't get a job somewhere else or … This is where they ended up or it was, at the time they joined, it was a slower stream environment and … So, you've kind of got that mixture of cultures, of some staff who are really motivated and then some staff who are thinking of it as older care- older people's care from the 1980s.

Helen suggested that older nurses are less able to cope with change:

Yes– the- the ones that have been there for quite a long – quite set in their ways. They like to do things how they used to do when they trained as a nurse.

Louise suggested that there is an "*old style, not really wanting to be there*" who would be more likely to be focussed on their breaks than the needs of the patients and doing the absolute minimum to get by, always thinking about finishing work, going home and generally view work as something that gets in the way of something else they would rather be doing. Kay describes her experience of the 'older generation' as "*basically went in the staff room and drank tea and came out when they felt like it*". Louise suggested being new to the [acute/elderly care] specialty now or newly qualified means a real desire to want to be there, understanding patients' requirements and being more able to put patient needs before one's own.

Any of the less desirable characteristics were observed in other age groups of nursing and expressed by all participants, regardless of age/generational category. Apart from one exception; a slightly older ward nurse participant, Deborah. Deborah identified her thoughts and experiences in relation to how nursing had changed over the years of her nursing experience. She identified nursing was now far too busy to be able to deliver effective nursing care. The context of care delivery is therefore a consistent theme affecting older people's nursing characteristics observed.

4.3.5 *Patient needs - being met or just not caring?*

The nursing and other professional study participants presented more detailed views in relation to the concept of *needs*. Putting one's own needs before the needs of the patient was interpreted by participants as simply an act of just 'not caring'. Taken through to its least desirable, any behaviours resulting from putting self before the needs of the patient was associated with, ultimately, putting a patient at risk of coming to harm.

The participant data demonstrated that nurses need to be selfless in their approach to their work, if nursing care is to be delivered effectively. The patient and their relatives should feel the patient's needs are a priority, and that the nurse should naturally portray this in their approach and understand that their own needs are not to be seen as more important so should not be displayed or talked about. For example, Helen suggests that patients should not hear staff describing time and again how stressed and busy they are:

And do you hear nurses say that to patients, 'we're short staffed' or 'I can't get to you'? Yeah. I- it cracks me up. It really does. Cos they don't need to hear that. They know when you're short staffed cos a ward's busy. You know…

Helen states she would rather help a patient get to the toilet or even offer to help a struggling staff member, than to worry about her own workload. She described how this selflessness will "*set the tone for the shift*", in turn demonstrating strong role modelling of conscientious decision making: Helen states:

"*You know, I would always go that extra mile, even if it puts me back doing my jobs. I can cope with my workload. I can get that done"*

Louise proposed that nurses who do not appear to care whether their actions or omissions have any effect on the patient are only focused on themselves and their own needs. Those nurses may see the job as an entitlement and subsequently do not have the desire to do one's best: Louise stated:

It's like, the best nurses I've ever met never complain that they miss their breaks or whatever. They just do what needs to be done for the patient and, as I said before, it's not that I expect nurses to miss their break but, you know, if you were working on the ward and patient X needed you for something … and actually, you were the only

person that could help them at that moment, you wouldn't come away going, 'oh, I've missed my break.' But that's, to me, a kind of – almost, it's like, the signal that actually somebody doesn't care, that it's their own needs, whatever is more important than the patient. So, they're putting themselves first before they're putting the patient.

4.3.6 *Summary - Conscientiousness*

Working from authentic self, as a nurse, conscientiousness is more than simply being able to undertake a completion of nursing tasks efficiently, whether considered basic or complex care needs. For the older people's nurse *conscientiousness* has to entail aspects of selflessness and a strong sense of *responsibility* and *ownership* of the patient's care needs, overlooking the nurse's own personal needs at the time, and despite the workplace context.

Conscientiousness meant different things to different study participants, with some participants more able to describe their own experiences in terms of those nurses who exhibited desired behaviours and those who did not, enabling the researcher to assign facet labels to these behaviours. These are summarised in Table 6 (below).

AUTHENTIC SELF: CONSCIENTIOUSNESS		
Least desirable behavioral facets		**Most desirable behavioral facets**
Inability to cope		Resilient
Puts self-first - egoistic		Puts patient need first - altruistic
Inflexible		Versatile
Negates responsibility		Retains responsibility
Careless minimalist		Needs focused
Essentials focused		Standards focused
Comfort in simplicity		Comfort in complexity
Careless		Diligent

Table 6: Authentic self: Conscientiousness as a scale of least to most desirable facets

Conscientiousness can be differentiated in relation to the specific key participant stakeholder groups:

For the patient/carer participants: *Conscientiousness*, at its most simplistic, can be identified as being a warm and kind person. A nurse who is able to keep older people and their relatives informed and getting the basics of nursing care right; such as communicating, washing, toileting, adequate pain control and always being treated with dignity. These *basic*

nursing behavioural requirements of *conscientiousness* are evident throughout the findings, specifically noted from the patient/carer participants.

For the nursing and other professional participants: *Conscientiousness* is seen as a more complex trait involving; a sense of responsibility, having a troubled conscience in wanting to ensure that all care (above and beyond basic care delivery) is provided without omissions. This may involve going '*the extra mile'*. This sense of responsibility is potentially seen as altruistic in nature, where patient welfare is a main concern. Being kind and getting the basic care right is not enough and whilst this may be measured as *conscientiousness* the nurse needs to exhibit more behaviours that truly represent this trait. Louise suggests that conscientiousness can be distinguishable when a nurse is asking "*why and how things need to be done* "as well as just the "*what needs to be done*".

The patient participants, in particular, described how patients and relatives make a judgment of nurses; whilst they make a decision as to whether to ask to see a nurse or not, based on how busy they perceive the ward to be. They also believe that 'not bothering' the staff will help foster a good relationship with them, avoiding being labelled as a difficult patient, thus adding to the staff ignoring or avoiding attending to their needs.

Betty described how she herself ended up helping a patient get out of bed and go to the toilet, as other nurses had dismissed her and avoided contact. When she got the lady back,

the lady refused to get back into bed and wanted to sit on the chair as she knew the staff on duty would not help her get out of bed again the next time she needed to. Whilst the *task* of toileting was complete, the fear felt by the patient remained evident. This example shows how nurse's approach and attitude to care behaviours are compounded by the nurse not only purposefully ignoring the patient's need, but also engaging in a process of dismissive communication, resulting in derogatory and humiliating comments.

A nurse who proactively communicates with patients and relatives and presents themselves as approachable, enables patients and relatives to bond with that nurse and build an *authentic* relationship. This next section explores more depth of what contributes to an authentic relationship between the nurse and their patients.

4.4 ***Sociability***

Sociability in the context of care delivery to older people appears to mean more than communication skills. Nursing *sociability* is associated here with a desire and need to form meaningful relationships with patients that will enable and facilitate more effective care delivery, resulting in positive experiences and outcomes for both nurse and older person receiving nursing care.

4.4.1 *Relationship building*

Helen, a nurse participant, described the need to interact with patients and relatives as a necessary and valued part of assessment that then informs nursing interventions. The effective nurse wants to interact and build relationships with their patients, yet it was not seen as a duty of care to do so with everyone. Chloe, a junior nurse study participant, was able to describe the difference between two types of nurse in relation to effective communication. It becomes evident that for some nurse participants, they are affected and saddened when they observe unacceptable practices, for example, Helen stated:

> *So, they're just really approachable…really patient and they developed a bond with the patient…they are positive and speak softly…they may use hand gestures and have good nonverbal skills and good eye contact and the response…well the response from the patient is brilliant.*

And, in comparison;

> *This nurse was very negative…..had a bad approach to patients, she didn't want to speak to them, she didn't want to get involved…it was sad to see…she didn't do her job properly, she didn't go the extra mile, she just wasn't bothered, it was really sad to see.*

The purposeful avoidance of communicating with patients and relatives was identified by both nursing and patient participants as being displayed by a lack or eye contact and not speaking to the patient or relative for long periods of time. When this was done, communication was short and only undertaken when absolutely necessary. Sarah describes one such nurse:

> *I thought she was horrible, yeah, she wasn't very nice. She was, oh I don't know, like those, like those funny ones you maybe see on the telly that's meant to be fun. Rude… Rude, yeah, didn't speak to anybody, didn't have good eye contact, was quite, you know, just 'Oh, well you're just an old person.*

Kay describes a similar nurse:

> *It's more in the – a-appearing to be rushed, appearing to be distracted, appearing not to be particularly interested. So, I think there's just something about, erm – it, er- it – [sighs] it – yeah. I guess it's being rushed, it's being uninterested, eye contact, all of those sorts of, erm, non-verbals as well.*

Helen also describes this type of nurse:

Sometimes they can get a little bit stroppy with- with patients or they don't wanna go and speak to the relatives or – it's sometimes, like – not that I've seen it, but they can have, like, a negative attitude to the patients. The who- like, 'quickly. I need to go and – I've got a million and one things to do. I – you need to take your tablets.'

The professional participants described how older people tend to have slightly longer lengths of stay in hospital than younger patients, due largely to presenting with complex comorbidities. Therefore, the older patient is likely to see the same nurses repeatedly, offering a greater opportunity and ability to form relationships. It was evident from study participant data that a lack of relationship building can lead to a lack of understanding, particularly of the complex needs of the older person. Therefore, ability and a desire to form relationship with the patient, from the nurse, may impact on the individual nurse's ability and desire to exhibit or feel *empathy*. Nurses who do not proactively communicate and build relationships would be seen by the patient, and/or the carer participants, as *cold* and uncaring, due to a lack of willingness, or ability to form a relationship on the nurse's part. Elaine described how simply putting a uniform on can seem "*officious"* but without the necessary communication skills, officious is just *cold* and *"robot like"*.

4.4.2 *Liking patients*

Deborah (a nurse participant) stated that she could tell "*instantly"* if she personally was not going to like a patient. Yet, she had more difficulty when asked to describe why this was the case and why she liked some patients more than others.

I don't know. It's just- there's just some things about some patients that you like…..some people you think, 'oh, they're lovely"'. And then somebody else is all they've got to say to you is hello, and you think, 'oh, I don't like you'. ….you go- you walk in and you look at the patient and you think, 'oh, I'm not gonna like you.' You've just got to treat everybody exactly the same. I used to remember, when my children were little, I always used to say to them, 'I might not like you. I'll always love you, but I might not like you.' And it's a bit like that with the patients.

Participants saw it as a very natural response to be drawn to some patients more than others. The effective nurses seeks out positive aspects of all patients, to foster and enable positive relationship building. They recognised that if a nurse only focuses on something they did not like, then relationships and communication would always be compromised. For example, Elaine described how nurses need and have to get along with all patients in some way, and that the better nurses are able to get to know them on "*a deeper level*".

Chloe stated that the ability to "*be in the moment"* with the patient is the key to relationship building through effective communication and liking the patient enough to spend time with them and not be distracted by all the other work going on around. This could be summarised as*; '*I might not like you, but I will always nurse you'; to re-phrase Deborah's quotation above.

4.4.3 *Dismissive communication*

Participants described examples of poor or dismissive communication as a conscious and purposeful act. Betty observed in particular how friendly communication that put the patient at ease, only occurred if the nurse actually liked you.

If the nurse is *comfortable* in the company of older people, then a closer contact is achieved between the nurse and their patient. Betty spoke of her own experience, in that she and other patients were in fact fearful of some nurses. They would not want to bother them, often to the extent they may end up wet (i.e. be incontinent), rather than interrupt the busy nurses.

Betty, a study participant rationalised how nurses could be dismissive of patients and relatives as associated with the fact nurses are busy. Participants suggested that being busy is not enough of an excuse, as it is as easy to be polite when under pressure, as it is to be rude. Kay explained that the ability to admit to being wrong and to apologise requires humility, and an ability to actually recognise that you may have been short with someone and to then care enough to try and rectify the situation. Being able to explain to someone who is anxious or unwell, is a very active process that requires a level of self-awareness, effort and a willingness to put the patient's needs above your own (i.e. showing *conscientiousness*) .

Kay provided an example; "*Its lovely to meet you, take a seat and I'll be with you in a few minutes"* said with a smile versus "*take a seat, it's very busy" s*aid in an abrupt manner with no eye contact. Helen, (a nurse participant) also observed this stating how she does not like hearing nurses saying they do not have time to speak to patients and relatives; "*I've got another seven patients.' Oh, god, I hate- it drives me mad. It does" (Helen)*.

Helen states:

> *A simple 'hello' to a patient can just mean so much, can't it? And let them know who you are and what nurse, who's looking after them, and speak to the relatives. 'I'm here if you need to come and have a chat.' It puts everybody at ease…..I don't know why some people actually come in to nursing if – do you know what I mean? Maybe it's just a job to them. But I think in elderly care, you've got to have a passion. I mean, I was always really polite. I- I would never be disrespectful or – but I think coming over to elderly care, they deserve even more respect.*

The ability to develop a meaningful relationship with a patient and have honest conversations with patients and relatives is required but the findings suggest, is probably not dependent on whether a nurse is shy (*introvert*) or more outgoing (*extravert*). Two nursing participants suggested it is more likely to be an extravert that will need to adapt their approach more often, therefore reflective skills are an absolute necessity. Helen

described these nurses as *bubbly*. *Extraversion* would be seen as someone who is more likely to barge in to a room and start lively conversation without necessarily understanding the need for a calmer and quieter approach. The differentiation between extravert and introvert nurses is something that would need further exploration and testing.

4.4.4 *Disposition: Being 'nice'*

A key characteristic required of a nurse, as something that was mentioned many times, particularly by the patient/carer participants, is to have a *nice* disposition. The word *nice* was used on many occasions and when prompted participants described the different meanings.

Being *nice*, is described as a tendency to act in a certain way that comes across and presents the nurse as approachable, polite and a good listener. Joan associated *nice* with asking the right questions and wanting to learn about the patient with "*a little bit of empathy*". Sarah describes below, a nurse she encountered who was not considered to be *nice*:

> *I just thought she wasn't a very nice person. She didn't, I didn't think she managed the nurses very well. She was almost bullyish and I didn't think she was very nice to the old people and the way she treated them all….Rude, yeah, didn't speak to anybody, didn't have good eye contact, was quite, you know, just 'Oh, well you're just an old person'.*

Participants describe a poor/bad nurse would be associated with having an abrupt and dismissive manner or disposition. Helen provided an example describing how a nurse with the right characteristics would say "*hello, oh, you need the toilet, no problem"*. Whereas a poor /bad nurse would not only be abrupt in manner, but they would probably instruct someone else to do help out, thereby being dismissive of the patient's needs and not seeing certain tasks as being their personal responsibility.

Helen also described how nonverbal communication is equally powerful, exerting authority or showing displeasure with an eye roll leaves the patient or relative under no doubt they have a "nuisance factor"'. A positive outlook was also seen as an important characteristic by several participants and Helen again states that she recognises her own personal characteristics as:

> *I am a dead positive person anyway. I just- I just think you- you- you come to work, it's hard enough doing the job that you're doing without mood hoovers who are gonna drag you down.*

Some participants struggled with understanding why some nurses work with older people when they clearly have no intention of wanting to get to know the patient and their family. Examples of this were one of the most widely commented upon characteristics of poor nursing care by the participants; ignoring patients and relatives and the damaging

consequences. Betty described her observations of a nurse dealing with a patient who was in the bed opposite her on the ward:

> *The lady in the bed opposite said – 'she rang the bell and she- and the nurse came and she said, 'I need to go to the toilet.' She said, 'I need help getting me to the toilet.' She said, 'you're old e- …' – she said, 'you must've been to the toilet before. You're old enough to go on your own.' [Gasps] well, I was absolutely astounded!*

Whilst Betty's example could also come under other trait headings as well as *Sociability* (such as *Coping and Integrity* which will be presented in Sections 4.5 and 4.6), it is evident that friendly communication as a skill forms the basis of *sociability* for this nursing group.

4.4.5 *Sociability and engagement*

This theme was powerfully evident in the findings. For some staff, being busy provides a convenient reason not to engage in a meaningful, friendly way with patients and relatives. Participants regularly described the hurried appearance and purposeful avoidance of eye contact they witnessed from staff with patients and relatives. Chloe stated:

> *Eye contact is so important….seem so interested… And seeing how the patient responds to that is brilliant [*and then speaking of the opposite kind of nurse*] yeah, she just didn't really want to be involved and she didn't go…. this nurse was very*

negative, erm, had quite a bad approach to patients. She didn't really spend the time to speak to them….she- she just wasn't bothered at all. So, yeah, that was- was really sad.

This avoidance characteristic results in a dismissive experience of care that is described by the study participants. The irony of this, as Betty described, is that patients all too quickly learn to earn/court favour with the nursing staff, by not bothering them, which ultimately leads to omissions of care.

Deborah, (a nurse participant), suggested that relatives seem to want an immediate answer to their queries and do not understand how busy the staff are. She described how it would be helpful if they could wait until the nurse has finished what they are doing, before interrupting and making any further demands. Kay suggested a disproportionate response from some staff in relation to what a relative has asked. Some nurses she described can 'make a big fuss' about being busy, when, in reality they have actually only been asked something quite simple that could be dealt with promptly and politely.

The findings demonstrated that rationalising 'being busy' appeared to allow those nurses lacking in *sociability* to transfer their frustrations to the patients or relatives. In turn, a lack of *sociability* was shown in poor communication styles (being dismissive) and thus effected poor standards of care. This is an important finding in terms of where and how to improve

standards of care delivery for older people in acute care settings, and will be discussed further in the next chapter.

Helen suggested that occasionally, frustration displayed by some nurses may be the result of being anxious and linked to the ability to *cope,* which will also be discussed in Section 4.6. The reverse of this was also described; a versatile thinker who views and appreciates the relative as a valued asset rather than a hindrance, is someone who can assist the nurse with planning and delivering the most effective care and actually decrease workload rather than increase it.

Joan (a patient participant), described herself and her sister as the "*relatives from hell*" when visiting their father in hospital. They constantly had to seek information from the same nursing staff, as these were the ones who would actively avoid them. When Joan's father deteriorated no one called them, so they were left unaware of his deteriorating health until they arrived at the hospital. When challenged, the nurse simply said "*oh we just thought we would wait until you got here to tell you*". The nurse's dismissive attitude was then further compounded by not being able to answer any questions about their father's condition or why he had been moved.

Joan suggested there is a specific kind of communication required when dealing with relatives that is focused around objectives and outcomes for the patient; informing the

relative of any new treatments and aims and the progress around these interventions. Betty described how she "'*gave in*" when nurses did not or could not tell her about the best way to help feed her father and this seemed to placate staff and make them nicer, but only when she stopped asking questions.

For Betty a lack of proactive communication by individual nurses led to issues on a day to day basis around significant aspects of her relative's care; end of life care, nutrition and pain relief. There was a feeling of being "*fobbed off"* with meaningless platitudes such as "*he is doing ok today"* rather than taking the time to sit and plan together what and how care should be best delivered. This experience of Betty introduces the issue of control and advocacy, which will be explored in more detail later in Section 4.8.3.

Elaine described how forming an emotional attachment shows signs of having achieved an authentic nurse-patient relationship. It means the nurse has gained a level of understanding of the patient, and having the ability to be *empathetic*, which is about having capacity to feel what another person is experiencing. Participants mentioned nurse's ability to demonstrate emotion, particularly through forming an emotional attachment with a patient. Sarah described one nurse:

So, she, you know, she just was a really, she just cared about what happened and, as I say, she cried when he died, so that said it all to me, because she never, I mean part of your make up is, isn't it…..well it shows you're empathetic with the situation.

Amy stated:

[you need] people who actually really want to do that….. And actually understand what being older actually means So that actu…I- I think that sort of they actually have that level empathy with them……. Because they can't walk in their shoes in the same sort of way…. But actually really understanding what it must be like not to be able to- to do things like they used to be able to do.

This can only be done if a nurse has the ability and desire to authentically communicate with the patient and relatives, in what colleagues and patients viewed as an appropriate way, as described above; respectfully, proactively and with a strong sense of desire to do the right thing; feelings of responsibility and conscientiousness expressed through emotion, as a humane reaction to someone else's situation and circumstances.

4.4.6 *Summary - Sociability*

The facets and associated behaviours identified within the overarching concept of *sociability* are not about being either one thing or another, but once again can be seen as a level of

scaling. These *sociability* facets are presented and summarised in Table 7. *Sociability* in the context of nursing care delivery with older people means more than a focus on communication skills. Nursing *sociability* is associated here with a desire and need to form meaningful relationships with patients that will enable and facilitate more effective care delivery; resulting in positive experience and outcomes for both nurse and older person receiving nursing care.

The desire and ability to develop appropriate and effective relationships with patients and relatives is powerfully evident in the data, yet is perceived not to be present in all nurses. Communicating and delivering information to patients and relatives ranges from complete and effective to incomplete, right along the spectrum towards a dismissive attitude and a 'purposeful ignorance'. This is a useful finding in terms of clarifying where and how to help those nurses who rationalise their dismissive attitudes through blaming their busyness, and ultimate ability to tackle a workplace culture of blame. (This will need testing further in the field and is identified in the future implications Section 6.4).

AUTHENTIC SELF; SOCIABILITY		
Least desirable facet behaviours		**Most desirable facet behaviours**
Purposeful ignorance		Relationship building
Uninterested		Curious
Dismissive		Inclusive
Isolating		Personable
Distracted		Attentive

Table 7 Authentic self: Sociability as a scale of least to most desirable facet

4.5 ***Integrity***

This section of the findings comes under this heading of Professional Integrity, and are derived in the main from nursing and senior staff, less so from the patient participants, relating in the main to veiwing the nursing role as a privilege which helps maintain patient identity and is underpinned by an inherent honesty.

4.5.1 *Vulnerability and privilege*

Older people were viewed by all participants as a more vulnerable group of adults, than other patient groups. To be able to care for them should be perceived as a privilege, particularly in those patients identified as being near to end of life.

Chloe stated; "*I think everybody's vulnerable but obviously, if people are palliative, I think they can be even more vulnerable"*.

Viewing the role of an older person's nurse as a privilege - and how the role makes the staff feel is an output of privilege. Nurses with *integrity* feel gratification from the simple act of helping someone and reward is unimportant. There is a need in oneself to 'do the right thing'. Louise stated:

But I like that feeling of going and helping somebody, helping them to wash, and then they saying at the end of it, 'oh, thank you. I really enjoyed that. I feel so much better. I get- I – I get a pleasure in that. I get- that- that makes me feel good. Even if it's just a tiny little thing, even if it's just laying the body out and protecting their dignity and modesty or whatever after death. Even that, the feeling of knowing, actually, I did that little thing for that patient and that was- that was important.

Nursing participants described a diversity of motivations to work with older people. Some nurses view their job as a means to earn money and could be working anywhere. At worst, seeing the job as an entitlement and not caring about the impact of care or lack of care on the patient, which relate to the findings around *needs* presented earlier in this section (section 4.4.6). Kay suggested that nurses should want to receive positive feedback or feel good about their actions. If this feeling is not valued, or not sought, then nursing care

delivery will be poor. Helen described how a patient wrote to the hospital's chief executive to praise her care. Whilst she did not want or expect it, she got a great feeling of pride, which she enjoyed, but ultimately felt that reward came from being able to see the positive impact of care on the patients.

4.5.2 *Identity*

The study findings suggest that viewing the care of an older person as a privilege enables the maintenance of identity; seeing the patient as an individual with a past and a purpose. Louise viewed neglect of basic care as the neglect of seeing the patient as having an identity, not understanding their needs. Sarah stated that all patients should be valued in terms of who they are and their identities respected:

> *Because it was like suddenly you're old and you're ill and it doesn't really matter if your, if your hair's dirty and you've got dirty skin. There was no, 'Where's this person been before? What's the outcome afterwards?'*

> *They have had many experiences in life that they've done. You know, that they've been nurses, they've been midwives, they've been – they've had such, like, er, a colourful background. And I think some people can see them as, er, it's just that patient in that bed. They've not always been like- they've not always had dementia.*

Helen demonstrated frustration at the disregard by some colleagues of the patient as an individual, for example:

……..not talk over the patients when you maybes rolling them. Not be discussing things, what you've done on nights out with other members of staff. That's what I would like to see in all- all nurses.

