THE NURSING MANAGEMENT
OF ACUTELY ILL OLDER ADULTS
IN HOSPITAL

Kathleen Kilstoff
RN, BA DipEd, MA (Macq.)

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STATEMENT OF AUTHENTICATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in part, for a degree at this or any other institution.

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ABSTRACT

The health care requirements of older people admitted to acute hospitals and their need for nursing care have been identified in current literature as problematic. Acutely ill older patients with concomitant diseases and disabilities are at a higher risk of further functional decline in hospital and so need knowledgeable and skilled nurses who can provide care that will address their complex needs. However, hospital organisations which are medically oriented and more focused on implementing programs directed by economics, efficiency and effectiveness may be unsupportive of nursing practices based on a professional value system. There is a need, therefore, to examine how health care structures that tend to promote cost containment and a technical imperative, impact on the professional capability of nurses to provide the standard of care required by acutely ill older hospitalised patients.

The study was developed in a constructivist framework (Guba & Lincoln, 1994), with multiple methods of data collection, not only to develop an understanding of nurses’ perceptions of their caring role with older patients in hospital, but to also observe their interactions and care. The main purpose of this research, therefore, was to investigate how nurses managed the care of acutely ill older adults in hospital. This was undertaken using interviews, observation of practices and documentation of care. There were four specific aims utilised during the process of data interpretation. The first and second aims identified nurses’ knowledge of what comprised competent care for older patients, of their shared understanding of the care they actually provided, and of how this care was being implemented. The third aim evaluated the congruence between nurses’ knowledge about what care should be provided for older patients and the actual care being implemented. The fourth aim assisted understanding of the nurses’ constructions about the consistencies or inconsistencies between their knowledge and the consequences of their actions.

The data, analysed thematically, indicates that the nurses were knowledgeable and potentially competent in providing the standard of technical and functional care required by older adults in hospital. However, although nurses articulated that they
wanted to provide the quality of care needed by acutely ill older patients, they nevertheless admitted they were optionalising this care because of constraints in the health care system. Nurses blamed the medically oriented hospital organisations for the lack of funding for staff and resources, which impacted on the time available to provide the care needed by older patients. While the nurses’ constructions revealed they believed technical tasks took up most of their time during shifts, it was evident during the observations that this was not the case.

It was important, therefore, that a deeper interpretation of the nurses’ practices on the wards should be undertaken, and so through the use of Giddens’s (1984) Structuration Theory a very different picture began to unfold about the incongruence between what they said and what they did. Giddens’s (1984) theory assisted understanding because of three main concepts: firstly, the ‘routinized intersections of practices’ in institutions referred to as the ‘transformational points in structural relations’; secondly, the modes in which such practices were connected to social integration; and thirdly, the capability of individuals to act with professional agency. According to this theory, the results demonstrate that the structural properties of the hospitals as institutions directed and controlled the way the nurses worked. The hospitals disciplined the nurses through their manipulation of ‘time and space’ in relation to the type of work they had to complete and the timeframe for doing it. The findings also reveal that nurses had a fundamental understanding that these structures elevated the importance of technical tasks, which meant that such work was expected to be completed as a priority or they could be formally sanctioned. However, the nurses also knew they could choose to optionalise their functional care for older patients because it was work which was only weakly sanctioned and not accounted for in the same way as the more esteemed technical work. In this way, the nurses demonstrated a lack of agentic behaviour by optionalising and limiting their care for older patients. The significance of this study is that, through the use of Giddens’s (1984) Structuration Theory, the incongruence found between the nurses’ knowledge and their actions has been revealed.
CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Background to the Investigation

One of the major challenges confronting nurses in Australia today is how best to manage the complexity of care required by the increasing numbers of older people with concomitant co-morbidities who are being admitted into the economically constrained hospital system. Ageing of the population implies higher levels of chronicity, and so as people reach their middle old age period (from 75 years) into frail age (from 85 years or more), they need skilled and knowledgeable nurses who can provide the quality of caring necessary to meet their specific health needs. Once this vulnerable cohort is hospitalised, they are more susceptible to debilitation because of a further loss of their functional capacity (Gill, Allore, Holford, & Guo, 2004). If competent care is not provided, these more incapacitated older patients may be discharged ‘quicker and sicker’, with a greater likelihood of not returning to their own homes and instead ending up in long term residential care with very little probability of ever leaving (Grimmer, May, Dawson, & Peoples, 2004). Moreover, they are also at a higher risk of being readmitted to hospital in a frailest and more vulnerable condition. Thus, the quality of life for these older people dramatically alters as they are forced towards often irretrievable physiological and psychological decline (Hart, Birkas, Lachmann, & Saunders, 2002).

Older people who are admitted into hospital need nurses who are knowledgeable and skilled, and who can provide quality caring practices that will protect them from adverse events. During their tertiary education programs nurses generally build a theoretical knowledge base, which provides guidelines for structuring and organising their clinical practices (Brooke & Kendig, 2004; Parker, 2006). These professional role behaviours are framed by disciplinary knowledge that incorporates both a technical and a functional approach to quality caring. Hence, professionally prepared nurses are expected to be able not only to undertake tasks requiring technical skill but also to
provide the type of preventive or functional care needed by vulnerable and older patients according to their disciplinary competencies (Australian Nursing & Midwifery Council [ANMC], 2005). However, the literature raises further questions concerning exactly how adequate the standard of care being provided for older patients is in the current budget-conscious and medically oriented hospital system.

Fiscal philosophy has dominated the way health care services are provided and has led to higher value being placed on measures that promote economy, efficiency and effectiveness (McCormack, 2002). This has resulted in speedy patient throughput (Duckett, 2005). The impact of this is that technology and cost-cutting strategies, which have directed the way patients are managed in hospitals, have resulted in a diminished emphasis on humanistically based functional nursing care. In addition, it appears from a vast amount of evidence that the care required by older people can be negatively prejudiced by staff who hold ageist attitudes, which then influences the types of decisions made and the treatments and care provided (Fagerberg & Kihlgren, 2001; Happell & Brooker, 2001; Tabloski, 2006; Victor, 2006). Nursing decisions made about the type of care required by older people in hospitals can be further constrained by economically rationalist policies, which for over twenty years have permeated the Australian health care system, resulting in reduced funding of staff and resources (Buchanan & Considine, 2002; Parker, 2006). Hence, the suspicion arises that acutely ill older patients may not be receiving the quality of care they need. One must, therefore, question what type of care is actually being provided for older adults with multiple diseases and disabilities who are admitted into a market driven hospital system.

1.2 Background of the Researcher

I have for many years had a strong interest in promoting gerontological knowledge and skills for both undergraduate and postgraduate students. This background has included the co-ordination of Aged and Palliative Care Postgraduate programs, co-ordination and development of aged care as a sub-major for undergraduate students, and consultancy in promoting research- and evidence-based practices in aged care residential facilities. In recent years these experiences have led to my concerns about the greater numbers of older people being admitted into health care settings who may not be receiving the standard of care they require. These concerns were supported by talking with nurses in
clinical settings, and so my suspicion that quality care was not being provided for older people came to frame the basis for this research.

1.3 Purpose of the Study

The purpose of this study was to investigate nurses’ knowledge and attitudes in relation to how they responded to and managed the care needed by acutely ill older hospitalised patients. Specific aims of this study, therefore, included:

1. identification of nurses’ knowledge about what comprised competent care for their older patients;
2. identification of nurses’ shared understanding of what care they actually provided and of how this care was implemented;
3. evaluation of the congruence between nurses’ knowledge about what care should be provided and the actual care they gave; and
4. understanding of nurses’ constructions about the consistencies or inconsistencies between their knowledge and the consequences of their actions.

The study was developed in a constructivist framework (Guba & Lincoln, 1994) with multiple methods of data collection, in order to better understand the knowledge, attitudes and practices of nurses. The aim was not only to develop an understanding of nurses’ perceptions of their role with older people, but also to observe nursing care and nurses’ interactions with these patients. Interviews were undertaken with nurses in order to identify their knowledge and attitudes about how they believed older patients should be cared for. Observation of their interactions with older patients provided a further insight into the congruence between their shared knowledge and their actual responses and practises. Furthermore, these observations and the review of the nurses’ documentation of their care provided a deeper understanding between their constructed knowledge and the outcome of their actions for older patients. Data were analysed thematically in order to understand the constructions of nurses; however, during this process it became clear that an additional interpretation was needed. Subsequently, Giddens’s (1984) Structuration Theory was employed in order to further interrogate the data.
1.4 Thesis Structure

This first chapter has briefly introduced the thesis and provided an overview of the research and the background in which it has been set. Chapter 2 reviews the literature relating to the implication for nurses in caring for an ageing population with associated co-morbidities that increase their risk of adverse events in hospital. The quality of care and services needed by these patients are discussed with reference to the constraints imposed by health policies, which are underpinned by economic rationalisation. The final section of Chapter 2 highlights the importance of a knowledgeable and skilled nursing workforce that can provide the standard of care needed to prevent further functional decline for older patients. It describes the theoretical preparation of professional nurses, which incorporates both a technical and humanistically functional approach to the caring role. The disciplinary education of nurses is identified as particularly important, not only in developing positive attitudes towards caring for older patients, but also in guiding competent practices. Chapter 3 outlines the philosophical approach, design and method of the study, guided by Guba and Lincoln’s (1994) constructivist paradigm. The multiple methods used in this study – which include the use of interviews, observations and nurses’ own documentation of their care – provide for a systematic analysis of the data, which is undertaken in Chapter 4. Furthermore, the use of Giddens’s (1984) Structuration Theory, in Chapter 5, allows for a further interrogation of nurses’ knowledge and capability, as well as their actual practices. Finally, the conclusions and implications of the study are discussed in Chapter 6.
2.1 Introduction

The nursing management of acutely ill older patients in hospital is complex, mainly because of the additional difficulties imposed by the ageing process, concomitant co-morbidities and hospitalisation. These difficulties place older people at a higher risk of further functional decline and adverse events. This chapter provides an overview of issues identified in the literature regarding how nurses manage the quality of care needed by acutely ill older patients in the present economic environment of the health care system. Furthermore, this chapter examines how organisational constraints impact on the capacity of nurses to provide competent care that is informed through their disciplinary body of humanistic and scientific knowledge, conceptual frameworks and national competencies.

2.2 The Implication of Caring for Older People in Society

The current fiscally constrained hospital system poses a challenge to the way nurses are able to manage the quality of care needed by acutely ill older patients. Nurses must provide a high standard of care that will address the complex health requirements of the increasing numbers of acutely ill older people admitted to hospital, who often suffer multiple co-morbidities (Buchanan & Considine, 2002; Crowley & Cutbush, 2000). However, years of cost-cutting in public hospitals has led to insufficient staffing and resources, and this has invariably impacted on the standard of nursing practices that can be provided (Armstrong, 2004; Buchanan & Considine, 2002; Chang, Chenoweth & Hancock, 2003a; Queensland University of Technology [QUT], 2004). A lack of staffing, combined with a business-oriented context in which issues of quality care are of secondary importance, has resulted in many nurses reporting feelings of
dissatisfaction and frustration with their inability to provide the care necessary for older patients (Buchanan & Considine, 2002). Hence, it is of the utmost importance to the discipline that nurses question how their professionally based practices should be managed in the present financially restrained health care climate (Buchanan & Considine, 2002; Courtney, Abbey & Abbey, 2004; Kendig, Andrews, Browning, Quine, & Parsons, 2001).

2.2.1 Population ageing and nursing practice

Global ageing is a reality and is having a direct impact in most countries in the world, including Australia (Australian Bureau of Statistics [ABS], 2006; Australian Institute of Health & Welfare [AIHW], 2002a; Crowley & Cutbush, 2000; World Health Organisation [WHO], 2006). Older people in Australian society currently have a high probability of reaching their sixty-fifth year, an outcome that cannot be expected by many global populations (ABS, 2006; AIHW, 2002a). As a result of these more favourable statistics, Australia is often referred to as a ‘lucky country’ – especially in relation to the influence that lifestyle and economic opportunities have for the health of its population. Even compared to statistics of the aged in New Zealand, older people in Australia appear to live longer (AIHW, 2004b), and so, as a result of the larger number of people surviving into old age and a general inclination to name anyone aged over 60 as old, the term aged should be redefined.

The implication of this for nursing is that caring for an older person in a particular age group is an important consideration, because ‘ageing’ is different for people in each age group and so affects their need for health care services, including nursing care (QUT, 2004). In both Australian (Crowley & Cutbush, 2000; Nicol, Lonergan & Mould, 2000; Onyx, 1999), and American (Bergquist & Neuberger, 2002; Eliopoulos, 2001) literature, people aged between 65 to 74 are often referred to as the young old, whilst those from 75 to 84 are defined as the middle old or older old and those people aged 85 or over are the frail aged, old old, or very old. Generally, those in the young old age group in Australian society have reasonably active, healthy and independent lifestyles, as well as the companionship of a spouse. However, this circumstance changes as people move into the middle old age period, and so it is this age group that becomes more important to nurses because of increasing disability (ABS, 2006; AIHW, 2004b; Victor, 2006).
Increased longevity and a change in the overall health of people in the young old to the middle and frail old age groups is reflected in government health statistics, with the profile of Australia’s ageing population expected to increase from 2.4 million in 2001 to over 6.5 million by 2051 (AIHW, 2002a). A rise in the number of older people in society is not only occurring in Australia but is also apparent in worldwide predictions for other developed countries (ABS, 2006; Commonwealth of Australia, 2004; WHO, 2006). In comparison to many other Westernised countries around the world, Australia’s population is relatively youthful and, according to the statistics, will stay this way for some time (ABS, 2006; AIHW, 2002a; AIHW, 2002b). At present, people aged 60 and over comprise about 13% of the Australian population, and by the year 2051 this proportion will increase to between 26% and 28% (ABS, 2005). The figures are even more startling for those aged 85 and over; the number of people in this group is expected to increase from 1.5% of the population in 2004 to 8% by 2051 (ABS, 2005). This increase in the number of frail old will have a marked impact on the nation’s economy and health and welfare services (AIHW, 2004b) including nursing practices (QUT, 2004). Population ageing, therefore, indicates that there is a vital need for the health care system to review its present strategies and policies so that they more directly acknowledge the level of quality nursing care required by this vulnerable and dependent older population in hospital (QUT, 2004). Age is still the most accurate indicator of the level of need for such services (AIHW, 2004b; Buchanan & Considine, 2002; Crowley & Cutbush, 2000). Because the proportion of people aged 65 and over is increasing (ABS, 2005; AIHW, 2001; Department of Education, Science and Training [DEST], 2002), greater numbers of older and more acutely ill people are being admitted into the hospital system than ever before (AIHW, 2004b; Buchanan & Considine, 2002; DEST, 2002); these people require skilled and knowledgeable nursing care (DEST, 2002; Lumby & Waters, 2005; QUT, 2004).

Population ageing is the result of three basic demographic components: fertility, migration and mortality (ABS, 2004; AIHW, 2000; Booth & Tickle, 2003). Population ageing is indicated by an increase in the proportion of older people, and this has been mainly attributed to lower fertility rates and an increase in the absolute number of older people (ABS, 2004; WHO, 2006). The second component, immigration, has had little effect in the short- or long-term on the pace of population ageing (ABS, 2004; AIHW, 2000). The third demographic component, mortality, has affected population ageing.
because of an increase in the numbers of older people against the younger working population (WHO, 2006). This is mainly due to advances in health care technology and overall improvement in general living conditions (AIHW, 2000; AIHW, 2004b; Palmer & Short, 2000). Lower mortality and an increase in life expectancy (ABS, 2004) are significant considerations for nurses working in the public hospital system, because with increasing age comes higher dependency, which will invariably influence the level and type of nursing care these people will need. For example, women are expected to live 5.4 years longer than men (AIHW, 2002b; Duckett, 2000). Women over 65 years of age constitute 52% of the aged population, 58% of those over 75 years of age, and 69% of those over 85 years of age (AIHW, 2002b). Across all three age groups more women than men will live alone (ABS, 2006; AIHW, 2002b; Brooke & Kendig, 2004; Victor, 2006). Of people 85 years of age and over, 92% of women and 60% of men have no spouse, and as there are double the number of women than men in this frail old age group (Brooke & Kendig, 2004) this means that most people aged 85 years and older who will be hospitalised will be women (AIHW, 2004a; AIHW, 2004b).

One possible result of this disparity is that older women may need to support themselves financially and might experience considerable financial hardship and physical burden because of this situation (AIHW, 2002b; Brooke & Kendig, 2004; Kendig, 2000; WHO, 2006). The greater proportion of the poor in our society are women, and their poverty becomes more severe as they grow older, which then impacts on their individual health (WHO, 2006) and need for quality nursing care (Brooke & Kendig, 2004; Meiner & Lueckenotte, 2006; Onyx & Benton, 1999; Sargent, 1999). Another likely difficulty for older people and their health management is that there may be a lack of close family support (Kendig, 2000; Nay, 2004). This is a general social problem for today’s society, because many of these ‘baby boomers’ have had fewer children than their parents, and often their children have moved away (Kendig, 2000; Liu, 2000). Older people in this group (who are able) may have to ‘search for a relative’ to support them in their old age (Palmer & Short, 2000). The situation is even graver for those aged people living in rural areas, as many have no relatives living close by, or even in the same state, due to the fact that many young people left rural areas during the 1990s in search of education or business opportunities (Kendig, 2000; Lavender & Keleher, 2004).
If older people cannot call on a network of family or friends, then as their health becomes more vulnerable it is left to the state to intervene with some kind of home- and/or community-care assistance (AIHW, 2002b; Lavender & Keleher, 2004). Older people who lack support, who live alone, who are financially vulnerable or who have poor accommodation and who may need to relocate often become anxious and stressed; this, too, can impact on their health (Lavender & Keleher, 2004; Tabloski, 2006). Older people at this stage of life are often too ill-equipped, both physically and psychologically, to deal with these social and health concerns; for these people, living a normal life within the community without state provision may become impossible (AIHW, 2000; AIHW, 2002b; Brooke & Kendig, 2004; Tabloski, 2006). The issue for the health care system, then, is how much government funding is available for services before institutionalisation becomes an economic necessity (Courtney et al. 2004). This issue is of considerable importance for nurses in managing the care of older patients. Economic and social disadvantage impacts on the personal coping and ability of older people to withstand the stress of acute illness, and on admission to the hospital system their health status can be further compromised by both physical and cognitive impairment (AIHW, 2000; Tabloski, 2006).

### 2.2.2 Health care services, including nursing

The rapid rise in both the absolute and the relative proportion of older people in society, therefore, is critical, as it will continue to pose an economic challenge for the funding of nursing staff and other health services (Courtney et al. 2004; QUT, 2004). The impact of this change, along with the awareness that there will be a need for greater government spending, has led indirectly to the perception that old age is a ‘social problem’ (AIHW, 2000; Duckett & Jackson, 2004). Although there is no disagreement that the Australian population is ageing and that health and welfare spending per person is increasing, these reports have been criticised for their basic assumptions and approaches (AIHW, 2000; AIHW, 2002b; Coory, 2004; Courtney et al. 2004; Spencer, 2005). According to McCallum (1997, p. 56), these pessimistic economic rationalist views of ageing have “redefined public anxiety away from being old in a young society towards being young in an old society.” Rothman (1998) notes that there might not be any need to increase the funding allocated to health as a ratio of GDP in the next half-century if one allows for health service productivity growth.
Advances in science and technology, along with a general awareness of the importance to contain health care service costs, means that the increased proportion of older people in Australian society need not increase health care funding appreciably (Commonwealth of Australia, 2004; Coory, 2004; Courtney et al. 2004; Crowley & Cutbush, 2000). The Commonwealth Department of Health and Aged Care (1999) reports that the annual increase in spending for health care should reach a ceiling of 1.8% in 2015, and then decline to about 0.5% by 2051. The yearly increase due only to population ageing should peak at 1.1% in 2015 and fall to 0.3% by 2051. Given the possible trend of actual GDP outlay over this period, it does not appear that the burden of caring for the health needs of the older population will be impossible for government (AIHW, 2000; Crowley & Cutbush, 2000; Kendig, 2000; Spencer, 2005). The problem with such a narrow approach is that it presumes that the ageing population will necessarily have a higher need for health care services, including nursing care. In reality, the relationship is far more complex and other issues should be considered (Coory, 2004; DEST, 2002; Kendig, 2000; Onyx, 1999; Spencer, 2005). In addition, it is important to note that Australian statistics do not show a reliable association between health care spending as a ratio of GDP and the aged demography (AIHW, 2000).

An assiduous attempt should be made to consider all factors which impact on health outlays (Commonwealth of Australia, 2004; Courtney et al. 2004). For instance, the government could offset funding presently allocated for younger people – those not working – and the multitude of services they access, in order to support the increased health costs of the rising number of aged persons (Crowley & Cutbush, 2000). Even if the present health care policies remain, it is improbable that Australia will face an insurmountable cost in meeting an ageing population’s health needs. While this may be reassuring for some, it is not the reality for nurses working now in the health care system. These statistics have not made the government complacent about its current funding of health care or its planning for ongoing increases in health care expenditure. Policies for the last decade or more have continued to concentrate on economic rationalism (Emmerson, 2006), with aggressive cost-cutting in hospital services, including nursing staff (Buchanan & Considine, 2002; Hancock & Mackey, 1999; New South Wales Nurses’ Association [NSWNA], 2006; Palmer & Short, 2000). One reason suggested for the federal government’s fiscal policies is that there was some concern during the period of rapid growth from the late 1960s to the 1970s, which greatly
increased the total expenditure for public hospitals. Because of that growth, the State governments expected the government to meet their spending costs in excess of the budgets they were allocated (Palmer & Short, 2000). The federal government in Australia, in an attempt to curb these costs in the public hospital system, began to increase the pressure on State governments to be more cost-effective; this pressure has been successful, as over the last two decades the States have severely restricted the funding they allocate to public hospitals (Armstrong, 2001, Palmer & Short, 2000; Parker, 2006).

The federal government’s assumptions about ageing were based on the belief that Australia had a surplus of hospital beds in conjunction with an overly high utilisation of them (Palmer & Short, 2000). So, in the name of cost-containment and efficiency in funding of the public hospitals, there was a reduction during the 1990s in the number of hospital beds per 1000 of population from 3% per annum in absolute terms (AIHW, 2001; AIHW, 2002a; DEST, 2002) and the number of inpatient bed-days (DEST, 2002; Gray, Yeo & Duckett, 2004). Thus, these economic rationalist policies of both the State governments and Federal government have impacted on the public hospital system, and this has resulted in decreased costs per occupied bed-day, costs per patient and costs per head of population (Andrews, 2003). These reductions have also led to substantial productivity gains, with increased patient throughput and reduced length of stays that have impacted on the role of nurses who care for the increased numbers of older dependent patients in staff depleted public hospitals (Buchanan & Considine, 2002; DEST, 2002; Nay, 2004; Palmer & Short, 2000).

### 2.2.3 Individual ageing and nursing care

Aside from the effect of population ageing on funding, it is also important to consider the consequences that individual ageing has on nursing care practices. The risk of co-morbidities (disease and disability) is greater in older age and, as such, has direct implications on the standard and intensity of care required (AIHW, 2000; Buchanan & Considine, 2002; Nichol et al. 2000; QUT, 2004). An improvement in survival does not in itself imply that older people necessarily enjoy a poorer health status, however longevity combined with chronic disease does (ABS, 2006; AIHW, 2004b). The incidence of chronic illness is high among the middle group of aged (75 to 84 years of age), and this, in turn, will potentially affect the levels of disability and infirmity for
those of frail age (85 years and over) (ABS, 2006; AIHW, 2004b). Early medical assistance influences the increase of disability into middle and frail age, although some of this disability can be attributed to the natural process of ageing (ABS, 2006; AIHW, 2000). Therefore, in 2003 in Australia, 56% of those aged 65 and over experience an increase in disability, with figures showing that 45% of people aged between 65 to 74 years had a disability, and 12% had a severe disability (AIHW, 2000). Of those aged 75 and over, 53% had a disability and 73% had a severe disability, whilst 82% of people in the old old age group reported having long-term conditions (ABS, 2006). These statistics show that the proportion of people in this frail older age group who have a severe disability (in relation to their ability to function independently and to provide self-care) is increased compared to those aged between 65 to 74 years (ABS, 2006).

As reported by the ABS (2006), 50% of older adults in 2005 had suffered a recent illness and had to visit a doctor, and practically all (99%) acknowledged that they had experienced at least one extended health problem. The most frequently noted conditions were arthritis (66%) and diseases of the circulatory system (57%). People who have these chronic conditions are prone to develop additional health problems (Meiner & Lueckenotte, 2006). Improvement in longevity, along with the often-associated effects of normal pathological ageing and disease, increases the risk of hospitalisation for older adults (AIHW, 2002a; AIHW, 2004b; Street, 2004). Since the 1980s, older adults’ hospitalisation rate has increased and they stay longer because they tend to be sicker (AIHW, 2004a; AIHW, 2004b). According to statistics from the Australian Institute of Health and Welfare (2004a), older people aged 65 and older account for more than 48% of patient days when compared to the younger population, and they occupy hospital beds longer. The average length of stay in hospital for older patients is 5.0 days, compared to 4.0 days for all age groups. Older women aged 75 to 79 had longer average lengths of stay in hospital than older men: 7.8 days compared to 6.0 days. The differences between men and women were most marked amongst the frail old age group, with men staying an average of 8.5 days in hospital, compared to 10.0 days for women in the same age group. Overall, these statistics show that with ageing of the population come larger numbers of older adults with disability and disease, and that the risk of hospitalisation for the middle and older age groups increases. This has many implications for the cost of resource distribution, including nursing staff, as people in these age groups who are hospitalised will require significantly more medical resources.
and quality nursing care than younger patients, and will need such care for a longer period of time. They are also at a higher risk of adverse events during their hospitalisation that can lead to long-term residential care.

2.3 The Impact of Hospitalisation on Older People

Hospitalisation itself may impact on the progress and recovery of the older person. Considered together, poor health and normal ageing increase the dependency of older people on nursing staff for assistance with their functional needs (Buchanan & Considine, 2002; Graf, 2006). An Australian project has found that with increasing age come feelings of vulnerability and a greater need for functional care (Chang et al. 2003b). These authors conclude that the hospitalisation process for many frail ill older patients may not result in an improvement to their health and wellbeing. Hart, Birkas, Lachmann, and Saunders (2002) found that when medical or surgical treatments are added to the care of older immobilised patients in hospital there can be further undesirable effects, which may include reduced physiological potential, functional ability and reserve, and loss of muscular power and cardiovascular strength. Physically weak older people who are hospitalised and have restricted activity were also found to experience a higher risk of disability (Gill et al. 2004).

Functional decline is more likely to occur when the focus of medical and nursing staff is mainly directed towards curing acute problems of older people rather than providing preventive care (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Williams & Botti, 2002). Inadequate management of immobilised older patients can result in negative outcomes, such as longer admission, increased mortality, higher rates of institutionalisation, and a greater need for rehabilitation and home services (Fink & Foreman, 2000; Foreman, Wakefield, Culp, & Milisen, 2001; Graf, 2006; Grimmer et al. 2004; Innouye, Bogardus, Baker, Leo-Summers, & Cooney, 2000; Polanczyk, Marcantonio, Goldman, Rohde, Orav, Mangione, & Lee, 2001; Street, 2004). Zalon (2004), in a correlational predictive study of older adults undergoing surgery, found that nurses need to monitor patients’ levels of pain, depression and fatigue, as all these were significantly related to functional status as well as self-perception of recovery. Acute pain depletes energy, resulting in fatigue and decreased movement, which then place the older person at risk of functional decline during hospitalisation and following discharge (Zalon, 2004). An audit of postoperative patients’ pain management revealed that many
patients experience moderate to severe pain whilst in hospital because of inadequate assessment and knowledge (Carr, 2002). A literature review which explored the barriers to the management of postoperative pain in older people concluded that staff need enhanced education and decision making abilities in order to understand the importance of individualizing pain assessment (Brown, 2004). In a study of patients in an Australian critical care unit, it was found that older patients received less medication for pain and were refused ‘pain killers’ more often than younger patients (Yorke, Wallis & McLean, 2004). Acute and chronic painful conditions associated with ageing are more likely to lead to depression (Gallagher, Verma & Mossey, 2000). Depression lessens the conservation of personal integrity and occurs in 5% to 50% of older hospitalised adults (Pouget, Yersin Wietlisbach, Bumand, & Bula, 2000). These studies support the need for a higher level of preventive care, aimed at maintaining optimal functional health, for frail older patients (Miller, 2002).

Older people are at a higher risk of being injured in hospital than younger patients (Hart et al. 2002), and their injuries may be more severe and are often preventable. A Melbourne study reported that over 60,000 patients were harmed in hospitals in 1994-1995, and that around 1700 died from these adverse events (O’Hara & Carson, 1997). Adverse events occur in about 16% of all patients admitted to public hospitals, and the 5% rate of adverse events grows with patient age (O’Hara & Carson, 1997). Another Australian study (Wilson, Runciman, Gibberd, Harrison, Newby, & Hamilton, 1995) found that 16% of patients experienced an adverse event when in hospital, whilst other reports cite the slightly lower figures of 10% (Australian Council for Safety & Quality in Health Care [ACSQHC], 2001) and 6.88% (Ehsani, Jackson & Duckett, 2006). In one examination of the literature, six categories were identified that pertained to adverse events: medication errors, delirium, falls, nosocomial infections, pressure sores, and treatment complications (Rothschild, Bates & Leape, 2000). The authors concluded that, in each of these categories, older patients appeared to be at a higher risk because of their diminished physiological reserve and co-morbidities. Runciman, Roughhead, Semple, and Adams (2003) found that 15-16% of errors occur in drug administrations using ward stocks systems. The findings from this study also indicated that previous allergic reactions to drugs were only recorded 75% of the time. Up to 94% of older patients with delirium in hospitals are misdiagnosed and mistreated,
and they are more prone to experience further adverse events, such as falls and medication errors (Ski & O’Connell, 2006).

Falls are a significant problem for nurses who manage the care of ill older people in hospital. Falls affect as many as 10% of older adults during acute care inpatient stays and contribute to the morbidity and mortality of those who are hospitalised (McCarter-Bayer, Bayer, & Hall, 2005). An observational study by Vassallo, Sharma, Briggs, and Allen (2003) found that 38.3% of older patients with an acute illness fell during their first week after admission. Research indicates that once older patients fall in hospital they often fall again (Vassallo, Sharma, Briggs, & Allen, 2003). The risk of falls for older patients in hospital can be reduced with targeted assessments and the implementation of falls prevention programs. For example, the use of a screening protocol for the assessment of older patients, was found to accurately identify those patients most at risk of falling (Callen, Mahoney, Wells, Enloe, & Hughes 2004; Salgado, Lord, Ehrlich, Janji, & Rahman 2003) and to direct nursing interventions which reduced the incidence of falls in the acute care setting (Dempsey 2004; McCarter-Bayer, Bayer and Hall 2005). A randomised clinical trial of a ‘targeted multiple intervention program’, in which the average age of participants was 80 years, found there were 30% fewer falls (Haines, Bennell, Osborne, & Hill, 2004).

Mobility problems and falls in hospital are also related to decreased sensory function. For example, a deficit in vision or hearing can have a potentially negative impact on a person’s safety (Yueh, Shapiro, MacLean, & Shekelle, 2003). Early and simple screening measures can evaluate sensory function and can assist nurses in preventing probable accidents from occurring (Yueh et al. 2003) one of the chief ten causes of disease burden for older men is hearing loss, while for older women visual loss is significant (ABS, 2006). In a study conducted in Sydney’s west, 39.4% of the older population was found to have hearing loss (Sindhusake et al. 2001).

The importance of nurses’ ability to proactively manage the specific care needs of older patients in hospital was highlighted in the literature reviewed by Courtney, Tong and Walsh, (2000). They reported that deficits in nurses’ capability and understanding of the needs of older patients significantly influenced the standard of care they provided. A further implication was that nurses did not often take older patients’ complaints seriously; this is particularly concerning, because complaints can be early signs of functional decline or of the occurrence of an adverse event. Staff disinterest in
older patients’ needs, can affect the quality of care these patients receive in hospital. An inability to detect early signs of change in an older patient’s condition was reported in one Australian study, which concluded that the care of older patients was rarely managed well in the organisational environment, which, in turn, had evidence of serious system inadequacies (Poole & Mott, 2003). Readmission of older people to hospital can be reduced, and discharge of patients to their own homes is increased when clients’ complex needs are fully assessed and treated whilst in hospital (Hart et al. 2002). The admission of older people with co-morbidities to acute care wards, therefore, requires co-ordination of care, which includes an assessment of an older person’s concurrent diseases and disabilities, based on knowledge of relevant research (Williams & Botti, 2002).

Aside from coping with acute illness, functional decline and adverse events, the older patient also has to cope with the additional stress of the hospital environment. Environmental stress can easily be overlooked by staff who do not understand the invidious effect it can have on the older person (Lyytinen, Liipo, Routasalo, & Arve, 2002). A decrease in awareness and knowledge about the consequences of hospitalisation for older patients can lead to a higher risk of adverse events, such as lengthier periods of hospitalisation, readmissions, loss of functional ability, and iatrogenic problems in relation to other age groups (Hart et al. 2002).

In this section it has been seen that the impact of hospitalisation on the care of increasing numbers of older patients with concomitant co-morbidities is an important consideration for the nursing profession. Vulnerable older people with a combination of potentially conflicting and multiple illnesses who are admitted into an acute care setting require knowledgeable and skilled nurses who can provide continuity and co-ordination of care. The combination of normal ageing, acute illness and chronicity increases older people’s dependency on nurses for assistance with their functional needs. Frail older patients are at an increased risk in hospital, because of medication errors, delirium, falls, nosocomial infections, skin breakdown and treatment complications. When medical treatments are added to the care of the older person, the effects of prolonged immobility can have undesirable effects, and this can result in further functional decline and a longer admission stay.
2.4 The Impact of Economic Constraints on the Nursing Care of Older Adults

The rigorous economic health policies of the Federal government are concerned more with instituting funding and labour market reform than with supporting the provision of quality care by nurses (Chan, McBey, Basset, O’Donnell, & Winter, 2004; Daly, Chang, Hancock, & Crookes, 2004; Dendaas, 2004; Eggert, 2005; Williams & Botti, 2002; Williams, Chaboyer & Patterson, 2000). This financial focus has directed hospital organisations to implement programs of competitive costing and efficiency of output that may be diametrically opposed to the role of professional nursing (Chan et al. 2004; Parker, 2006), which is concerned with addressing the needs of older patients holistically (Buchanan & Considine, 2002; Johnstone, Da Costa & Turale, 2004). Williams (2001b) in her study showed that quality care practices that supported the psychological or spiritual needs of patients were constrained in fiscally oriented organisations, in which the focus was directed more towards medically oriented goals of diagnosis, treatment and cure of mainly physical problems as quickly and efficiently as possible. These findings imply that a health care system that promotes cost-containment, cost-effectiveness and curing does not ‘sit well’ with professional nursing values of providing caring practices for older patients based on a holistic and individual patient-centred approach within meaningful nurse–patient relationships.

Nurses are confronted, then, with the reality that economic rationalisation is now a part of the landscape of health care systems in most Western democratic countries (Chan et al. 2004; Cummings, Hayduk & Estabrooks, 2005; Dingel-Stewart & LaCoste, 2004; Duckett, 2005; Duffield & O’Brien-Pallas, 2003; Johnstone & Stewart, 2003; Stokowski, 2004). Concern is often raised about how this stringent climate is impacting on the way nurses manage the specific care needed by the greater numbers of acutely ill older people with attendant chronicity who are admitted to hospital (Buchanan & Considine, 2002; Cummings et al. 2005; Daly, Speedy & Jackson, 2006; Jackson & Borbasi, 2006; Jackson & Daly, 2004; Johnstone et al. 2004; Lumby & Walters, 2005; Williams & Botti, 2002). A study by Fagerberg (2004) found a complex interrelationship between the health care organisation and patient care, particularly because nurses need adequate resources and support in order to ensure quality practices. This finding was also supported in an Australian study which concerned the perceptions of intensive care nurses about organisational restructuring (Wynne, 2004). Inadequately
staffed wards led to a greater likelihood of complications for older hospitalised patients (Needleman et al. 2002), excessive workloads for nurses, errors in decision-making, and unsafe care (Mrayyan & Huber, 2003). Aiken, Clarke and Sloane (2002) reported that these negative or adverse events were often influenced by task-centred behaviours, however they were found to decrease when the organisation supported the professional role values of nurses.

Task behaviours are often introduced by managers to wards when staffing is not at an adequate level. The strategy is seen to be a more efficient way of organising work patterns. This practice can result in nurses performing isolated, routine work and not utilising their higher professional skills of critical thought and judgement, which are needed in making decisions about the standard of care necessary for ill older patients (Shorr, 2000). Takase, Maude and Manias (2006) found that task delegation practice showed a significant association with the intent of the nurses to resign from their jobs. Inadequate staffing not only results in the improper allocation of tasks on wards, but also affects how nurses choose to organise care for their patients. For example, Williams (1998) found that when the conditions on the ward were perceived to be unworkable, the nurses used a system of ‘selective patient focusing’, where some patients received total care and others received compromised care. Compromised care is evident in the actions of nurses, which demonstrates a devaluing of functional care. An Australian study found that although nurses considered nutritional care important for their frail older patients, many had difficulty in raising its priority above other nursing activities because of a lack of time and the need to complete tasks (Kowanko, Simon & Wood, 1999). A prior study undertaken in the same hospital by Byron and Leu (1997) found that 15% to 24% of the patients in four medical wards were identified as suffering from malnutrition. A more recent study conducted in two Sydney teaching hospitals found the malnutrition rate to be at 36%, and the incidence of mortality in these patients after one year was nearly 30% (Middleton, Nazarenko, Nivison-Smith, & Smerdely, 2001). The findings from these studies and others show clearly that a lack of appropriate staff, resources and time impacts on the ability of registered nurses to adequately assess patients’ needs and to implement the necessary standard of care (Davis, 2005; Gunther and Alligood, 2002; Hegney, Plank & Parker, 2003; Jackson & Borbasi, 2006; Nolan & Tolson, 2000; Tutton & Seers, 2004), including the need for trust and security (Fagerberg & Kihlgren, 2001).
Nurses who felt it was important to complete organisational objectives – such as schedules and tasks – in lieu of patient care were found to distance themselves more from older patients (Fagerberg & Kihlgren, 2001). These findings were supported in a literature review conducted by Williams (2001a), which found that providing quality care was extremely difficult or even impossible to achieve because of the effect the current market driven health system had had on nurses’ working role. Williams also noted that this had led to a lower level of contact with frail patients, which over time had created conflict for nurses, who felt they had to primarily fulfil the tasks or aims of their institution. An ethnographic study conducted in the late 1980s and early 1990s in the United Kingdom by Latimer (2000), also found organisational constraints placed pressure on the nurses’ conduct in providing quality patient care. Management judged medicine for its effects on curing disease and judged the nurses’ work on their effectiveness and efficiency to free up beds for new admissions. In this way nurses experienced tension on the wards between managing organisational objectives and their caring role. According to Latimer, nurses when under these types of agendas which stress efficiency and economy, compete with each other to justify their practices. Nurses come to see ‘purposeful work’ as different to their professional values and in a ‘quest’ for professional status Latimer believes they will follow medicine and ‘abandon’ their bedside caring role. Latimer (2000, p. 8) states “that nurses are not, despite many professional and theoretical accounts which stress their individual accountability, free to do whatever they will.”