John posed an interesting perspective; respect of individuality in the acute setting is about wanting to "*fix someone"*, whereas respect in an older people setting is about acknowledgment of life contribution and enabling a good quality of life. This was supported by other participants who associated dignity with enablement (patient-centred) and not with the need to just fix a problem (task focussed).

The notion that nurses call patients "Luv" or "Pet" appears to be patronising at a surface level by some of the professional participants. However, Helen stated that the effective nurse will judge their relationship with the patient and ascertain the appropriate way to address the patient. Both John and Amy drew the analogy between the dependency level of the older patient and those of children, which in itself may be viewed as patronising. John and Amy explained that the key driver of this analogy is simply about dependency, not about treating the older patient as a child. Amy stated:

And actually- actually wants to do their absolute best. And when I compare sometimes what we have with the children….the nurses we have working with children……who are absolutely passionate about children, and enjoy playing with them……and all those sorts of things, you need the same characteristics for the older population.

There are examples of behaviour described as patronising by some of the participants, for example around nurse's tone of voice used to persuade patients to do something when the relationship appears to be that of a parent 'ordering about a child'. This was seen as not respecting their elders. John's example below offers some more clarity on this:

….actually, to my mind, that's where the compassion bit is, which is, you don't make any pre-judged – on a child, you see them as a child. So, when you look at an older person, actually, I think a lot of your preconceived views on that individual and the fact that they are- look a bit old and a bit wrinkly and whatever…Sort of, somehow, potentially clouds the way you treat them.

Being respectful of a person's identity may also be applicable in how staff interact, as respectful colleagues. Helen and Chloe described their colleagues by name or job title. Deborah referred to colleagues as simply *"healthcares"* and "*qualifieds";* perhaps shorthand terms, but this labelling implies a lack of respect for a person's individual identity or can be

seen as showing there is not any emphasis placed on having any personal relationship associated with her colleagues. Deborah stated she can tell instantly if she is not going to like a patient, expressed that relatives should wait until a nurse has finished what they are doing before they talked or approached her.

4.5.3 *Honesty*

The concept of *honesty* is implicit throughout the data and is broad in range. For example, Elaine believed that *honesty* can be demonstrated by "*giving a little of yourself to the patient*", that is , letting them in to your life and allowing them to get to know you in the same way you are trying to get to know them. A nurse who demonstrates this level of honesty in their communication would be seen to be trustworthy, as they demonstrate trust in the patient to get to know them *authentically.* Helen described an example of dis*honesty* directly affecting patient care and safety:

> *And I think it's about being honest. If you don't know something, I think it's about being honest and saying, 'look, I'm really sorry, I don't know how to do that.' Rather than… Cos, that's, like, rather pretending and then getting it wrong. Cos then that's – you know, you're- you're cheating yourself, really. I worked with somebody who said she did something, I knew she hadn't done it, but said that she had. And I knew she hadn't done it. It's a massive deal, it was the crash trolley. And I thought, 'if you've said that, what type of nurse that makes you? 'You- you said you did something and I clearly know you haven't done it. Like, what type…' – it's like your character. I was*

just gobsmacked. You've got to be honest, you've got to be open, you've got… We have keys with medications on. You know, if- if you've lied about something so s- so trivia… What else can you?

Integrity, as a finding in this study, was centred on respect for the patients, relatives and colleagues. The notion of self reward that can only be achieved if caring for older people is seen as genuine privilege and not just a job.

The facets within the trait of *integrity* are summarised in Table 8. There is an underlying simplicity in how the nursing and senior staff talk about *integrity*, in that *integrity* is something that cannot be learnt and it is an intrinsic part of who you are. *Integrity,* when described in relation to the participant's experiences, is mainly around the concept of simply doing the right thing and would be defined by being honest, respectful and open and not feeling a need to seek reward.

AUTHENTIC SELF; INTEGRITY		
Least desirable facet behaviours		**Most desirable facet behaviours**
Entitlement		Privilege
Requires reward		Self-found gratification
Dismisses identity		Seeks identity
Purposefully Inhibited		Confidently open
Dishonest		Honest

Table 8 Authentic Self: Integrity as a scale of least to most desirable facet

4.6 ***Coping***

Coping in relation to the care of older people, in these findings, ranged from being able to deal with intimate care (such as toileting or being able to care for patients who may be exhibiting aggressive behaviours), right through to being able to manage complex problems in relation to planning and coordinating care.

4.6.1 *Coping strategies*

The ability to *cope* was talked about in relation to nurses being described as '*capable*'. Sarah stated that *"the perfect nurse is rare*" but she summarised excellent care she had witnessed delivered to her relative by an individual nurse as; *"I've never seen anything like it".* John described this type of nurse as "*scarily capable"*. Whilst Sarah described a particular type of *coping* that is unique to the older people's nurse:

You've got to want to be able to cope with all the smells and all the nasty bits and also all the issues and not cry and stay positive and not take it home, which none of those things I could do.

The demands of working as an older people's nurse were frequently described as complex and were associated with a significant amount of unpredictability in the role and the need to be able to solve complex problems. Helen suggested:

A nurse can get quite frustrated if things don't go to plan….'cos some things are out of their control aren't they, things change so quickly especially in elderly care, that's why we need ward rounds, board rounds, huddles. So, I think, you need to be being open-minded as well. And I think you just – yeah, adapt – er, just adapting to the situation. Erm, not getting frustrated.

The nursing participants, apart from Deborah, described nurses who do not have effective *coping* strategies demonstrate a range of behaviours. Some were described as being quite "*highly strung"* and *anxious*, other staff would be more likely to, for example, argue with a confused patient as they get more frustrated with the situation. These nurses would be likely to 'hide behind' operational pressures or use being short staffed as an excuse for poor behaviour. Helen gave the example of a relative asking to talk to a nurse:

'I can't speak to you. I'm too busy. You'll have to…' – I think, 'oh, god, you- all you've got to say is, "I'm just a little bit- I'm just busy at the moment. I'll come- come and give – what time are you going home?"' Cos they want- they need to feel comfortable and confident that you know what you're doing, looking after their relative.

4.6.2 *Patience*

The demands of the job were frequently mentioned and that nurses must be able to *cope* with fatigue, both mental and physical. An example offered was that looking after confused patients for a 12-hour shift requires high levels of tolerance and patience. Helen stated "*…..sometimes you can see pe [people]- nurses getting – not frustrated, is the probably the wrong word. Like, [sighs] they're taking too long to do something".*

Sustainability of certain characteristics came through strongly in relation to the incongruence between the need to work at pace in a busy acute ward and the lack of ability for many older people to be able to move or act with pace. Therefore, coping ability related to patience and not being easily frustrated were described as being needed at high levels; Helen described this as "s*ustained mental pressure"*. The ability to be patient was talked about many times by participants and that the ability to be patient enables *coping*. Chloe described how patience is a necessity as it will enable the delivery of the best care, taking time with patients when required enables the nurse to see the whole patient. Deborah described the need for patience in a slightly different way:

A lot of older people have- they go over the same thing again and again and again. And after about the tenth time of saying to them, 'your wife's at home. She'll be in to see just now,' it does wear a bit thin.

Helen stated:

……sometimes you can see pe- nurses getting – not frustrated, is the probably the wrong word. Like, [sighs] they're taking too long to do something. But I- I think as a patient and as a relative, especially if you don't want to see that. You don't want to see the nurse looking after you rolling their eyes or tutting.

Patience was apparent in the data as the key characteristic nurses need to have in order to deliver effective care and promote enablement. The nurse who gets frustrated will not have the patient's best interests at heart and Helen stated:

It's not about making them feel any less of a person for not being able to do it……It takes lot for me to lose my rag. And I wouldn't do- I would never do it at work.

Deborah described how, if her patience was challenged, she feels the need to physically vent that frustration. For example, in kicking a cupboard door to release the pent up anger

at the situation. Demonstration of *coping* described by other participants was very much around having a naturally calm disposition and the ability to control reactions and maintain a dignified demeanour when under pressure. However, there was also recognition that stress and frustration are natural reactions, but an effective nurse would have the ability to develop or have insight into their own stressors and triggers so that the threshold to demonstrate frustration is high and any short tempers are not evident. Amy stated:

> *…..the older persons nurse, some- something about all patients need to…all staff need to be patient. But older p- persons nurses have to be even more patient. Erm, and kind of coupled with that, with the challenging patients is that underlying calm demeanour. So if somebody's more prone to being short-tempered, which some people can't help, they just- they just are.*

Louise described an incident that demonstrated that nurses need to be able think and reason before reacting, that also relates to previous discussion about liking and not liking certain patients:

> *Well, I remember as a staff nurse, erm, a patient, an older gentleman was, erm – I can't remember what we were doing. I think we were trying to wash him. And, erm, he was, erm- he was getting quite distressed and quite agitated and he spat at my, er, ward sister. And she spat back at him. That was just an instant response from her,*

where she di- obviously, didn't think about … she was quite curt I think she probably had patients that she liked and patients that she didn't. He just pressed the wrong button and- and she responded as she, I think, would've responded if he'd done it to her in the pub!

Other *coping* mechanisms described by the nursing participants included the use of humour and being able to "*unwind*" with colleagues. The uniqueness of nurse's humour was mentioned, although Deborah suggested that humour is not as acceptable now as the profession is too "*politically correct*" so you cannot make jokes with patients.

4.6.3 *Reflection on action*

Some of the nursing participants described how more effective nurses would know which nurses will *cope* and which ones will not, either by something simple as the dismissive way in which they talk to patients and they will be more likely to be absent from work due to sickness. Therefore, nurses must have the ability to ask for help and nurses who do this want to develop in their role. Elaine stated:

You can start to label how you're feeling. And once you've labelled it, then you can express that and ask for some help or just share it. Just get it out. And whe-when you know yourself better and you've got, erm, good insight, then you know how best you can help and support other people and where your limitations are. Erm – some- you

know, some people who've worked with older adults a long time, I don't know that that would be seen as their priority. I'm not sure that that's what they would say.

Louise stated, "*I think there is an element of self-reflection in- when you're in situations, to think actually, have I handled that correctly*"? The ability to be a reflective practitioner was seen by most of the professional participants as a vital component of older people's nursing. The ability to reflect would help enable *coping* with the stress and demands of the role but also to enable professional development and the development of new knowledge. Generational differences were also evident in the data, with discussion around the nurses who have worked in the specialty for a long time not actively seeking development, and who would not practice reflection routinely. Jo presented an example of this:

I had a feedback from quite an- an elderly patient about the way that she'd been cared for a by a nurse on the ward. Erm, and the nurse, quite an older, you know, in terms of, erm, the workforce. And when I sat down with him and said, you know, I've had some feedback, the patient wasn't happy about this, and it was very much like, I didn't say that. And I think sometimes they find it difficult to sit back and look at it and think actually, whether I said that or- or not, it's how has the patient…why- why is the patient feeling that way. And actually what can I do different the next time… to prevent a patient feeling like that. So they're intention probably, you know, definitely his intention wasn't there. But I really struggled to have that dialogue with him to say, but what I need you to do is be able to reflect on your behaviour. And how- how

you've interacted, how you've spoken, how you've cared for this patient, to understand why they weren't happy with the care that you've delivered and… So a lot of older nurses, I know we didn't use reflection as much.

However it was also acknowledged by Amy, Elaine and Louise that reflection is now an embedded part of the nursing curriculum and considered 'everyday business' but nurse training over 20 years ago may not have placed such an emphasis on the need for reflective practice.

4.6.4 *Motivation and ambition*

The data suggests that the ability to *cope* and the desire to reflect and develop also appears to be grounded in what motivates a nurse to work in older people's care, almost bringing the findings back full circle to the start of this section, and a nurse's natural desire to help people. There is an undertone in the findings, that looking after older people is worthy and that certain individuals are highly suited for the role. However, this notion is also accompanied by a perceived conceptual opposite - that of ambition and that nurses, in the main, fall into two categories; highly motivated and ambitious, or vocational nurses who do not leave 'the shopfloor' [10] but make up the stable workforce imparting their wisdom and

[10] Shopfllloor; commonly used expression originating in production industries which differentiates the types of work and the physical allocation of space between the 'production 'area and administrative work.

knowledge. Therefore, the ability to *cope* with the role is linked to whether a nurse is actually in the right role, and ambition and personal drivers play a role in that.

Deborah described herself as part of a group of staff who are happy to stay on the shopfloor, and you would find that in all specialties. However, some senior participants suggested that a perceived lack of ambition should not be seen as a negative characteristic, although it is inferred that this group may not be as able to lead a service or adapt easily to change; for example, the increase in pace of acute care in the NHS today, which will be discussed later in this section. In addition, the nursing participants describe how leaders of older people's services come from outside the service, they are not developed from within the service, further supporting the notion that many older people's nurses lack ambition. This is borne out by the professional participants themselves who specified that the ward managers and matrons have indeed come from other specialties. Elaine described the 'shopfloor' phenomenon:

> *Maybe it's about the satisfaction. You know, sort of, they do a good job, they're happy where they are, they're satisfy- it's about satisfaction, isn't it? They obviously get some satisfaction from that. Erm, so it's that kind of language, that, you know, 'I love old people.' And other people, may- whether it's ambition or just- just satisfaction and just the need for something more. Yeah, they're not career nurses and, you know, sort of mapping out their career plan trajectory.*

There was a strong sense in the findings that job satisfaction could be achieved from simple hands-on care delivery, which makes sense as this is what the majority of nurses are doing and that vocation and ambition cannot be defined in terms of passion and drive. Amy described ambition as simply wanting to do the best that you can do. However in the main, ambition was viewed in terms of needing to do something more, which would either result in leadership roles or moving in to advanced practice roles. When Helen, a junior charge nurse who had moved to older people's care from another acute ward, was asked if she thought older people's nurses lacked ambition her reply was "*codswallop"!* John suggested;

> *What a lack of ambition shouldn't be is a lack of energy, an apathy, a lack of interest. That's the wrong lack of ambition … When you've got someone that just can't be bothered. But where there is an ambition and a passion for the care of patients as opposed to an ambition and a passion to be the best and the highest I can reach in my career … That is still hugely valuable ambition.*

For John and the senior nursing participants the key was to differentiate between lack of ambition and apathy. John described how apathy may set in if someone has been in a role that has not progressed for many years, equally a highly ambitious nurse would not allow apathy to set in. For John, Kay and Amy, a key differentiating factor appears to be the decision to work in older people's nursing, that is, those nurses who entered many years ago, who traditionally were seen as not very good, versus those nurses who make a specific

career choice to work in older people's nursing now because it is viewed as, and is, a very technical and complex role. Louise states;

> *I think the people who stand out are the people who have entered that ward because they really want to make a difference to older people. And they- they've come to this because they want to. But I think where we've got problems is that we've equally got a number of staff who've been moved into that area … Because either they didn't get a job somewhere else or … This is where they ended up or it was, at the time they joined, it was a slower stream environment and … So, you've kind of got that mixture of cultures, of some staff who are really motivated and then some staff who are thinking of it as older care- older people's care from the 1980s. And I think the two don't- they don't necessarily mix well I think where you've got people who really run with older people, they tend to end up in the nurse practitioner roles.*

Sarah described her own experience of older people's nursing and suggests reasons for the drivers to be an older people's nurse:

> *There's more of a passion to do the job… Well, it's got to be passion, hasn't it? Now I see passion for a job… and it's because it's vocation. Those nurses, when I was a student nurse, didn't have that, I don't think. They didn't have what I would call passion, they, for me, I just felt at that time they were very lazy, So, I just think that*

[tuts], from then to now and certainly looking here as well, there's more of a passion to do the job… because obviously they're not particularly well paid So, it's got to be vocation and a passion for making a difference, and I don't feel those nurses, back in 1980, whatever it was, had that, that drive or that passion, it was purely a job and they couldn't be bothered.

Some interesting contradictions and dichotomies were also revealed in the findings. For example, Elaine described her own experience having moved to work on an older people's ward, colleagues suggested she was not able to *cope* in what were regarded as more acute areas compared to other older people's care settings. However, what was evident from the participants was that care of the older person in an acute setting is highly complex and demanding and requires enhanced *coping* skills. This relates to a further finding which was around the perceived pace of older people's care in acute hospitals

4.6.5 *Pace*

Driven by the obvious influence of genuine organisational operational pressure, the participants were able to articulate a disconnect between the pace an organisation requires for the delivery of acute care and the need/desire to spend quality time with patients and relatives, giving rise to tensions. Jo was surprised when she moved into older people's care:

I worked on gastro, so very challenging, very quick… quick turnover and fast pace. And I was very much like, oh I'm going to older peoples, is it gonna be acute enough for me, is it- is it gonna give me enough spark that I want. But actually it does [chuckles].

John stated:

You want to make them comfortable, you want to reassure them, and you spend time with their family. So, what the organisation places value on in terms of nursing performance I think needs to be balanced with obviously what the patient places value on, and therefore, how do you find an individual that can cope in those environments?

The ability to work at, and *cope* with, a fast paced work environment was evident in the data. The need to work at pace was related to the acute care settings. Nursing participants described how discharge planning starts on admission and yet patients are acutely unwell with complex problems requiring technically skilled care, as well as the need to balance the time and patience (described earlier in this section) to get to know the person and manage their relatives anxieties. This is quite an undertaking for a nurse and some senior nursing participants described the need for "*super nurses"* in older people's care and indeed that the most talented nurses should be employed to work in this area. However, it was

apparent in the findings that the ability to work with pace as a single characteristic is not evident in all staff.

It was recognised in the participant data that the need to work with pace is associated with the risk of omissions of care; simply being too busy may lead to missing something. When discussing the need for pace, Chloe stated:

> *Yeah, I completely agree. I think a lot of the time, because of the needs older people have … I think you struggle with the time …and some things get missed, like the MUST [*nutrition assessment*] …you feel so guilty.*

In the main, this concern was associated with *conscientiousness* and the acceptance that pace is required because of the nature of the acute care environment and that there is an ability and desire to *cope* with the pace. As described earlier, these staff may feel guilty if they feel they have not given the care at the high standard they have set themselves.

The participant data demonstrated that being busy provides nurses with an excuse not to communicate with patients and relatives. Indeed, Amy suggested that some staff will use the pace as an excuse for omissions of care and say that the pace is too quick to enable the delivery of good quality care. There was a pragmatic reasoning by some nursing participants that hospitals are busy, therefore nurses should expect to be busy? However, even though

acute care is now busier, there are more things in place to help nurses, such as technologically based developments. This reasoning related in the main to nurses who prefer to work in a low adrenaline charged, slower paced environment. Examples given were those who have worked in older people's care for a long time or may have moved into the hospital setting from a care home. Jo described these staff:

> *I'll just plod along, you know, I've got a routine, I- I do this routine all day, every day, and- and that's how I'm gonna work. And so they don't work differently.*

Deborah described her own experience:

> *You meet yourself coming back and that's not good for me, it's not good for the patients and it's not good for the relatives. Because they look at you and- and – the relatives, they mi- they might just want a drink of water, but they won't ask you because they can see you're running around like somebody not right, which is wrong. Maybe it was just the way we were in the old … I think. I think you had more time to care.*

> *….But because I was in two different bays and I had a patient who had a hypo. But because I was in a different bay with somebody else, I very nearly missed this hypo...*

Erm, thankfully it was one of the doctors who said, 'oh, this man doesn't look very good. Can you come and have a look?'

Omissions of care were viewed as purposeful by some nursing participants and linked with not caring, not being conscientious. In order to prevent omissions nurses must be able to work at pace and demonstrate the various facets of *conscientiousness* described earlier in this section.

The participant data suggests that relatives want nurses to be able to display a sense of urgency, as it reflects the intention to care and means communication and care will be delivered in a timely manner. However, the nurses who prefer or are only able to work at a slower pace are not to be undervalued or seen as a failure, as the characteristics demonstrated by this group are required in other areas of nursing and indeed are hugely valued by the patients. For example, Betty described her experience as a patient moving from an acute ward to a rehabilitation ward, and says the first thing she noticed was the pace and that staff appeared to have more time to spend with her.

4.6.6 *Flexibility and versatility*

The findings suggest that staff who can demonstrate the ability to be versatile in their thinking will be able to *cope* with the unpredictability of the role and the need to work with different agencies and of course the various personalities of patients and relatives. A linear

and rigid task based approach to care, which will be discussed in more detail later in this work, does not enable individualised patient centred care. Nurses who are adaptable and open minded will not only be more able to *cope* with high demand situations but will be more open to developing and seeking new skills. Elaine described what this nurse needs to demonstrate:

> *People who work with older adults need to be more creative. Being curious, exploring different options, erm, trying to- to drill down to what's important rather than trying to, you know, one size fits all. And it absolutely doesn't.*

> *…can't hold strong beliefs and opinions about the way things should be. Somebody who- who's quite rigid and not able to be flexible. Somebody who, erm, thinks that situations are predictable. I think somebody who wants certainty and reliability could potentially be quite damaging. I think we- you need a much softer style, much more flexible and much more fluency and curiosity, going with the flow at the time but being able to critically reflect as you're going through.*

4.6.7 *Education and skills*

The final contributor to *coping* identified in the findings was associated with education and skills, that is, the education and skills need to be appropriate to the role. If a nurse does not have adequate education and skills the ability to *cope* will be lessened. The type of skills

required are relatively easy to list; it is the connection with nursing characteristics and the 'how' the skills are delivered that is of interest here. There was a basic agreement between the findings of the more senior professional participants that nurses enter the workforce with the same fundamentals of knowledge and the same skill set. However, the aptitude for and the ability to deliver these skills will be different between nurses and 'how' the skills are delivered are fundamentally different and influenced by nurse's own characteristics. The key difference between older people's nurses and other specialty groups is the ability to sustain compassion and patience for prolonged periods.

There was a tendency by the professional participants to differentiate what were commonly described as *"technical" and "soft"* skills. Acute skills were relatively easy to define and seen as technologically focused and associated with being *clever*, as these skills will be very apparent in areas like intensive care, where robust understanding of pathophysiology is aligned with care planning and delivery. Softer skills were challenging to articulate and fall under the general umbrella of compassion. All participants attempted to describe these skills and there was an absolute belief that, although they are difficult to describe, you absolutely know compassion when you see it. Kay attempted to define the softer skills:

> *And there's absolutely something about kindness. And it can be the very little things, you expect that people can manage a syringe driver and to manage a pump, but actually, if you watch somebody deliver mouth care or turn somebody and they do it in a way that is kind and considerate and pay attention to dignity and just, it's that*

whole package, isn't it? That actually, matters as a patient or a relative…I've seen hugely compassionate care. And real- real kindness and – and then you see people who just are, perhaps – they'll go in and technically they're absolutely fine, they're doing the syringe driver and they're doing everything they need to do, but they're not talking to somebody. They're not thinking actually, 'I know you like to wear that nightdress. I know you …' – er, an-and just thinking about the total person. And I think it's sometimes very difficult to quantify, but you know when you've ha- when you've received or you've observed it.

For the nursing participants it was very evident that, whilst the traditional view of older people's nursing is that you only needed the softer skills, actually both technical and soft skills are required and are of equal importance. Both are required to deliver effective care in what is now a very acute and technical specialty so the actual demand of the nurse is very high. It is not enough to be caring as you may be ineffective and skills alone do not achieve the desired outcome.