A study undertaken with Australian nurses also found they felt under ‘constant’ pressure by the fiscal constraints operating within the hospital context and were concerned about the effects of this on their ability to provide quality care and maintain a professional value system (Wynne, 2004). An Australian survey of patients’ perception of their nursing care showed that 42% provided some form of negative comment, and this was felt to be a result of the busy hospital context (Darby & Daniel, 1999). A lack of quality care in economically constrained hospital wards is problematic for the profession, as older patients are more vulnerable to complications than younger patients (DEST, 2002; Street, 2004).

Another consequence of financially constrained hospital organisations is that they contribute to the emotional cost of caring for nurses, who struggle to provide quality practices based on their professional values (Cummings et al. 2005; Fitzgerald,
and for debilitated older patients, who most need this care (Cooper, Frank, Hansen, & Gouty, 2004; Parker, 2006; Street, 2004; Commonwealth Fund, 2004). Job stress and job dissatisfaction experienced by nurses have been found to be associated with the problems the Australian health care sector has in recruiting and retaining nurses (Bartram, Joiner & Stanton, 2004; Dunn, Wilson & Esterman, 2005; Humpel & Caputi, 2001). These demanding workplace environments impact on nurses’ satisfaction because of their overriding drive towards efficiency of output, shorter lengths of time for hospitalised patients, and reduced staffing and resources (Bartram et al. 2004; Buchanan & Considine, 2002; Nolan & Tolson, 2000). Moreover, when nurses are dissatisfied in their role it results in anxiety and stress, to the detriment of quality care provision (Armstrong, 2004; Cummings et al. 2005; Fagerberg & Kihlgren, 2001; Milisen et al. 2006). Begat, Ellefsen and Severinsson (2005) found that ‘time allocation for tasks’ correlated with nurses’ lack of satisfaction, leading to physical symptoms and time off work for ‘sick-days’.

It is clear that the financial climate of the public hospital system in Australia has resulted in the disintegration and dehumanisation of services and in decreased nursing satisfaction and standards of care (Armstrong, 2004). Role stress and dissatisfaction was found in clinical nurses who participated in a Queensland survey on nursing workloads, which had a response rate of 53% (Hegney et al. 2003). The results indicated that 50% of nurses in the aged-care sector, 32% of those in the public sector and 30% of those in the private acute sector experienced difficulties in meeting patient needs because of insufficient staffing levels. In addition, these participants also complained about the poor skill-mix of staff, which they believed was mostly caused by a lack of funding and too few experienced and too many inexperienced staff.

Ongoing cost-cutting in Australian hospitals, which has become particularly acute in the last five years, has also impacted on the number of permanent staff employed on wards. A study commissioned by the NSW Nurses’ Association found that the focus on cost-control in managing the care of patients is now all-pervasive and has generally resulted in a loss in permanent nursing positions and a diminished capacity for remaining nurses to provide quality care to dependent ill patients (Buchanan & Considine, 2002). A lack of permanent staff means that when nurses are absent from wards there are not enough skilled or experienced hospital staff available on the rosters
to replace them. The only solution available to the ward managers is for temporary staff to be employed, which can then lead to compromised care for frail older patients (Auditor General for Western Australia, 2002).

The use of casual and temporary staff for core duties has increased in Australian hospitals and now forms a major section of the nursing labour force (De Ruyter, 2004). A report by the Auditor General for Western Australia (2002) found that up to 38% of level-one registered nursing positions were being filled by agency nurses. The report concluded that, in many cases, a lack of pre-employment checks on the competency and skills of agency staff was putting service delivery and the quality of care at risk, especially when agency nurses made up a significant proportion of the staffing mix. A policy from the Victorian government indicated that it would only fund agency nurses for unplanned staff absences because such costs rose by 80% through 2001 (Senate Community Affairs References Committee [SCARC], 2002). When higher numbers of agency nurses are used on a shift, the risk for older patients is increased (Auditor General for Western Australia, 2002). Not only has the government employed casual staff but also greater numbers of less experienced staff, such as enrolled nurses (ENs), assistants in nursing (AINs) and patient care assistants (PCAs), in an attempt to save the high costs for registered nurse positions (Daly et al. 2006). Moreover, these less experienced staff have been used to replace many aspects of the registered nurse’s role, which has resulted in situations where such staff have limited knowledge, skills and understanding of the complex health needs of the acutely ill, frail older patients (Australian Nursing Council Inc. [ANCI], 1997; Daly et al. 2006; Greater Metropolitan Transition Taskforce [GMTT], 2003).

Reducing levels of staff may be a short-term economic solution, but has long-term economic consequences. For example, the results from an American study noted that a higher number of permanent nurses on wards, was associated with a 3% to 12% reduction in the rates of adverse outcomes (Needleman et al. 2002). Even more significant was the finding that if all types of nurse staffing were increased then the incidence of patient complications fell from between 2% to 25% (time of hospitalisation, episodes of urinary tract infections, bleeding in the upper gastrointestinal tract, pneumonia during hospitalisation, shock of cardiac arrest and failure to rescue) among patients. These results implied that such outcomes were indicators of quality nursing care.
2.4.1 Organisational support for quality care of older patients

Supportive organisational and ward environments ensure that nurses are more able to provide quality care practices according to their professional value system (Anthony et al. 2005; Capuano, Bokovoy, Halkins, & Hitchings, 2004; Cummings et al. 2005; DiMeglio et al. 2005; Manojlovich, 2005). This is important for frail older patients because of their diminished reserve capacity, which places them at higher risk of complications and functional decline (Hart et al. 2002; Needleman et al. 2002). Cooperative ward climates that provided recognition, respect, fairness, adequate resources, support and information were found to also provide opportunities and flexibility for nurses to control their own professional work (Kramer & Schmalenberg, 2003; Manojlovich, 2005; Spence Laschinger, 2004). This then has been found to contribute to excellence in quality patient care behaviours (Kramer & Schmalenberg, 2003; Sengin, 2003) and to higher levels of trust in management (Laschinger, Shamian & Thomson, 2001; Spence Laschinger, Almost, & Tuer-Hodes, 2003). Supportive organisational structures and psychological empowerment were found to predict 38% of the variance in how nurses perceived their ability to enact their professional role (Manojlovich & Spence Laschinger, 2002). Nurses who believe they are effective and who do not imagine their own failure add to their own professional empowerment (Simoni, Larrabee, Birkhimer, Mott, & Gladden, 2004). Furthermore, when nurses feel they can influence the hospital environment it can lead to an increase in both structural and psychological empowerment, resulting in improved patient care and outcomes (Manojlovich & Spence Laschinger, 2002).

Nurse managers who were able to actualise their own power by making use of the resources and regulations available to them within their organisation were found to exhibit innovative behaviour in the workplace (McMurray & Williams, 2004), have empowered other nurses to achieve autonomy (Mrayyan, 2004), their goals of quality patient care (Cummings et al. 2005; Sieloff, 2004) and to have mitigated against the negative effects of high strain and frustration on the job (Cummings et al. 2005; Hall, 2004; Sargent & Terry, 2000). The study by Turner, Lee, Fletcher Hudson, and Barton (2001) also found that when the nurse manager of the intervention ward supported the highest quality care for the older patients, it resulted in shorter lengths of stay, fewer readmissions and less frequent use of restraints, compared to a control ward in which older patients were found to have more problems with pain, incontinence and mobility.
A study by Stewart, Stansfield and Tapp (2004) offered more instances of hampered autonomy, where nurses’ practices were constrained and unsupported within their organisation. For example, on fiscally run wards affected by staff shortages, managers were found to allocate a higher patient workload to nurses, which interfered with their ability to meet patient care needs (Buchanan & Considine, 2002; Shaver & Lacey, 2003). Such a situation has the potential to end in conflict (Courtney, Yacopetti & Rickard, 2001). Research shows that a lack of support by managers is perceived by nurses to be an obstacle to providing ‘good nursing care’ (Milisen et al. 2006), and can result in nurses believing they are helpless to effect any changes on their wards (Dunn et al. 2005) and can lead to nurses ‘quitting their job’ (Gardulf et al. 2005).

In an extensive review of literature published between 1985 to 2003, McVicor (2003), found that organisational aims, management style and professional conflict impacted negatively on the role of nurses in meeting patients’ needs. Organisational aims that do not demonstrate a high level of support for nurses are evident in the way the health care system replaced the clinical nurse supervisor’s position (Charge Nurse) with a nurse unit manager’s position. The new Nursing Unit Manager (NUM) role was structured to be primarily concerned with budgeting and administrative responsibilities, rather than the supervision and support of quality nursing care (Wynne, 2004). This situation, many nurses believe, has impacted on the quality of care provided for patients in hospitals (Buchanan & Considine, 2002; Wynne, 2004). The findings from a study undertaken very shortly after this role was implemented in the late 1980s found that 84% of nurse managers did not believe that they should be involved much in ‘supervising patient care’ (Duffield, 1989). The strategic move by the health care organisation to eliminate the clinical supervisor’s role has resulted in a situation in which nurses feel they have little support at the clinical level (Buchanan & Considine, 2002; Wynne, 2004). Perhaps, as found in one study, nurse managers feel they lack real power to effect any change or influence at the organisational level (Suominen, Savikko, Puukka, Doran, & Leino-Kilpi, 2005). The reality is that nurses need an accommodating organisational climate if they are to demonstrate their professional agency in providing a standard of practice that does not result in negative outcomes for frail older patients.

The capability of nurses to provide a high standard of care needs not only the support of the organisation but also the assistance of the nurse manager. Clinical supervision raises the importance of the degree of quality caring required by older
patients and provides a context for valuing work based in the gerontological specialty of nursing (Ford & McCormack, 2000). Nurses working in such supportive environments avoid being victims and blaming others for their perceived helplessness and instead are able to focus on their own professional agency in finding ways to change the social conditions operating in some ward contexts.

Economically run organisations that are more concerned with imposing restrictions on adequate levels of funding for staff and resources are however, less likely to value the professional expertise and empowerment of nurses who agitate for change in the care of older patients. According to Ford and McCormack (2000) there are a number of nurses in the United Kingdom now who have higher qualifications in nursing or in the specialty of gerontology, however there has been little noticeable change in the outcome or evidence of the influence of their expertise in the care of older people. Latimer (2000) notes that in trying to find some balance between management demands and quality practices, nurses in her study chose instead to exclude care to some patients. Nurses understood they are responsible and professionally capable in providing an appropriate standard of care but collude in their own powerlessness when they place the efficiency and economic aims of the organisation above the conduct expected of them as professionals (Latimer, 2000). Nurses need to critically reflect on the continuing impact organisations have on their professional role and as individuals, become more politically active in the types of choices they make about their care (Parker & Clare, 2006). Professional agency implies action by nurses to distance themselves from the overriding institutional objectives inherent in hospital management systems (Barnard, 2006).

The literature examined throughout this section has clearly emphasised the interrelationship that exists between structural constraints in hospital organisations and the ability of nurses to empower themselves in order to provide a professional standard of patient care. Hence, the fiscal policies which predominate in these business-minded institutions, which are more focused on management tactics that result in reduced numbers of permanent nurses and higher numbers of relatively inexperienced and casual staff, impact on the service delivery and quality of care available for at-risk older patients. Such controlling contexts work to deny nurses the support they need in order to exercise autonomy and decision-making over their own practices. However, professional nurses can as individuals, through a critical examination of their conduct of
their caring role within hospital settings, question whether their actions are acceptable or not. As practitioners, nurses need to examine the conflicting and competing claims which impact on their professional agency and carefully evaluate their legitimacy in order to advocate for a high standard of care for older patients.

2.5 Providing Competent Care to Older Adults

Acutely ill older adults in hospital require competent nursing care that is framed by the disciplinary body of humanistic and scientific knowledge (Barnard, 2006; Nelson & Gordon, 2004: Parker, 2006). A ‘technical approach’ to care includes treatments or tasks which are generally related to the scientific-medical model of curing and are monitored and managed by nurses (Barnard, 2006; Fitzgerald, 2006; Griffiths & Crookes, 2006). By comparison, a ‘humanistic approach’ to nursing includes care that is related to the affective and functional needs of patients (Fitzgerald, 2006; Jackson & Borbasi, 2006; Maguire, 2006; Walker, 2006). Affective and functional care differs from technical care in that it is mainly initiated by nurses and is based on the assessment and implementation of caring actions, which protect helpless and/or immobile patients from harm in hospital (Fitzgerald, 2006; Maguire, 2006). The findings by Chang et al. (2003b) found that older patients rated functional care as more important than younger patients. This finding may reflect that with chronicity and frailty there is a higher need for physical assistance in hospital.

These expressive and technical approaches to nursing knowledge guide the professional value system that is implicit in quality caring practices (Parker, 2006). This system promotes autonomy, advocacy, independent decision-making, planning and implementation of skilled clinical care, and power to evaluate caring practices (Scott, Sochalski and Aiken, 1999). A study by Weis and Shank (2000) measured the significance of the ‘Caring’ professional values and found that eight factors accounted for 58% of the total variance, while the ‘Caregiving’ factor (competent ‘hands-on’, or functional, care), in particular, accounted for 31.45% of the variance. The importance of competent caring and expressive behaviours was emphasised by Yam and Rossiter (2000), whose study reported that nurses who held high professional values described their caring role as one which incorporated using good clinical skills to provide holistic care which would meet the patient’s physical, emotional and social needs. These values, which incorporate knowledge guided by both the technical and functional approaches to
care, are therefore extremely important in preventing further physical decline for acutely ill older adults in hospitals. The necessity of quality functional caring of frail older patients was indicated in a study by Baldursdottir and Jonsdottir (2002), who found that a patient’s age correlated significantly with scores on all subscales, and that the older the patient the more important was the technical knowledge and competency of the nurses who provided functional care.

The provision of care which is ‘patient-focused’ is now a part of the language used by health care providers to describe the importance for nurses to develop professional nursing relationships with their patients (McCormack, 2003). For example, the research conducted by Clarke, Hanson and Ross (2003) found that understanding a patient’s history and background assisted nurses in knowing the older individual more fully and in forming a closer and more caring relationship. Knowing the person was also identified as significant in a study in which those nurses who emphasised the importance of a professional relationship with older patients provided ‘quality focusing’ (Williams, 1998). Another study, by McCormack (2003), also suggested that nurses who supported a professional value system needed to ‘particularise’ the older patient, which helped them to know about the individual’s functional care needs. It is important for nurses to have this practice focus, considering the impact of the hospital environment, which can include institutional discourse, the dynamic of power and control, and the limitation of access to knowledge and professional authority, on vulnerable older patients.

2.5.1 Quality nursing care and patient satisfaction

Individualised or person-centered care is guided by both scientific and humanistic approaches and is more likely to result in a positive relationship between older patients and their nurses. Schmidt (2004), who examined nursing care and its relationship to patient satisfaction, described patients’ perceptions of quality caring practices as: seeing the needs of the patient, explaining, watching over and responding. These aspects of the caring role illustrate the functions, knowledge and tasks implied in the capability of professional nurses’ actions (Begat & Severinsson, 2001; Jackson & Borbasi, 2000). Schmidt (2004) reported a significant relationship between how patients viewed nurses and how they perceived quality nursing care. A literature review conducted by Chant, Jenkinson, Randle and Russell (2002) concluded that empathy and communication
skills are important components in improving patient satisfaction. Gotlieb (2002) also found that when patients develop a positive evaluation of nurses and their caring and communicative behaviours, the hospitalisation experience becomes more satisfactory (Gotlieb, 2002). In addition, this research showed the importance of patient involvement in a ‘mutual negotiation’ of care, as patient satisfaction with ‘patient-centred nursing care’ was enhanced greatly when nurses individualised care and allowed patients to have some control over the care they received. According to Rodwell (1996), the antecedents to empowerment of patients in decisions about their care include: mutual trust, respect, education, support, participation and commitment. McCormack (2003) also notes that when nurses adopt a person-centred approach to practice, they recognise the fundamental right of older patients to participate in their care. This recognition is based on an interdependent and interconnected relationship between the patient and nurse, which is also restorative. McCormack (2003) indicated that there were five ways nursing practice supported an older patient’s autonomy: flexibility, mutuality, transparency, negotiation and sympathetic presence. The nurses in McCormack’s study demonstrated a high level of quality care in their role, which confirmed a connectedness in the way they understood and engaged with older people.

Person-centered care that is implicit in the professional nursing relationship can have enormous therapeutic value for the acutely ill older patient, because it can sustain the frail person during often critical and complex treatments prescribed during hospitalisation (Thomas, Finch, Schoenhofer, & Green, 2005). Irurita (2000) demonstrated in her grounded theory study that therapeutic effectiveness was acknowledged by patients who perceived that nurses possessed the means with which to preserve their personal integrity. These patients placed a high value on their relationship with nurses and felt that positive nurse attributes included competency and effective communication with patients, as well as between members of the health care team. Raftpoulos (2005) findings from a grounded theory study showed that the empathy and professionalism shown by nursing staff is important in patients’ evaluation of their hospital experience. To ensure older patients are provided with person-centered care, they need nurses who are knowledgeable and skilled about the specific health and social needs of older adults.
2.5.1.1 Person-centered care and specialty aged care nursing

Nurses who espouse person-centered care based on humanistic values will, according to Ford and McCormack (2000), inevitably be drawn to understanding the importance of developing practices which are informed by gerontological knowledge and expertise. Specialty gerontological education is seen as vital in ensuring a high standard of care (Nurses Board of Victoria [NBV], 2002) for the increasing health needs of greater numbers of older people in the population (ABS, 2006; Joy, Carter & Smith, 2000). The nursing profession, as primary health carers, has a responsibility to be well prepared, to use new approaches, so that a competent standard of enhanced care can be provided for older people (Berman, Mezey, Kobayashi, Fulmer, Stanley, Thornlow, & Rosenfeld, 2005; Meiner & Lueckenotte, 2006; QUT, 2004). A literature review conducted by Joy, Carter and Smith (2000) highlighted the concern felt regarding the necessity for more nurses to have the requisite knowledge and skills required to care appropriately for older people. Gerontological nurse specialists have specific knowledge of the health and social needs of older people and are highly competent and skilled in holistic care. However, aside from calls for greater numbers of gerontologically prepared nurse specialists, it is evident that there has been a commensurate deficit of aged care content in Australian undergraduate nursing curricula (Joy, Carter & Smith, 2000; NBV, 2002; QUT, 2004). Australian reviews have consistently found that nursing programs were not adequately preparing student nurses about the complexity of care needed by older people (DEST, 2002; NBV, 2002).

Against this background the Australian Government recognised that there was an urgent need to promote nursing and nurses who provide care for older people (QUT, 2004). This imperative arose because of the predicted demand for health care services, including quality nursing care that would be needed by elderly people across varied health care contexts. Hence, it is only in recent years that nursing undergraduate programs in Australia have, in response to this initiative by the Government, increased the amount of aged care content in their curricula. Although there may have been a limited focus in these programs on specific aged care issues, students have nevertheless, been comprehensively educated as professional nurses who have a mandate to care for all vulnerable people, including older adults. The theoretical content in these programs prepares nurses who are potentially capable of demonstrating their professional agency according to the discipline’s competency standards for registered nurses (ANMC,
2005). The knowledge and competent values implicit in the professional role of nurses who understand the importance of providing quality care for older people, are corroborated by the vast amount of research based on the discipline’s theoretical models, which promote quality nursing practices that are theory-based (Alligood, 2006b).

2.5.2 Theoretically based nursing practices

Theoretically based nursing practices are guided by disciplinary models, which are also referred to as frameworks or theories (Meleis, 2004). Whichever term one applies to these approaches, it is undeniable that it is more important to focus on how the concepts in the framework, model or theory assist nurses to know about the older person, their health status, the effect of stressors in both their internal and external environment, and the specific care needed (Fawcett, 2005). The concepts that are broadly described in these models are based on more abstract ideas contained in the metaparadigm of nursing, which include the person, health, nursing and environment (Fawcett, 2005; Grace, 2006). Such concepts highlight the philosophical direction of the theorist, which may be towards either a scientific or a humanistic approach (Parker, 2006). However, both approaches promote the quality of care needed by debilitated older patients across various types of practice areas (Alligood, 2006a). Nursing practices which are based on the professional literature, therefore, alerts nurses to what they know and to how they can use their knowledge to inform their decision-making, while also concentrating on the holistic needs of the ill patient (Alligood, 2006a). The following list by Alligood (2006a) gives some of the most frequently acknowledged models used by nurses internationally in guiding caring practices of the older person: King’s Theory of Goal Attainment (1981); Rogers’s Theory of The Science of Unitary Human Beings (1970); Roy’s Adaptation Model (1970); Levine’s Conservation Model (1966); Neuman’s Systems Model (1995); and Watson’s (1985) Theory of Caring.

Theories such as these have framed nursing knowledge and disciplinary practices for the caring of older adults (Alligood, 2006b). For example, King (1981) noted that her Theory of Goal Attainment was a normative theory, and that, as such, it should set the standard of practice for all interactions between nurses and their patients when health is the goal. The five concepts outlined in this model provide a theoretical orientation of holism and dynamic interaction: goals, structure, functions, resources and
decision-making (Frey & Norris, 2006). Woods (1994) used King’s theory (1981) to examine how nurses could better support older women in understanding and coping with their chronic complaints. Although this research is not recent, the findings are still relevant today. The results showed that the theory was a useful guide for nurses in their interventions with older women, as it encouraged sharing of information, mutual agreement on suitable goals to be achieved, perceiving the importance of life events to the situation and understanding the patient’s values and beliefs. This process facilitated a mutual identification of goals and the implementation of caring actions that would achieve these goals. The older women in this study became more knowledgeable and responsible about their health and were able to cope more successfully with their chronicity. Even though the research was not undertaken in an acute care setting, the model is still pertinent for nurses caring for older patients who are experiencing chronic health problems. The theory is recognised as assisting nurses in the development of a therapeutic relationship with patients, which is important because ‘relatedness’ promotes the ethical rights of the older person to participate in decisions about their care. In addition, it is a process that encourages the nurse to focus on how best to help the individual person cope with health and the stress of illness and crisis (Hagerty & Patusky, 2003; Meleis, 2004; Woods, 1994).

Research based on Rogers’s theory of The Science of Unitary Human Beings (1970) and Roy’s Adaptation Model (1970) has implications for nurses’ critical thinking and knowledge in relation to how they organise and manage the care needed by frail ill people in acute care settings (Gunther, 2006). Nurses in professional practice may need to consider the effect of hospitalisation on older patients because of the hazards of functional decline (Gill et al. 2004; Hart et al. 2002), negative outcomes and further readmission (Fink & Foreman, 2000; Street, 2004). In particular, older people who are admitted to hospital with sensory deficits, such as vision or hearing problems, which are compounded by a lack of sleep or rest in the often-noisy environment, are potentially at an increased risk of falls (Eliopoulos, 2001; McCarter-Bayer et al. 2005). Research based on the Rogerian Theory of Ageing highlights the need for nurses to consider how immobilisation and inactivity can impact on the health of older patients (Alligood & McGuire, 2000). This study indicated that inactive older people would tend to experience time as being slower, which would result in less satisfying sleep patterns. Hence, nurses need to understand that older adults may find time in the hospital
environment slow and sleep and rest difficult, which can make them more susceptible to adverse events because of fatigue and a lack of energy (Zalon, 2004).

The sensory deficits experienced by many older patients were also a consideration in the design of an intervention study using Roy’s theoretical framework (Tolson & McIntosh, 1996). This project examined contextual stimuli in the ward environment, which impacted on older patients who were hearing-impaired. The results were noteworthy. The programme inspired nurses’ reflective practice and appeared to help them identify problems and execute changes in how they implemented the quality of care needed to protect hearing-impaired patients. The model caused changes to be made on the ward and the development of new nursing care plans for older patients, which consisted of goal-setting, specified interventions and evaluations, as envisaged by Roy. The findings of this study are beneficial for nurses, showing how nurses can more readily recognise the complex and multifactorial nature of the contextual stimuli that affect hearing-impaired older patients in hospital wards. The knowledge and skills demonstrated by this theory can empower nurses, leading them to adjust hospital environments in order to reduce the effect of stimuli on older peoples’ hearing.

The findings from a correlational study conducted by Dunn (2005), based on Roy’s (1970) theory, are also useful in the care of acutely ill older adults. In addition to coping with sensory deprivation, such patients have to cope with the added burden of chronic pain. The results from Dunn’s study showed significant direct effects; that is, contextual stimuli must be taken into account by nurses when developing a plan of care for older adults who experience chronic pain. The research indicated that chronic pain is a multidimensional stressor that negatively affects individuals physically, psychologically and spiritually. Even moderate levels of pain can affect self-care abilities and can lead to increased symptoms of depression, a worse global health status and decreased satisfaction with life (Covinsky, Fortinsky, Palmer, Kresevic, & Landefeld, 1997). The findings of a study undertaken by Zhan (2000), also based on Roy’s (1970) Adaptation Theory, are useful for nurses caring for older people in hospital contexts. The study explored the association between cognitive adaptation processes and self-consistency in older people with hearing deficits. The results showed that the cognitive processes of clear focus and methods, knowing awareness and self-perception, had significantly added to the preservation of older people’s self-consistency. Research-based interventions, such as these research studies, are essential
Levine’s (1966) theory has also been successful in informing nursing knowledge and the structure of care, so that older people are protected during hospitalisation. The Theory of Conservation of Structural Integrity formed the theoretical framework for a descriptive study which investigated protocols used by nurses to prevent pressure ulcers in patients at high risk of skin breakdown (Hanson et al. 1991). The recommendations made in this study are useful for preventive care as they concern the use of nursing protocols for repositioning patients who are more prone to develop pressure ulcers. The protection of older patients from neglect in hospital was also a prime consideration in a study undertaken by Delunas (1990), who recommended the use of Neuman’s Systems Model. This model was first developed by Neuman in 1970 to promote a process of critical thinking in relation to application, analysis, synthesis and evaluation, and this then provides a clear format for multidimensional assessment, diagnosing, planning and implementing of actions (Geib, 2006). The holistic approach used in this theory incorporates a person’s physiological, psychological, socio-cultural, developmental and spiritual variables (Neuman, 1995). Neuman’s theory has been successfully applied to nursing practice and has supported nurses in their clinical assessment of the total needs (variables) of older patients and those who are also cognitively impaired (Chiverton & Flannery, 1995; Neuman, 1995; Peirce & Fulmer, 1995). The significance of Neuman’s theory for nurses managing the care of acutely ill older adults in hospital is that it promotes ethical and professional actions, which are mutually negotiated with the patient and are preventive in nature (Fraser, 1996; Freese, 2006).

Neuman’s theory was used as the framework for a study conducted by Schwarz (2000), which assessed the potential predictors of early readmission of older adults to hospital. The theory was seen to be beneficial because it emphasised that the primary goals of nursing were to reduce stressor impact and to increase client resistance. The findings from this caregiver study showed that approximately one-third of the older patients discharged from hospital were re-hospitalised within 3 months. These older people were not able to cope at the time of their discharge, and because they had no support they experienced further functional decline. According to Neuman’s (1995) theory, interpersonal stressors, such as a lack of social support, determine how one is
affected by chronic illness and, thus, how one adjusts to one’s environment. Consistent with Neuman’s conceptualisation of social support, Schwarz’s (2000, p. 7) study indicated an increase in tangible forms of social support for the older person’s family, such as “transportation, watching possessions, and integration or reaching out to help others, were significant predictors of a lower number of early hospital readmissions” of the older patients. The importance of this finding is that it reminds nurses involved in discharge planning that they should assess the needs of the older patients and their families for material support.

Aside from these more scientific or objective approaches to nursing knowledge, Watson’s (1985) Theory of Caring emphasises the humanistic approach to aspects of the caring role. Watson’s theory is based on a conceptual framework that directs nurses in their caring role; because of this philosophy, it is also a useful model for application by clinical nurses in their functional care of older patients (Neil & Marriner Tomey, 2006). Bernick (2004) notes that in providing care to older patients, even small changes can make a difference. Watson’s model offers nurses greater opportunities as ‘change agents’ to rethink how they might alter the impact of the environment on the older patient. The caring theory of Watson (1985) has also been used by Beauchamp (1993), to focus attention on the level of competency needed by nurses in developing a humanistic or helping–trust relationship with older patients. The theory highlighted themes significant to the caring role of nurses, which included dignity, love, security, presence, respect and sensitivity. Clayton (1989) used Watson’s theory to understand the caring behaviours used in interventions between nurses and older people and to determine the care needs of those older adults. Four recurring themes were identified as important in caring interventions: a higher sensitivity to patients’ feelings before and after the intervention; the helping–trusting relationship; a supportive environment that is protective and permissive; and an appreciation of the meaning of what is happening. The older people in this study were found to need protection and independence to share life events and to know how they were doing daily. In drawing on this theory, nurses can be more conscious of the complex and cumulative challenges that the older people face: challenges associated not only with individual ageing in relation to chronicity, but also with social and spiritual concerns.

Although not all research undertaken using Watson’s theory has been directly related to the care of older people in hospital, these findings are nevertheless useful as
they further the technical, as well as the ‘expressive understandings’ of any nurse caring for ill older patients. For example, some areas of practice addressed in studies that have used Watson’s theory concern the care of patients: following myocardial infarction (Cronin & Harrison, 1988); following hypertension (Erci et al. 2003); in the emergency department (Baldursdottir & Jonsdottir, 2002); with depression (Mullaney, 2000); and undergoing radiation or chemotherapy (Smith, Kemp, Hemphill, & Vojir, 2002).

The evidence obtained from theoretically based research highlights the importance of conceptual knowledge for nurses who must provide a quality of care for all adults, including those who are old (Wood & Alligood, 2006). According to Bernick (2004, p. 134) nursing practice then draws on both scientific and humanistic approaches to caring, which are directed at the “quality of life, the complexity of human experience and culturally-sensitive transpersonal care.” The author concludes that this level of theoretical understanding prepares the nurse to focus attention on what matters most in caring for older adults. For nurses, then, professional and competent care is not about choosing either a scientific or a humanistic focus to their practices, but rather about learning how to skilfully blend the two, so that older patients receive the standard of care which will address their holistic needs (Barnard & Sandelowski, 2001).

2.5.3 Technical work values and patient-centred care

Maintaining a balance between providing care that is based on the scientific and humanistic approaches may be difficult for nurses in hospital organisations. This is because of the greater importance placed on technological changes, which have altered patterns of work, changed skills and knowledge and increased standardisation of care for nurses (Bleich et al. 2003; Locsin, 2001; Sandelowski, 2000). The immense amount of literature on the professional role values highlights the importance for nurses to achieve a balance between both technology and competent functional caring behaviours, however this may be difficult in medically oriented hospital organisations (Barnard, 2006; Benner, 1984; Chan et al. 2004; Hardy, Garbett, Titchen, & Manley, 2002; Kapborg & Bertero, 2003; Leininger, 1984; Parse, 2004; Pepin, 1992; Weis & Shank, 2000). A study conducted by Mantzoukas and Jasper (2004) found that the dominant culture within health care settings attributed more validity to scientific or technical practice and ignored the functional caring or multifarious types of humanistic knowledge implemented by practising nurses. The authors concluded that the
privileging of technology at the expense of humanely based functional care is legitimated and reinforced by health professionals, who base their clinical decisions on scientific knowledge, which is then considered the norm. Furthermore, staff who do not accept this value system can be marginalised as abnormal and highlighted as needing supervision. The advancement of technology apparent in hospital settings, therefore, has significantly impacted on the functional caring practices of nurses, in relation to how they do things, how they organise their professional role and what they value most about this role (Barnard, 2006).

Nurses who undertake more valued or esteemed technical tasks may have a greater sense of power, recognition and acceptance by other allied health practitioners (Fitzgerald, Pearson, Walsh, Long, & Heinrich, 2003; Hagedorn, 2005; Jackson & Borbasi, 2006; Logan, Franzen, Pauling, & Butcher, 2004). Thus the nursing role becomes defined in the way some nurses perceive it, and this may then become a strong motivational force for nurses to adopt what they feel are more worthwhile or important work practices (Kilstoff & Rochester, 2001; Parker, 2006). The problem with nurses favouring a technological focus to their role is that functional care, which is extremely important for protecting frail older patients in hospital, can be marginalised. The results from a survey of nurses’ perception of their own competency working in hospital wards found that they considered they were least competent at ensuring patients received an appropriate standard of functional care. According to the researchers, this may have been due to the influence of technology within the organisation as well as ongoing restructuring and a lack of resources (Meretoja, Leino-Kilpi & Kaira, 2004). The embracement of technical work may be due in part to the perception that humanistically based functional care has lower esteem because it is seen by some nurses as physically hard, dirty and mundane work (Barnard, 2006). Hence, when nurses tend to favour a more technical orientation to their work it may take precedence over care that is necessary for maintaining an older person’s functional status (Barnard, 2006; Grimmer, Gill & Moss, 1999; Hagedorn, 2005; Williams & Botti, 2002) and can place ill and dependent patients in a vulnerable and powerless position (Nurses Registration Board [NRB], 1999).
2.5.4 Nursing attitudes and care of the older adult

Ageist attitudes that are widespread in the community are also evident in the nursing profession (Happell & Brooker, 2001; Minichiello, Somerville, McConaghy, McParlane, & Scott, 2005; Tabloski, 2006). When these attitudes are combined with practices that are not informed by theoretical and disciplinary knowledge, it can influence how nurses view their relationship with older people (Joy, Carter & Smith, 2000; Meiner & Lueckenotte, 2006; NBV, 2002; Victor, 2006) and can lead to actions which cross the boundaries of safe and effective professional practice (ANMC, 2005; NRB, 1999). Many nurses acknowledge that caring for older people is an undesirable aspect of their role, and this has created some concern in the profession (Fagerberg & Kihlgren, 2001; Letvak, 2002; Meiner & Lueckenotte, 2006; Nay, 2004). A study conducted in Victoria found that nursing students considered caring for older adults as the least popular area of practice (Happell & Brooker, 2001). Wells, Foreman, Gething, and Petralia (2004), in an Australian study, found that nurses had less accurate knowledge about caring for the older person than any other health professional. These nurses also expressed some anxiety about caring for patients who were old and were more likely to believe that working with older adults was associated with low esteem in the profession. An action research study conducted by Kelly, Tolson, Schofield, and Booth (2005) also found that nursing older people was perceived as having a lower status. Nurses with ageist attitudes, therefore, may allow their practices to be influenced by those work values that support technically oriented tasks which are preferred or recognised as more worthwhile, to the detriment of the person-centred or humanistic care needed by older patients.

2.5.5 Social influences on quality patient care

Dominant work values shared by staff on a ward can exert a strong influence on other nurses to conform (Hawkins & Kratsch, 2004; Kilstoff & Rochester, 2004; Kramer, 1974; Mantzoukas & Jasper, 2004). This intimidation to conform can be subtle and confronting for some nurses, resulting in psychological stress and fear. The literature refers to this workplace abuse in terms of ‘horizontal violence’ and ‘oppressed group behaviour’ (Freshwater, 2000; Peter, Lunardi, Lerch & Macfarlane, 2004; Rowe & Sherlock, 2005). Submissive or subordinate behaviour can be due to gender and medical domination (Brown & Seddon, 1996; Friere, 1971; Nazarko, 2004). Nurses who
demonstrate oppressed group behaviour often have a low self esteem and dislike of their own culture, feel powerless and desire to be like those who have more prestige and power (Roberts, 2000). In hospital organisations this means that those nurses who may be the leaders of an oppressed group, tend to adopt the attitudes and behaviours of the dominant group in order to be more accepted. In this way nurses are socialised into structures and dysfunctional relationships on the wards, which can result in abusive or oppressed behaviour towards other nurses (Crookes, & Knight, 2001; Taylor, 2001). Those nurses who are left behind may then repeat this abusive behaviour with other nurses which is referred to as ‘horizontal violence’. Rowe and Sherlock (2005) found that 80% of abuse received by nurses was from other staff nurses, which led to stress, work dissatisfaction and absenteeism.

Acceptance by the prevailing group may provide nurses with some degree of predictability in their work role (Hawkins & Kratsch, 2004; Kilstoff & Rochester, 2001). Chaboyer, Najman and Dunn (2001), in an Australian study, found that nurses shared common understandings, beliefs and actions, which they acquired through social learning and socialisation within their professional group and which, as such, were manifestations of the group’s culture. These findings imply that if certain work values are seen to be more socially desirable, important and worthwhile by a collective of nurses, then those practices will prevail and permeate through the ward culture (Hawkins & Kratsch, 2004; Stein-Parbury, 2005).

Nurses who are influenced by ‘sanctioned norms of behaviour’ on wards may feel personally uncomfortable because they are not providing what they feel is a professional standard of care, and in order to cope they may choose to withdraw or to blame themselves, others or the system (Hawkins & Kratsch, 2004; Sullivan, 2004; Walker, 2000). In a literature review of research on workplace stress in nursing, ‘blaming’ the hospital or nursing administration was found to occur when nurses felt they were not recognised or rewarded for a demanding workload, experienced conflict with colleagues or other nurses, and had poor group cohesion (McVicar, 2003). Thus, when nurses feel they cannot manage their workloads they may find it more comfortable to adopt the value system of the other staff, ward or the hospital organisation in preference to those humanistic values they understand to be professionally important, such as giving functional or basic care for dependent and older patients (Kilstoff & Rochester, 2001).
Taking action about inappropriate practices on the wards may not be in the interest of the more controlling aims of health care organisations, which are “highly politicised environments at the micro and the macro level” and are not “apolitical or neutral” sites (Huntington & Gilmour, 2006, p. 171). According to Hutchinson, Vickers, Jackson and Wilkes (2005) it is important to examine the administrative structures of organisations in order to understand how power operates within healthcare institutions. Furthermore, they note that workplace bullying must not be just quietly accepted as a dysfunctional behaviour of nurses, but must be seen to be what it actually is, abusive behaviour perpetrated within the structures of the organisation. Mantzoukas and Jasper (2004, p.11) highlighted that any form of resistance, activism or consciousness-raising about the accepted norms operating on a ward can be difficult, as anyone resisting can be labelled as ‘being outside’ the dominant group which can have “a socialising effect of bringing the deviant back in line.” Mantzoukas and Jasper suggest that if nurses want to provide quality patient care according to their professional values, they may have to exert some unity and control over their practices. However, the conclusion reached in this interpretative ethnographical study was that nurses’ efforts can be invalidated by other staff if they are seen as a threat to the current equilibrium of control and power existing on a ward.

Disciplinary cohesion and teamwork is vital for influencing change in workplace contexts, and this was the strategy used by nurses in an Australian study to assist them to resist the dominant anti-humanistic values of the ward culture (Chaboyer et al. 2001). However, enacting quality care without the support of others on the ward can be stressful for many nurses, as they attempt to grapple with the heavy demands of work environments that are ‘provider-focused’ as against ‘patient-focused’ (Jackson & Borbasi, 2006; Tutton & Seers, 2004; Williams et al. 2000). In provider-focused environments nurses experience stress because they cannot meet patients’ needs (Hall, 2004). Other studies have found that when they are able to provide ethically based patient-centred care according to their professional frameworks, nurses achieve more satisfaction in their professional relationship with patients (Biton & Tabak, 2003; Furaker, Hellstrom-Muhli & Walldal, 2004).