The findings suggest that, to meet this demand, the older people's nurse has to have a very determined attitude. It is considered human nature to want to fit in but this is not the right approach if a ward culture is not optimum, as the nurse needs to be able to challenge poor care. The desired characteristics are a confident belief in their own ability, be sought after and approachable and not be influenced by others described forcefully by Helen as "*this is my bag, this is what I am trained to do and these are my standard*s". Kay describes a

situation where older people's care has the most talented nurses as a *"hospital Utopia"*! Below are attempts to summarise these nurses:

Louise: You know, I can care but not be very effective and I can care and stroke your hand but actually, if I've ignored the fact you've got a pressure sore or that you're telling me you've got pain in your heel and I've not done anything about it, or that actually, I'm influenced by nurse X and I'm still dragging you up the bed. Then actually, it doesn't really matter that I'm touchy-feely and I'm caring.

Kay: it's somebody who is – bright, current, research-focused, but also someone who's hugely compassionate and kind. . You know, you want- you want your brightest nurses, don't you? You want people who challenge, who, erm, want to, er, drive practice forward, as well as being genuinely compassionate to the older person. So, it's both, isn't it?

Elaine: I think the positive things are the communication skills, the interpersonal skills. Maybe that's to the detriment that would they pick up on the acute signals of, you know … And it shouldn't be. It should be the same thing. But I just think that characteristics of people who work with older adults … If their tendency is to be only the interpersonal skills, is that to the detriment of being able to pick up on the acute signals and cues? What I'm saying, it sounds like you're either one or the other but

actually, to be successful, you need both. And I think that probably the successful people working with older adults do have both and can pick up those cues.

John: So- I think from the right personality to be looking after the elderly is about someone that is clever enough and emotionally intelligent enough to realise that they don't need to demonstrate their competence. That's a given. What they do need to do is demonstrate that they know how to apply that confidence … In a way that makes the individual feel … That you understand them and you are working with them … As opposed to delivering a set of things to them.

The desire for ongoing professional development has been mentioned earlier but here the specific requirement to gain further academic qualifications is apparent. There was agreement amongst the professional participants that whilst in previous times, older people's nurses were not seen as a priority to develop academically, this is now changing. There is an undertone that excellent nurses have natural ability, however, academic achievement will contribute to knowledge development and ultimately improves patient care and prevents harm. A reasonable intellectual ability is required to enable articulation of aims and goals. For the patient and carer participants the softer skills remain the priority.

"*The ability to cope with*….." was the preface to many codes in these research findings. The characteristics identified within the overarching title of *Coping* are not about being one

thing or another. The findings again suggest there are scales of demonstrable characteristics, which are summarised in Table 9.

AUTHENTIC SELF; COPING		
Least desirable facet behaviours		**Most desirable facet behaviours**
Apathetic	⟷	Ambitious
Self-doubting	⟷	Confident
Indifferent	⟷	Sympathetic
Easily frustrated	⟷	Patient
Uncompromising	⟷	Flexible
Not self-aware	⟷	Reflective
Overly impressionable	⟷	Empowered
Lacks persistence	⟷	Resilient
Technically dismissive	⟷	Technically appreciative

Table 9 Authentic Self: Coping as a scale of least to most desirable facet

4.6.8 *Summary of concepts of Older People's Nursing as aspects of authentic self/authentic relationships*

In conclusion, four main trait headings have been developed, which represent the personification of the exemplar older people's nurses. These traits and facets have been represented and summarised in Tables 6-9. The summary tables are just that, summaries of

complicated constructs, and offer a visual presentation of desired or ideal facets. However, what is not known at this stage and will be explored in more detail in the Discussion chapter (Section 5), is that whilst nurses are perceived to exhibit or not exhibit the desired trait behaviours it is not possible define an exact scale from which to further monitor or measure application.

To close the findings section on *authentic self*, and its implications for forming authentic nurse/patient relationships, brings to the foreground identified aspects of the essence of the nurse, identified through traits of *conscientiousness, sociability, coping* and *integrity.*

The older people's nurse arising from the authentic self is identified then as someone with a sense of responsibility, which is centered around complete focus of concern for the patient, to the extent that the nurse's own needs, or workplace context (i.e. being busy or short staffed, stressed or staying late after their shift has finished) become of secondary importance to that of meeting the older person's basic and complex care needs.

Delivery of only essential or basic nursing care is not satisfactory to this nurse. More attention is given to the deserving (i.e. vulnerability/frailty) nature of the older person, which stimulates the nurse and means they willingly are 'going the extra mile' as a natural part of the role. This nurse is able to deliver both compassionate and highly technical, complex care at pace, whilst concurrently demonstrating immense patience in challenging

circumstances for sustained periods of time. Coping relates to having inherently high levels of patience, calmness and reflective ability. The care being given to older people is viewed as a privilege and, as such, self-reward is unimportant. The desire and ability to form meaningful authentic relationships with all patients and relatives goes beyond knowing only the basics of what care is required, but is seen instead as a necessary, enjoyable and required element of nursing practice, particularly if empathy is to be demonstrated. Liking or not liking a patient is never in question. These multifaceted demands of working from a place of authenticity become integral elements of the older person's nursing role. These highly sophisticated levels of the identified characteristics associated with working from authentic self, to form authentic relationships required to be able to fulfil the role, is potentially what sets older people's nurses apart from other nursing groups.

The findings thus far describe desired behaviours and enable the researcher to identify appropriate traits and facet labels that appear to have a direct effect on the delivery of patient care. However, contextual variables can also influence care on a day to day basis and have been alluded to by the nurse participants.

4.7 ***Context***

The nursing participants suggested that older people's care is not viewed as an attractive place to work, as it is traditionally associated with hard manual work and intimate care delivery. However, there is a strong sense that a perception of what older people's care includes is changing, and that nurses are choosing to enter this area as they view it as an

effective place to work to develop acute, complex and problem solving skills. In addition, there is recognition that the number of older people in hospital is increasing year on year so actually many more nurses need to understand and have experience of delivering good care for this patient group outside of specialist older people's units/services.

Louise stated:

> *So, you've got a whole load of people who feel that they're not appreciated for what they do. But actually, what they're doing is a really complex job. So, there's a kind of feeling, I think, in that the nurses who work on acute medical wards, they're much better than us. So, I think that's why to me, it's about actually saying no, we- we need this core skills a go- across …And actually, to me, you know, in the future, we probably don't need to have older people's wards. Cos actually the new model should be that actually, people should be cared for in the community or if they're coming in for an acute problem, they'll go to wherever they need to be.*

The importance of finding the right type of nurse was evident in the findings. Recruitment of the right nurses will need to be much more strength based and move away from looking for staff who simply say they enjoy looking after older people.

Louise stated:

I think, if we look at what we've got now, I think the people who stand out are the people who have entered that ward because they really want to make a difference to older people. So, you- you see the, kind of nurses coming along …Who are newly qualified, or they've had one lot of experience …And they- they've come to this because they want to. But I think where we've got problems is that we've equally got a number of staff who've been moved into that area …Because either they didn't get a job somewhere else or …

John stated:

One thing that we- we need to look at is how- is how we assess for those characteristics at interview. - you know, a lot of the work we're starting to do on strengths is all about where have you got the right blend of strengths, personality types, whatever they are, that you can cope in that environment. And sometimes you might find that you're not necessarily the highest performing nurse as per the academic structure … But you are the highest performing nurse in that area because you will do the things that that patient group requires. So, you'll spend time, you're committed, you're passionate you want to make them comfortable, you want to reassure them, you spend time with their family. So, what the organisation places value on in terms of nursing performance I think needs to be balanced with obviously what the patient places value on, and therefore, how do you find an individual that that can cope in those environments?

It was apparent from some participants that the influence of the some of the 'older nurses' is still very powerful and describe a lack of respect by some older nurses of younger staff, especially if they view them as high achievers and ambitious. From a patient perspective, Sarah described her own experience of training in the 1980s:

> *The treatment of the old people, at that time, was appalling… and the nurse, nurses, for want of a better word, were very lazy… I don't think, I didn't feel they were being washed correctly…*

Louise stated:

> *I think the people who stand out are the people who have entered that ward because they really want to make a difference to older people. And they- they've come to this because they want to. But I think where we've got problems is that we've equally got a number of staff who've been moved into that area … Because either they didn't get a job somewhere else or … This is where they ended up or it was, at the time they joined, it was a slower stream environment and … And I think the two don't- they don't necessarily mix well.*

The senior nursing participants suggested that a negative, stagnant culture and attitude towards older people will stifle some nurses and, unless they have a strong enough

character to challenge, they too will succumb to accepting inadequate standards of care delivery. In addition, if leadership is not strong enough to challenge and change culture, those stronger staff will move on to other areas and the situation continues to worsen. In addition the more senior participants suggested that older people's care has suffered from a lack of investment for many years. The perception of the senior nursing participants was that we are now in the midst of a rescue and development phase of the specialty, as these minority staff are leaving the profession and being replaced with a newer generation, at the same time as increasing investment in areas such as education and staffing. However, they also point out staff have always had a personal responsibility to seek out education and development opportunities.

In addition to having the right type of nurses, staffing levels were also mentioned briefly by the more junior nursing participants. However, there were key differences between Deborah and two colleagues, Helen and Chloe. Deborah associated low staffing levels with simply not being able to do her job, whilst Helen and Chloe associate low staffing levels with the need for effective leadership, doing the best that is possible and helping each other. Seeing staffing levels as a challenge, that requires different ways of thinking about how effective care can still be delivered, also lends itself to inclusion under the heading of *coping*.

4.8 ***Consequence***

When considering the theoretical framework detailed in Section 4.2, *consequence* is discussed here as perceived outcome and impact of older people's nursing trait characteristics on care delivery. So far, the participant data demonstrate how *consequence* of nurse's trait characteristics is the delivery of either holistic patient centred care, which is viewed as required and at an optimum level, compared to task based care, which is viewed as inadequate and unacceptable. Consequences is now further broken down into component parts, drawing once again from participant observation and experiences of older people's nursing practices within acute care contexts.

It has become evident in the findings so far that the concept of holistic person centred care is considered a gold standard; therefore, understanding what this means enables a clearer understanding of the impact of the older person's nursing personality trait characteristics required.

4.8.1 *Holistic and Person Centred Care*

As previously explored as part of authentic relationship development, having in-depth knowledge of the patient and their family context is required, which relates to earlier discussion about wanting to, and having the ability to, really get to know people; the ability to form relationships and remain curious. A proactive effort is required to get to know patients and this differentiates the older people's nurse from other specialties. Being able to genuinely care for a patient's holistic needs appears to relate in the main to *coping* and to

the ability to identify needs, and link different problems to enable effective holistic person centred care planning.

Joan was a cardiac nurse as well as a carer of her elderly father. Her sister was also a nurse who looked after older people. Joan described their different characteristics:

> *You see my sister as a nurse and me as a nurse, er, we're very, very different. I think you can tell that my sister did care for the elderly. – she seemed to understand what was going on with my dad sometimes a lot quicker than I did … she was like, 'look at this' and 'look at that.' You know, 'he's not progressing. He's not doing this and he's not doing that'. You know, I would've wanted him to get better. And he wasn't doing that. ……I think my sister has more empathy. The patients I used to see, if they've come in acutely ill, get better and go off home, some of them were there for a l-long length of time. People who care for older people in hospital have more patience, are very tolerant.*

A genuine concern for others is required to enable the delivery of holistic person centred care and relates to earlier discussion about a genuine desire to care for people. Louise summarised this by stating "*a genuine empathy and a genuine kindness will enable genuine holistic care*". However, this will only occur if the nurse has commitment, which relates to the ability to be conscientious and driven to do the right thing.

John states:

> *……..it isn't- it isn't the mechanics of nursing that- what makes a difference. Its how you leave someone feeling. So, to me, a good elderly care nurse is- is the embodiment of all the nursing values …*

The participants discussed how a nurse who is able to plan and deliver holistic person centred care does so in partnership with the patient and their relative(s), and will effectively assess their desire to be involved in care delivery, and to what extent. Effective nurses will view a relative as a valuable asset to enable effective care, whereas a less effective nurse may see a relative as a threat to their control, or simply as a nuisance.

Deborah and Chloe offered differing views:

> *Chloe: I also like to work with the families as well. I think, like, it's so important to include the families, obviously if the patient's given consent Kind of, involving them and, you know, what their wishes are and things.*

> *Deborah: I – [sighs] I suppose relatives expect more nowadays. There's the internet, there's the newspapers, there's everything as you walk around a corner, it's, erm,*

how to complain, you know? And that's the first thing out of people's mouths. 'Well, if you don't do this, I'll shout and I'll and- and it's wrong. And it- it's not – and- and don't get me wrong, I don't want to go back to the years where it was, 'yes nurse, no nurse, three bags full nurse I'll do anything you say nurse.' Don't get me wrong, I don't want that. But the amount of times that you'll go in and you'll say, 'oh, hello.' 'Me dad hasn't had a drink.' 'Yes, your dad has had a drink'.

4.8.2 *Task-based care*

Based on the findings, the opposite of holistic, person-centred care is task-based care. This was referred to as '"*task-based care*" by all nursing participants, apart from Deborah. The carer/patient participants described this type of care but did not label it as task based care.

Task-based care is perceived by the participants to be care that is delivered as a series of tasks or activities that simply need to be completed. Therefore, any action undertaken, in achieving the task, does not lend itself to meeting the individual needs of the patients. It is about getting a task completed and is often associated with being busy. John stated:

[care] is about that selflessness where you are- you are accepting of your professional knowledge, but applying it in a way where you are empathetic to the needs of the individual you're serving … As opposed to following through what the

clipboard says, and then kinda going, 'so, I- I have done the job in the best way possible.

Holistic person-centred care means being able to move away from seeing the person as a condition, to being able to piece together a complex jigsaw of care and recognise multiple facets of care requirements. Ranging from acute skills delivery, intertwined with basic cares that reflect compassion, right through to recognising and understanding the specific need for human company, or for quiet and rest; plus ensuring safe and effective ongoing care from others in the health care team, or from relatives, who can deliver tailored care the best for that person.

However, more disturbing findings are around characteristics that suggest the nurse does not actually care enough to deliver holistic care. Therefore, task-based care actually allows for emotionless, cold care. Louise described some examples:

They do turn a blind eye, they don't- they're not diligent, they- they walk away when things aren't finished. So, they don't shave the person or they don't ask if they want to be shaved. They're not bothered about the fact that the bed's still wet or it's got a stain on it, o*r that they're wearing a gown rather than their own clothes That's not registered with them, that's the problem they're not thinking and- and, erm – and I guess there's an intellectual part to it too, that they're not considering the*

implications of what they're saying. So, the patient's not eating, they're not even thinking, actually that could be affecting this or that. It's that- that 'do my best for you to- so that you can be as well as you can be.' So, when we have a lack of care, it's that – as I say, it's that walking away and not thinking and not actually being- feeling responsible or feeling that you- you can do something. Just thinking it as a task that you either do or you don't and you have no emotional attachment to it.

The data suggest this as emotionless, task-based care which does not allow or include any time with patients, to allow and foster meaningful communication working towards achieving authentic relationship. It further compounds a lack of assessing the patient's holistic needs. This task-based 'detached' care is disingenuous and appears distracted and rushed. John stated that these nurses are recognisable by their lack of ability to be "*in the moment"'* with the patient and "*look and act like this is just the thing on a long list of to-do things that I've got to do*" and not see "*every touch point is special*".

Participants described how nurses who are more task focussed see patients as problems and obstacles to getting their list of tasks completed. In contrast, holistic care means meeting individual needs, and for nurses who are task focussed this may impede a set ward routine or the way a nurse wishes to plan and compete their tasks.

Deborah described how this occurs:

You might have eight patients to look after, so you want that patient to get out of bed as soon as they can … So, you can sit them in the chair and get on to the next patient to give them the tablets and whatever, but you can't. You've got to stand there and you've got to let them tell you their life story, if they want to tell you it ….. I'm not saying I'm great and I'm not saying, you know – but one of my things is – on a morning, is I go around with the medicines. I've done the obs, I do- I'm going round with the medicines. If the patients need feeding, I give them their breakfast and their medicines at the same time …

In this way task-based care was seen as efficient and may provide a false job satisfaction. However, no other participant suggested anything positive about task-based care and the nurses who deliver it. It is not individualised, holistic or dignified as Elaine described:

It's a quite robotic approach to nursing. You know, sort of, task orientated or, erm, thinking that they know what the person's needs are without fully investigating it. Or, you know, 'let's toilet the patients.' Absolutely drives me mad. So, somebody who's very much into the rounds. You know, the rounds of toileting, the rounds of 'let's feed them …' – all of those quite derogatory comments. Erm, and getting through the tasks of the day.

For patients, this relates to earlier discussion about being fearful of disturbing some nurses as Betty states "*if they liked you, you were alright".* These nurses like patients if they are compliant and do what staff tell them and do not disturb their routine and task completion. Betty described her experience in hospital and trying to influence a nurse's behaviour:

> *Like the one girl in the be-bed opposite had said something and, er, oh, they were really huffy with her she said something about – she said – oh, she said, 'I- I think I need my banda- my bandages changing and I need a shower' And she said, 'I've been in longer than her [Betty] and you put her in the bath. Why haven't you put me in the bath?* T*he nurses sort of turned against her. So, I said to one of the nurses, I said, 'oh, for god's sake, put her in the bath'. Yeah, the nurses thought they were in – the nurses really were in control. And she wanted – she wanted them to deviate from the way they were going*, *she wanted things done a different way to what they were doing it.*

The findings suggest that task-based care is seen as 'care without caring'. But it is not as straightforward as it first appears. Task-based care is described traditionally as being efficient. However, task-based care will also result in omissions of care because of the link with a lack of basic desire to do the right thing. Amy described how there is a lot of emphasis put on the requirement to meet basic needs. However, it is clear from the findings that for task based care, the basic care needs will be just that - the absolute basic. Kay provided an example of task-based care as washing a patient's bottom and giving them a

clean sheet to lie upon, whereas holistic basic needs will be doing more than just washing the patient's bottom. Holistic care incorporates putting some of the required cream on, then ensuring there is some comfortable underwear, whilst all the time talking to the patient about how they are feeling and checking out they are getting what they want from the interaction.

Participants suggest that poor care can be very subtle. It can be experienced as a feeling of simply the nurse "*can't be bothered".* Jo described these staff as "*slapdash*". Task-based nurses will not recognise that they are delivering poor care, as the delivery of the absolute basic will be accepted as satisfactory to them. This leads to omissions in the assessments and plans that enable individualised and as importantly, clinically optimised, care such as nutrition and continence assessments. This would also be reflected in communication with colleagues as well and Jo described an example where lunch is seen as a task and not a nutritional objective and relates strongly to *conscientiousness:*

> *I think it's the cutting corners. And not thinking. Making sure that people have got things within easy reach. That the tables are clear in front of them so they can actually get to things. Making sure that from a nutrition point of view they're really seeing what somebody's actually eating, rather than it being a something that well, you know, erm, I think they've had their lunch. Well actually they've only took two spoonfuls of mash potato, that's it. You know, it's about well what else then can we*

suggest that maybe they- they would like. You know, is there anything else we can do. Er, and it's not actually going the extra mile, it's just going the right mile.

Amy described how, in the extreme, task-based care will be associated with safeguarding allegations as nurses deliver care that suits them and does not address the needs of the patient, such as rigid routines around toileting and feeding. Amy described how choices need to be the best for the patient, not the easiest for the nurse:

You know- you know, can we walk somebody out to the toilet rather than bringing a commode or something like that? This might take us ten minutes longer, but actually that's the right thing to do

Kay provided a further example:

I've had examples – where, erm, you know, people have done things like stripped beds and left the beds up high so, people can't get back into them. You know, that sort of awful, awful practice that you just can't believe.

Most participants found it a challenge to understand why nurses behave in this way and why anyone would not want to do their absolute best.

4.8.3 *Advocacy and control*

Advocacy is an integral part of the delivery of nursing care and the ability to advocate will influence how care is delivered to a greater or lesser extent. Some nursing participants suggested that those nurses who have a strong desire to be in control and those who are inflexible or opinionated may be seen as unsuitable to look after older people as the emphasis should be on advocacy not control, again, relating to task-based care and Helen describes how this is detrimental:

> *….just doing everything to save time…., cos I think – you can take a patient's independence away if you're doing a lot of things for them, they're gonna expect you, that's how it's gonna be.*

However, being viewed as too compliant will also compromise patient care as you need to be able to stand up for the patient. Advocacy was seen by participants as the passion to do the right thing for the patient and is a fine balance between patient welfare and patient choice. John did draw attention to those patients who may struggle to make choices and inferred the child analogy:

> *Whereas you get older – and again, it's about the children thing. As you get older, 'I have less a- I have less ability to make choices … As you get older, you need people*

around you that can help you make the right choice. Cos you're aren't necessarily able to do that yourself.

In order to be an effective advocate, a nurse needs to be forward thinking and able to reassure and not induce fear, have gentle persuasion skills and a quiet assertiveness, which represents a fine balance with the use of coercion and control. The intent of the nurse seems key in determining genuine advocacy. An example offered by Elaine was that of trying to persuade a patient to have a bath and they don't have one – is this because it fits the nurse's task based approach to care or the patient really will benefit from having a bath? Jo describes how some staff will not recognise a situation where they need to advocate for the patient, and that some staff will be inclined in the opposite direction and want to maintain control:

Some nurses really don't put themselves out there. You know, are not really the advocate for the patient, saying actually no, we need to do x, y, and z, or actually this patient's fit for discharge, can we get them home today. Nurses who, erm, don't acknowledge the patient needs, they put their own needs before the patients or they just want to control the situation. Not really thinking about advocating for the patient And I think in- in with that mix of things as well, is- is control of the routine. So it's like come on you have to get up now because it's part of my routine and if you don't get up now I've then got to come back. Rather than looking at what the patient wants and the patient needs.

There was a- a patient who, erm, it was an elderly patient who had an eating disorder, was in and out of hospital, obviously very depressed. Had no lust for life, didn't want to get out of bed. Didn't want to engage with anything. And I could see why the nurse wanted to get her up and out of bed and in the chair. But equally the patient was saying I don't want to get up and out of bed and in the chair. And the nurse then said, right come on, I'm getting you up, and then just gets them up and just sits them in the chair, and the patient's saying no. There was a student nurse with her when this was happening so she went back to the university and reported it. So the nurse ended up being suspended whilst there was an investigation ongoing. Erm, so I think there are a small proportion of nurses that…don't listen to the patients. And just, you know, look at what- what their needs are. It's working round routine and cultures of the ward.

Elaine described her thoughts:

We have skills. You know, you – people don't rehabilitate because we give them exactly what they want all the time. It's a balance, isn't it? So, we might not be saying to be authoritative, it might be saying to be coercive or, erm, charming [chuckles]. It might be about using charm and charisma, erm, manipulation at times? And it's, erm, the nurses being able to use their skills to say, 'oh, come on now, get you all nice and clean now and then, er, you can go to bed and have a couple of hours rest on your bed' – is that a bribe? Is that bribing a patient to conform? Maybe

it is. But hopefully, the intention is best- best intentions or best interests for that person. So, maybe it comes back to the intention. The patient, anybody who- that goes in to hospital with a wristband on their- their hand is vulnerable. It's about trying to engage with the person so, they feel as if they've got some say. They're feeling that they've got the control, that they are able to make decisions, but within parameters. I've experienced situations where [sighs] erm, nurses, erm, can be more authoritative than need be, can use language, erm, that I think is unnecessarily harsh. Erm … I just don't think that's acceptable. Getting people to conform. I don't think its right. But by, erm, using a different approach … You know, you can do it in a softly, softly way but your intention and the outcome are the same. But it just feels and sounds differently. Alternatively, I've experienced where, you know, 'Mrs Jones doesn't want to get out of bed today so, I've left her'. Not acceptable, you know?

The *authentic self* consists of predispositions to behave in a certain way, and is dependent on the presence of the trait facets and potentially the levels of these facets. The associated behaviours then have a direct influence on the type of care delivered. Further facets have also been identified within this section and are summarised in Table 10. These characteristics have been aligned under the headings of *conscientiousness* and *Sociability* in a complete summary table of characteristics in Section 5 (page 215).

CONSEQUENCE – CARE DELIVERY		
Least desirable facet behaviours		**Most desirable facet behaviours**
Inconsiderate		Mindful
Detached		Inclusive
Controlling		Advocates
Confrontational		Negotiates
Task focused		Holistic analyst

Table 10 Consequence: scale of least to most desirable trait facet associated with the delivery of person centred holistic care.

4.8.4 *Summary*

The data has enabled the identification of four specific traits and associated facets grounded in the experiences of the stakeholders who were able to describe the required behaviours of nurses looking after older people in the acute setting. Section 5 will explore these findings in relation to the context of the literature, in order to demonstrate if the aims of the research have been met.

5 Discussion

5.1 *Introduction*

The discussion chapter is constructed by utilising a grounded theory process, which enables a constant comparison to be undertaken, not just during data analysis (Charmaz, 2014). This helps to facilitate a robust understanding of the different phases of the study and can help to further identify where findings differ, agree, challenge or transcend existing ideas.

Discussion is centred on the relationship between study findings and how this relates to the literature reviewed in Chapter 2 and additional new literature (not previously reviewed) sought to support deeper explanation of study findings. Therefore, discussion allows for a refined review of the relationship between study findings and FFM traits headings and other related literature. The discussion concludes with a section addressing the strengths and limitations of the study.

5.2 *Older People's Nursing: The impact of authentic self on care delivery*

The literature review revealed research that measured personality traits of nurses seeking to consider personality in relation in some way to job performance, arising most often from descriptive studies. To date, there are no studies that have identified how older people's nursing care delivery could be enhanced when taking into consideration nurses' personality traits. This study proposes four main personality traits and their associated facets, as those required specifically in nurses who look after older people (Table 11). This is the first time

these traits and facts have been clearly pulled together under the one heading of working from the authentic self. Table 11 indicates a continuum from poor nursing care delivery through to a gold standard for older people's nursing in acute care settings.

Throughout the process of analysis, it has become clearer how these traits relate to nursing care delivery, how they are displayed by the nurse and what the consequences are on the patient experience of care. What has been revealed is a core category of *authentic* self alongside associated consequences for the patient, their carers and for nurse's professional integrity. The previous chapter culminated in the *consequence* of the impact of personality traits, on how nursing care is delivered. The Discussion section will start with considering *consequence* as a means to initiate the thread of person centred care throughout the chapter.

THE AUTHENTIC SELF		
CONSCIENTIOUSNESS		
Least desirable facet behaviours		**Most desirable facet behaviours**
Inability to *cope*		Resilient
Puts self-first		Puts patient need first
Inflexible		Versatile
Negates responsibility		Retains responsibility
Careless minimalist		Needs focused
Essentials focused		Standards focused
Comfort in simplicity		Comfort in complexity
Careless		Diligent
Inconsiderate		Mindful
Task focused		Holistic analyst
SOCIABILITY		
Purposeful ignorance		Relationship building
Uninterested		Curious
Dismissive		Inclusive
Isolating		Personable
Distracted		Attentive
Confrontational		Negotiates
INTEGRITY		
Entitlement		Gratitude
Requires reward		Self-found gratification
Dismisses identity		Respects identity
Dishonest		Honest
Controlling		Advocates
COPING		
Apathetic		Ambitious
Self-doubting		Confident
Indifferent		Sympathetic
Easily frustrated		Patient
Uncompromising		Flexible
Not self-aware		Reflective
Overly impressionable		Empowered
Lacks persistence		Resilient
Technically dismissive		Technically appreciative
CONSEQUENCE – CARE DELIVERY		

Table 11 Traits and associated facets required for older people's nurses

5.3 *Consequence: Impact of authentic self on nursing care delivery*

Whilst the literature review identified no application to date of the meaning of personality traits to direct nursing practice, it has become apparent there are personality trait facets that are perceived by stakeholders as proxies for caring.

Consequence is the term applied to a core study theme that describes what nursing care is being delivered and how this then is linked to a nurse's personality traits. As outlined in this study, consequence can be seen as either holistic and person-centred or task-based. It is not apparent from the literature alone what *caring* means in terms of how the actual care is delivered if a nurse exhibits one characteristic or another. Therefore, a comparison of person-centred care, the FFM and the researcher's findings is presented to identify commonalities that aid a wider understanding of personality and older people's care. The comparison starts broadly by addressing *consequence* and person-centred care and then focusses in on comparing person-centred care model prerequisites with the FFM and TOPNACS traits that ultimately help identify the strengths and weaknesses of the proposed TOPNACS model.

5.3.1 *Person-centred care and the authentic self*

Oliver (2014, p6) states that:

> *Services for people with long term conditions tend to focus on single conditions, whereas many people over 75 have multiple co-morbidities and want to be treated*

as an individual who needs coordinated, person-centred care rather than as a collection of diseases. Too often, these strategies ignore common conditions associated with ageing and, in particular, fail to mention the unique challenge of frailty. Older people who are frail often require a different level and type of support to those who are younger and fitter.

Person-centred care is a concept widely acknowledged in healthcare. It is linked to optimum approaches to care delivery. Person-centred care has been conceptualised within a widely recognised theoretical framework developed by McCormack *et al.* (2011), which provides teams with the means to operationalise person-centred care in practice. The Person Centredness Framework has four key constructs: pre requisites that focus on the attributes of nurses, the care environment that focusses on the context in which care is delivered, person-centred processes that focus on delivering care through a range of activities, and the outcomes (the central part of the framework) are the results of person-centred nursing. At it's core is the establishment of a therapeutic relationship between healthcare professional and the person (patient or family).

Despite widespread use of the person-centred framework, there are few studies that provide concrete examples of what facilitates nurses to provide person-centred care, particularly for older people in the acute setting (Nilsson *et al.,* 2019). However, a key concept within the framework is that of *prerequisites,* the notion that it is the attributes of staff that must be considered as a prerequisite to the quality of care delivery, thus leading

to effective person-centred care. This notion of attributes, as prerequisites to standards of nursing care delivery, aligns with the inferences from the findings of this study about the consequences arising from nursing with a series of desired traits and facets.

Following publication of the Person Centred Practice Framework, (McCance *et al*., 2011), Slater, McCance and McCormack (*Slater et al.,* 2017) developed a Person-Centred Practice Inventory (PCPI) that examines how staff perceive person-centred practice. The construct definitions under the heading of 'prerequisites' are: 'professionally competent', 'developed interpersonal skills', 'being committed to the job', 'knowing self' and 'clarity of belief and values'. Key examples are listed below of person-centred care pre requisites aligned with the researcher's study findings, emphasising the potential impact of identifying the ideal personality type to deliver true person-centred care:

Considering the trait of Coping with PCPI Knowing Self and Professionally Competent:

The need to be a reflective practitioner within the trait of *coping* was identified in the researcher's findings and within the PCPI; the construct of 'knowing self' would be measured by:

- I take time to explore why I react the way that I do
- I use reflection to check out if my actions are consistent with how I am working
- I pay attention to how my life experiences influence my practice.

The ability to gain education and skills was identified within the trait of *coping* in the researcher's findings and within the PCPI; the construct of 'professionally competent' would be measured by:

- I have the necessary skills to negotiate care options
- When I deliver care I pay attention to more than just the immediate task
- I actively seek opportunities to extend my professional competence

Considering the trait of sociability with PCPI developed interpersonal skills:

The ability to proactively build relationships with patients and families and work effectively with colleagues was identified within the trait of *sociability* in the researcher's findings and within the PCPI; the construct of 'developed interpersonal skills' would be measured by:

- I ensure I hear and acknowledge others perspectives
- In my communication I demonstrate respect for others
- I use different communicating techniques to find mutually agreed solutions
- I pay attention to how my nonverbal cues impact on my engagement with others.

Considering the trait of conscientiousness with PCPI being committed to the job and clarity of belief and values:

The ability to deliver person-centred care with a feeling of significant responsibility was identified within the trait of *conscientiousness* in the researcher's findings and within the PCPI; the construct of 'being committed to the job' would be measured by:

- I strive to deliver high quality care to people

- I seek opportunities to get to know the person and their family in order to provide holistic care
- I go out of my way to spend time with people receiving care
- I strive to deliver high quality care that is informed by evidence
- I continually look for opportunities to improve the care experience.

The ability to challenge others and support colleagues was identified within the researcher's findings. Within the PCPI; the construct of 'clarity of belief and values' would be measured by:

- I actively seek feedback from others about my practice
- I challenge colleagues when their practice is inconsistent with our team values and beliefs
- I support colleagues to develop their practice to reflect the team's shared vision and beliefs

The PCPI construct definitions provide meaning to elements of the wider PCPI to ensure that person-centred care can be successfully implemented but stops short of describing how these prerequisites might be measured in terms of personality. The PCPI is generic and is aimed at other healthcare professionals not just RNs and is not unique to older people. However these prerequisites are arguably personality behaviours therefore, this style of 'I' statements may be an interesting approach to designing *tests* of the proposed personality traits in the researcher's study findings. For example, when cross referencing the PCPI with the findings of this study there are some overlaps – however this does not reveal anything further when related to personality traits.

5.3.2 *Re-considering Caring - as nursing behaviours arising from personality traits*

Despite best intentions, nursing work does not always include a caring moment. Today's nurses are challenged with increased patient acuity and ever changing medical technology. This can turn the nurse's attention away from caring for the patient and focusing on the acuity of the patient's illness and/or the technology. New strategies are needed to provide patient-centred in the technology-rich environment. A nurse who does not care sees the patient as an extension of the technology, an object to do things to (Johns, 2005; Ackerman, 2019). This lack of ability to be 'in the moment' with the patients whist delivering care may relate to technology and acuity as suggested above but will also, as proposed by the researcher's findings, relate to the personality of the nurse and how they ensure person-centred care can still be delivered, dependent on levels of the four identified required traits.

5.4 ***Comparing elements of the Person-centred care framework, the FFM and the authentic self***

The traits and characteristics identified in the literature may well be appropriate for many areas of nursing. However, the researcher's findings demonstrate a need for, not just adequate care, but a nurse who can offer outstanding older person-centred care, reflected in the apparent deserving nature of patients simply 'being older'. For the older people's nurse, it may be specific traits and facets identified in this thesis that are required, at the most desirable end of the spectrum that will enable holistic (older) person-centred care.

Task-based care, which is viewed as inadequate and unacceptable by the participants, may well be viewed as efficient in some specialties. Therefore, being *conscientious* displayed as efficient may be adequate in many clinical areas, but may not be adequate in an older people's nurse. The trait facets described in this study can be forced to *fit* into the FFM, as *conscientiousness,* however the facets within this FFM trait may not be specific enough. The FFM (McCrae and Costa, 1987) is frequently referred to in the literature and is a commonly used tool by which to measure personality. However an incidental finding of this work is that, whilst the identified traits in this work can approximately align to the FFM traits, the specific facets within them indicate that the FFM would not be adequate to identify the most appropriate traits and facets for older people's nurses.

Specific characteristics identified in this work are a requirement for effective high quality nursing care delivery to older people in acute care settings, as identified from key stakeholder perspectives, including nurses themselves. There is opportunity to align the researcher's proposed Trait-Based Older Persons Nursing in Acute Care Settings (TOPNACS) model, against the pre requisites within the PCPI and the constructs of the FFM. This alignment is presented visually in table 12 below.

Person Centred Nursing Framework (McCance *et al.*, 2011; Slater *et al.*, 2017)	**Trait based Older Persons Nursing in Acute Care Settings (TOPNACS) (Day, 2019)**		**FFM**
P= Prerequisites	AS = Authentic Self:	Conscientiousness	Conscientiousness Agreeableness
		Sociability	Agreeableness
		Integrity	Agreeableness Conscientiousness
		Coping	Neuroticism Openness to experience
The care environment		Context	
Person-centred processes		Context	
Outcomes		Consequence	

Table 12 Alignment and overlap of the person centred framework, TOPNACS and the FFM

Undertaking this comparison helps to emphasise the specificity of the traits required for older people's nurses working in acute care settings that will further enhance and enable person-centred care delivery to be optimised. Undertaking a comparison also helps to illuminate the prerequisites of the PCPI and highlights the weaknesses of the most commonly used personality testing tool (the FFM) as no longer being sensitive enough to enable identification of an effective older people's nurse. This research has provided a more contemporary theoretical framework. The four proposed traits identified in this study will now be discussed further within the context of the FFM and the PCPI.

5.5 ***Conscientiousness***

In comparison with the literature, the FFM trait of *conscientiousness,* demonstrated by the facets of diligence and thoughtfulness, is reflected in the researcher's findings as a required

trait in older people's nurses. The literature demonstrates that *conscientiousness* is repeatedly associated with job performance and job satisfaction in many professional groups, and some of these trait's facets would be seen as a proxy for caring in some nursing studies. What is not evident in the literature is which facets directly influence care delivery. The researcher's findings have identified some very specific facets that are identified as a requirement for older people' nurses under the headings of *conscientiousness.*

5.5.1 *Conscientiousness and job satisfaction – retaining responsibility*

Being conscientious is defined and described based on stakeholder experiences as a key trait required for older people's nurses. Being conscientious is also a key personality trait that appears most often throughout the existing literature as being linked with job performance and job satisfaction (Mount *et al., 1998;* Hurtz and Donovan, 2000; *Witt et al.,* 2002; Colbert *et al.,* 2004; Ellershaw *et al*., 2016; Aslan and Yildirim, 2017).

In addition, *conscientiousness* has been demonstrated to be higher in various nursing groups (Williams *et al.,* 2009; Eley *et al.,* 2010; Eley *et al*., 2012; Pitt *et al.,* 2014). Job satisfaction was not mentioned specifically by participants Rather, it was discussed in terms of enjoying the role, however, the specific facet of 'retaining responsibility' was able to be defined and is associated with pride in one's work, an inherent need to 'go the extra mile' and reward is not viewed as important. The closest related facet in the FFM to *conscientiousness* is 'goal striving' and the behaviour exhibited would be described as 'working hard' or, at the other end of the scale, 'doing just enough to get by'. However, 'working hard' does not pinpoint

specific aspects and nature of the strong feelings of responsibility that nurses need, as reflected in the study findings, as part of *conscientiousness*. In the prerequisites identified in the PCPI, this differentiation falls under the main heading of *'being committed to the job'.*

Drach-Zahavy and Srulovici (2018) demonstrated that *conscientiousness* is associated with high levels of personal accountability and fewer omissions of care. However, the findings in this study suggest that being conscientious, as an older people's nurse, is not just about working hard and getting the job done. It means working hard with a level of thoughtfulness, tenacity and patience that may not be observed in other nurses working in the context of older people's care. In addition, the researcher's study findings suggest a nurse can be considered conscientious but not be able to cope with work pressures, affecting what is viewed as a priority by the nurse. This is perhaps of particular importance for nurses working within acute settings, that are considered fast paced with technologically driven interventions, balancing this with the need to offer time to listen and understand what an older person's particular care needs are within that acute and busy context. These clinical prioritising choices, whether made deliberately or subconsciously by the nurse, can be excused by patients as seeing staff as 'being rushed off their feet', or at worst, seen by patients and their relatives as an uncaring dismissive demeanor. The nurse is able to mitigate this, through using their trait characteristics, for example as shown in the next facet.

5.5.2 *Conscientiousness – 'going the extra mile', putting patient needs first*

'Going the extra mile' was discussed multiple times in the data, and is demonstrated by staff putting patient needs before their own, and again strongly links to a sense of responsibility. The participants described the "*old style, not really wanting to be there*" nurse, who would be more likely to be focussed on their breaks than the needs of the patients and doing the absolute minimum to get by, always thinking about finishing work, going home and generally viewing work as something that gets in the way of something else they would rather be doing. In the PCPI 'going the extra mile' can be aligned with "*I go out of my way to spend time with patients in my care"*. The study findings suggest that a sense of *ownership* of the patient is required, in order to feel a sense of *responsibility* for the care being delivered.

'Going the extra mile' implies a willingness and desire to do more than basic level of nursing care. It may be driven by what motivates the nurse. High motivation to be an older person's nurse appears to equate with the more willing the nurse is to provide the best level of nursing care they can offer. Barrick *et al.* (2013) suggest that natural striving as expressed in personality, is linked to higher order goals such as: 'achievement striving', 'status striving', 'communion striving' and 'self-determination'. The FFM traits are positively related to these higher order goals. For example, *conscientiousness* and *emotional stability* relate to the goal of 'achievement striving'*, agreeableness* and *emotional stability* to the goal of *'*communion striving*'* and then *openness to experience* and *extraversion to the goal of '*self-

determination/autonomy striving.' Employees will experience greater motivation if they are able to pursue these goals (Barrick *et al.,* 2013).

The participants described some nurses as being not as nice/pleasant as others. This may have more to do with the nurse's personality not fitting the job and not aligning with higher order goals, than simply not being a very nice person. The 'achievement striving' described by Barrick *et al.* (2013) does align with the trait *conscientiousness* and supports the study findings, under the FFM facet of *conscientiousness*. For example, 'self found gratification' can be identified under the wider heading of *Integrity*. Whilst *integrity* stands alone as a trait required for the older people's nurses in this study, it is also inextricably linked with *conscientiousness* in the study findings*. Integrity* is a requirement that enables a depth of *conscientiousness* required for older people's nurses otherwise care may be a set of completed tasks, but not addressing holistic needs of the patient and family.

Comments in the findings such as; *"I just had to do it*"; "[I] *wouldn't expect everyone to do it and that is ok"*; "*She couldn't have done any more, I don't think you can be taught that or trained",* refer back to a dominance of *conscientiousness* and a higher order goal of '*achievement striving'* as required/necessary traits to be had in older people's nurses, with the need to observe for the specific facets that have evolved from the data. This is supported by the specific PCPI suggested pre-requisite of "*I strive to deliver high quality care".*

A marker of an effective older people's nurse is identified in how personal reward appears unimportant. Therefore, *extraversion* associated with 'status striving' would appear to be an unnecessary trait. *'*Status striving', a higher order goal associated with *extraversion,* was not revealed in the researcher's findings. Rather, any sense of reward achieved was related more to a feeling of personal satisfaction of having done a good job. Recognition gained from others was again not considered as necessary or required for the nurse to continue to deliver high quality nursing care to older people. Existing literature also supports this concept, demonstrating that nurses gain more job satisfaction in relation to factors around the quality of the job. When linked to the traits of *agreeableness* and *conscientiousness, status striving* is strongly related to job satisfaction over job performance in their work (Kovach *et al.*, 2010; Aslan and Yildirim 2017).

Two self-regulatory processes are associated with the higher order goals of 'purposefulness' and *'*experienced meaningfulness'. These are key mechanisms by which personality affects work actions (Barrick *et al.,* 2013). 'Experienced meaningfulness' refers to the meaning an individual gains from their work activities. The enriched social relationships required in older people's nursing, and the selfless non reward seeking approach to work, appear to be the meaningfulness sought by effective older people's nurses, as demonstrated by the study findings.

5.5.3 *Conscientiousness – resilience and the potential consequence of compassion fatigue*

The influence of 'emotional labour', mentioned in the introduction to this work (Section 1.4.1) as a possible influencer on how care is delivered and within the category of *Context*, requires discussion. Emotional labour has an impact on how care is delivered, *'*compassion fatigue'*,* is the diminishing devotion to care observed in nurses who are emotionally exhausted. However, the need to demonstrate expected emotions that are incongruent with how nurses are actually feeling and the resultant compassion fatigue can be moderated if nurses feel the support of their employers (Chou e*t al*., 2012; Riley and Weiss, 2015; Mauno *et al.,* 2016). This literature aligns with the researcher's findings where participants have inferred the negative impact of a poor culture care delivery in terms of workload and poor role modelling. In relation to personality, there are some studies that demonstrate compassion fatigue is associated with higher levels of neuroticism (Chen *et al*., 2017; O'Mahony *et al.,* 2018).

Therefore, compassion fatigue does not fully account for how care is delivered but may contribute to not actually being able to 'go the extra mile' and within the PCPI under the heading of 'knowing self' there is a specific proposed pre requisite of "*I take the time to explore why I react as I do in certain situations".* However, being reflective may not be enough to enable behavioural change. *Neuroticism* may be the FFM trait that, if observed in higher levels, may make an individual more susceptible to compassion fatigue*.* Regarding the researcher's findings, lower levels of the facets identified within *coping* trait may relate to susceptibility to 'compassion fatigue' and warrant further investigation.

Compassion fatigue was not referred to specifically by the participants and does not explain poor care, rather a sense of 'can't be bothered' or a lack of ability to work at pace and *cope* with complex problems and unpredictability of workload. Therefore, the researcher's study findings suggest a reason why task-based and less conscientious nurses 'stand out' from stakeholders' experiences in older people's care is the significant gap between expectations of higher standards of care required for older people alongside other patient groups.

Perhaps, there is a possibility that *conscientiousness* can still be present, as traits do not exist in isolation of each other. Nurses want to get tasks completed, but may lack other traits which ensure nursing care is effective, such as *integrity* and *sociability*, which would ensure tasks are not viewed as simply that - tasks to be completed without regard for the patient.

Not only is the ability to form relationships with others paramount in older people's nurses, it is a desire to do so that is significant within the *authentic self* of an older people's nurse. Barrick *et al.* (2013) describes this in terms of higher order goals as the 'communion goal'; the motivation to gain acceptance and get along with others. The two traits associated with this in the FFM are *agreeableness* and *emotional stability.* Agreeable individuals appear to be those who are keen to help others and are sympathetic. This became evident in the findings as nurses were described as ranging from proactive and totally inclusive in their communication to dismissive and unkind. At this point, divergence from *conscientiousness* as the completion of a set of tasks, and *conscientiousness* as completion of a set of tasks

with consideration for the patient and relatives, is apparent. The completion of tasks effectively is associated with high levels of empathetic communication and *integrity,* and the ability to *cope* with multiple challenging situations. Therefore, very specific facets within *conscientiousness* need to be identified in potential older people's nurses.

5.5.4 *Conscientiousness – versatile and comfortable with complexity*

Orderliness is a facet of conscientiousness in the FFM and suggests a characteristic that is less associated with flexibility and adaptability and can be aligned with the preparedness ability described in the researcher's findings. Preparedness is required in order to process complex information from multiple sources and plan effective care delivery. A lack of preparedness would result in incomplete care. However, in the extreme of this facet this may be demonstrated by excess attention to the completion of a required task, and emphasis on holistic care will subsequently be lost. Ellershaw *et al.* (2016) suggest that nursing may demand more active virtues of conscientiousness. Flexibility and versatility were identified in the study findings as a requirement for an older people's nurse, where a fine balance between preparedness and flexibility must be achieved.

The question remains as to who has the ability to adapt? For example, can all behaviours be adapted and to what extent? Perhaps adaptability relates to the trait of *openness to experience,* which is a trait that would be desired. As the study findings suggest, the need for nurses to be versatile thinkers to enable *coping* with the unpredictability of the role is essential. *Openness to experience*, demonstrated by imagination and insight in the FFM,

may benefit both the role and the need to be able to adapt one's own behaviours. However, Sackett and Walmsley (2014) warn that the possibility of personality change should not be used to argue against the use of personality testing for employment, as the relative costs of selecting for an attribute will be lower than attempting to change an attribute through training and conditioning. In healthcare management this notion is of paramount importance, not just due to cost, but as there is no current data to suggest what facet behaviours can adapt and how this can occur, it may be of detriment to employ a nurse with an overt undesirable characteristic.

The trait that should be selected is *conscientiousness,* and the specific facets within it need to be those identified by the researcher and not specifically those within the FFM, in order to identify an effective older people's nurse. Aiming for adaptability of a trait or characteristic is not staying true to the concept of the *authentic self.*

5.6 ***Sociability***

5.6.1 *Sociability and extraversion*

The FFM trait of *extraversion* is demonstrated by excitability, assertiveness, talkativeness and high amounts of emotional expressiveness. This behaviour pattern was not reflected in the researcher's findings as a trait that is required for effective older people's nursing. Whilst prosocial behaviours and the desire to form effective relationships is necessary in older people's nurses, there is nothing in the findings that suggests these facets relate to extraversion, particularly not related to excitability and talkativeness. Specific pre-requisites

suggested within the PCPI, under the heading 'developing interpersonal skills', relate more to listening, hearing and acknowledging others. These are not, however, strongly linked to extraversion.