This section has outlined the responsibility and potential capability of professional nurses to provide the standard of quality care required by vulnerable older patients. Knowledgeable and skilled caring practices are guided by the professional
values introduced during nurses’ disciplinary preparation, which is based on both scientific and humanistic approaches to care. The literature has emphasised the importance of these caring values, supported by theoretical frameworks, in forming therapeutic ‘patient-centred’ relationships. Such a focus is particularly significant when one considers the impact of the hospital environment on older people, which include power and control over the older person’s access to knowledge, services or care within the institution. The dominant culture of hospital organisations promotes the importance of a technical orientation to care and ignores the functional caring role of professional nurses. The sanctioning of medical or technical work over nursing care is legitimated and reinforced within the organisation by health professionals who frame their treatment decisions on scientific knowledge, which then makes such attitudes the norm. Nurses who adopt this norm may feel they achieve more status, power and recognition, but they marginalise the humanistic care needed by vulnerable older patients. A stronger adherence to the importance of technical tasks, in conjunction with ageist attitudes, can influence the behaviour of all nurses on a ward in relation to which patients are cared for and how much care is provided.

2.6 Conclusion

The research question for this study concerns how nurses manage the care needs of acutely ill older adults in hospital. This issue is extremely important, when one considers the impact that the ageing of the population will have on the need for a high standard of health care services, including nursing care. Clinical nurses, therefore, have to consider not only the effects of disability and disease caused by individual ageing, but also the consequences that hospitalisation has on acutely ill older patients’ recovery and functional status. Older people in hospital require nurses who are knowledgeable and skilled so that they are not placed at a higher risk of adverse events – a risk that increases with age. However, years of cost-cutting in the public hospital system has resulted in reduced resources and funding for nursing staff, and this has impacted on the care received by older patients. The economic ethic that is pervasive throughout health care organisations in Australia means that the driving philosophy may be more towards efficiency of output rather than support for the caring values that are implicit in the professional role of nurses. It is important, therefore, to understand how this climate is
impacting on the professional responsibility of nurses to provide the level of safe and competent care required by acutely ill older patients in hospital.
CHAPTER 3

METHODOLOGY

3.1 Overview

The purpose of this chapter is to outline the methodological approach to the study. It begins by explaining the research question and aims, and then provides an explanation for why the qualitative paradigm of constructivist inquiry has been chosen. In addition, the chapter discusses the methods used for data generation, data analysis, ethical considerations and research rigour.

3.2 Research Question and Aims

The specific purpose of this study is to investigate how nurses manage the care of acutely ill older patients in hospital. Specific aims of this study include:

1. to identify nurses’ knowledge about what comprises competent care for their older patients;
2. to identify nurses’ shared understandings of what care they actually provide and how this care is implemented;
3. to evaluate the congruence between nurses’ knowledge about what care should be provided and the actual care they implement; and
4. to understand nurses’ constructions about the consistencies or inconsistencies between their knowledge and the consequences of their actions.

3.3 Research Design

The philosophical approach chosen for this study, its design and method has been guided by Guba and Lincoln’s (1994) constructivist paradigm of inquiry, which they described in an earlier work as ‘naturalistic inquiry’ (Lincoln & Guba, 1985). The constructivist approach is one of four paradigms – positivism, postpositivism, critical
theory and constructivism – that ‘inform and guide the inquiry process’ (Guba & Lincoln, 1994). Each of these paradigms has its own “system of beliefs or axioms, along with its accompanying methods”, which direct the research in “ontologically and epistemologically fundamental ways” (Guba & Lincoln, 1994, p. 105).

3.3.1 Constructivist inquiry

According to Lincoln and Guba (1985, pp. 37–38), there are several assumptions that underlie the implementation of naturalistic, constructivist inquiry, and these should be used to determine whether the paradigm is appropriate and ‘fits’ the focus of the proposed inquiry. The constructivist paradigm was seen to be appropriate for this project because of the following five axioms:

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<td>1.</td>
<td>It acknowledges that there will be an interaction between the researcher and the nurse participants during the inquiry process (epistemology).</td>
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<td>2.</td>
<td>It allows for an investigation to take place about the ‘nature of the nurses’ reality or constructions’ (ontology) about their practices with older adults, including the constructions of the researcher.</td>
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<td>3.</td>
<td>It recognises that the phenomenon under inquiry, ‘nursing care’, is context-dependent and this may affect generalisations that are made.</td>
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<td>4.</td>
<td>It understands that there is the possibility of causal linkages.</td>
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<td>5.</td>
<td>It admits that the inquiry is value-bound.</td>
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**Table 1 Five Axioms of the Constructivist Paradigm**

These five axioms inform the research in particular ways. For example, using this paradigm with regards to the epistemological position allowed the researcher to question participants’ understandings of how they see their world, or ‘Verstehen’ (the meaning of social phenomena) (Guba & Lincoln, 1994). This is what is termed ‘the emic point of view’, which is characterised by a concern to understand the meaning individuals attach to their life and how they define a particular situation. In order to make sense of these constructions, a process of interpreting and reconstructing what people know of their world and the actions they perform is also undertaken (Schwandt, 1994). Knowledge in this study, therefore, will be shaped through interaction between the researcher and the nurse participants, where the “knower and known are inseparable” (Lincoln & Guba, 1985, p. 37).
The second axiom concerns the nature of reality or ontology. In applying constructivism, there is an assumption about relativism which states that people have formed multiple and sometimes conflicting social realities that are the products of their intellects. Such realities may alter over time as individuals become more knowledgeable and sophisticated (Lincoln & Guba, 1985). The third axiom notes that these realities are developed from specific contexts and local experiences, and so they are not really able to be generalised but may nevertheless share some characteristics with other individuals and cultures who are able to appreciate this fact and take it into account (Lincoln & Guba, 1985). For example, people may use a common term to formally define some known entity, but often individuals can understand or construct the term in different ways. These entities or phenomena exist and are ‘tangible’, but the “meanings and wholeness derived from or attributed to these tangible entities” in order to make sense of them are what is known as “constructed realities” (Lincoln & Guba, 1985, p. 84). The absolute truth in these constructions cannot be proven unconditionally, but ontologically these realities should match each other as nearly as possible, in order for them to represent what would be most people’s understandings about a phenomenon for some worthwhile knowledge to be achieved (Guba & Lincoln, 1994). Hence, the truthfulness of multiple ‘knowledges’ is determined by a general consensus at the time or, at the very least, movement towards some agreement. Nevertheless, individuals must always remain open to continuous review of their knowledge in relation to other and different constructions.

In using this paradigm, human constructions that are accumulated are refined, modified and shaped through an interactional process that takes place between the researcher and participants in the study. According to the fourth axiom, the researcher imposes some type of ‘purposeful structure’ that emerges from the interaction and leads to a mutual shaping of meanings (Lincoln & Guba, 1985). Schwandt (1994, p. 129) contends that this process occurs through an exploration of the issues raised during the research process and ongoing “analysis, critique, reiteration and reanalysis”, until each reaches some shared understanding. The researcher then becomes both a participant and a facilitator in the inquiry, and all commonly held constructions are evaluated in relation to how they compare, and the extent to which they are credible and have relevance (Guba & Lincoln, 1989). In this way, the philosophical orientation or values of the researcher will specifically affect how the research study will be conducted. The
implication is that the particular meanings attached to this inquiry are shaped or reconstructed by the intent of the researcher, in order to make sense of the “complex world of human experiences from the perspectives of those who live it” (Schwandt, 1994, p. 118). This aspect brings us to the fifth axiom, in that this constructivist inquiry will be value-bound (Lincoln & Guba, 1985). According to Guba and Lincoln (1994, p. 114), this process is “ineluctable in shaping inquiry outcomes”, and any attempt to dismiss such values would not be acceptable. Their explanation for this is that the constructions held by individuals in the study are of equal importance to those of the researcher or any other audience and so deserve the same consideration.

Lincoln and Guba (1985, pp. 39–43) also emphasise that there are fourteen other characteristics that depend on the primary five axioms and that “once one is selected, the others more or less follow” (see Table 2). These characteristics inform the research procedures.

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Natural setting: to elect to carry out research in the natural setting or context of the entity for which the research is proposed.</td>
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<tr>
<td>2.</td>
<td>Human instrument: where both the researcher and the participant(s) are seen as the primary data gathering method or instruments.</td>
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<td>3.</td>
<td>Utilisation of tacit knowledge (intuitive, felt): as well as propositional knowledge.</td>
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<tr>
<td>4.</td>
<td>Qualitative methods: are elected over quantitative (although not wholly) as appropriate to dealing with multiple realities (interviews, observations, document analysis).</td>
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<tr>
<td>5.</td>
<td>Purposive sampling: because it increases the scope or range of data exposed – multiple realities, local or contextual conditions and participant shapings of their experiences.</td>
</tr>
<tr>
<td>6.</td>
<td>Inductive data analysis: in preference to deductive data analysis, as the process is more likely to highlight the multiple realities to be found in the data.</td>
</tr>
<tr>
<td>7.</td>
<td>Grounded theory: as the guiding substantive theory is more likely to emerge from the (grounded) data.</td>
</tr>
<tr>
<td>8.</td>
<td>Emergent design: to allow the research design to emerge or flow, cascade or unfold rather than to construct it preordinately, because it is unlikely that enough could be known ahead of time.</td>
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<tr>
<td>9.</td>
<td>Negotiated outcomes: to discuss meanings and interpretations with participants from which the data have mainly been collected, because it is their constructions of reality that the researcher is attempting to reconstruct.</td>
</tr>
<tr>
<td>10.</td>
<td>Case study reporting mode: because it is more suited or adapted to an account of the multiple realities of the participants at the site.</td>
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<tr>
<td>11.</td>
<td>Idiographic interpretation: to interpret data ideographically (in relation to the particulars of the case) rather than nomothetically (in relation to law-like generalisation), because different interpretations are likely to be meaningful for different realities.</td>
</tr>
<tr>
<td>12.</td>
<td>Tentative application: about some hesitancy in making broad application of the findings, because realities are multiple and different as they depend on the interactions which occur between the researcher and participants.</td>
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</table>
13. Focused determined boundaries: to set limitations for the inquiry on the basis of the emergent focus, as it allows the multiple realities (and not the inquirer's preconceptions) to determine the focus.

14. Special criteria for trustworthiness: because it is likely that conventional trustworthiness criteria (external and internal validity, reliability and objectivity) are inconsistent with the axioms and procedures of naturalistic inquiry.

**Table 2 Characteristics of the Constructivist Paradigm**

The concern of this study, therefore, is with the world of nurses, their relationships with their older patients and with other staff, and the meanings and understandings that enlighten them. The interpretations of knowledge accumulated about the perceptions and expectations of these nurses, from their emic or insider point of view, will allow a deep and intense understanding of how they perceive their practices – as will the values and beliefs of the researcher in shaping this inquiry process. The researcher and others in the constructivist paradigm are seen as the main data-gathering instruments. In this way, the ‘human instrument’ is able to understand and assess the meaning of any discrepancies evident during interactions. According to Lincoln and Guba (1985, p. 40), “all instruments are value-based and interact with local values but only the human is in a position to identify and take into account (to some extent) these resulting biases.” Another important implication of the constructivist paradigm is that the meanings nurses attach to their work will alter and change with time and in light of new experiences (Schwandt, 1994). The aim of this constructivist study, therefore, is to understand and reconstruct the meanings that nurses attach to the care they provide for their older patients within the public hospital context. In this process, the researcher will endeavour to remain open to changing interpretations whilst looking for some agreement and refinement during data analysis.

### 3.3.2 Structuration Theory

It became apparent following the preliminary analysis using the constructivist inquiry that further interpretation was needed in order to fully understand the constructions of the nurses in this study. Therefore, an interrogation of the data was undertaken using Giddens’s Structuration Theory (1984). Giddens began to develop his theory mainly because he saw that other theories “did not have an adequate explanation of action in social systems” (Callahan, 2004, p. 1429). Callahan (2004, p. 1429) asserts that these theories are from functionalist and structuralist perspectives and, as such, mainly
focused on “purposes, reasons and motives for an individual’s action and not [on] the equally important concepts of power, change and institutional analysis.” Giddens (1984) attempted to combine these perspectives and the interpretive approach to sociology by maintaining “meaningful action and social structure are a ‘duality’” – they are not separate (a dualism) or as totally one or the other but “as two sides of the same coin” (Porter, 1998, p. 160). Hence, the ‘duality of structure’ is a central tenet of Structuration Theory as confirmed by Giddens (1984, p. 25):

The constitution of agents and structures are not two independently given sets of phenomena, a dualism, but represent a duality. According to the notion of the duality of structure, the structural properties of social systems are both medium and outcome of the practices they recursively organize.

Giddens (1984) does not see structure as a form that only constrains action or even determines it, but that it is also enabling in the way it allows people to perform actions. Hence, the concern in Structuration Theory, which is also shared in this study, is not about whether “structure or action is more important but that the focus should be on social practices which socialize actors or individuals and symbolizes structure”, and which, for Giddens, emphasises the “creative and transformative aspects of action” (Craib, 1992. p. 34).

### 3.3.3 Structuration Theory and the social practices of nurses

There are, according to Porter (1998, p. 164), “few examples of the use of structuration theory in interrogating issues relating to nursing practice.” The reason for choosing Giddens’s theory for further interpretation in this study is that it offers a framework that not only allows an in-depth description of practice or action but also “re-orientates ‘the social’, returning it to its central, constituting position in furthering discussions about nursing practice” (Purkis, 1994, p. 317). According to Purkis (1994, p. 315), “within a practice-based discipline such as nursing, work is accomplished between social actors” and within a particular system. The problem Purkis (1994, pp. 315–6) finds is that when one reads the literature “to discover the ‘how’ of practice, it is common to find prescriptions for improved communication skills and alternative definitions of nursing concepts.” The point she makes is that only a limited amount of attention is directed towards understanding ‘how’ nursing practices are provided, and it is this that concerns her the most, as “this marginality arises . . . from an exclusion of ‘the ‘social’” (Purkis,
Giddens’s (1984) theory, therefore, provided a framework, following the initial analysis process, which assisted in a more systematic elucidation of the meanings nurses have about the way they manage their care of older patients within the environmental constraints of the current health care system.

3.4 The Method

Constructivist inquiry draws not only on the five axioms but also on specific characteristics that assisted in putting this study into operation. The first of these characteristics demands that a natural setting be used for data collection, because participants “take their meaning as much from their contexts as they do from themselves” (Lincoln & Guba, 1985, p. 189). This also supports the ontological position from the first axiom (constructed realities) and the third (generalisations), as ‘meaning’, which is obtained from observations, is dependent on the environment and time in which the study takes place. The study design also allowed the research site to be only ‘provisionally defined’, as it was possible that it could change over the period of data collection (Lincoln & Guba, 1985). However, in using the constructivist paradigm for this grounded study it was important to have some idea of where a useful sample of nurse–patient dyads would primarily be found, and it was also vital to consider that, as data was collected and analysed, a site might need to be extended to include a second site that would yield the type of information sought in the research.

3.5 Research Settings

The focus for this research inquiry – the meanings shared by the nurses about the way they managed the care required by older patients in hospital – assisted in establishing both the boundaries for the study and how the context should be defined (Lincoln & Guba, 1985).

3.5.1 Site A

The participants chosen from the first site were recruited from a 25-bed ward that admitted both male and female adult patients. The ward was situated in a 740-bed acute general teaching hospital located in the metropolitan area of Sydney. It was thought to be an appropriate site for the study because it admitted mainly older patients (over 65 years of age) for both medical and surgical care. Staffing was also an important
consideration, as the sample criteria (see section 3.6) required registered nurses with at least two years’ experience. The ward chosen as Site A fulfilled these conditions as it consisted of a nursing unit manager, thirteen registered nurses – nine of whom had over eight years’ clinical experience – one enrolled nurse, two patient service assistants and one clinical nurse educator.

The ratio of staff to patients varied over the morning, evening and night shifts. For example, on the morning shift the nursing staff consisted of a nursing unit manager, an educator and approximately five registered nurses for patient care. Alternatively, one registered nurse could be replaced with an enrolled nurse. In addition to this roster there were two patient care assistants (PCA), but on the weekends this would be decreased to only one PCA. Five registered nurses, or four registered nurses and an enrolled nurse, were rostered for the evening shift. On night duty the staffing numbers were reduced to three registered nurses, or two registered nurses and one enrolled nurse. The allocation of patients to nurses varied according to the dependency level of the patients on the ward and the experience of the nurses available for each shift.

3.5.2 Site B

As the study continued it became necessary to look for additional nurse–patient dyads in order to gain a greater appreciation of the constructions of nurses about their practices. Hence, a second hospital site – Site B – was chosen, mainly because it allowed access to a larger number of varied wards with an ageing demography. The interest and ready agreement of nursing unit managers to allow the research to be undertaken on their wards were also factors. Site B was a 217-bed district public hospital which offered services to older patients. It allowed research access to four wards for data collection: a 31-bed medical ward, which included oncology/cardiac unit with eight telemetry-monitored beds; a 28-bed general surgical ward, including urology, vascular, gynaecology, ophthalmology, plastic surgery, ear, nose and throat, and other specialities; a 20-bed orthopaedic ward for both elective and emergency patients, including hip and joint replacements; and a 23-bed medical ward and aged care rehabilitation unit. There were enough registered nurses on these wards to satisfy the recruitment criteria. The composition of staff on the wards generally was as follows: a nursing unit manager, and eight to eleven registered nurses, most of whom had seven or more years’ experience, two or three enrolled nurses and a trainee enrolled nurse.
The ratio of nursing staff to patients varied, depending on the beds that were open at the time, but generally the medical and orthopaedic wards had a higher number of registered nursing staff when compared to the surgical and rehabilitation wards. If there was a registered nurse shortage, beds were closed on any day and on any of the wards. The ratio of staff on these wards generally consisted of the following: on the morning shift there was a nursing unit manager, five or six registered nurses and an enrolled nurse or a PCA; on the evening shift there were three or four registered nurses and an enrolled nurse; and on the night shift there were one or two registered nurses and an enrolled nurse. In these wards the allocation of nurses to patients relied on the expertise of the nurses and the acute illness of the patients.

3.6 Participants

To be eligible for inclusion in the study the registered nurse participants from both sites needed to have been working within the public hospital system for at least two years. They must also have been experienced with caring for older patients (65 years and over) and have worked in a range of specialities, including general medical or surgical wards. The reason for selecting clinicians with this degree of experience is that, according to the seminal work of Benner (1984), nurses who have been working for at least two years can be expected to practice at a more proficient level and should be able to plan care in terms of long-range goals and problem-solve using deliberate, conscious, abstract and analytical skills. At this level, nurses should be able to provide structured and organised care with regards to the thought processes they use in reaching clinical decisions about patient assessment and planning and the rationales on which these decisions are based. These nurses should be experienced enough as practitioners to not feel unduly distressed or anxious about having their work observed. It was also perceived that a sample of experienced nurses would offer a broad range of data about the way nurses cared for older patients in an acute care setting (Erlandson, Harris, Skipper, & Allen, 1993). For the patient participants at both Sites A and B to be eligible for inclusion in the study, they had to be 65 years of age or older and allocated to one of the nurse participants for care during the shift.

At the beginning of the study it was important to locate experienced registered nurses who not only met the preceding criteria but also who would be specifically caring for older patients aged 65 years or more. The main focus of the study was on the
way the nurses provided care and not on the patients themselves, and so for this study the older patients were seen to be bystanders in the inquiry approach. Nurses who had been practicing less than two years were excluded from the study.