The literature presents differing evidence of the value of extraversion. There are some findings where it is viewed as desirable, particularly in leadership roles. However, this is not a consistent finding. The characteristics defined in the researcher's data under the heading of *Sociability* align more readily to those of agreeableness than those of extraversion in the FFM, again highlighting the requirement of 'getting along' rather than 'getting ahead'.

The study findings demonstrated little about *extraversion* specifically, only a general inference that it is more likely to be a *bubbly* extravert that will need to adapt their approach more often than less extravert individuals. Therefore, reflective skills are an absolute necessity for a nurse. An extravert may be seen as someone who is more likely to walk in to a room and start lively conversation without necessarily understanding the need for a calmer and quieter approach.

Extraversion was not consistently associated with job performance in the literature reviewed in Section 2.4. However, the work of Kennedy *et al.* (2014b) found high levels of *extraversion* in an Emergency Department nurse participant sample. How, then, might this trait be high in other nursing sub specialties? What does its presence enable emergency

department nurses to achieve when compared to other groups? This may relate to higher order goals described by Barrick *et al*. (2013) where *extraversion* is linked to the pursuit of status. Accident and Emergency is a very high profile specialism where the low levels of *extraversion,* demonstrated by 'preferring to be alone' and 'will wait for others' may not be desirable or effective in this role.

In order to 'get along', people need to be seen as cooperative and somewhat compliant. But to be seen as 'getting ahead' and successful, these are often viewed as competitive and means a person is trying hard to be recognised. These descriptors are associated with *extraversion* (Hogan and Holland, 2003). The 'getting ahead' category of people does not come through strongly in the researcher's data.

The trait of *extraversion* appears to raise some controversy. Yeh *et al.* (2016) stated that *extraversion* was associated with greater efficiency in nursing leaders, but only when a leader who had high levels of *extraversion* also demonstrated an initiating leadership style. Being task oriented and instructing the team were given priority over consideration for the team. This offers a challenge, as efficiency may be presumed to be required in a healthcare system under immense operational pressure but not at the expense of team motivation, which in itself is associated with increased productivity. In addition, being focused on task does not lend itself well to the particular care needs of the older person. For example, the nurse can take a person to the toilet and leave them there, as a task achieved, whereas someone with conscientiousness would engage the person in conversation, using the task as

an opportunity to undertake other forms of nursing assessment. This brings back the need for relationship building, which does enable effective person centred care.

The researcher's study findings define characteristics under *sociability* as *curious, inclusive, personable and attentive*. Personable may be a word that could be associated with *extraversion* but in the *context* of the study findings, it is not seen as evident. Therefore *extraversion* is seen as an undesirable trait when present in high levels on the scale. As with other studies, the level of *extraversion* is critical. If displayed at too high a level, this may be detrimental to relationships and performance. Similarly, whilst high levels of *neuroticism* tend to pertain to the individual's view of themselves, they may require more input and support from those around to enable them to feel more central to the social network.

The existing literature does not present findings relating to lower levels of *extraversion* which may be referred to as *introversion*; those that are more reserved and need to expend energy in social settings (McCrae and Costa, 1987), particularly when considered in relation to job performance and satisfaction. The researcher's findings also do not present anything specific around this trait. *Extraversion/introversion* remains a trait that is not fully understood in this work. However, it is evident that extraversion is not a pre requisite in older peoples' nursing.

5.6.2 *Sociability as forming authentic nurse/patient relationships*

The desire and ability to form meaningful relationships and enjoy being with older people is a necessary trait in an older people's nurse. When successful job performance requires 'getting along' *emotional stability, conscientiousness and agreeableness* should predict performance (Hogan and Holland, 2003). *Emotional stability* is discussed in the study findings in the context of adaptive *coping* mechanisms. However, Barrick *et al.* (2013) state that *emotional stability and agreeableness* are also the traits related to *'striving for communion'*, a higher level goal associated with individuals who are highly motivated to achieve meaningful contact and get along with others.

Kovach *et al*. (2010) states that the relationship between *conscientiousness* and job performance is negligible when workers have low levels of interpersonal skills. This is supportive of the researcher's findings, which suggest that nurses described as conscientious are also described as having the desire and ability to form close relationships with patients and relatives, and this is required in order to deliver effective care.

Interpersonal skills would also be required to work effectively as part of a team and when nurses work together and help each other, only then does patient satisfaction increase. The trait associated with this is *agreeableness*. Individuals with higher levels of agreeableness may avoid conflict, which is conducive to teamwork (Aslan *et al.,* 2017). Avoiding conflict was apparent in the study findings, in that it was considered important to be able to build

meaningful relationships with patients and colleagues to enable high quality care. Any kind of communication avoidance, or conflict, was seen as unacceptable.

The strong desire and ability to form relationships that appear beyond the norm in older people's nurses are key to the delivery of effective care and appear strongly aligned to the theory of higher order goals; personal agendas that individuals are motivated to pursue. In the FFM, *agreeableness* will link with individuals striving to interact harmoniously, and *emotional stability* links with individuals who are friendly, calm and confident and therefore maintain positive relationships with others.

5.6.3 *Sociability and neuroticism*

Extraversion and particularly *neuroticism* (low *emotional stability*) have generally been described as less desirable traits that may impede effective relationship building and communication, although the level at which these traits become less desirable is unclear. However, whilst study findings have highlighted facets of *conscientiousness* and *agreeableness* that lend themselves to *sociability* and *integrity*, Regts and Molleman (2016) suggest that *extraversion* and *neuroticism* may also have positive relationships with job satisfaction and performance, in relation to being part of the social network in the work setting.

High levels of *neuroticism* appear to imply that concerted effort is required on behalf of the individual for workplace environment to be viewed as positive, which may well impede on professional relationships. It also aligns with previous discussion on the ability of an individual to adapt. The workplace environment for the older people's nurse is busy and demanding and, if viewed negatively, will only compound the possibilities for poor care. The ability to form effective relationships with patients and colleagues is apparent in the researcher's findings and this needs to be an inherent characteristic of the older people's nurse. In addition, high levels of *neuroticism* are associated with low resilience and maladaptive *coping,* inferring that low levels of *neuroticism* and *extraversion* remain preferable.

5.6.4 *Sociability and agreeableness*

The FFM trait of *agreeableness,* demonstrated by facets of *trust, altruism, kindness* and *prosocial behaviours,* is reflected in the researcher's findings as a required trait in older people's nurses. The literature demonstrates that *agreeableness* is highly sought after by employers when conflict needs to be avoided and effective teamwork is paramount. However, in older people's nursing, *agreeableness* means so much more than just teamwork and the facets of *altruism* and *prosocial* behaviours are not enough to adequately describe the characteristics required in older people's nurses. Therefore, the extensive list of facets required that may relate to *agreeableness* have been identified under three headings; *conscientiousness, integrity* and *sociability.*

5.7 ***Integrity***

Integrity is generally viewed as the practice of being honest and showing an uncompromising adherence to moral ethics and values. The study findings relate *integrity* to the need to 'do the right thing', participants view the role as a privilege, and it is associated with being honest and open. Compassionate and clinically effective care appears to be value based as all participants can describe what a 'good nurse' should be. However, there appears to be an incongruence between the theoretical value system and the enactment of care delivery. This is evident when participants are questioned about what they actually mean by their theoretical value based descriptors, which takes us a step further towards understanding the impact of personality on care and this is ultimately made meaningful when participants describe real experiences.

5.7.1 *The meaning of integrity*

Values are generally defined as beliefs or principles that influence behaviour and represent basic conviction of what is right (Baillie and Black, 2014). The 6C's (as previously described in Section 1) implemented by the Chief Nurse for England with a view to identifying a unifying set of values for all nursing staff to aspire to, across England, are:

- Care
- Compassion
- Courage
- Communication
- Competency
- Commitment

The NHS Constitution, first published in 2011 updated in 2015, set out core NHS organisational values as being:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

It may be interesting to also map specific facets arising from the study findings to these widely accepted values, or accept them as at the centre of any model of personality requirements of nursing staff within the NHS setting. This might help to demonstrate the close relationship between values and traits, showcasing how *integrity* is a foundation or springboard trait for professionalism, enabling the 'doing' or action based traits to be delivered at a high level of *conscientiousness.* Sackett and Walmsley (2014) state that *integrity* is related to *conscientiousness*, *emotional stability* and *agreeableness.* These are highly ranked by employers in the health industry along with dependability and concern for others. Yet, this does not give examples of how *integrity* is demonstrated, implying that *integrity* will mean different things in different professions.

The study data suggest *integrity* is demonstrated by a desire to do the right thing without the need for reward. For an electrician the 'right thing' may be to arrive to a job on time or to not overcharge. For a nurse, the 'right thing' may be a technical skill, a gesture or

intimate delivery of care. Therefore, *integrity* becomes more challenging to measure or observe for. Clarity of belief and values within the PCPI is around seeking feedback and challenging colleagues. This approach suggests *integrity* is a driver trait that enables the more specific 'doing' actions described under the heading of *conscientiousness*.

5.7.2 *Integrity – respect and honesty*

Conscious thought enables a clearer articulation of accepted values, demonstrated by the ease with which participants were able to describe what effective nursing care should be for a group of older patients who *deserve* the best care. The care delivered to older people is described by participants as almost a level above other patient groups. Stakeholders outlined how, in their view, older patients have earnt their right to good care by virtue of their longevity, frailty and contributions to society. Many participants discussed this concept of deserving better care and it was effectively summarised by John, who stated that in other acute areas the aim is to simply *fix* the patient but in older people's care it is about acknowledging life contribution and enabling a good quality of life.

For a nurse, the values that relate to patient care involve respect of the patient's identity and subsequent needs. There is an apparent gap between the theoretical value based standards of care and the actual delivery of care, which is potentially bridged by direct ability of the nurse to deliver care based upon their conscientious awareness of their own personality traits (i.e. *authentic self*). There are also identified restrictive effects of personality traits and associated challenges that arise, enabling the nurse to adapt

behaviour in response to contextual variables, such as situation and culture (i.e. *conscientiousness*).

Viewing care delivery as a privilege when working with older people was apparent in the researcher's findings and co exists with the trait of *honesty*. A job role, when viewed as privileged, is associated with nurses who are honest about circumstances and events (i.e. will not lie when telling the patient, "*I will be back in a minute",* but not really intending to return to the patient that quickly) and will inherently always try to do the right thing for the patient. The incongruence between how some nurses describe how care should be delivered, and the enactment of care delivery, is evident in the study findings. It appears that values or desired behaviour that can be described by nursing participants may dictate intent and the conscious process of how a nurse will communicate. But ultimately, how nursing actions are delivered and the level of effectiveness, are directly influenced by the nurse's personality. The researcher suggests that if 'the self' was consciously aware of this the associated statement may be that there is a deliberate intention to demonstrate conscientiousness in the nursing role and to do the right thing. However care delivery is influenced by ability to achieve that due to levels and expressions of integrity.

5.8 ***Coping***

Coping implies how people manage their lives, both broadly speaking and in specific situations, particularly when exposed to potential stressors. The FFM describes low levels of *emotional stability (*high *neuroticism),* as demonstrated by maladaptive *coping* responses.

This will reveal in a person who panics easily and is prone to stress response (McCrae and Costa, 1987). "*The ability to cope with…..*" is the preface to many codes in the researcher's findings, which were suggestive of the need for a variety of coping strategies.

Nurse's work performance has been described as including consideration of the emotional labour exchanged between the patients and the nurse (Smith, 2012). However, as the focus in healthcare is increasingly shifting to technological efficiencies and cost effectiveness, nurses are being removed from spending time to get to know and understand the patient as a person. A negative impact of emotional labour is termed as 'compassion fatigue'. This can start to take its toll on nurses in raising their sense of not coping, ultimately leading to burnout. For the patients, nurses with high emotional labour can be observed in terms of omissions of care. In addition the effect of increasing focus on technology and the inability of nurses to deliver 'caring moments' (as described in section 5.7 above) may also contribute to these feelings of being separated from the patient, leading to high level stress and burnout.

5.8.1 *Coping - emotional stability, confidence and patience*

The literature reflects high levels of *emotional stability* as a necessary trait in employees by employers, but is viewed as more difficult to assess. Again, there is little that is specific to nursing in the literature however, as low levels of *emotional stability* are associated with maladaptive *coping* mechanisms. *Coping,* as a major trait heading, has been identified with facets within this reflecting what is required in terms of *emotional stability*.

Facets that make up the trait of *coping,* in an older people's nurse as described by the participants, appear to be required at the highest end of the conceptual scale; extremes in aspects such as patience, the need to cope with unpredictability and the need to build effective working relationships. Whilst these 'coping extremes' would be facilitated by other traits such as *conscientiousness,* it is apparent that *emotional stability* is also required. It is seen as unacceptable for an older person's nurse to display behaviours such as irritability, ignoring patients or arguing with them in an attempt to *cope* with a role or aspects of a role that are presenting as extremely challenging. The study findings alluded to a 'grey area' between *coping* ability and *conscientiousness*, if a nurse continues to think or worry about patient care even when their work shift has ended.

The researcher's study findings suggest that *emotional stability,* as demonstrated by the presence of immense patience and calm, are an integral requirement for an older person's nurse. Therefore, *emotional stability* is identified as a desired trait.

5.8.2 *Coping - versatility and openness*

The FFM trait of openness, demonstrated by imagination and insight, is reflected in the researcher's findings as a desirable trait. However, as with *conscientiousness* and *agreeableness* this trait is not sufficient to encompass all the facets required for older people's nurses.

The researcher's findings suugest that nurses who can demonstrate the ability to be versatile in their thinking may be able to *cope* more effectively with the complexity and unpredictability of the role, and those who are naturally curious have the ability to form relationships and the ability to *cope* with the demands of the patients. An individual's level of adaptability may also influence, if an individual is able to adapt how a given facet behaviour is displayed. The FFM trait that aligns with adaptability is *Openness. Openness* is not discussed widely in the research literature as relating to job performance or satisfaction; openness is more linked to adaptability (Ellershaw *et al.,* 2016; Hey *et al.*, 2016) and lower levels would mean an individual would struggle with abstract thinking.

The study findings have also identified a facet which has been labelled *flexible* but, in this instance, the opposite would be *uncompromising* and, therefore, still aligning with the FFM trait heading of *openness,* which would describe this as traditional and struggles with change. However, *openness* is a multidimensional construct which is also characterised by intelligence, curiosity and broad mindedness. At a facet level, intellectual interest was least predictive of work performance for Ellershaw *et al.* (2016) but it still related to adaptability. Therefore, *openness* is of importance and appears to be a desirable trait but specific aspects need to be observed for in older people's nurses.

The FFM traits associated with *coping* are *emotional stability* and *openness*. The findings present a theoretical and real dichotomy between the need for an older people's nurse to deliver high levels of basic and complex care simultaneously and *cope* with high levels of

unpredictability in the role. Therefore, the researcher has identified *coping* as a stand-alone trait with its own set of specific facets that need to be identified in older people's nurses.

5.9 ***Context***

Whilst personality may directly influence how care is delivered, the impact of context is that it may still affect how behaviours are displayed. For example, the study findings demonstrate that the term *culture* is multifaceted and means slightly different things to different participants. McCance *et al.* (2011) describe this context as 'the care environment' and stress how staff require organisational systems that are supportive.

5.9.1 *Organisational culture*

There is little consensus amongst scholars over the precise meaning of organisational culture (Scott *et al.,* 2003). Confusion over meaning is reflected in Edgar Schein's (2010) influential work, which describes culture as a dynamic phenomenon that influences us in many ways. But at the same time culture implies rigidity and stability, a set of rules by which we comply to maintain order. Culture is further complicated in organisations as stability is reflected in length and emotional history from when they were founded (Schein, 2010).

Person-centred care is described by McCormack *et al.* (2011) as an underpinning culture of teams and organisations. However, there are contextual factors that can hinder or enhance how person-centred care evolves that relate to organisational culture. The findings refer

repeatedly to the need for holistic patient-centred care when considering effective care delivery for older people within acute care settings. Patient-centred care is an expression used in healthcare, however McCormack *et al.* (2011) differentiates between "*person-centred care'"*and "*person-centred moments"*. Person-centred moments are experienced by nurses and are particular times when care delivery is associated with the feeling of satisfaction and reward. This aligns well with participant data, as described in Section 4.4 and 4.6. However in order to ensure person-centred care as an underpinning culture of teams and organistaions a shared purpose is essential and one of the founding principles of practice development in establishing person-centred safe and effective practices that enable everyone to flourish (Manley *et al.,* 2014; Akhtar *et al.,* 2016)

5.9.2 *Culture change*

Parmeli *et al.* (2011) state that the precise nature of culture change in healthcare is underspecified and feasibility strategies are often called into question. However, the emphasis on improving culture in the NHS is ever more apparent in the post Francis Report (2013) era, with the aim for a patient-centred culture with 'zero tolerance' for patient harm. Culture Change in the NHS (2015) describes how the NHS has made fundamental shifts in the following areas: preventing problems, detecting problems early, taking action early and ensuring staff are motivated.

The compassionate care agenda has been mentioned earlier in this work but at no point in that agenda or Culture Change in the NHS (2015) is there mention or encouragement to

actually perform research in relation to who is delivering care in our organisations. Emerging research around creating learning environments for compassionate care (CLECC) are a significant and positive direction change, away from 'sign up to' campaigns (Bridges and Fuller, 2014). Davies *et al.* (2008) state that building learning organisations requires attention to some key cultural values if it is to be successful, including being 'outward looking'. Outward looking may require challenging some of the more embedded foci, such as compassionate care campaigns, and be brave enough to research more difficult areas, such as nursing personality, that would still contribute strongly to patient safety and high quality care and align effectively with embedding models like CLECC.

5.9.3 *Organisational effectiveness - Creating a context for effective workplace cultures*

Organisational effectiveness is driven by facilitating personal and organisational change through interventions with their roots in behavioural and social science knowledge (Schein and Gallos, 2006). Organisational Development (OD) is the department strongly aligned to Human Resource (HR) management and, with roots in social science, presents an opportunity to generate interest in research around nursing behaviour via this route. To become more effective, organisations need to change and a central role of OD is to create and manage change making OD the ideal route for the researcher into further work around prerequisites and personality in the workplace.

Research that focusses on understanding more about the workforce that delivers the majority of care in the NHS needs to be able to explore experiences and thoughts, and take a more holistic approach to the study of the phenomena. Whilst this will challenge the traditional empirical approach to research in healthcare, it would provide richer understanding of the workforce. Being able to demonstrate a simple programme progression for this research may also foster support for this research via the OD and HR route and could incorporate the influencing variables of emotional labour and cognitive dissonance described in the introduction to this work (Section 1.4.2). That is, this initial research may be about generating theory around personality traits, nursing and care delivery and a set of propositions. Subsequent work can be developed relating to staff engagement and performance, recruitment and retention, and testing a causal relationship between a nurse's personality and quality of care.

5.9.4 *Negative image of older people's care*

Some nursing participants describe culture in terms of the 'older style' nurses and the associated poor care remains synonymous with older people's care. These nurses were observed to be less likely to perform well. In the nursing profession both job performance and job satisfaction are inextricably linked. Presented in the study findings were nurses who would be described as *conscientious*, who also demonstrated feelings of positivity associated with doing a good job. Therefore, from an organisational perspective, employees who feel job satisfaction are more likely to continually improve performance. This is beneficial to the patient and to the wider business, and implies an organisational responsibility to create a positive workforce culture.

5.10 *Personality theory*

Section 2.6 presented the reader with an introduction to personality theory to enable a more effective understanding of personality related research papers. Several theoretical approaches were discussed however trait research appears to be the most commonly used approach to the study of personality.

The researcher has constructed a specific set of traits and associated facets from the research findings and over the course of the work, an established personality trait model (FFM) has been used as a *lens* through which to view the study findings and frame subsequent discussion. What this process has demonstrated is that the FFM would not be sufficient in identifying effective older people's nurses. First, it may not be sensitive enough to identify the very specific facets. Second, the FFM does not take into consideration the context and consequences of a professional role and associated values expected within that chosen profession. Therefore, as the conclusion to this work approaches, the researcher's reflections are that the sole use of a trait based assessment of personality may not be adequate to identify the optimum *type* of nurse for older people's care. The inference from the more holistic theorists that traits can adapt, or at the very least some behaviours can adapt in response to situation and context is vital in a profession such as nursing and a combined approach to the assessment of personality that considers both traits and adaptability would be a preferred option.

5.11 *Summary*

This study has revealed an understanding of the meaning of specific traits and associated facets in nurses working with older people in acute care settings, and how these affect the delivery of nursing care. The study findings offer a theoretical framework, derived from this stakeholder driven research, that highlights inadequacy of using the FFM as a sole means by which to recruit older people's nurses. Operationally, the emergent theoretical framework and associated trait meanings offers a set of propositions that can be tested in the development of a practical nursing recruitment assessment tool for education of older people's nurses.

5.12 *Strengths and limitations of the study*

Understanding meaning of personality traits in relation to their effect on older people's nursing care delivery has been the focus of this study. The strengths and limitations of the study are now considered.

5.12.1 *Study Strengths*

- Meeting the requirements of interpretivist and social constructionist grounded theory enabled a co-constructed understanding of the personality traits and facets required for effective older people's nursing care delivery, arising from key stakeholder study participants' knowledge and experience. The study findings work

would require additional testing to consider the sensitivity of applying findings to other specialist areas of nursing, such as mental health or midwifery.

- Prolonged fieldwork, memo writing and robust supervision promoted trustworthiness of data collection, data analysis and theory development. Undertaking a detailed analysis, and interpretation of the data, enabled the research findings to remain grounded in the data, and not be influenced by pre conceived opinions to proceed in one direction or another. Effective reflexivity underpinned all aspects of trustworthiness, and served to allow the unique knowledge and experiences of the researcher to contribute to data analysis and theory development. This is a lengthy process, yet the pace of change in the NHS and its current workforce demands are presenting an immediate challenge. However, this work can be taken forward to be tested in a questionnaire, that might then provide a convenient method of placing nurses in 'the right job'.

- The theoretical framework developed incorporates 4 key personality traits proposed as an indicator of effective/well-suited older people's nurses. It also has provided a potential new insight, offering what underpins meaning of these traits and facets within the context of older people's nursing in acute care settings. The findings represent a socially constructed, values based theory of older people's nursing that may facilitate the development of both observational and measurable means by which to assess behaviours (in older people's nurses) that could lend itself to several methodologies and epistemologies seeking clarification of values and traits in other

specialist areas of a person's preference and relevance for working within that area of professional practice.

5.12.2 *Limitations*

- The research participants, as key stakeholders of older people's nursing in acute care settings, did not include current in-patients receiving care in hospital. A rationale for this was provided in Section 3.6. It would undoubtedly have been useful to have those in direct receipt of care in real time as research participants, as live accounts to avoid time and memory lapse. In addition, the researcher has considered that recruitment of patients at the point of discharge who were not going to be receiving follow up care may have been useful participants and recommends this be considered for future studies. If there is concern memories have faded or even been distorted over time, the accounts of the participants still imply their lived experience and associated meaning of how they observed, or recall the nursing care being delivered.

- The study findings are specific to the social, cultural and historical setting of the research site, however an in-depth exploration of this setting enabled construction of new and important understanding about the question. Therefore, repeating of the study using the same methods utilised in this research could be applied to other nursing groups, or indeed other professional groups, to develop a series of

theoretical frameworks providing meaning to personality traits that are appropriate for each profession and would increase study findings generalisability.