3.6.1 Participant recruitment at Site A

A range of approximately fifteen to twenty participants is generally agreed to be sufficient for descriptive field research concerned with understanding the phenomenon under study (Baillie, 1996; Polit & Hungler, 1997; Chenitz & Swanson, 1986) and to recognise repetitive themes (Chenitz & Swanson, 1986). The number of participants is not an important aspect of the constructivist paradigm, which emphasises participant realities that are developed from specific contexts and local experiences (Lincoln & Guba, 1985). Additionally, the design of this inquiry was an important aspect in the ongoing selection of nurse participants, as it allowed for any gaps in the constructions nurses attached to their care to be filled, since data was collected across the two sites. For instance, the first site included thirteen registered nurses from one ward who were caring for older patients. Recruitment was to be finalised when the researcher believed that redundancy had been achieved in the type of information being collected (Lincoln & Guba, 1985). The rationale for this is that it is unlikely “that enough could be known ahead of time about the many multiple realities” of the nurses and the care they provided for older patients to predetermine what information would be required (Lincoln & Guba, 1985, p. 41). Background information about these nurses was not seen to be necessary as the study aim was to understand the meanings they attached to their work caring for older patients, not to measure variables. Nevertheless, some information about the participants’ experience in general nursing was believed to be useful in understanding how they constructed their world. Of the thirteen female nurse participants at Site A, seven were qualified with a Bachelor of Nursing degree and six had completed a hospital training program. Of the six who were hospital trained nurses, one was a Clinical Nurse Consultant and the other was a Clinical Nurse Specialist. Both nurse participants had completed a postgraduate qualification in clinical nursing. Only four hospital trained nurses had not undertaken further professional study. Background information revealed that seven nurses had worked in medical or surgical nursing from 2.5 to 7 years, and six nurses had worked from 15 to 25 years. The background of the older participants at Site A showed that there were seven female and
six male patients. The ages of these older participants varied but most were in the ‘middle to frail old’ age groups. For example, there were two female patients in the ‘young old’ age group (65 to 74 years); one female and five male patients in the ‘middle old’ age group (75 to 84 years); and three female and two male patients in the ‘frail old’ age group (85 years and over).

Recruitment at Site A began by contacting the hospital’s nursing administration. It was important to follow this procedure so that an appropriate ward-site would be suggested with a variety of nurse participants. Site A was chosen because of its size, as it was seen to provide a sample of nurses caring for older patients, and a further consideration was its close proximity to the researcher’s place of work. This was seen to be essential because on some occasions following contact with the wards it was desirable to be able to quickly attend the site if appropriate nurse–patient dyads were available. Preliminary permission for the study to proceed was obtained from the hospital’s Nurse Manager in Education, who then asked the researcher to contact the Division Nurse Manager responsible for several specialty areas. Following a meeting with this administrator, it was suggested that not all wards would be appropriate at the time data was to be collected, and so it was advised that one specific ward would be suitable. The Nursing Unit Manager (NUM) of this ward was then approached for permission to conduct the research study and a meeting was scheduled, during which the researcher would inform the staff about the study. At this meeting, the nurses who met the sampling criteria were invited to participate in the inquiry process and were provided with an information letter (see Appendix C).

Initially, this process did not yield a timely response from the nurses on the ward, and contact was again made with the NUM, who suggested that this might have occurred because of staff shortages on the ward (and throughout the hospital), which may have meant heavier workloads for the remaining staff. She suggested that staff should be approached again to discuss the study, and if they were agreeable at this second meeting they could be asked to sign a written consent form (see Appendix D). If repeated contact was required with any nurse, then verbal consent would be requested on each occasion. According to Polit and Hungler (1997, p. 134), this process allows “participants to play a collaborative role in the decision-making process regarding their ongoing participation”, which is a “transactional process referred to as process consent.” All nurses were informed that they could withdraw from the study at any time.
without repercussions. This approach was successful and so the study was eventually able to commence at Site A.

3.6.1.1 Patient selection at Sites A & B

Although older patients were not deemed to be the primary focus of this study, they were integral to understanding the meanings that nurses attached to their care. Patients were selected if they were being cared for by a nurse participant and if they fulfilled the selection criteria. Prior to the observation, the participating nurse was asked by the nurse researcher if she was caring for an older patient over 65 years of age. The nurse was then asked to obtain verbal permission from the older patient. Once given, the researcher then approached the patient and, if necessary, answered any questions. On agreement to participate in the study, the older patient was then asked to sign a written consent form (see Appendix F). No patient was initially approached directly by the researcher and nurses were asked not to approach older patients who may at that time be feeling distressed by their illness, have symptoms such as pain or nausea which were inadequately controlled.

3.6.2 Participant recruitment at Site B

A further fourteen registered nurses were recruited at Site B, so that the realities shared by nurses at Site A could be compared to those of Site B. Nurses at Site B were selected from diverse speciality areas within the acute care wards, where it could be expected that there would be ample opportunity to further understand the phenomenon of the study. Of the fourteen participants, thirteen were female nurses and one was a male nurse. Seven participants had been trained as nurses in a hospital program. Of these seven nurses: two had not completed any other qualification; one had completed a conversion course for the Bachelor of Nursing degree; one had completed a palliative care course; three had completed postgraduate certificates in gerontology and rehabilitation, bioethics and palliative care. Seven participants had a Bachelor of Nursing qualification and one of whom had completed a Masters Degree in Health Education and Promotion. One nurse had been a hostel supervisor for four years in an aged care residential complex and one nurse was currently a Clinical Nurse Consultant (CNC), who had worked in rehabilitation and aged care areas for twenty years. The professional clinical experience of these 14 nurses was mainly in general medical and
surgical wards. Six of these nurses had 2.5 to 7 years’ experience and eight nurses had 10 to 25 years’ experience. The background of the older patient participants at Site B showed that there was only one male patient in the ‘young old’ age group; five male and seven female patients in the ‘frail older’ age group.

Permission for the research to be conducted at Site B was initially sought from the Director of Nursing. Following this, a proposal was then lodged with the Hospital Ethics Committee, for approval of the research. The outcome of this process was that each of the NUMs on all four wards (orthopaedic, rehabilitation, medical and surgical) were approached for written agreement that the study be conducted. Following this process, the researcher attended staff meetings on all the wards in order to inform staff about the study. Staff were provided with an information letter (see Appendix C) and, if they agreed to participate in the study, they were asked to sign a consent form (see Appendix D).

3.7 Data Collection

In order to collect information about multiple realities, a constructivist inquiry recommends using varied sources of data collection. These include observations, interviews and documents (Erlandson et al. 1993). Data collection at both sites occurred during 1999 and 2001. At Site A, only observational data was collected. The rationale for this decision was: firstly, to allow the researcher to enter the field and acquire experience in collecting rich observational data; and secondly, to develop a deeper understanding of the contextual situation and the meanings of the nurses about their professional practices. Data collection at Site B incorporated observations, interviews and documentation. Before conducting the observations, it was necessary to decide what level of participation would be desirable and/or possible. According to Erlandson et al. (1993), when planning for data collection a decision has to be made about the degree of observation – for example, whether full participation or overt observation will be used. It was decided to undertake only an observational role; only on occasions when the nurse requested assistance would some participation take place.

3.7.1 Observation schedule for Sites A and B

A general or partially structured format was used to give some direction to the way observational data was to be collected. The reason for using a general format to guide
observations is that, according to Burns and Grove (1995), there is some difficulty with subjectivity when spontaneous unstructured observations are used. The schedule used, therefore, provided a reasonable framework, firstly for observing the ward context and staff, and secondly for observing the nurse–patient dyad. Initially, using observations of the ward and staff was seen to be important for furthering understanding about how the ward organisation might assist or prevent the work of the nurses in caring for their older patients. The observation sessions of the nurse-patient dyads at Sites A and B were conducted over a two to three hour session with one to two hours spent at the nurses’ desk observing the ward context and staff. The information obtained assisted in understanding the third aim of the study, which concerned the congruency between nurses’ knowledge about what care they should provide and the actual care they implemented.

Information was collected about the proximity of the nurses’ desk to the patients’ rooms and other treatment areas in the ward. This was deemed to be useful in making interpretations about the way care was being provided for older patients. Included in this part of the format was the level of nurses’ experience, their roles on the ward and how they were allocated patients. The second section of the observation guideline assisted the researcher in collecting specific data about the nurse–patient interactions. The information in this guideline also concerned the layout of the patient’s room, the technical equipment being used and where the patient was positioned. Other questions raised are set out in Table 3.

<table>
<thead>
<tr>
<th>Question</th>
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<tr>
<td>Who initiates the contact?</td>
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<td>What information or explanation is provided to the patient by the nurse?</td>
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<tr>
<td>How are the patient’s questions answered?</td>
</tr>
<tr>
<td>To what extent are the patients involved in the nurse-patient interaction?</td>
</tr>
<tr>
<td>What is the duration of the interaction or intervention?</td>
</tr>
<tr>
<td>What justifications or explanations are provided prior to or during specific interventions or procedures?</td>
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<tr>
<td>If the patient shows signs of anxiety or discomfort or uncertainty or distress – then how does the nurse respond?</td>
</tr>
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</table>

Table 3 Observation Guideline for Sites A and B
3.7.2 Observation procedure for Sites A and B

During observations it was important to remain in an appropriate area of the ward, near the patient’s bed so that “theoretically relevant observations could be gathered” (Denzin, 1989, p. 73). On the occasions that the nurse participant required assistance, the researcher was readily available. An observation consisted of a critical incident that occurred between the nurse and the patient. The observation was recorded \textit{in toto} – that is, everything that occurred between the nurse and the patient was noted for analysis (Denzin, 1989). Initially, data was collected about the ward setting (including where the patient’s room was placed), the staff who were working that shift, their experience level and the number of patients they were allocated. As well, a full description was made of the patient, the medical or technical equipment being used and where the patient was positioned in the room. During the nurse–patient interaction the researcher observed if it was the patient or nurse who initiated the encounter, what the patient said, how the nurse responded to questions posed by the patient or to the patient’s condition, assessments made or actions taken.

Notes were also made about any nonverbal information, such as environmental influences on the care being provided by the nurses. These environmental effects included noise levels, location of patients, visitors, other staff and ward activity, and resources (Erlandson et al. 1993). A record, or reflexive journal, was also kept for analysis of both verbal and nonverbal information, as were personal comments or insights regarding impressions of the observations and interviews. In this way, the record provided some support for the trustworthiness of the study, as it was a part of the audit trail (Erlandson et al. 1993). The number and variety of observational incidents that occurred during the prolonged time for data collection over the two sites was intended to assist in highlighting a wide range of nurse–patient interactions. Consequently, this data was deemed to be vital in order to see some depth in the “here and now experiences of the nurses in their natural setting” (Lincoln & Guba, 1985, p. 273). The rationale for this process was that an extended engagement in the research site observing nurses interacting with older patients was essential in learning about the ‘culture’ of nursing, and it also allowed the researcher to check on misinformation and build up some trust and rapport with the nurse participants (Lincoln & Guba, 1985). Persistence and prolonged engagement in the field are two techniques which establish trustworthiness (Erlandson et al. 1993).
3.7.3 Interview schedule for Site B

The following section will describe the procedures used for data collection at Site B. These included not only observation, but also interviewing and documentation. Although multiple sources were used it is also important to note that in the naturalistic-constructivist paradigm the researcher is the primary instrument in data collection (Erlandson et al. 1993). The researcher is able to evaluate the meaning of the interaction with the participants and can take into account local values and perceptions about what is happening. Since the purpose of this study was to identify factors that influenced the way nurses managed their care of older adults in hospital, interviews about the way meaning was attached to these interactions provided first-hand information from the practitioners themselves. In naturalistic research, interviews replicate a purposeful conversation that allows opportunity for some ‘back and forth’ discussion (Erlandson et al. 1993). In this way, the interview process was a vehicle to gain valuable insights into how nurses perceived, described and explained their care within the hospital environment (Kaufman, 1994).

A semi-structured interview format was implemented that consisted of several questions or issues that were developed around the way nurses care for older patients (see Table 4).

<table>
<thead>
<tr>
<th>General prompting questions:</th>
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<tr>
<td>Think about a significant experience you may have had when caring for an older patient.</td>
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</table>

<table>
<thead>
<tr>
<th>Follow-up questions will depend on the responses received and are likely to include some or all of the following aspects of nursing management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did this particular interaction with the patient come about?</td>
</tr>
<tr>
<td>What information did you use to help you during this interaction?</td>
</tr>
<tr>
<td>Tell me about how you managed your care or interventions for this patient for example:</td>
</tr>
<tr>
<td>What assessments did you make?</td>
</tr>
<tr>
<td>What conclusions did you draw from your assessment?</td>
</tr>
<tr>
<td>What decisions did you make?</td>
</tr>
<tr>
<td>What was significant in this situation?</td>
</tr>
</tbody>
</table>

| How might your past experiences have influenced this interaction? |
| Are there any other factors, events or activities that influence the way you interact with your older patients? |

Table 4 Interview Schedule
These questions were useful because they were able to provide some organisation early in the interview sessions (Swanson, 1986a), and their partially structured open-ended format did not force a rigid adherence to a set category of questions (Erlandson et al. 1993). As the interview process was unique for each nurse, there was greater opportunity to adjust the wording of questions and the order in which they were asked, and to probe and clarify as necessary (Kaufman, 1994).

Focus remained on the essential areas but some ideas, meaning and questions could be explored at greater length (Burns & Grove, 1995). The partially structured interview questions were composed from a review of the literature and were concerned with aspects of nurses’ professional knowledge about their role in caring for older patients, their assessment and planning of care and contextual events that may have influenced their practices on the ward setting.

### 3.7.4 Interviewing procedure

Semi-structured interviews were conducted with each of the fourteen nurse participants, in a quiet area of the ward, at a time that was convenient for the nurse, and generally closely followed the observation sessions. Interviewing the nurse on the ward provided less disruption to his or her work. It was also important to involve the nurse in setting the time when the interview could take place. Although this was beneficial and was generally satisfactory, it did create some problems for an interview session conducted on one ward, as staff often interrupted the interview for one reason or another. For example, staff would enter the office to use the telephone or to check documents stored there. It was also important in this study that all interviews were undertaken soon after the observation session with the nurse so that it was possible to confirm, clarify or obtain further elaboration about any issues that may have arisen from the clinical observations. An empathetic approach by the researcher was important in these interviews in order to understand the way the nurses perceived their work (Bondi, 2003).

Although nurse participants had been informed about the interview and its general format when they initially gave their consent, the researcher nevertheless restated, at the commencement of the interview, what the interview would cover and the purpose for which the data would be used (Lincoln & Guba, 1985). Following this introduction, the interview session began with a broad statement which asked the nurse
to ‘think about a significant experience they may have had when caring for an older patient’. Several issues highlighted in the literature also guided the interview and were used mainly if the informants had not covered the highlighted areas during the discussion. As the interview progressed the researcher enquired more specifically about the type of information the nurses were sharing. The fourteen nurses at Site B were interviewed once following the two to three hour observation session and the length of time for each interview was approximately an hour. These fourteen interview sessions were tape-recorded and transcribed by the researcher as soon as possible afterwards, so that any interpretations that may have been missed or nonverbal observations noted during the interview could be attended to whilst the sessions were recent (Lincoln & Guba, 1985).

3.7.5 Procedure for reviewing the patient’s records

In addition to collecting data by observations and interviews, a review of nurses’ reports of their actions was also undertaken at Site B if it was deemed necessary. Lincoln and Guba (1985, p. 277) note that such documents, prepared by an organisation, were useful for “attesting to an event” and are “a rich source of information, contextually relevant and grounded in the contexts they represent.” They are ‘rich’ sources because they are written in the language that nurses use in their workplace and are ‘legally unassailable’, as they must show accountability for the health professionals using them. These records were also useful because they confirmed the frequency and quality of actions undertaken and the progress of each older patient after an incident. Hence, this information contributed to a measurement of the consistency of the data collected.

3.8 Ethical Considerations

Before the study could commence, ethics approval was obtained from the two hospital ethics committees and the university ethics committee. In conducting constructivist research there is a need for researchers to be cognisant of ethical considerations or standards because they form the essence of what one is about in the research and so can only augment it (Erlandson et al. 1993). There were several standards of practice that were included in this research proposal, and these were highlighted in the consent forms for both the nurse participants and their patients (see Appendixes D and F). Nurse participants were reassured that no foreseeable psychological harm or loss of dignity
would come to them if they participated in the study. In addition, it was important to inform them they would not benefit personally if they agreed to be part of the study. Nurses were also told that they could postpone an interview or observation session or withdraw from the study at any time without providing an explanation and that this decision would not affect their employment in any way. Finally, nurses were made aware the interviews and observations would only take place at a time which was convenient for them. It was important that the nurses did fully understand that all interviews would be tape-recorded but they would have an opportunity to review, amend or edit the transcripts if they wished.

A second ethical concern was the privacy and confidentiality of all the participants. Nurses were reassured that their names and references to their wards or hospitals would be removed from all documents and that a code would be allocated following data collection. They were also informed that all information would be treated in confidence, and if used in publication their anonymity would be maintained. The consent forms also noted that data would be kept in a locked cabinet and, following completion of the study, the tape-recordings would be erased. It was important ethically that there would be no unjustifiable deception of participants. To avoid this occurring, the purpose of the research was shared with all participants and even with the staff with whom they worked. All nurse participants as well as their patients were given an information letter about the study (see Appendixes C and E). A final ethical requirement was that all participants should give informed consent before the study commenced; they were required to sign the consent form prior to participating in the study.

As a nurse and a researcher I was aware that at times I could be placed in a conflicting situation regarding my professional role as a nurse and my concerns about the care of older patients. During the course of this study I did observe some nursing practices, which were bordering on being unsafe. On these occasions it was difficult to resolve how to solve my ethical dilemma - whether to remain quiet and continue to observe or to intervene. If the patient’s comfort or safety was compromised I chose to speak to the nurses, which occurred during three observation sessions. The nurses were approached when some time had passed and they had not answered the older patient’s calls for assistance, such as if the person was in pain, or was hungry or thirsty or if there was a need to offer assistance with toileting. There were other times during the observations when I chose to remain silent in order to determine the type of clinical
decisions made by the nurses in relation to the type of care, how much or when it would be actioned.

3.9 Trustworthiness

In this constructivist inquiry, it was important to ensure trustworthiness and rigour throughout the study, particularly for those who may wish to use the information with some confidence. In order to be assured of this level of confidence, Lincoln and Guba’s (1985) four criteria – credibility, transferability, dependability and confirmability – have been met.

3.9.1 Credibility

Naturalistic inquiry recommends several techniques that increase confidence in the credibility of the findings from the study. These techniques include: prolonged engagement, persistent observation and triangulation; and use of peers to check on the inquiry process. Prolonged engagement in the field was achieved in this study by data collection that continued for over two years, in the five wards across Sites A and B. The extended length of time allowed for any distortions in the data (from the researcher’s presence or the participants’ misconstruction of questions) to be taken into account (Lincoln & Guba, 1985). As well, this length of time in the field was important in order to learn about the specific culture of the wards and to build trust and rapport with the nurse participants. In addition to the time spent on the wards, persistence in the number of observations undertaken also provided some depth and focus for the data. Triangulation was also used, to support credibility by a comparison between the three separate methods of data collection: observation, interviewing and reviewing of responses.

Another technique for credibility was conducted – the use of a debriefing session with peers who were external or outside the study focus – to check on the inquiry process. Discussions about the data analysis were held on several occasions with a group of experienced researchers and doctoral students who met weekly in a nursing professorial unit. At these meetings, the content of the transcripts, preliminary coding, ideas and meanings were shared with the team of peers for feedback while data collection and analysis were ongoing. These experienced peers probed the data analysis by asking searching questions about the meanings and interpretations that were being
made. Another aspect of peer debriefing was that, early in the data collection and analysis, there was some doubt about the way the inquiry process was proceeding. The team of researchers was able to listen empathetically and, in doing so, provided a great deal of support and encouragement about the quality of the data. They also emphasised that persistence in the data collection and ongoing analysis was worthwhile.