- The study findings demonstrate a direct impact of personality and associated behaviours on how nursing care is delivered. However, the findings do not provide a complete explanation as to how contextual factors, such as organisational culture, specifically impact potential of nursing's emotional labour, or how behaviours are displayed when considering specific personality traits, might change over time.

- The study findings propose four key personality traits and their associated facets for older people's nursing, but it is not possible to ascertain if varying high levels of some facets may compensate for varying low levels in others, nor which facets definitively have to be present at high levels.

6 Conclusion

This chapter presents the conclusions of the study and describes the original contribution to knowledge, researcher reflections and implications for nursing practice.

Substandard care of older people in hospital settings across England is not fully explained by merely focusing on operational pressures. When investigating how personality traits influence how nursing care is delivered, the literature revealed a significant knowledge gap. Existing descriptive studies of trait measurements, mainly using the FFM, did not relate findings to the quality of care being delivered to patients by nurses. Therefore, the aim of this research was to undertake a critical exploration of the behaviours of registered nursing staff working in older people's acute care settings, gathered from the perspectives of key stakeholders, to identify new insights into whether there are distinguishing traits of nurses who care for older people.

Utilising grounded theory methodology, a theoretical framework has been developed where the traits of *conscientiousness, sociability, integrity and coping* align under a core heading of '*the authentic self*'. How behaviours are displayed are directly influenced by these underlying trait dispositions and the facets aligned to them. The '*authentic self'* represents a nurse's true nature and reflects complex relationships between desired traits of an older people's nurse and how these may, or may not, be displayed through behaviour and, therefore, impact on the standards of nursing care delivery.

Twelve stakeholder participant's data has been presented in the Findings chapter based on their personal experiences and knowledge of older people's nursing. This provides for a rich level of detail, offering insight into older people's nursing behaviours associated with older people's nurses. There appear to be scales of desirability around these trait facets, which are perceived as more or less desirable and have associated positive or negative *consequence*s.

The substance of a core category heading of the *authentic self* is proposed as the more direct influence on how care is delivered. The effect of these traits is then considered through a thematic heading of *consequence*. Other variables emergent from the data identified may affect how these trait behaviours are displayed, captured within a wraparound category of *context*.

The participants' views about nurses did not differ significantly, despite their varied experiences and backgrounds. One participant, Deborah, stood out as she often offered differing views and perceptions of effective nursing care from the other participants, for example, her reference to relatives 'nowadays' being quite demanding and should wait for nurses to finish what they are doing. As opposed to other participants describing how nurses should be able to integrate relative communications and indeed proactively seek relative opinion as part of care planning.

All participants were able to talk about what behaviours a 'good' nurse should demonstrate and how they should deliver care using descriptors like *warm, honest and approachable,* words that describe values and what is important about being a good nurse. On prompting to think about examples of nurses or nursing care, participants were able to bring these behaviours to life enabling the researcher to assign facet labels and validate their descriptors.

In summary, based on the perceptions of key stakeholders, there appear to be distinct groups of older people's nursing staff being described as;

- Those who want to work with older people but may not have the appropriate levels of trait facets.
- Those who work with older people but have no real desire to do so.
- Those who work with older people because they want to, plus demonstrate the facet behaviours that enable the delivery of highly skilled and compassionate care.

It is the latter statement that is perhaps a goal for future recruitment strategies for nursing workforce in older people's care.

Whilst the traits of *conscientiousness, integrity*, *coping* and *sociability* may be desired in other nursing groups, the findings of this work have identified that these traits are required for the care of older people in the acute setting. The extremes at which the trait characteristics need to be displayed are described with specific reference to the care of older people. For example, it is not enough to be conscientious and get a job completed. The meaning of *conscientiousness* for the older people's nurse is to be conscientious with a depth of thoughtfulness that can ensure completion of a job being done with the holistic needs of the patient in mind. A sense of responsibility, demonstrating patience, being comfortable with unpredictability and pace, humility, desire to build relationships and a natural curiosity are the characteristics that enable the delivery of holistic, patient-centred, therefore effective, care that is both recognised and valued by colleagues, patients and relatives.

Figure 1 is presented as the introduction to this section and also serves to summarise and reiterate the direct influence of the four key identified traits on the consequence of care delivery, and the wraparound influence of contextual variables.

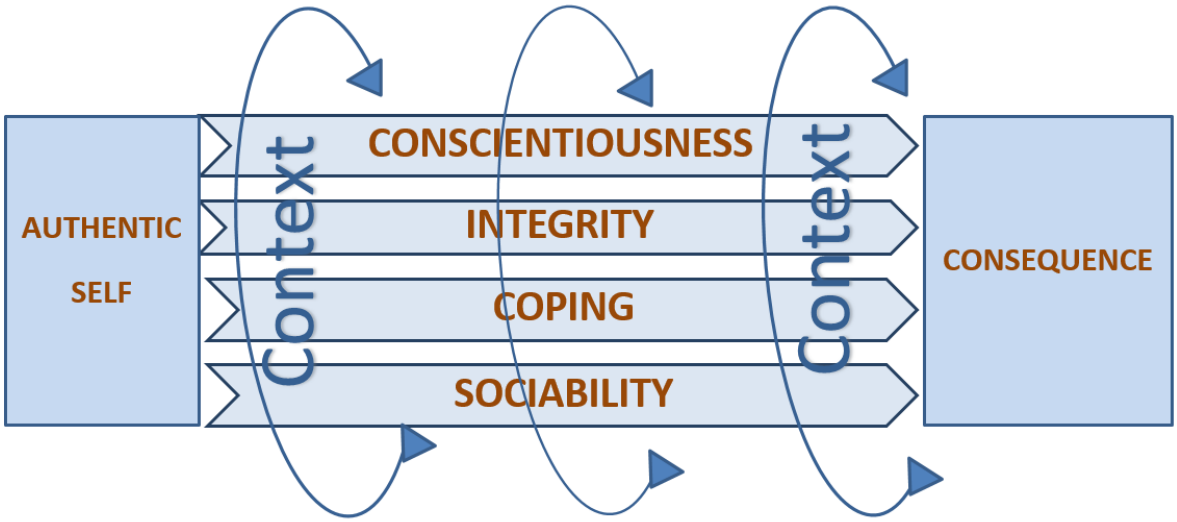

Figure 1 A theoretical framework representing effect of key personality traits on the care of older people - Trait based Older Persons Nursing in Acute Care Settings (TOPNACS) (Day, 2019)

6.1 *How has the research answered the research objectives?*

Research objective 1: To gather stakeholder perceptions of registered nurse's behaviours when caring for older people in acute care settings and to consider how different behaviours as an output of their personality might impact on nursing care delivery.

A range of older people's nursing stakeholder participants, (as those people who have experience of how older people's acute care is delivered) provided meaningful detailed examples as accounts of their personal experiences, knowledge and thoughts about the behaviours, (both desired and undesired) of nurses caring for older people in acute care settings. Arising from which, core theoretical findings around notions of *authentic self* and *consequence* have been presented. Capturing in-patients in real-time of receiving care would have further strengthened the research findings, as would a replica study being

undertaken on a comparison site. Within the Discussion Chapter, these elements were discussed further, taking into consideration a broader understanding of the implications of these findings for older people's nursing.

For the carer/patient participants, their specific priorities were to have older people's nurses who could demonstrate high levels of patience. They identified nurses who were focussed on meeting the basic care needs (e.g effective communication skills) that enabled the maintenance of dignity. They also identified how nurses need to have the ability to be proactive, respectful and empathetic in all their interactions with patients and families, despite the busy, fast pace of working in an acute setting.

For the professional participants, their priorities are for older people's nurses to have adaptive *coping* strategies. This may include high levels of patience and an ability to be versatile in their clinical decision making and subsequent planning of care delivery. Nurses need to be *conscientious*, which meant going beyond just being diligent. The older peoples nurses needed to have an internal drive and actual desire to go 'the extra mile' and deliver care with thoughtfulness, tailored to that patient's specific needs and circumstances. Older people's nurses should demonstrate *integrity* and have an inherent desire to 'do the right thing' as well as the desire and ability to form effective person-centred relationships with patients and their families.

All of the stakeholder participants were able to describe how different behavioural characteristics resulted in different types of care. Those nurses without the desired characteristics would deliver care that would be seen as *cold* and 'task orientated', rather than the desired type of care, which would be holistic, person-centred and delivered with thoughtfulness and empathy. Task orientated care would be associated with minimal effort, purposeful omissions of care and a purposeful avoidance of communication.

Research Objective 2: To undertake conceptual clarification of whether registered nurses working with older people have specific personality traits which relate to behaviours exhibited whilst delivering care that may inform an older people's workforce strategy.

A wide range of specific facets have been proposed under four trait headings; *conscientiousness, sociability, coping* and *integrity*. The facets under these trait headings are required to meet needs of acute older people's services, and some need to be at significantly high levels. The development of a validated assessment method for these traits and associated facets may inform a recruitment strategy.

Research Objective 3: To propose a theoretical framework of how registered nurses' personality traits related to behaviours that could sustain quality care delivery across older people's care services.

Using grounded theory methodology, a theoretical framework was constructed based on stakeholder experiences of older people's nursing in acute settings. Four main traits have been identified under the heading of *the authentic self ,* which have a direct influence on the type (task or technical) and quality (interpersonal) aspects of care being delivered to older people in the acute care setting. The overall effect on care being described is identified in the framework as that of *consequence* in how these personality traits convert into direct aspects of care delivery. The four traits identified are *conscientiousness, sociability, integrity and coping*. *Context* will influence how behaviours may be enacted (see figure 1 above). *Consequence* is described as *how* care is delivered and is directly influenced by an individual nurse's characteristics. Acknowledging that context within a given situation may affect how some behaviours are displayed, complex demands of caring for older people are associated with the trait of *coping* and the ability to deliver effective care is associated with the traits of *conscientiousness, sociability* and *integrity*. All of which have been represented across a continuum within the theoretical framework model within which a nurse may fluctuate, depending on the situation and context. However, it is proposed the best older people's nurses continue to work at the positive end of the spectrum, no matter what conditions and circumstances they find themselves working within. This model, however, requires further testing in the field.

Key study findings are identified as:

- There appear to be specific facets under four distinctive personality trait headings, sought in older people's nurses, as deduced from the key stakeholders engaged in this study.

- Older people's nurses appear to require many of these characteristics at the higher levels on the theoretical framework model's continuum, in order to enable delivery of high quality, effective and compassionate older-person centred care, due to the complexity, pace and unpredictability of acute older people's care contexts.

- Delivery of effective older people's person-centered care is challenging as there is an incongruence between contexts (i.e. the pace of working an acute ward with the pace at which many older people can be cared for). An effective older people's nurse needs to be self-aware of their level of conscientiousness, in how they interact and engage, as reflected and in response to a patient's functional ability and frailty, plus taking into consideration their relatives'/families' levels of anxiety and requests for information or reassurances.

- Whilst the traits identified in this work may well be observed in other nursing and professional groups this study has demonstrated facets and behaviours specifically required for older people's care in the acute setting. Some personality trait facets when working with older people, need to be displayed at significant high levels for sustained periods of time. For example, a high level of patience without

demonstrating short temperedness or frustration. This requires the nurse to have a personality trait of *conscientiousness, integrity and sociabiity*, alongisde a series of *coping* facets that enable them to function at high levels at all times.

- The research findings suggest that nurses who have low levels, or an absence, of these trait facets are perceived to deliver detached, dismissive and 'task orientated' care. This is received and observed as care that is ineffective and actually distressing for the older patient and their relatives. This poor standard of care is also considered unacceptable to other nurses who themselves have higher levels of the necessary positive traits as identified in the theoretical framework model.

- Nurses with only moderate levels of some of these trait facets may not be equipped to work with older people in the hospital setting over long periods. This assumption would need further testing. They may well be able to be taught through having access to high level role models, for example, and understanding which traits lend themselves to adaptability.

- Nurses with high levels of the identified trait facets may be better equipped to deliver highly skilled and compassionate care that meets the specific needs of older people in the acute care setting. These nurses would be identified as key role models and mentors for other nurses either new to the setting, or with middle level traits (as outlined above).

- The findings reveal the presence of these core older person's nursing personality traits and facet behaviours on a scale or continuum between those staff who work with older people but are perceived to have no real desire to do so. Those who demonstrate higher level traits and associated behaviours are those that ensure highly skilled and compassionate care is consistently being delivered to older people within acute care settings. Whilst acknowledging the influence of contextual variables, this study has added to the understanding of personality and nursing behaviours by identifying the different characteristics of nurses who have no commitment to older people's nursing and those who are highly engaged.

- Conscious thought enables a clearer articulation of accepted values, demonstrated by the ease in which participants were able to describe what effective nursing care should be for a group of older patients who 'deserve' the best care. The care delivered to older people is described by participants as almost a level above other patient groups. Stakeholders outlined how, in their view, older patients have earnt their right to good care by virtue of their longevity, frailty and contributions to society. For a nurse, the values that relate to patient care involve respect of the patient's identity and subsequent needs. There is an apparent gap between the theoretical value based standards of care and the actual delivery of care, which is potentially bridged by direct ability of the nurse to deliver care based upon their conscientious awareness of their own personality traits (i.e. authentic self). There are also identified restrictive effects of personality traits and associated challenges

that arise, enabling the nurse to adapt behaviour in response to contextual variables, such as situation and culture (i.e. conscientiousness).

The findings can be aligned with the FFM trait headings of *conscientiousness*, *agreeableness* and *emotional stability* as desirable traits. However, the FFM would not be sensitive enough to identify the very specific facets required for effective older people's nursing standards of care delivery. What can be concluded therefore, is that the specific traits, as identified in this work, are required to enable effective care. Effective standards of care may be considered acceptable in other nursing groups, but what makes this model effective is understanding which aspects are required to achieve outstanding and holistic older person-centred care.

At the conclusion of this thesis, the model proposed has enabled greater clarity of understanding of what meaning specific trait facets have, and the complexity in how these effect the delivery of nursing care to older people.

The findings, and identified older person's nurse trait theoretical framework, offer two significant insights. First, they highlight the inadequacy of using the FFM (McCrae and Costa, 1987) or a similar tool as a sole means by which to recruit older people's nurses. Second, there is meaning underpinning trait characteristics identified as required for older people's nurses and understanding of what effect these will actually have on care delivery.

6.2 ***Researcher reflections***

I included a biography as part of the introduction to the Methodology chapter highlighting the researcher's view that the value of delivering care with kindness is the only way to deliver care (Section 3.4.1). I maintained a reflective diary throughout the research process and it has become clear that the negative experiences which I have been exposed to had a very strong effect on me. This effect led to difficulty for me to see the challenges of caring for older people require a very specific set of skills and without doubt require the presence of some very specific personality traits and high levels of defined trait facets. The negative experiences I have encountered were in the extreme and are not everyday occurrences, however, nurses that may be in a job that is not best suited to their personality may be a more common occurrence.

What is interesting to me is that I have never had a clinical interest in gerontology and I have enough insight into my own personality that I would not have been an effective older people's nurse. Therefore, I have exercised caution, through reflexivity both at work and during this research, to my critical approach to nurses who, in my perception are not delivering the highest quality care as I, by my own admission, would not be able to work permanently in this setting. I might be competent but I would find this speciality too 'emotionally draining', which is ironic as I used to care for critically ill children. Again, this highlights the very unique needs of this patient population. Not all emotionally charged specialties can be pulled together under one homogenous label of 'vulnerable' or 'emotional', all specialities require specific skills and personality types.

Effective reflexivity enabled me to concentrate on the positive aspects of personality and the effect on care rather than seeking reinforcement of my pre study bias that there was a lot of poor care being delivered that may relate to the personality of nurses. Therefore, I have not 'changed' as such. However, my approach to understanding the needs of older people and their families in relationship to the personality traits of nurses is increasingly appreciative of the complexities of care delivery in this area and the requirements of both patients and staff enabling a more critical and effective approach to care delivery.

6.3 *Original contribution to knowledge*

In summary, the principal research question and objectives have all been met. Utilising stakeholder experience, ideal personality traits and their associated facets have been identified that are associated with older people's nurses. In addition, the development of meaning, associated with those traits in terms of how care is delivered, comprises an original contribution to knowledge. The theoretical framework represents a new substantive theory. New context relates to finding meaning of traits in terms of their effect on care delivery.

6.4 *Implications for practice*

The theoretical framework and associated trait meanings offer potential insight into the traits required for older people's nurses. These propositions could be tested and then thoughts around utilising the findings to contribute to, for example, recruitment or educational strategies in older people's care may be considered. Unresolved questions around trait stability over time and the impact of *contextu*al variables need to be considered as implications for practice are suggested.

- *Recruiting for older people's nursing – availability and retention of registered nurses*

In May 2019 the Nursing and Midwifery Council stated that around 8,000 more nurses, midwives and nursing associates are now registered to work in the UK compared with 12

months previously (NMC, 2019). However, nursing vacancies remain a concern nationally with approximately 40-42,000 posts advertised in 2018 (Nuffield Trust, 2019).

Research impact at a micro level: Finding the right person for the right job will enhance feelings of job satisfaction and morale in the individual which, in turn, will contribute to organisational and professional benefit.

Research impact at meso level: This research may contribute, not only to the effective recruitment of older people's nurses by being able to identify the right nurse for the job, but also to the retention of nurses. The right person for the job is likely to have increased job satisfaction and be less likely to leave the role or the profession. In turn this may enable improved patient experience and organisational productivity in relation to improved staff job satisfaction. The findings in this work and the researcher's own experience suggests that the longstanding unattractive image of older people's nursing appears to be slowly improving. Changes in perception and reality could be expedited if organisations were to implement an effective approach to recruitment that considers traits and behaviours and the unique requirements of older people.

This work focused on older people's nurses, however, all specialties have their own unique needs and requirements of their nurses. This work could be repeated with other nursing

specialties, leading to the development of a catalogue of nursing profiles that allows recruitment and selection of the right nurse for the right job.

- *Specialist education and training for older people's nursing – addressing the increasing ageing population*

There is an increasing number of older people in hospital with comorbidities as discussed in the introduction to this work. Treatment and care for those who need it associated with increased life expectancy it has be addressed. The often complex needs associated with the older person in hospital require nursing staff that not only have the appropriate personality but also have the rights skills and competencies. Without progressing to testing the theory generated in this work it will still be possible to utilise findings to develop educational tools, such as scenario based or reflective exercises. Education was highlighted as a priority for nursing staff, and the findings in this work can contribute to specific education programmes for older people's nurses both informally or opportunistically and more formal approaches.

On a wider scale, the key findings in this work also prompt the need for the researcher to have discussion with higher education institutes around the nursing curriculum, with specific reference to how education and training are delivered around care of older people. Clinical competency based training alone will not be sufficient, an education program for nurses caring for older people needs to incorporate aspects of coping, such as patience. Nurses should be enabled to try and reflect inwardly and recognise in themselves if they have the required skills and disposition to care for older people, propagating the positive

approach into the specialty, not taking a misguided path into an old fashioned, slow paced clinical field.

Understanding what is important to patients and relatives is different to what is seen as important by the staff, and it is imperative that this is addressed in educational delivery to ensure effective care. On qualification, ongoing education must be addressed to ensure that the highly technical skills that are required to care for older people in the acute setting are provided to nurses to enable effective care delivery. Whilst this may have cost implications, costs may be offset by retention of staff and improved productivity.

- *Influencing recruitment outside of the nursing profession*

The NHS Plan (NHSE, 2019), outlines a number of changes required to improve the care of the population and includes a specific focus on the needs of the older person with frailty. It includes three ambitious new service models:

1. Identify and provide proactive support to older people living with frailty in the community.
2. Enhance rapid community response at times of crisis.
3. Improve NHS care in care homes.

The aim is to support people to age well and to stay independent at home for longer. Therefore, whilst this study has focused on acute care based older people's nursing, the health demands of a growing ageing population has implications for everyone involved with the care of the older person, both in hospital and the community for professional third sector and carer groups. This study can be used to inform educational and recruitment initiatives on all groups, as aspects of the findings are transferable into other groups, such as social care. For example, if the highly technical aspects of care are stripped away it allows focus on the fundamental characteristics required to care for older people in other settings, such as care homes.

6.5 *Further areas of research*

- The four identified traits under the heading of the *authentic self* warrant further exploration. The findings in this study are a first attempt at developing behavioral indicators of personality traits that directly influence care delivery, and further study would ensure that no trait facets have been missed or mislabelled. User involvement would be invaluable in this work to ensure future practice is informed by those who receive firsthand experience of care delivery. Further research in this area may help refine if high levels are required in all the proposed facets, or if varying low levels of some facets can be compensated for by varying high levels of other facets and which facets definitively need to be present at high levels.

- Personality theory presented differing views around whether personality traits were fixed over time. Useful further research may be longitudinal studies around measuring personality traits and/or asking the same participants about their responses to a given situation at different points in time over a defined period and ascertain if levels of any facets are different from the initial base measurement. Desired characteristics in older people's nurses include reflective ability and adaptability, and research such as this may help identify those characteristics.

- Effective *coping* ability, which encompasses a wide range of required characteristics, was deemed necessary in older people's nursing. *Coping* may be linked to being able to develop resilience or effective responses to the contextual variables, such as staffing level challenges, which may lead to '*compassion fatigue'* and compromise the delivery of effective care. Further research into correlation between ability to *cope* and organisational pressures may be useful to ensure that, despite unpredictability or cultural challenges, nurses are still able to deliver effective care to older people.

- The extent of the influence of contextual variables, particularly 'emotional labour' and burnout on how some behaviours are displayed is not known. Further research exploring the 'tipping point' for nurses at which their value based behaviour changes and that 'tipping point' in relation to what personality profile a nurse has, warrants

further investigation. Without this, personality testing alone to inform workforce strategies will still have inherent weaknesses.

- Care of the older person with frailty is a national focus within the NHS, therefore the possibility of joint research with other organisations, including the third sector, within the context of the NHS Forward Plan could be explored

In conclusion

This study has constructed a social theoretical framework, grounded in the experiences of key witnesses, older people's stakeholder participants, in order to clarify what personality traits and associated facets are required of nurses who care for older people in the acute setting. The meaning underpinning traits in relation to care delivery has indeed been clarified and is further defined for the first time, specifically refering to older people's nursing.

A theoretical framework of older people's nursing in acture care settings has identified four key personality traits of; *conscientiousness*, *sociability*, *integrity* and *coping* under a core category heading of *'the authentic self'*, which is a direct influencer on how older people's nursing care is delivered.

The *consequence* is how the process and outcomes of older people's nursing care delivery, as experienced by stakeholders, assimilates to the influence of *context*. The theoretical framework is an original contribution to knowledge. It is intended to help influence how best to capture a future workforce of specialist older people's nurses who can provide consistent levels of holistic, older person-centred nursing that can transform the lives of those who are at one of the most vulnerable periods of their lives. Not only this, but the framework has also shown how this approach to older people's nursing also can have a positive impact on the experiences of the older person's relatives, during a distressing period of time when their loved one is acutely unwell and in hospital.

Being a nurse requires consistently displaying values that relate to high quality patient care delivery. This involves *respect* of the patient's identity, situation and subsequent health or social care needs, plus working, and speaking respectfully of, colleagues in the team.

The potential to enable a nurse to adapt their behaviour in response to contextual variables, such as extreme workplace busy-ness, and pressures, is suggested and this may be assisted through a workplace culture of critical reflection and awareness-raising of the consequences of actions on care quality, where effective role models can be found who act as professional mentors and older people's nursing in acute care settings clinical supervisors, in order to further share their clinical expertise and wisdom around coping.

This research offers a mechanism to narrow any gap that remains between the theoretical value-based standards of care and actual person-centred older people's care delivery. A potential bridge is in whether or not the nurse can deliver care based upon a raised awareness of their personality traits, particularly in their ability to work from a place of *authentic self*.