3.9.2 Transferability

Transferability is an aspect of trustworthiness, which is concerned with providing a database that can make ‘transferability judgments’ possible for those wishing to use the findings. In this study, thick description of the two hospital settings and the five ward areas, along with the time the data was collected, has been presented to assist in this endeavour. It is an important process, so that those who are interested in transferring the findings to some other context can make appropriate conclusions.

3.9.3 Dependability and confirmability

Dependability is concerned with the authenticity of the recorded data, and this was achieved in this study by the use of an inquiry audit. A nursing colleague experienced in research work was invited to perform this audit by reviewing the raw data (interview guides, observation notes and patients’ records) and peer debriefing notes in order to verify their accuracy. Confirmability allowed an audit to be made of the trustworthiness of the study by an examination of the inquiry context. The tables used for coding and the themes that were allocated to categories and the analysis reports from the software program, which showed the themes linked to the statements or observational incidents, were all assessed in relation to the context of the research. These two techniques verified that the data collected in the five hospital wards, along with the research processes used, conformed to the intent of the study. As well, this colleague examined notes from a reflexive journal that was used like a diary or notebook, where ideas and information concerning the way the study was unfolding and information about the hospital environment were recorded. Contextual information was used as part of the description of the ward settings and was a part of the audit trail, because it allowed for others to evaluate the ideas or insights and decisions recorded about the methodology, and so it also served as a check on the dependability and confirmability of the study (Erlandson et al. 1993).
3.10 Data Analysis and Constructivist Inquiry

Data analysis in this naturalistic, constructivist study has been progressive, having been undertaken during the data collection process across both hospital sites (Erlandson et al. 1993; Lincoln & Guba, 1985). Part of this preliminary analysis process concerned ‘what is happening in the data’. This can be facilitated by using several techniques of ‘peer debriefing’ (Erlandson et al. 1993; Lincoln & Guba, 1985). In this study, a discussion was undertaken with a senior nurse academic who had an understanding of the methodology but whose research background was in a different specialty area. As well, ongoing discussions continued with other research students and their supervisors about the processes used in data collection and analysis. The typed transcripts and preliminary coding were shared for feedback as data collection and analysis progressed. A meeting was also held with one senior researcher to examine the analysis process in more detail.

3.10.1 Data analysis of the observations

Data analysis consisted of a preliminary review of the observations about the nurse–patient interactions. Several different strategies were used during this process of early analysis. At first the observational transcripts were read and reread for the particular incident, issue, idea or problem that was being managed by the nurse participant during the interaction with the patient. These incidents became “units of information” that were used later on in the analysis process to decide on the thematic categories (Lincoln & Guba, 1985, p. 344). The research focus at this point in the analysis was directed towards the nurse–patient interaction, and as each line and paragraph was read the occurring issue or idea was underlined and coded with a conceptual action label or theme. The theme name was placed in a column to the right of the transcription. In a second column next to the theme a category was allocated, and subsequent to this process a theoretical note was made in a third column. The note consisted of ‘questions and thoughts’ and descriptions of what were happening during the analysis (Corbin, 1986). At this stage in the analysis process a memo was written about what themes were recurring in the analysis and what the meaning of these themes and their categories was.

From this examination of the themes and their categories, a ‘conceptual frame’ began to evolve, which concerned the way nurses related or connected to older patients. “Connection” was demonstrated in this design by nurses’ behaviour – firstly by the care or actions implemented, and secondly in how they interacted or related affectively with
their older patients (Erlandson et al. 1993, p. 112). During data collection, other procedures were also used in order to attempt to understand the meaning of observations. These processes were important because they assisted in making sense of the multiple realities of the nurses in providing care for their patients and so assisted in further data collection. For instance, during the analysis of the early observational data, a table was created that highlighted a problem or issue in the transcript, and in the adjacent columns the nurse’s actions and decisions were noted. In the final column the perceptions or impressions of the researcher were recorded.

As the analysis progressed, another method was employed that allowed for an in-depth and detailed examination of the nursing process used (see Table 5). In this technique, each full transcript of the incident was placed in the first row of a table, and an interpretation was made of the incident in following rows in relation to the conceptual frameworks used by the profession, which guide the understanding of nurses in how they provide care for acutely ill older patients (Alligood, 2006a; ANMC, 2005). The in-depth examination of the data was an important part of the analysis procedure because it allowed the researcher to ‘become intimately involved’ in what was occurring in the data (Denzin & Lincoln, 1998).

<table>
<thead>
<tr>
<th>Extract (O7:O:H2)</th>
<th>The student nurse is feeding the older dependent female patient. The registered nurse bent down to the patient at eye level. She speaks to the patient (in a soft, gentle tone), and informs the patient in a questioning tone that she ‘has her medication’? Further into the interaction the nurse says to the older woman, Your beautiful daughters want to take you home.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring about the therapeutic relationship with the patient (spiritual needs)</td>
<td>The nurse is engaging with the patient by bending down to the patient’s level, eye contact and her tone of voice. Shows an interest in the patient. At this level the patient can see the nurse and can respond. The nurse is inviting the patient to participate in the decision. She is gaining consent.</td>
</tr>
<tr>
<td>Caring about psycho-social needs</td>
<td>Assessing the level of response &amp; understanding of this patient through the greeting, eye contact and questioning. She is seeking mutual negotiation of care by including the patient in the treatment and offering an explanation.</td>
</tr>
<tr>
<td>Caring about physical / developmental needs</td>
<td>The nurse understands that the patient needs assistance. The patient is immobile and is not eating or drinking adequately and needs prompting with food and fluids.</td>
</tr>
<tr>
<td>Managing the patient</td>
<td>The nurse is managing a patient-focused situation.</td>
</tr>
<tr>
<td>Demonstrating standards in practice (conceptual frameworks)</td>
<td>The nurse is modelling for the student nurse who is feeding the patient. The nurse is meeting two of her professional standards: professional and ethical practice analysis and critical thinking.</td>
</tr>
</tbody>
</table>

Table 5 Analysis of Nurse–Patient Interactions from Site A
3.10.2 Data analysis of the interviews

Following transcription, interviews were analysed using a similar approach to what had been undertaken for the observational data (see Table 6). Interview transcripts were reviewed for issues or incidents, which were then underlined. In the next row of the table a theme was indicated. Following this process the theme(s) were allocated to a category. Theoretical notes were then recorded, which explored the researcher’s and the nurse’s constructions of the meaning behind the incident.

| **Extract of an interview for issues** | Well, again, their posture, whether they look at you or not, whether they turn their head, whether they respond at all. It’s like I asked a lady, “How are you this morning?” and she said, “I’m just really dragged down,” or something. Everybody has a day like that. “Here, let me help you with your pills and then I will come back later and see if you want anything to eat.” |
| **Theme** | Observing the patient.  
Assessing the patient.  
Understanding the patient’s affective needs (spiritual & psychological needs).  
Offering to assist the patient with instrumental care (connecting). |
| **Category** | Connecting to the patient.  
Knowing the person. |
| **Theoretical note** | This nurse was observing her patient and was using knowledge about the emotional needs of the patient, non-verbal and verbal, empathy, and some understanding about the external stressors in the ward context that might be impacting on the patient. This assessment of the patient is providing information for the nurse to make a clinical judgement about the patient’s psychological/spiritual needs. |

Table 6  Analysis of Interview Data

Following this examination of the transcripts, further analysis was also undertaken in relation to the researcher’s questioning and responses from the participant nurses (see Table 7). In this table, the researcher’s questions were placed in the first row of the table. The response from the nurse participant was placed in the next row. Action coding was used, as was a line number linking it to a particular part of the transcript. These action codes were useful in that they assisted in recognising interrelated processes that were occurring in the data. The last row provided an interpretation of the theme. Each thematic code had a corresponding memo attached, which helped to explore the themes and maintained some focus during the coding process (Charmaz, 2000).
Researcher | You mentioned you would talk to the older patients. . . why is that?
---|---
Participant (I5) | I think even I . . . you’ve got someone, even a [patient who has had a] CVA [Cerebrovascular Accident patient] who has lost a lot of their speech, they can still understand, so I find it important just to talk to them as you are doing things with them.

Talk to them and tell them what you are doing and isn’t it a nice day, and just have a conversation. . . they’ll be brighter and they might laugh.

Theme / Code | Talking to them.
Line | 109

Interpretation | The nurse talked to the older patients because she believed it was important not to ignore them because they felt better when they were respected. The use of CVA to refer to the older patient could indicate disrespect in that the nurse talks about the patient as a disease category, however this sense is not evident in the way she continues to discuss the importance she places on her interaction with the older patient.

| Table 7 | Analysis of the Researcher’s Questioning and Responses by the Participant |

All the transcripts for both interviews and observations were eventually entered into the NVivo software programme for management and then coded under the reworked thematic labels. These themes were then allocated to categories. Theoretical notes and memos were also entered into the software program for analysis. Objectivity in the study was undertaken by checking the information obtained from both verbal and written data so that discrepancies could be noted and attended to (Swanson, 1986b). Memos were also used during this process aimed at the construction of conceptual analyses of the data (Charmaz, 2000). These were used during the interim phase between coding and the first part of the completed analysis.

3.10.3 Data analysis of the patients’ records

Information from patients’ medical records was used only to make sense of the nurses’ knowledge and understanding about the care needed by the older patients and how they actioned and evaluated this care. For example, reading what some of the nurses had or had not written in the records enhanced the researcher’s understanding of their professional role in the hospital, and it also assisted in a richer description of the data being analysed (Erlandson et al. 1993). It was important to use the three multiple
sources of data for analysis (interview, observation and records) as they are significant in this type of constructivist study because they provide some validation of consistency when triangulated (Lincoln & Guba, 1985).

### 3.11 Data Analysis and Structuration Theory

Following the primary data analysis using the constructivist inquiry process, a secondary interrogation of the data was undertaken using Giddens’s (1984) Structuration Theory. Giddens’s theory allowed a greater examination of nurses’ constructions and actions as they worked within the social system of the hospital wards. A central tenet of Giddens’s theory is the idea that there is a ‘duality of structure’; that is, an individual’s actions cannot be seen to be separate from the social structure. In this way, a more in-depth examination of the data was obtained, which assisted in exploring further the congruence between the nurses’ knowledge and potential capability as professional agents, and their actual actions in caring for older patients on their wards. The theory was able to provide a framework that allowed a better understanding about how nurses’ ‘face to face’ actions, conducted in the context of the wards, produced and reproduced the practices that continued to connect social with system integration. The theory also allowed questioning of the transformative capability of nurses as professional agents able to take action in order to change how their practices were being conducted on the wards. Furthermore, the use of time–space distanciation in Giddens’s (1984) theory was important for this study for several reasons: its ability to reveal how structures in systems are maintained by the links which exist between system and social integration; because it allowed for the differentiation of different forms of society; and finally, because it was integral to understanding how power is being generated in these institutions (Loyal, 2003).

### 3.12 Conclusion

The aim of this naturalistic, constructivist research design was to understand the meanings that nurses attached to the way they shaped care for acutely ill older patients. The use of this inquiry paradigm was particularly suitable for conducting this type of research as it allowed for several types of data to be collected across varied ward settings with a diverse group of nurse participants. Giddens’s (1984) Theory of Structuration provided a deeper interpretation of the data, which furthered
understanding of the ‘how and why’ of nurses’ care of older patients in the social context of the ward settings.
CHAPTER 4
CARING FOR OLDER ADULTS

4.1 Introduction to the Study Findings and Analysis

In this chapter, the findings from the study are presented. The study participants and the researcher have constructed the interpretative description of the experiences of registered nurses as they cared for acutely ill older patients across five wards and in two hospital settings. The description emerged from nurses’ verbal accounts of their experiences when giving care to older patients, from the researcher’s interpretation of the interview transcripts, and from the researcher’s observations of nurses interacting with their patients and patient records. The nature of nurses’ reality or constructions of their world determined the way they reflected and behaved in their nursing role.

4.2 Identification of Themes

Several themes emerged from the analysis of the data. These themes were categorised according to the kind of information obtained and not to the individual participants. These themes assisted in understanding the knowledge and skills of the nurses during the time they managed the care of their older patients on their busy hospital wards. Excerpts from the participant observation field notes, quotations from the interview transcripts and, where necessary, information from the nurses’ reporting of their care in the patients’ records provided validation of information. All the data is presented as indented and italicised, however the data from the observations and nurses’ documentation of their actions is presented in a different font to the interview data, in order to distinguish them from the descriptive analysis.

Analysis of the data from interviews, observations and documents has yielded three major themes that emerged as important in nurses’ experiences and perceptions, with regards to the way they implemented care for the older patients. These major themes include: knowing about care, optionalising care and blaming. The first major
theme, *knowing about care*, consists of two themes: being informed about the older patient and valuing the relationship as therapeutic. The second major theme, *optionalising care*, consists of two themes: prioritising patients and limiting care to older patients, and substituting time needed for care of older patients. The final major theme, *blaming*, consists of three themes: the context of the health care system, themselves and other nurses and older patients (see Table 8).

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing about Care</td>
<td>~ Being Informed about the Older Patient</td>
<td>~ Meeting the older patient’s needs</td>
</tr>
<tr>
<td></td>
<td>~ Valuing the Relationship as Therapeutic</td>
<td>~ Caring focused on the older patient</td>
</tr>
<tr>
<td>Optionalising Care</td>
<td>~ Prioritising Patients &amp; Limiting Care to Old Patients</td>
<td>~ Insufficient time for caring for older patients</td>
</tr>
<tr>
<td></td>
<td>~ Substituting Time Needed for Care of Older Patients</td>
<td>~ Completing technical work in lieu of functional care for older patients</td>
</tr>
<tr>
<td>Blaming</td>
<td>~ The Context of the Health Care System</td>
<td>~ Hospital and nursing administration</td>
</tr>
<tr>
<td></td>
<td>~ Themselves and Other Nurses</td>
<td>~ Powerlessness to provide quality care</td>
</tr>
<tr>
<td></td>
<td>~ Older Patients</td>
<td></td>
</tr>
</tbody>
</table>

**Table 8**  Themes and Sub-Themes Identified from the Constructions of the Nurse Participants

### 4.3 Knowing About Care

This major theme emerged from nurses’ articulations of their knowledge and potential capability to provide a standard of care they knew would address the needs of hospitalised older patients. The nurses’ constructions demonstrated that they were adequately informed, even if at different levels of knowledge, about the importance of
providing quality care based on a focused and therapeutic relationship with older patients.

### 4.3.1 Being informed about the older patient

This sub-theme included knowing about patients’ medical history. Many nurses recognised that the ageing process and co-morbidities, such as diseases and disabilities, can affect patients’ progress and recovery. Two other important aspects raised by nurses were: knowing about an older patient’s level of cognition, and looking for cues or signs and symptoms so that competent and individualised care could be planned and implemented.

> Well, you know about their cognition from their history. You check the medical history. That must cover a lot of issues. You just use common sense. (01:I:H2)

> Looking for those sorts of cues that they are going to give, yeah, they are getting a bit restless . . . (06:I:H2)

> Yes, I assessed them and see how they responded to me . . . If you, kind of, just when you first meet them, chat to them for a little while you can kind of feel something. (010:I:H2)

The complexity of caring for the frail patients is evident in nurses’ constructions of their knowledge and understanding about the importance of being informed about their patient’s history.

> You know . . . if they have a medical condition and then they have a surgical (operation) . . . like, say, if they are a diabetic, for example, and they have a surgical procedure and the wound doesn’t heal up as well as if somebody was, like, not diabetic . . . yeah . . . (014:I:H2)

> You know if someone has a fall, it’s not because they have just tripped over something, you need to find out, it’s because of everything, it’s because they are probably not eating properly, they probably can’t get to the shop, they can’t get food, maybe there are obstacles the house; that’s why they have tripped over. Maybe there is some underlying medical condition, maybe they are depressed, maybe they are separated from their families, maybe they are looking after somebody. You know, there are just so many reasons;
you can’t take one single thing with older people, because everything has a
knock on effect. Its like – someone who is confused and they could be
constipated, why are they constipated? Or maybe they are not eating
properly and, you know, it just goes on and on and on. So you have to assess
that for the aged, a culture thing. (02:I:H2)

Aside from knowing about the background and medical diagnosis of a patient, most
nurses at some point in their articulations were able to indicate that this information was
important because it guided their ongoing critical assessment of the patient in relation to
sudden changes which could be caused by infection, medications or fluid and/or
electrolyte imbalance.

Yeah. And if people have medical causes such as cardiac or liver failure,
that can have problems with UTI or, I mean, there’s the medications,
antibiotics, that’s probably the cause of their confusion. Quite often people
who get a urinary infection, it sets off confusion. I know electrolytes
[imbalances], too, cause complications . . . (08:I:H2)

In their interviews, nurses demonstrated their knowledge in the way they talked about
looking at the person in order to assess their internal stressors – both physical and
psychological. They are aware that they needed to be vigilant in regards to older people
as this cohort of patients can experience functional decline more rapidly. One of the
reasons provided by the nurses concerned the importance of observing levels of
hydration, which some would understand could place the older person at risk of a fluid
imbalance. Being intuitive for the nurses in this study had to do with ‘knowing about
the person’ and recognising when changes can occur in a patient’s condition. Nurses
noted that, in detecting these changes, they were alerted to the fact some patients may
have been affected by internal stressors, such as cognitive impairment, which can
impact on their ability to negotiate the external environment of the ward.

When you can usually tell from their posture if they are comfortable in the
chair or if they are starting to slip, if they get agitated, it is just a matter of
observing them . . . (07:I:H2)

Assessment is more important with the older person than with the younger
person because . . . You know, prevent any complications by assessing their
hydration . . . (04:I:H2)
You’ve got to be careful in your assessment. You’ve got to be careful of the older patients when you care for them. I think you just keep an eye out for it – assess early for problems and you just ask them [the other staff] to look for certain things . . . (01:I:H2)

Have a look at them and ask questions about how they cope . . . you can kind of know [what is wrong]. 010:I:H2

The process of ‘looking at the person’ was mentioned often by the nurses, demonstrating their understanding of the complexity of nursing care needed by older patients who are potentially at a higher risk of complications in hospital. Nurses showed their professional responsibility in the way they discussed the importance of ‘finding out’ – that is, by assessing the holistic needs of the older patients before they went into further decline. Through many discussions, the nurses revealed their knowledge and potential competency not only about the impact of ageing but also about the concomitant chronicity which can lead to multisystem breakdown. Assessment skills were seen by these nurses to be a critical part of their role in planning and providing proactive care. For example, nurses discussed how they have conceptualised the needs of the frail older patient in relation to what type of clues or problems can lead to further impairment and dysfunction. Many nurses were able to recognise that ‘no one thing’ would cause a problem in the older patients; rather, that it was more likely to be several factors, including not only physiological but also psychosocial causes. In their hypothesising, nurses showed that they were thinking critically about the many probable events that can lead to an older person’s actual decline in hospital.

4.3.1.1 Meeting the older patient’s needs

The nurses’ aim of being informed about the older patients not only involved clinical assessment but also included planning and implementation of humanistically based functional care. For instance, this care was often referred to by nurses in this study as the basic, good, quality or proactive care that demonstrated that older patients’ functional needs were central to their practice. Some nurses indicated that their practices were structured and organised according to a theoretical framework.

Oh. Here again, there are a whole lot of things, now. Um, well, basic needs, you know, food water, you know, security. Well, care about safety has got to be a priority, one of the priorities. It’s the first step approach. (04:I:H2)
Nurses also discussed their understanding of ‘real basic nursing skills’, which have to do with actions that protect older patients from complications. In the literature, this care is sometimes referred to as ‘hands-on’ care, which implies it is ‘focused’ care that addresses the individual patient’s physical needs.