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APPENDIX I - Older people's experiences of dignity and nutrition during hospital stays

Secondary data analysis using the Adult Inpatient Survey (Vizard and Burchardt, 2015)

- Experiences of poor or inconsistent standards of dignity and help with eating were too high in the "vast majority" of NHS trusts
- 23 per cent of people reported experiencing poor or inconsistent standards of dignity and respect. This is equivalent to 2.8 million people annually, of whom 1 million are aged 65 and over.
- Of those who did need help eating, more than one in three patients did not receive enough assistance. This is equivalent to 1.3 million people on an annual basis, of whom 640,000 are aged 65 and over.
- Amongst older people, poor or inconsistent care was more likely to be experienced by women, and those aged over 80. The risks were also higher for those with a long-standing illness or disability such as deafness of blindness.
- For patients who experienced a high risk individual 'journey' through hospital (for example, staying in three or more wards, or having a long stay) the risks were even higher.
- The quantity and quality of nursing care, and whether or not there was a choice of food, had a large, statistically significant association with the probability of experiencing poor standards of help with eating. These are key policy levers for meeting individual nutritional needs.
- There has been "remarkably little change" in the percentage of individuals reporting inconsistent and poor standards of care over a substantial period time.

Appendix II – Summary of personality testing tools

NEO Five factor Inventory	Barr (2018), Bradham *et al.* (1990);Burgess *et al.* (2010); Baldacchino & Galea (2012a); Colbert *et al.* (2004); Drach-Zahavy and Srulovici (2018); Ellershaw *et al* (2016); Kennedy *et al.* (2014b); Louch *et al.* (2016); Hey *et al.* (2016); Witt *et al* (2002); Yeh *et al.* (2016)
Temperament Character Inventory (TCI)	Eley *et al. (*2012)
Narcissism, aloofness, confidence, empathy - NACE	Gibbons *et al.* (2007); Munro *et al.* (2005); Pitt *et al.* (2014)
Ten item personality inventory (TIPI)	Williams (2009)
Personal Qualities Assessment	Eley *et al.* (2010); Pitt (2014)
Personality Research Form	Bradham *et al.* (1990)
Eysenck Personality Questionnaire	McLaughlin *et al. (*2007)
Hogan Personality Inventory	Kovach *et al.* (2010)

Appendix III –Personality and non-healthcare professions – literature review

Personality and job performance

Colbert *et al.* (2004) tested four hypotheses around workplace deviance and perceptions of work situation in relation to FFM traits of *conscientiousness, emotional stability* and *agreeableness:*

Hypothesis 1. Positive perceptions of the development environment are negatively related to withholding effort.

Hypothesis 2. Perceived organisational support is negatively related to interpersonal workplace deviance.

Hypothesis 3. *Conscientiousness* is negatively related to withholding effort.

Hypothesis 4. *Emotional stability* is negatively related to withholding effort.

Four sample groups were recruited; shop workers (n=319), managers (n=239), sales/customer service workers (n=173) and clerical workers (n=122). Personality was measured using the FFM and withholding effort was measured using a six point measure developed for the study. Using multiple regression analysis Colbert *et al.* (2004) revealed support for these hypotheses and they specifically found that the relationship between organisational deviances was stronger for employees low in *conscientiousness* and *agreeableness.* One limitation of this work was that only one aspect of workplace deviance was addressed which was withholding effort and a large number of situational perceptions

could have been examined. Despite the limitations, withholding effort would be seen as deviant behaviour in any occupation so may be applied to nursing.

Barrick and Mount (1993) investigated the moderating role of autonomy on the relationship between the FFM and supervisor ratings of performance. They suggested that the relationship between personality characteristics and behaviour may be moderated by demands of a situation. Thus, a high demand situation would be one associated with a high need for conformity.

The 146 participants in the Barrick and Mount (1993) study were civilian management trainees in the United States Army. The degree of autonomy was measured using a simple questionnaire and rated by both the participants and their supervisors. Job performance was rated by the supervisors. Results demonstrated that *conscientiousness, agreeableness* and *extraversion* had a positive relationship with job performance. However when autonomy was analysed, results demonstrated that in high autonomy jobs, managers low in agreeableness performed better than those high in agreeableness. A limitation of this study is the number of potential biases associated with multiple types of supervisor ratings within this particular army group; i.e. both civilian and army. However, when considering if these findings may be applicable in nursing, it is of interest to note that there may be an incongruence between an organisation's need for employee conformity to values and process and the need for autonomous practitioners, thus, almost a need for autonomy within conformity.

Witt *et al*. (2002) analysed seven independent samples from diverse occupations to test a hypothesis that the relationship between *conscientiousness* and job performance would be stronger in those with higher levels of *agreeableness* (Total N= 1773). Occupations included clerical workers, sales representatives, manufacturing staff, managers and truck drivers. Job performance was rated by supervisors and the personality traits and facets were of *agreeableness* and *conscientiousness* and were measured using self-reported FFM questionnaires.

Witt *et al*. (2002) found the hypothesis was supported in five of the seven samples where the *conscientiousness –job performance* relationship was stronger in those workers at the mean and above levels of *agreeableness.* The two samples where there was no relationship between levels of *conscientiousness, agreeabl*eness and job performance were those workers who had little or no cooperative actions with others. Overall, even those employees who had high levels of *conscientiousness* but lacked *interpersonal sensitivity* may be ineffective in jobs where *interpersonal sensitivity* is required. A limitation of this study is that the professions are not related to nursing or healthcare. However, the need to demonstrate *interpersonal sensitivity* is required in nursing, therefore the relationships between this and *conscientiousness* becomes important and transferable.

Mount *et al.* (1998) initiated several years of studies undertaking a meta-analysis examining the relationship between personality and job performance. This particular 1998 meta-analysis involved 11 studies (total N =1586) where the key inclusion criterion 'interaction

with others' had to be a critical component of the job. Eight of the 11 samples were working in customer service roles. The remaining three were working in a counselling role. Each study examined the relationship between the supervisor assessment of performance and interactions with others and the personality constructs taken from the FFM (McCrae and Costa, 1987).

Results following meta-analytical procedures demonstrated that *emotional stability*, *conscientiousness* and *agreeableness* are more strongly related to performance in jobs where teamwork is required than in those where employees provide a direct service to clients (Mount *et al.*, 1998). Whilst a key limitation of this study is sample size, with 11 being relatively small for a meta-analysis, these results provide an effective starting point for research in this area. Sample participants were not working in a healthcare setting but findings may still be useful in the context of healthcare as nurses do need to work effectively in a team and be 'customer' focused when engaging with the general public as patients or relatives or colleagues therefore levels of *conscientiousness* and *agreeableness* are of significant interest. A limitation of this study is that there is no discussion around whether the type of team moderates the relationship between personality and job performance.

Hurtz and Donovan (2000) performed a meta-analysis of 26 studies, which met the inclusion criteria of including explicit measures of job performance, using a personality inventory based on the FFM. The participants in the 26 study samples held jobs in customer service,

sales and management. The results of Hurtz and Donovan's (2000) work demonstrated that *conscientiousness* is a valid predictor of job performance. However, *agreeableness* did not appear to influence task performance or ratings of interpersonal facilitation, whilst *emotional stability* has a small but consistent impact on performance. Results also demonstrated that being *extravert* positively influences sales and managerial jobs and *openness* to new experience positively affects performance in customer service jobs. Limitations of this study resulted from the small number of moderators relating to the managerial occupational category, which decrease reliability of results in this area. Again, of particular relevance is in the link between performance and personality traits which in this case is a positive correlation with *emotional stability* and *conscientiousness.*

Hogan and Holland (2003) performed a meta-analysis of 43 samples of studies meeting criteria around personality based job requirements (Total N = 5242). The participants of the 43 samples were from a very diverse range of occupations including clerks, Sheriffs, truck drivers and managers. Their results demonstrated that *extraversion* inconsistently predicted performance even in jobs requiring significant interpersonal interactions; the strongest correlation is associated with jobs where success is defined as 'getting ahead'. Hogan and Holland (2003) suggest that in a job that requires an employee to 'get along' with others then there is a positive correlation with *conscientiousness, agreeableness* and *emotional stability*.

Judge and Bono's (2001) meta-analysis of 135 study samples examined the relationship between four personality traits; *self-esteem, self-efficacy, locus of control* and *emotional stability* (low *neuroticism*) and job performance and satisfaction. In general, the findings demonstrated that these traits are the best for dispositional predictors of job satisfaction and performance. *Self-esteem* can be described as the most fundamental in job performance and satisfaction as it represents a person's values placed on oneself.

Judge and Bono's (2001) analysis demonstrated that individuals prone to experiencing positive emotions responded favourably to situations designed to induce positive affect whereas individuals prone to demonstrating negative emotions were less likely to respond positively to such situations. In addition, individuals who pursue goals for autonomous reasons demonstrate better judgment than those who have goals that are controlled. The main limitation of this study is that the validity of core self-evaluations in predicting job satisfaction, and performance is not addressed. This study is still of interest in healthcare settings as nurses require exceptional judgement but the challenges posed by meeting organisational goals often dominate day to day practice.

Network Centrality: Issues of conformity and sociability

Mount *et al.* (2005) describe how motivational processes influenced how an individual makes choices about the tasks to engage in, and the amount of effort to exert on those tasks and how to persist with them. Vocational interests may be viewed as another aspect of personality and reflects traits that influence behaviour through an individual's preference for certain environments, activities and types of people. The RIASEC vocational interests are

those most widely applied in the literature first described by Holland (1997). These interests consist of two fundamental dimensions; *Conformity* and *Sociability*. The Conformity dimension is aligned with Conventional type and Artistic type and the Sociability dimension bisects two sets of interests ranging from Enterprising Social to Realistic Investigative types.

The strength of Mount *et al.* (2005) work is the RIASEC types and the FFM traits are both non cognitive dispositional attributes that influence recurring behaviour. The sample was large; 46 samples with 12,433 individuals. Cluster analyses and multi-dimensional scaling identified that personality traits and interests can influence basic motives. *Social interest* and *extraversion* represented preferences for interacting with others. This study found that effort and attention would be given to environments and activities that involved interactions with others. In addition, artistic interests and *openness* traits represented the desire for personal growth, to seek new experiences and to express oneself in creative and intellectual ways.

A limitation of the findings of Mount *et al.* (2005) is the linearity. For example, whilst interests and traits influence motivation they will be different in how this occurs. For example, *extraversion* and *social interests* are associated with the motive to interact with others, it is the trait that influences how behaviour is exhibited in a given environment with others. Mount *et al.* (2005) describe this limitation with an example around *extraversion*; *extraverts* are likely to set goals, however there is no evidence to suggest that individuals high in social interest are more likely to set goals than those low in *social interest*. Of

interest in Mount *et al.'s* (2005) study is a reminder that, whist individuals may show a propensity to work with and care for others underpinned by vocational interests, the trait of *extraversion* remains the vital component of influencing the *exhibition* of behaviour. At a simple level, wanting to do something may not be enough to make an individual effective at doing something.

Appendix IV– Recruitment correspondence

Appendix IVa Participant invite for AGE UK

Initial email to AGE UK:

Dear…..I am undertaking research as part of a doctoral program of study. The research is to understand the meaning of personality traits of nurses caring for older patients. It would be of great benefit if the research could be informed by the opinion and experience of the older patient and / or relative of the older patient who has had experience of hospital nursing care. I appreciate Age UK perform research so I enclose my full proposal to help provide you with context. If you are in agreement could you assist me with recruiting 2 – 3 patients or carers? The letter I would send to the patients or carers is attached to this email along with the participant information sheet. Would it be possible for you to put me in touch with an appropriate colleague who may be able to help me take this project forward? Dependent on the outcome of that conversation we can decide the best way forward of approaching potential participants'

Appendix IVb - Email invite to Governors, Lecturers and Senior Nurses

Dear…..You are being invited to take part in a research study which forms part of my doctoral program.

I am undertaking research as part of a doctoral programme of study. You may be aware that much research has been conducted to look at staffing on older peoples wards in terms of both staffing levels and the quality of care delivered. There is little in the way of research that examines the personality characteristics of nurses who care for older people. Therefore the aim of my research is to understand the meaning of personality characteristics of nurses caring for older patients and the potential influence of personality characteristics on decision making and care delivery.

It would be of great benefit if the research could be informed by the opinion and experience of colleagues who have worked / taught / have an interest in the field of older peoples care.

Your participation would be in the form of one perhaps two interviews and I enclose an information sheet with all the details of this process. The interview would be arranged at your convenience. We need somewhere relatively quiet and private as I will be audio recording the interview so that I can transcribe and accurately document what you have said to me. Your contributions will be anonymised.

It is important that you understand why the research is being done and what is involved before you make a decision. Please read the enclosed participant information sheet. If you are prepared to be a research participant please confirm by way of replying to this email and we can arrange an interview date and time at your convenience. If you have any queries please do not hesitate to contact me on this email address'

Appendix IVc

Dear Sir/Madam

Thank you for considering participating in my research. I hope the information sheet provided you with useful information. You can ask more questions at any point in the process.

Your participation would be in the form of one perhaps two interviews and I enclose an information sheet with all the details of this process. The interview would be arranged at your convenience at a venue that is comfortable for you. I can come to your home or you can come to meet me. We need somewhere relatively quiet and private as I will be audio recording the interview so that I can transcribe and accurately document what you have said to me. Your contributions will be anonymised.

If you could let me know by way of:

1. Response to this letter using the enclosed reply form and pre-paid envelope (this does not imply full consent and we will go through a written consent form together when we meet to confirm you are happy to proceed with the interview)

Or

2. Send me an email verifying you are willing to be interviewed to dayh3@lsbu.ac.uk.

Or

3. Call me on 01642 854699 (Monday to Friday 9am-5pm)

Yours sincerely

Helen Day, Doctoral student, London South Bank University

Appendix V– Recruitment poster

RESEARCH PARTICIPANTS REQUIRED

Are you a registered nurse, Band 5 -6 who has been qualified for at least 6 months?

- As a student of London South Bank University I am undertaking research as part of a doctoral programme of study.
- The aim of my research is to gain understanding around the personality characteristics of older peoples' nurses and perceived effect on their practice.
- It would be of great benefit if the research could be informed by the opinion and experience of nurses who care for older people.
- Participation involves 1, potentially 2 interviews, lasting approximately one hour each.
- The interview format consists of open questions.
- Please see the participation information sheet attached to this poster with all the details of this process.
- The interview would be arranged at your convenience at a venue that is comfortable for you. We need somewhere relatively quiet and private as I will be audio recording the interview so that I can transcribe and accurately document what you have said to me.
- Data will be anonymised.

Can you help? If you are willing to be involved please take a 'post it' and jot down your name, email address and mobile phone number and pop it in one of the pre - addressed internal envelopes and I will be in touch as soon as possible

If you have any queries please do not hesitate to contact me:

Helen Day, Doctoral student, London South Bank University

Tel: 01642 854699 email: dayh3@lsbu.ac.uk

Appendix VI –Examples of field notes & reflections

AGE UK – North Yorkshire branch – October 2017

After no response to emails sent to North Yorkshire and Middlesbrough branches of AGE UK to try and recruit participants, I called directly to the North Yorkshire branch situated in Northallerton, conveniently close to where I live and work (within half an hours drive). The branch manager was extremely helpful on the phone and said that he would speak to his manager and get back to me by email which he did within 24 hours and we arranged for me to attend one of their monthly coffee mornings.

I prepared by printing out some participant information sheets and practiced what I would say but I wasn't sure of what the format of the meeting would be. I did envisage something quite formal, maybe a little 'fancy', after all this is affluent Northallerton! I was slightly taken aback when I arrived to be shown in to a run-down front room of an old house. Why had I thought it would be fancier? After all, it's still a charity.

It was clear there was a mixture of people in the room, approx. ten, ranging from the educated and stereotypical 'middle class', a couple of folk who were a little confused and one lady who appeared to be hard of hearing but was enjoying the company. Two ladies had taken charge of the kitchen and were making tea and coffee and had brought home made scone and cakes which they ironically displayed next to the British Heart Foundation healthy eating freebie jigsaws!

I was made very welcome and sat down next to 2 other 'guests' who introduced themselves to me as Patient Public Involvement Lead and the Deputy Chief Operating Officer of the CCG. They were asked to speak first and their topic was about mental health services. Interestingly it wasn't long before someone asked about proposed changes to provision in the Friarage Hospital in Northallerton which is part of the Trust I work for and the local people are 'up in arms' about reduced services! I thought 'oh no, what if they just want to ask me about that'?! When it was my turn I introduced myself by name and said I was a registered nurse but I did not state my role or workplace and emphasised the fact I was a student doing a doctorate!

I described some of my background and how I had become interested in the care of older people and I described in very simple terms the development of my proposal and research question and how interviews could take place and tried to offer as relaxed a scenario as I could. What happened next?! At least half of the room all started telling me they would know people who would be interviewed and started talking very enthusiastically about the state of the NHS and how nurses aren't what they used to be, not caring, and don't talk to you anymore! Two people described how poor their recent care experiences had been, my immediate thoughts were – interviews will be hard with any of these folk! My second thoughts were, yes the interview will be hard but they have a lot of interesting things to say. I left some PISs, response forms and some pre-paid envelopes…..several folk laughed and said they could put a sticker over the address and use the envelope! They may have been serious as I have not received any replies!

Several people wanted to talk about negative experiences which immediately led the researcher to think about poor nursing care without considering other factors. I am aware that I associate poor care with a set of characteristics of nurses who should not be working with older people and need to consider that this may impact on subsequent data analysis.

Participant recruitment – AGE UK – North Yorkshire branch – October 2017

Ladies Heath Living Group (AGE UK) – Northallerton November 2017

I was asked to attend when the organiser was informed of my visit to the main AGE UK meeting described above. This was a very different experience. I stood at the front to speak to approximately 20 ladies and explained little of my background interest and outlined my research interview requirements. I was immediately met with 3 or 4 ladies all wanting to 'tell me' about how terrible care is in hospitals. I acknowledged their concerns and agreed

that we had much to do however we had come a long way in the last few years and gave them some examples of improved care for patients with dementia. One lady said this sounded good but what about care for patients with dementia on specialist wards (non older person) as her husband had had a hip replacement on an orthopaedic ward and the care was awful **(NOTE: one interview participant said that all nurses should have the same skills, no such thing as an older persons nurse and another said defining factor between nursing groups is patience).** One lady was quite aggressive and said nurses didn't do anything just talked at the desk all day but she didn't say where she had this experience. Another lady said she had been on an older persons ward when she broke her hip but she was very bored and no one came to help her walk around, it was if they didn't care.

Interview

L1. 1/1//17 10am - Pre transcription/immediate post interview thoughts

General: Felt comfortable and at ease. Consent process easy. We chatted informally about each other's backgrounds – achieved sense of 'comradery'. L1 had booked an interview room within the university, no disruptions.

L1 described how nurses do not articulate the 'nobleness' of caring for older people and that leaders are not grown within that field. We explored this and L1 thinks this is OK and that nurses do not have ambition to develop and lead, they want to stay in shop floor nursing and that this is OK – there is something in their character which is expressed as lack of ambition/wont progress.

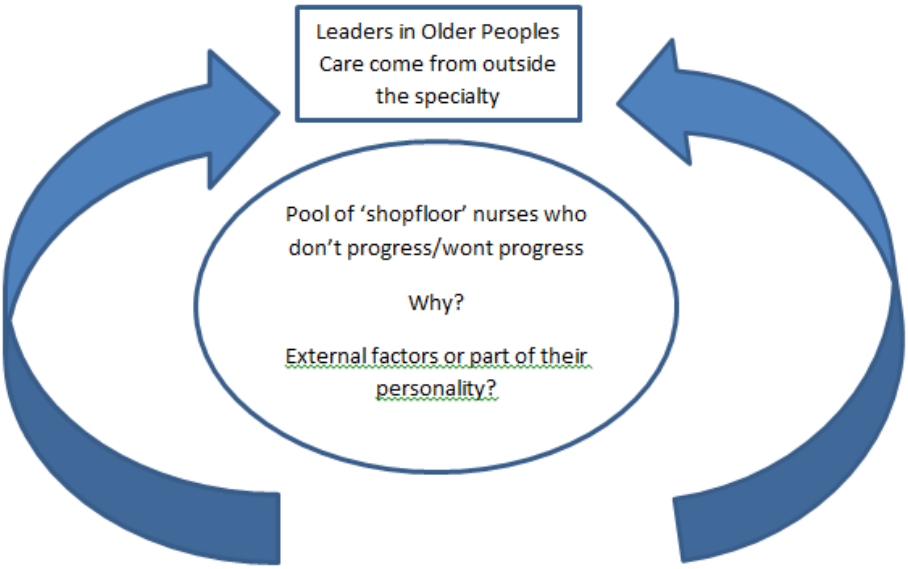
Reflexive note – this is taking up headspace. Why? Am I tending to focus on negative image of older peoples nursing? I am ambitious therefore am I seeing those who are not as 'weak'?

Questions/discussion points:

Relationship between lack of ambition and personality trait?

Is lack of ambition at odds with professional image and aims?

Vocation vs technical skills



Appendix VII - Interview guide

Conversation/achieving comfort:

1. What is your role here in relation to care of older people (nurses, governors, lecturers)
2. Why do you attend AGE UK? (patients/carers)
3. Have you been in hospital and been cared for on an older person's ward or a member of your family?

Opening/open questions:

1. What are your thoughts and opinions about the characteristics of nurses who care for older patients?
2. What effect does personality (characteristics) have on nursing care behaviour?

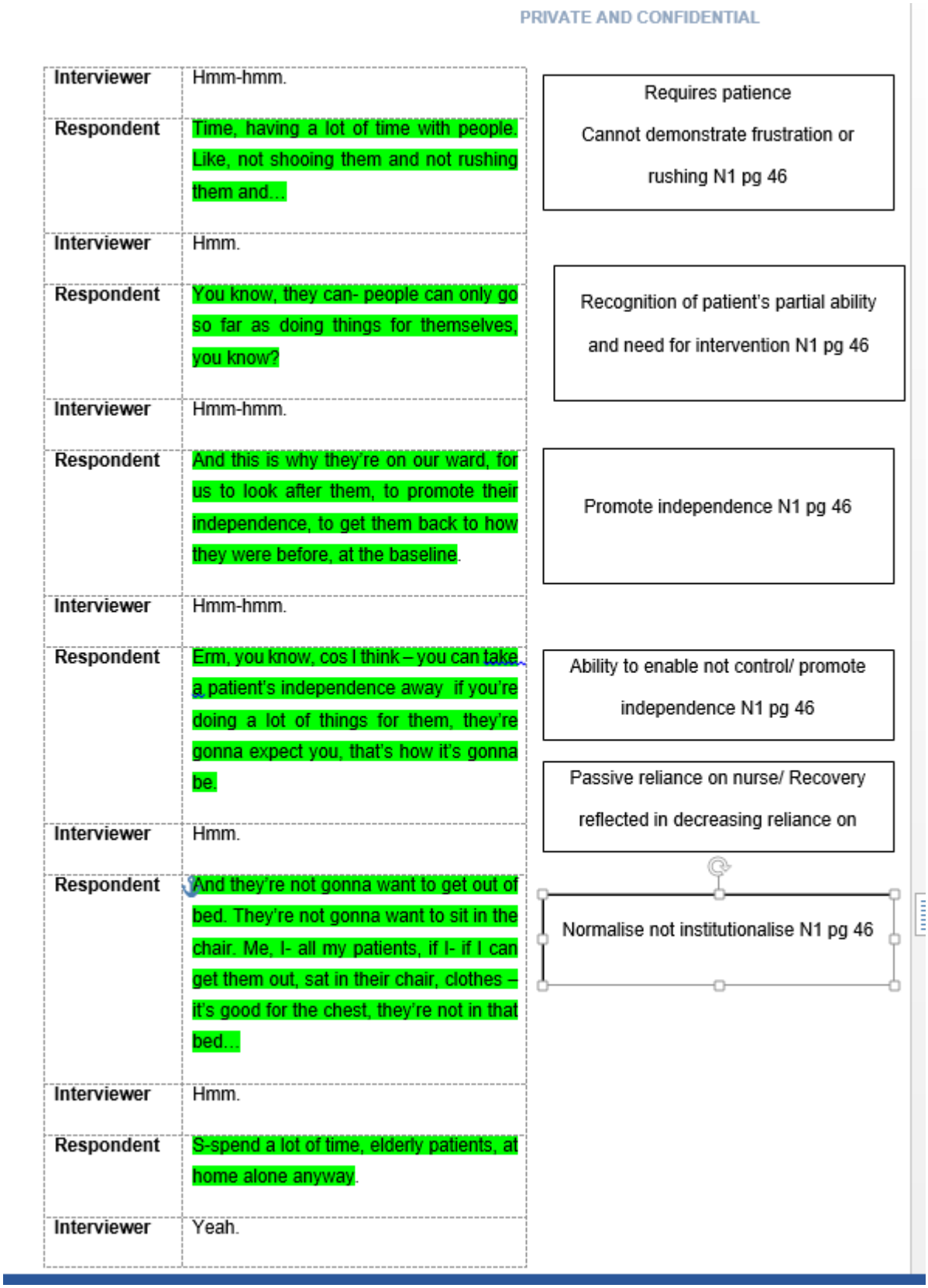
NB more detailed question will be elicited from the participant's responses and may include;

1. Tell me about what you regard as positive or beneficial characteristics?
2. What might these characteristics look like in terms of care delivery or communication
3. How might these characteristics make you feel/made you feel?
4. Tell me about what you regard as negative or less beneficial characteristics?
5. What might these characteristics look like in terms of care delivery or communication
6. How might these characteristics make you feel/made you feel?
7. Do the negative or positive characteristics you have talked about apply to different nursing groups e.g. Accident and Emergency Nurses?

Prompts and considerations

- Have a simple explanation of 'characteristics' ready if needed.
- Allow the participant to talk for as long as they need to
- Do not intervene or presume an end to their experience, thoughts and opinions.
- Explore the 'how' with subsequent questions and avoid the 'if' or 'why' to encourage participant's thoughts and experience not 'answers'. Ask for examples to clarify what is meant by descriptive words e.g. 'friendly' or 'caring'

Appendix VIII – Examples of initial coding



PRIVATE AND CONFIDENTIAL

Interviewer	Hmm-hmm.
Respondent	Time, having a lot of time with people. Like, not shooing them and not rushing them and...
Interviewer	Hmm.
Respondent	You know, they can- people can only go so far as doing things for themselves, you know?
Interviewer	Hmm-hmm.
Respondent	And this is why they're on our ward, for us to look after them, to promote their independence, to get them back to how they were before, at the baseline.
Interviewer	Hmm-hmm.
Respondent	Erm, you know, cos I think – you can take a patient's independence away if you're doing a lot of things for them, they're gonna expect you, that's how it's gonna be.
Interviewer	Hmm.
Respondent	And they're not gonna want to get out of bed. They're not gonna want to sit in the chair. Me, I- all my patients, if I- if I can get them out, sat in their chair, clothes – it's good for the chest, they're not in that bed...
Interviewer	Hmm.
Respondent	S-spend a lot of time, elderly patients, at home alone anyway.
Interviewer	Yeah.

Requires patience

Cannot demonstrate frustration or rushing N1 pg 46

Recognition of patient's partial ability and need for intervention N1 pg 46

Promote independence N1 pg 46

Ability to enable not control/ promote independence N1 pg 46

Passive reliance on nurse/ Recovery reflected in decreasing reliance on

Normalise not institutionalise N1 pg 46

Respondent	…you don't just say, 'I'll be a nurse'…
Interviewer	Hmm-hmm.
Respondent	⚓..do you? It's got to be, you've got to want to, through all the trials and tribulations, look after people. The good and the bad.
Interviewer	Hmm.
Respondent	Those nurses, when I was a student nurse, didn't have that, I don't think. They didn't have what I would call passion, they, for me, I just felt at that time they were very lazy, and they just would take advantage of two student nurses…
Interviewer	Hmm.
Respondent	…who shouldn't have even been doing things like hoists and…
Interviewer	Hmm-hmm.
Respondent	…we weren't trained in it, I was, you know, always been very slim and they just sort of took advantage of that day and basically went in the staff room and drank tea and came out when they felt like it. So, it was, I don't… I just used to, I just used to, I just used to think I couldn't believe it. You did an evaluation at the end…
Interviewer	Yeah.
Respondent	…you had to write a report, which I did, and that was only in St Luke's

Vocation and desire P2 pg 10

All-encompassing role must be acceptable and desired P2 pg 10

No passion results in laziness / vice versa? P2 pg 10

Poor nurses let students do the work P2 pg 10

Poor nurses put students at risk P2 pg 10

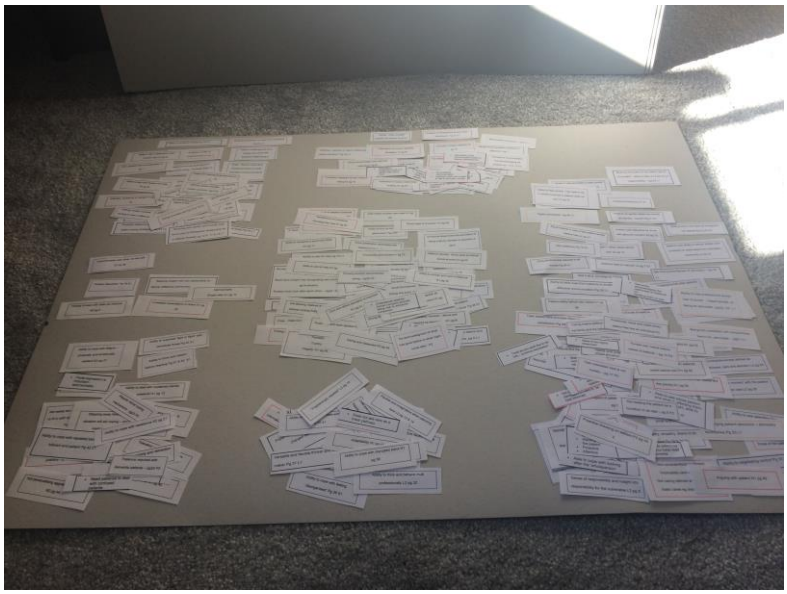
Nurses own needs before needs of patients – tea pg 10

No proactive approach to care Minimum approach to care P2 [g

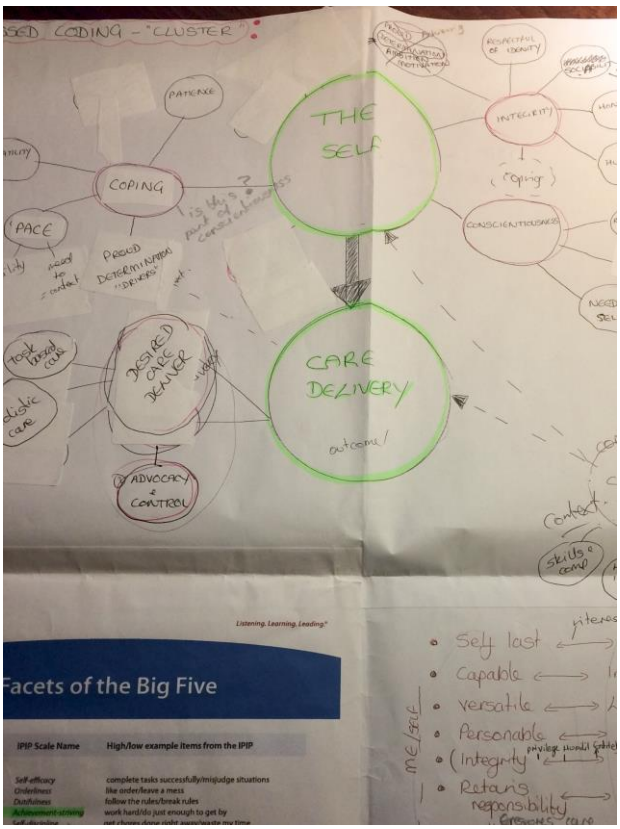
Poor standards hard to accept P2 pg10

Appendix IX Visual evidence of coding and cluster diagramming

Appendix IXa - Visual example of sifting codes and forming categories



Appendix IXb – Progression of category formation – cluster diagram



Appendix X - Examples of memo's

8.11.17 Interview

M E M O

Reflexive note – this is taking up headspace. Why? The intangible characteristic of passionate was obvious but how? What was it about this nurse that made me think I would want her to look after my mother? N1 talked about needing to smile and be positive – first impressions? Do people with a natural demeanour of not being smiley turn me off? Do I link this with not being a good nurse? Does it make then less compassionate? If some can't talk with enthusiasm and excitement do I think they are less compassionate? Am I comparing them to me?

Reflexive note- I found myself focussing in on N1s comments about not having enough staff as this appeared to link with another participants view that many shop floor nurses can't *cope* with the pace that is required now in older peoples care. The acuity of the patients is higher. N1 related the hard work to not enough staff which is a common suggestion from the shop floor but the researcher is reminded of the reason for this research is that there is more to poor care delivery than staffing levels. Do we have enough staff but not the right type of staff?

Can build on above diagrammatic thoughts – add in 'pool of shop floor nurses who can't *cope* or do not like working with pace and acuity' –thought –if you don't like

something you won't give your best? The necessary characteristics are those of wanting to give your best in any situation not just those that you really like.

10.11.17 Interview

MEMO

Reflexive note – this is taking up headspace. Why? At this point I don't know why I am thinking about strengths based recruitment and statements that describe older peoples nurses in a similar way to psychologist use statements to describe behaviour in trait e.g. not conscientious 'leaves clothes round bedroom', not conscientious 'does not comb hair when delivering hygiene care' . Is that too simple?!

Appendix XI– Ethics approval documents

Appendix XIa – London South Bank University ethical approval

School of Health and Social Care

Dr. Adéle Stewart-Lord
Associate Professor
Chair HSC School Ethics Panel
School of Health and Social Care
London South Bank University | 103 Borough Road, London, SE1 0AA
t: +44 (0)20 7815 7931|
e: stewara2@lsbu.ac.uk

Ms. Helen Day

6 October 2017

Dear Helen

RE: The personality of older people's nurses and perceived effect on their practice. (What do stakeholders reveal about the characteristics of registered nurses who work in older people care settings?)

Thank you for submitting this proposal and for your amendments to the Ethics Application form; Participant Information Sheets, Consent form; Trust R&D response and Invitation E-mails made in response to the reviewers' comments.
I am pleased to inform you that full Approval for this study has been given by Dr. Adéle Stewart-Lord, on behalf of the School of Health and Social Care School Ethics Panel.

If you wish to make any changes to the research protocol or any of the documents related to this study you MUST seek approval from this panel before making those changes.

Please include your reference number HSCSEP/17/14 in any future correspondence and on all PIS and Consent forms.

I wish you every success with your research.

Yours sincerely,

Dr. Adéle Stewart-Lord
Associate Professor
Chair HSC School Ethics Panel
School of Health and Social Care
London South Bank University | 103 Borough Road, London, SE1 0AA
t: +44 (0)20 7815 7931|
e: stewara2@lsbu.ac.uk

cc: Prof. Sally Hardy (Supervisor)

Appendix XIb – NHS Research and Development ethics approval

[redacted] NHS
NHS Foundation Trust

Research & Development / Academic Division
[redacted] Institute of Learning, Research and Innovation
[redacted] University Hospital
[redacted]

[redacted]

Email: researchdevelopment[redacted]

27th July 2017

Miss Helen Day
[redacted]

Dear Miss Day

RE 130916 The personality of older people's nurses and perceived effect on their practice.

Thank you for your re-submission to Research and Development.

Following review it has been concluded your work falls into the category of Service Evaluation and poses no unacceptable governance or ethical issues.

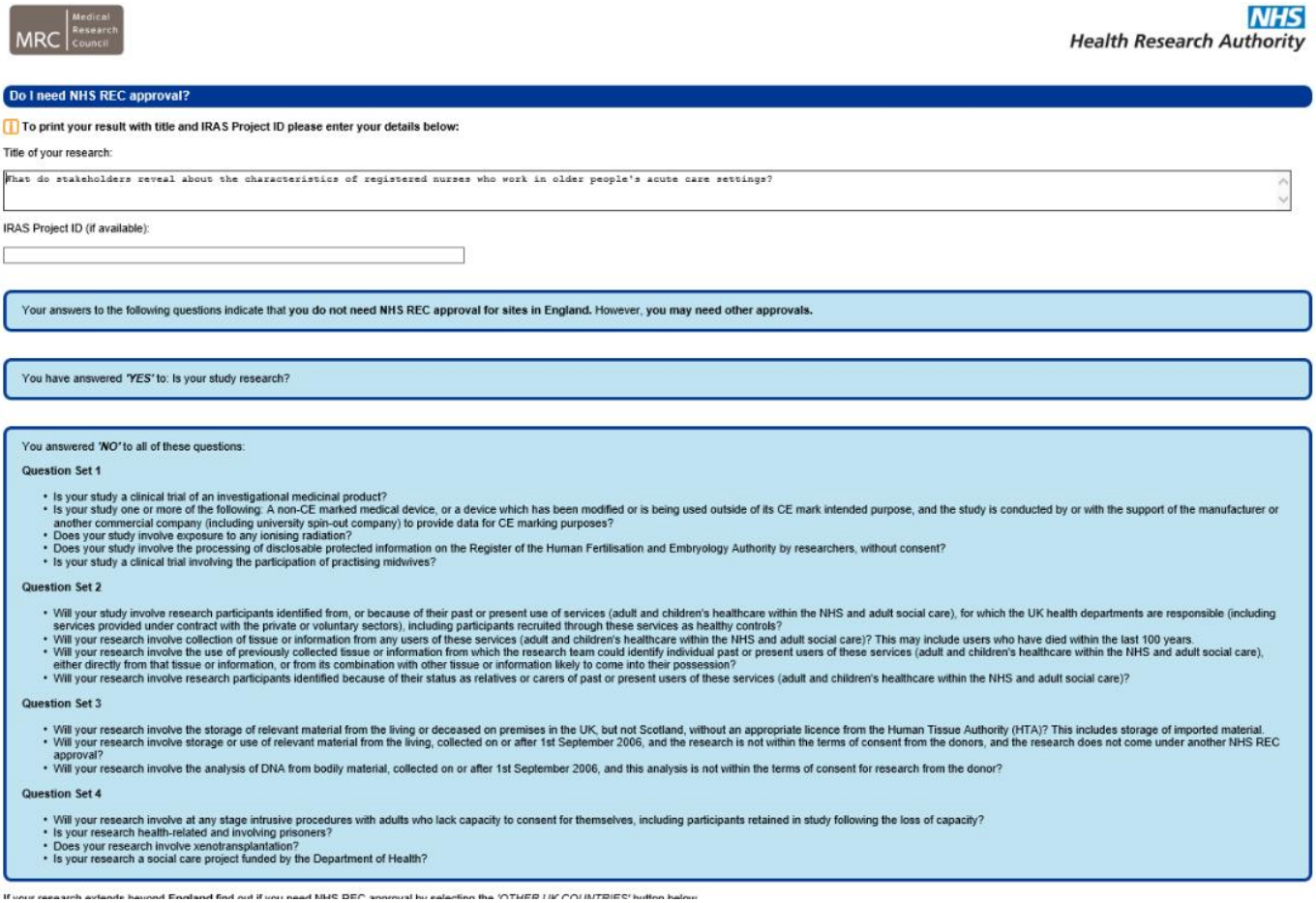
Therefore, R&D has approved your Service Evaluation, pending your University Ethics Approval and I wish you well with your study

Kind regards

[redacted]

Dr [redacted]
Research & Development Director
[redacted]

Appendix XIc – Health Research Authority statement (April 2018)



MRC Medical Research Council

NHS Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

What do stakeholders reveal about the characteristics of registered nurses who work in older people's acute care settings?

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

You have answered *'YES'* to: Is your study research?

You answered *'NO'* to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?
- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

If your research extends beyond **England** find out if you need NHS REC approval by selecting the *'OTHER UK COUNTRIES'* button below.

Appendix XII – Research project consent form

London South Bank University
EST 1892

Research Project Consent Form

Full title of Project: What do stakeholders reveal about the characteristics of registered nurses who work in older people's acute care settings?

Ethics approval registration Number: HSCEP/17/14

Name: Helen Day

Researcher Position: Doctoral student, London South Bank University

Contact details of Researcher: email: dayh3@lsbu.ac.uk. Tel; 07717850848

Taking part (please initial the box that applies)	**Yes**	**No**
I confirm that I have read and understood the information sheet/project brief and/or the student has explained the above study. I have had the opportunity to ask questions.	☐	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without providing a reason.	☐	☐
I agree to take part in the above study.	☐	☐
Use of my information (please initial the box that applies)	**Yes**	**No**
I understand my personal details such as phone number and address will not be revealed to people outside the project.	☐	☐
I understand that my data/words may be quoted in publications, reports, posters, web pages, and other research outputs.	☐	☐
I agree for the data I provide to be stored (after it has been anonymised) in a specialist data centre – this will be destroyed 5 years post completion of the doctoral program in line with university guidelines.	☐	☐
I agree to the interview being audio recorded.	☐	☐
I agree to the use of anonymised quotes in publications.	☐	☐
I agree to assign the copyright I hold in any materials related to this project to London South Bank University.	☐	☐

Name of Participant _____ Date _____ Signature _____

Name of Researcher _____ Date _____ Signature _____

Project contact details for further information: Professor Sally Hardy Email: sally.hardy@lsbu.ac.uk Phone:02078158022

Appendix XIII – Participant information sheets

RESEARCH PROPOSAL: What do stakeholders reveal about the characteristics of nurses who work in older people's acute care settings?

Participant Information Sheet – Patient Governor/Patient and carers

You are being invited to take part in this research study which forms part of doctoral programme. It is important that you understand why the research is being done and what is involved before you make a decision.

Please read the following information carefully and ask questions or discuss it with others to help you make a decision. It is important that you take your time in deciding if this is something you want to do. The following information provides a summary of the important points if you have any other questions or anything is not clear please ask.

What is the purpose of the study?

There has been very little research exploring how personality characteristics of nurses who care for older patients affects how they deliver care. This research is being carried out to learn more about this and how it may contribute to better nursing care for older patients.

Why have I been chosen?

You have been chosen because you have appropriate knowledge and experience of nursing care and hospital experience therefore you are able to give valuable opinions.

Do I have to take part?

No, you do not have to take part. If you do wish to take part you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason and with no consequence.

What will be expected of me if I take part?

If you agree to take part, you will be interviewed by the researcher and that may take about an hour. The interview will be audio recorded with your permission to ensure nothing important is missed, however all information gathered will be kept on the researcher's private computer, not on a shared or networked drive and password protected. The interview will take place in a private room at a location of your convenience and arranged at your own convenience. The nature of how this research is being performed means you may be asked for a second interview but

this will not be known at the onset until the researcher has done an initial review of the interview data.

What are the possible disadvantages and risks of taking part?

You may find it distressing to talk about poor experiences of nursing care. Hopefully this will not happen to any extent that causes a problem for you. However at the end of the interview you will be offered a post interview de brief with a senior nursing colleague.

What are the benefits of taking part?

There are no immediate benefits to you in taking part in this research however the information you provide will be used to inform practice in this area.

What happens if something goes wrong?

If you are unhappy at any stage you can contact the researcher's supervisor and their contact details are at the end of this information sheet.

Will my taking part in this study be kept confidential?

All information gathered from you will be kept confidential. When information is shared with another party such as in publications or in supervision sessions all identifying elements will be removed so you cannot be identified. The only exception to this is that if you disclose something that relates to patient risk or a harm that has not been managed appropriately, this confidentiality clause may have to be broken. This would only occur in exceptional circumstances and if not doing so compromises the researcher's adherence to the NMC Code of Conduct.

What will happen to the results of the research study?

The results of the study will be anonymised and used in the thesis of the researcher as part of the doctoral program of study. The results will be read by a university board that mark the work and may be published at some point but your identity is fully protected throughout and would be discussed with you prior to disclosure. All participant data will be destroyed 5 years post completion of the doctoral program as per university guidelines.

Who has reviewed the study?

The study has been approved by:

London South Bank University, 103 Borough Road, SE10AA and has been reviewed by University Research Ethics Committee. **HSCEP/17/14**NHS Foundation Trust Research Ethics Committee.

Contact for Further Information: Helen Day, Principle Investigator. Telephone 07717850848. Email; dayh3@lsbu.ac.uk.

Contact for concerns about the study - Researcher supervisor: Professor Sally Hardy Email: sally.hardy@lsbu.ac.uk Phone number:02078158022 **Thank you for considering taking part in this study.**

RESEARCH PROPOSAL: What do stakeholders reveal about the characteristics of nurses who work in older people's acute care settings?

Participant Information Sheet – Nurse/Lecturer

You are being invited to take part in this research study which forms part of a doctoral programme. It is important that you understand why the research is being done and what is involved before you make a decision.

Please read the following information carefully and ask questions or discuss it with others to help you make a decision. It is important that you take your time in deciding if this is something you want to do. The following information provides a summary of the important points, if you have any other questions or anything is not clear please ask.

What is the purpose of the study?

There has been very little research exploring how the personality characteristics of nurses who care for older patients affects how they deliver care. This research is being carried out to learn more about this and how it may contribute to the improving care of older people by informing recruitment and performance management processes.

Why have I been chosen?

You have been chosen because you have appropriate knowledge and experience in nursing therefore you are able to give informed and valuable opinions.

Do I have to take part?

No, you do not have to take part. If you do wish to take part you will be asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason and with no consequence.

What will be expected of me if I take part?

If you agree to take part, you will be interviewed by the researcher and that may take about an hour. The interview will be audio recorded with your permission to ensure nothing important is missed, however all information gathered will be kept on the researcher's private computer, not on a shared or networked drive and password protected. The interview will take place in a private room and arranged at your own convenience. The nature of the research methodology means you may be asked for a second interview but this will not be known at the onset until the researcher has done an initial review of the interview data.

What are the possible disadvantages and risks of taking part?

You may find it distressing to talk about poor experiences of nursing care. Hopefully this will not happen to any extent that causes a problem for you. However at the end of the interview you will be offered the opportunity for a post interview de brief with a senior nursing colleague.

What are the benefits of taking part?

There are no immediate benefits to you in taking part in this research however the information you provide will be used to inform practice in this area.

What happens if something goes wrong?

If you are unhappy at any stage you can contact the researcher's supervisor and their contact details are at the end of this information sheet.

Will my taking part in this study be kept confidential?

All information gathered from you will be kept confidential. When information is shared with another party such as in publications or in supervision sessions all identifying elements will be removed so you cannot be identified. The only exception to this is that if you disclose something that related to patient risk or a harm that has not been managed appropriately, this confidentiality clause may have to be broken. This would only occur in exceptional circumstances and if not doing so compromises the researcher's adherence to the Nursing and Midwifery Council Code of Conduct.

What will happen to the results of the research study?

The results of the study will be anonymised and used in the thesis of the researcher as part of the doctoral program of study. The results will be read by a university board who mark the work and may be published at some point but your identity is fully protected throughout and would be discussed with you prior to disclosure. All participant data will be destroyed 5 years post completion of the doctoral program as per university guidelines.

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London South Bank University, 103 Borough Road, SE10AA and has been reviewed by University Research Ethics Committee. HSCEP/17/14

NHS Foundation Trust Research Ethics Committee.

Contact for Further Information:Helen Day, Principle Investigator. Telephone: 07717850848. Email; dayh3@lsbu.ac.uk

Contact for concerns about the study - Researcher supervisor: Professor Sally Hardy Email: sally.hardy@lsbu.ac.uk Phone number:02078158022