_The more basic the care the happier the patient is... Just like the caring, things, like, you know, your, just like what I call the “really basic skills” that you learn, you know... everything about pressure area care, the things about mobility... things like independence, the kind of things that I think nursing is about._ (01:1:H2)

_As long as I am providing good patient care for my patients and they are happy with it, then I go home happy._ (03:1:H2)

During observations of nurses’ interactions with older patients, only some nurses demonstrated their knowledge and actual capability to provide competent care. During such episodes, the nurses questioned the older patients, listened to their responses and in their planned actions showed empathy and concern.

_The nurse asks the patient, “Have you had a back rub lately... have they turned you around?... Do you mind if I look at you?” The nurse examines the patient’s back, and asks, “Are you sore?”... “My back feels sore and I would very much like a rub.” The nurse replied, “I will rub [wash and massage with cream] your back and your feet.” The nurse checks the fluid balance chart and says to the patient, “Have you had anything to drink since lunch time?... The nurse responded, “Yes, you need to drink more water,” and says, “Here it is, your glass, have some now.”... She then says to the patient, “I’ll just put the oxygen prongs on – your oxygen sats [saturation measurement] were quite a bit low on room air. You haven’t got any fractured ribs or...” She attaches the nasal prongs over the patient’s ears. The patient explained to the nurse that the nasal prongs “were not very comfortable in my nose, it’s so dry.” The nurse replied, “I will put it down to 2L for you... so it’s not that strong.” She then explains why the oxygen is important for the heart._ (012:O:H1)

Through their constructions, the nurses demonstrated the importance of being informed about the older patients and of providing preventive care that would keep them safe in hospital. Their knowledge and potential capability was evident from their articulations about understanding the complexity of care needed by older patients who may have
multiple diseases and disabilities. Some nurses showed by their actions that they were aware of the effects of hospitalisation on the older person. However, this understanding, shared in their interviews, was not always observed in the way the nurses practised on the wards.

4.3.2 Valuing the relationship as therapeutic

In many of their articulations, nurses described the ‘value’ they placed on their relationship with their older patients. They demonstrated their tolerance and respect and their understanding that the relationship itself could be therapeutic by enhancing the older patient’s personal integrity.

That the patient feels good and I feel good, in that relationship? I think that’s the relationship that decides whether a patient is going to enjoy, not enjoy their hospital stay, but have a good hospital stay. (03:I:H2)

The value associated with providing care that was focused on a patient-centred relationship was highlighted in the different approaches used by nurses in their practices, which made both the nurse and the patient feel more satisfied.

4.3.2.1 Caring focused on the older patient

Throughout the interviews, nurses articulated that they used several patient-focused approaches to form a professional, caring relationship with their older patients. Such approaches assisted them in establishing trust and a connection with older adults, and included speaking with them, keeping their word, providing extra care, looking after them, being there, acknowledging the patient as a person, understanding the person’s routines, giving reassurance, use of touch and humour and judging the patient’s behaviour and coping ability. These strategies or approaches showed the value nurses placed on developing a trusting and caring relationship that was patient-focused and that was also seen to be therapeutic in nature.

Just like the caring, communication, things like, you know, your, just like . . . that you learn you know [about the person] . . . communication . . . the kind of things that I think nursing is about. (01:I:H2)

I think that’s important, to have that contact with them because they are still a person. (08:I:H2)
The importance of speaking with older patients when they were in their rooms or during treatments was acknowledged by nurses as an essential means to develop trust. Nurses noted the importance of getting to ‘know’ the patient as a person through the use of communication skills. Nurses also mentioned the therapeutic benefit of speaking with older patients when they were around them, as it oriented them to the hospital setting, made them more alert, helped them cope and would offer them some protection against social isolation and cognitive impairment.

But the difference, just physiologically, is they have got a little bit better and more alert if you interact with them . . . you’ve gone through the rough and the smooth with them for a month or 6 weeks and you have established a rapport and they suddenly seem to “ahhhh” be brighter and respond to you. That’s what I do. Sort of talk is I encourage . . . use encouragement, positive thought. I think I would like more time with the patients, just sit and talk to them. (04:I:H2)

It's important to . . . talk, communicate with the patients. To prevent problems . . . (09:I:H2)

In my nursing care I orientate the older person to time and place, answer any questions; explaining what has happened to them but not overloading them with too much information. If they want to know more they can start asking for more. (08:I:H2)

Communication, if they have got a tracheostomy, making sure they can write things down or they can elaborate with pictures or . . . (011:I:H2)

Helps with their healing as well. I mean, they can come in with a broken leg, but if you can make them feel good about their broken leg, then they are going to heal a lot faster. Even, if it is just mentally and the bone may still take 6 weeks to fix but they are going to feel a lot better about what they are doing instead of getting in here and wishing. (03:I:H2)

Talk to them and tell them what you are doing and isn’t a nice day, and just have a conversation whether you are getting any feedback or not, is not the thing, that you are actually talking to them its important not to ignore them, and that must be dreadful because they are still able to understand and they’ll be brighter and they might laugh. (08:I:H2)
Establishing trust in the relationship also involved nurses ‘keeping their word’ with their older patients and providing what some felt was ‘extra care’. Being trustworthy was evidently important; nurses described it as helping others when it is needed even though it may cause them more ‘effort and time’. Quality caring implied a need to make their patients feel more valued – because they were being ‘looked out for’ and therefore respected. ‘Doing something more’ was often not the care that is an expected part of nurses’ formal or technical work role, but the humane functional type of care that provides not only physical but also psychological comfort for older patients, who are often helpless and dependent on the nursing staff. Feeling comforted, valued and acknowledged was seen by nurses as being associated with a patient’s psychological and social functioning.

*All you need to do is establish trust, like keeping your word, and going out of your way to prove it you know, at your own cost, little things like, making the effort to get something for them when you’ve said you would do it and just don’t forget it, that you actually go and do it.* (07:1:H2)

*You can walk past and you look at them . . . [acknowledge them]* (01:1:H2)

*And also creating an environment that, you know, where it’s psychologically safe, where they feel they, you know, they can find out, acceptance and support.* (04:1:H2)

Knowing patients’ routines was also thought to enhance trust-building, and nurses could then accommodate this into the care plan.

*Ask them what their routine is or what they like . . .* (07:1:H2)

Forming a connection in the relationship by establishing trust was evident in the way nurses provided care that was reassuring and that allayed patients’ anxieties.

*The nurse says to the patient, “What I’ll do is a couple more temperatures here and then get a bowl and give you a wash.” She takes the thermometer away from under the patient’s arm and says, “That’s good . . . and your BP is . . .”* (012:O:H1)

*The nurse enters the room and goes to the patient. He opens his eyes and says to her, “Can I have something to drink?” The nurse says, “You can have nothing to drink, dear, nothing, but I can give you a bit of a mouth-wash.” She then asks*
him, “What’s this leg doing here?”, and she moves his leg from the railing. She goes out and gets the mouthwash and returns a minute later. (013:O:H1)

Another approach used by nurses to build a closer relationship with their older patients concerned the ways in which they used touch, humour or smiling. Their relatedness, according to one of the nurses, made the patients feel ‘good’ and also reassured them that they were ‘there’ for them when needed.

Just give him reassurance really. Just little things, like you put arm around him and smiling at him, you know, just let him know that you are there. And he responds to that, and he smiles back himself. I think he likes to see a smiley face. (010:I:H2)

Making sure that your patients are happy . . . and they smile at you. (01:1:H2)

I use humour . . . put a bit of humour in it. (05:1:H2)

I think good patient care involves making sure that your patients are happy even though they are in pain, you can walk pass and they smile at you. (03:1:H2)

And where I have got the most satisfaction as a nurse is to be able to love them in a . . . you know, embrace them, to cheer an old lady up and to give them a kiss and a cuddle to really get an old chap laughing and shake his hand and share together. (04:1:H2)

Yes the care is very important [to me]. I mean, basic care is really what makes your patient really comfortable and makes them feel they are being looked after better. Satisfaction in what you do is also very important. (01:1:H2)

The formation of a patient-centred relationship was seen to be important to most of the nurses, because it assisted them in ‘knowing’ about the person. In this way, their more involved connection allowed them to interpret or judge when their older patient was not coping well. If this was the situation, then nurses did not insist on treatments that could result in further stress or anxiety.

Sometimes they can be a little overbearing too, and I just back off. I suppose it’s just a judgement call. I don’t think she is terribly at risk [for a complication]. You have to really talk to her gently around her personal
needs or she would get anxious. In addition, you talk to them, I mean, talking. I personally find you get more information out of them than just observing. (05:I:H2)

You use all sorts of different approaches, and eventually you can get him [to have the treatment]. Apart from that, I will just keep an eye on him today. I’ll chat to him whenever I can. (01:I:H2)

**Theme Discussion: Knowing about Care**

As can be seen in the preceding section, nurses in this study were able to demonstrate that they were knowledgeable about and capable of safe and competent care for their acutely ill older patients. They understood that this care needed to be of an appropriate standard in order to protect older patients from adverse events during hospitalisation. Nurses shared that their practices were guided by an understanding of their disciplinary body of knowledge, which is based on both a scientific and a humanistic approach to caring (Barnard, 2006; Parker, 2006). During their interviews they revealed that they were informed in the way they described their ability to think critically about what was happening, or could happen, to the older person and about planning preventive actions. Nurses reported that they stayed informed by ‘looking at the person’, which involved a comprehensive assessment concerned not only with a patient’s physical needs but also other multidimensional needs, such as psychological, spiritual, cultural, social and developmental (Neuman, 1995).

Nursing knowledge of the holistic aspect of the assessment phase of the nursing process is well documented in many of the discipline’s theoretical frameworks (Neuman, 1995; Rogers, 1970; Roy, 1970), which highlight both a scientific and a humanistic approach to the provision of quality care. In her systems model, Neuman (1995) referred to this part of the nursing process as ‘primary prevention’, by which nurses assess, plan and then implement functional care that can assist older patients to withstand or cope with stressors that occur in either their internal or their external environment. Care that is focused on the person has components of both the technological and humanistically functional approaches, which, according to Neuman’s (1995) theory, is important for retaining, attaining and maintaining the safety and comfort of an older patient in hospital. For example, the Neuman (1995) nursing model emphasises that preventive care is centred on the frail older person, who, because of
vulnerability to environmental stressors, requires competent nursing assessment and actions to prevent multi-system breakdown and further functional decline.

Attitudes informed by the discipline’s theoretical frameworks and professional standards guide nurses in developing patient-focused relationships with their vulnerable patients, including older patients, in order to promote quality practices and maintain wellbeing (Alligood, 2006a; ANMC, 2005; Neuman, 1995; NRB, 1999). Many of the attributes of a therapeutic relationship that were acknowledged by nurses in this study were also reported in research, such as love, respect, trust, mutuality, spiritual expression and enhanced personhood (Thomas et al. 2005). These caring aspects are developed by the value nurses place on their relationships with patients, in regards to the way they relate and interact, and by their particular life experiences (Hagerty & Patusky, 2003; Luker, Austrin, Caress, & Hallett, 2000; Sumner, 2001). When the relationship is focused on the patient as a person rather than on the nurse’s own subjective or judgemental beliefs, it can be more therapeutic.

A therapeutic relationship promotes the wellness and comfort of the patient because its foundation is built on mutual negotiation, trust and reciprocity of care (ANMC, 2005; Hagerty & Patusky, 2003; Neuman, 1995). Nurses discussed the importance of keeping their word, of looking out for the person, of providing extra care and of acknowledging the person, all of which are approaches that demonstrate trustworthiness. Trust, as reported by these nurses, is one of the caring aspects of a professional relationship. It is developed through nurses’ values and attitudes and is demonstrated during their caring interactions with older patients. It was also noted by nurses that they used touch, smiling and humour to encourage attachment, intimacy or closeness in the relationship. These concepts were found, in several studies, to be intrinsically related to the therapeutic potential of nurses, and included levels of disclosure, sharing personal experience, patient dependency and vulnerability, and instrumental touch (Luker et al. 2000; Williams, 2001b).

Connecting in a personal way with patients has been discussed as ‘hands-on’ care and is recognised by nurses as necessary in meeting holistic or multi-dimensional needs, such as physical, psychosocial, developmental, spiritual and cultural needs (Engebretson, 2002; Neuman, 1995). Therapeutic caring relationships, then, show that trust has progressed beyond a superficial interaction, as nurses display values of reliability, consistency, competency and honesty (Stein-Parbury, 2005). Hagerty,
Lynch-Sauer, Patusky, and Bouwsema (1993), emphasise in their theory of human relatedness, the importance of ‘involvement’ and ‘connectedness’ in ensuring comfort and a sense of well-being. The significance of forming a professional relationship with older patients, even when contextual influences in the hospital impact negatively on the nursing role, is crucial in ensuring that quality care is provided (Barnard, 2006; NRB, 1999). Hence, making time to build this trusting relationship demonstrates the value nurses place on providing care that is focused on the older person (Barnard, 2006; Dunn, 2006) and, according to Hagerty and Patusky (2003), even short encounters with a patient can assist a relationship to evolve that is mutually satisfying and beneficial to both nurse and patient. It is important to note that the majority of the nurses in this study had tertiary qualifications and only four of the hospital trained nurses had not completed further professional development. Only one nurse had specialist gerontological knowledge, however, most had participated in educational programs in which their theoretically based nursing practices would be guided by disciplinary frameworks and the national competency standards for registered nurses (ANMC, 2005). The nurses in this study demonstrated their knowledge and skills and potential professional agency in the way they described the importance of being informed and of meeting the specific needs of debilitated older patients. However, it became evident in the observations and through a review of some patient documentation that this standard of care was not the usual practice on the wards.

4.4 Optionalising Care

Nurses in this study discussed how they made decisions to ‘optionalise’ their care. This included choosing which patients to care for and how much care to provide. Optionalising care practices meant that, for some nurses, there was more time available for social interaction. Substituted time concerned the way in which many nurses avoided older patients and devalued their professional relationship.

4.4.1 Prioritising patients and limiting care to older patients

Nurses used several strategies to manage their work, including the prioritising of those patients who nurses decided needed care and of what care to implement, limit or eliminate. In their interviews, nurses showed that they recognised that the standard of
care expected of them as professionals was not actually being provided on the wards. Functional or personal care was seen by many of the nurses as ‘optional these days’.

There’s a shortage of nurses here . . . because we’re so short staffed there is not time for chatting and sitting by the bedside, washing hair and other things [personal care for patients] that are almost seen as optional these days. (013:I:H2)

Yeah, choosing to eliminate some aspects of work. (014:I:H2)

The provision of care for older patients was also described as time-consuming, even though nurses realised that this type of care was important for preventing complications for vulnerable older people immobilised in hospital.

Everything [nursing the aged] takes twice as much time . . . (013:I:H2)

This ward isn’t actually geared to look after older patients who take up so much time (03:I:H2).

4.4.1.1 Insufficient time for caring for older patients

Nurses often stated that because of time issues they were unable to manage the complexity of care required by older patients. As well, they felt it was often problematic for them to control their time in the busy hospital environment. They were frustrated about the ward conditions and the heavy workload that impacted on the care they stated they wanted to give, but they felt they could not give that care because of a lack of time.

Lots of things impact on that! Being busy all the time impacts on being able to give the care you want to give. You can run out of time for the care . . . As a nurse, I guess, you’re just so busy all the time and the situations are alike all the time and say you might have the [nursing care] plan but because of the workload it just doesn’t occur like that, it doesn’t happen like the plan of care. Someone might fall, someone might get ill or have to go to the theatre immediately, or . . . things [are] changing all the time. (012:I:H2)

Well the problem . . . its not the problem with Admin . . . its just the problem with nursing in general as to, um . . . moving of beds you see because so many beds on the weekend and so you are moving and shifting of beds continually, the beds are full . . . and so you’re busy. (014:I:H2)
Its very hard to catch up and it puts more stress and pressure on you and it just accumulates through the shift and if you don’t get on top of your work, if you don’t stay on top of your work, and your patient load and you’ve got someone like . . . it can topsy-turvy and [turn] our shift into a nightmare, you know, you just, you’ll just be drained. (04:1:H2)

The shortage of staff, time limitations and the work environment were discussed often by many nurses, who found it was a major problem that impacted on their ability to complete their patient care. Not having adequate time to give the total care needed by frail older patients was highlighted as a frustrating part of their role. They discussed feeling a sense of helplessness about the conditions in their workplaces, which impacted on their capability to implement the basic or functional care they knew should be provided for debilitated patients. However, there appeared to be some inconsistency between their knowledge about the care being implemented and the consequences of their actions for the older patients. The nurses understood that care that is not at a safe level can leave older patients at a higher risk of complications, such as metabolic imbalance, infection, falls and cognitive impairment. Some of the nurses acknowledged that the ‘biggest problem’ for them, was being caused by the higher numbers of older patients with co-morbidities who were admitted into hospital.

If that’s the case, I think the challenge in nursing, um, is that you often don’t always have the time . . . We don’t have time these days in hospital, we’re rushed and we just don’t have the funding to staff the beds . . . You don’t have the time to adequately assess them, you’ve got to spend a fair bit of time and watch them over a period of time . . . might be weeks. (013:1:H2)

Yeah, so there is many, many more of this sort of . . . older patient . . . and we are keeping them longer in the hospital . . . That is the biggest problem. It’s huge. It’s a huge problem. (06:1:H2)

Nurses articulated that some older patients required more of their time and that this time was needed to complete other technical or routinely required tasks. There was a sense of resentment in the comments by some nurses about the additional burden that caring for older patients placed on them.

Well, it’s hard in the system, it’s not, but it’s hard when you’ve got other patients [as well as the older patients] and there is not enough staff or time, because it is mentally draining, it’s not only physically draining. (04:1:H2)
They [older patients] just totally throw out everybody’s time-management.
(03:1:H2)

A lack of time was perceived by these nurses to influence the type and quality of care they believed they could provide for the larger numbers of older patients now admitted to hospital wards. They professed that the hospital and ward environments impacted on their ability to assess older patients and manage their own time, which meant they could not carry out essential patient care. Lacking time meant they often felt irritated because they fell behind in their workload and could not catch up. Nurses were critical of the amount of work they were expected to complete on a shift. In these shared meanings, nurses appeared to understand what care they were actually providing on the wards and how this care was or was not being provided for older patients.

4.4.1.2 Completing technical work in lieu of functional care for older patients

Throughout many interviews, nurses stated that they preferred to undertake the more technical and interesting work that was generally ordered by medical staff, such as medications, wound dressings and intravenous infusions. The work they did not favour was the nurse-initiated functional or basic care required by frail older patients, such as repositioning, continence management, active and passive exercises, deep breathing and coughing. The perceived importance of or challenges in providing technical care rather than the more basic nature of functional care was acknowledged by some nurses.

What else with care, I ’spose when you think of oldies, it’s just that holistic [care] – old people need twice as much help, they need cleaning up . . .
Yep . . . but I don’t mind really hard work, so its not so much it’s hard work, it’s just that I don’t find it challenging . . . and . . . that’s the thing I like to do [nurse younger patients] . . . keep you on your toes . . . you make judgments you know and evaluations very quickly to plan your actions, whereas with the aged you know what you’re doing, it never changes while you’re helping that person. (013:1:H2)

The pathway some nurses had chosen did not offer them consolation about their lack of ethical resistance to the dominance of technical work over nursing work values. Reasons given for not finding time to attend to older patients’ needs included being too busy on the wards, having to answer buzzers ‘going all the time’, and staffing shortages.
Many articulated that they were not satisfied by this situation as they realised that their older patients were not being given an appropriate level of care.

She wasn’t being made to look good, I mean to get the satisfaction that everyone wants, finish the patient totally and do everything at once, and in that sort of case you need someone else to help you with your turns and everything else but you didn’t have that and the patients didn’t look good, so you were not satisfied with the care you were giving, in and out, the buzzers were going and someone [other patients] had something more medically going on that needed some more urgent attention you wouldn’t get back so . . . (01:1:H2)

If patient care was interrupted by medical treatments or other technical tasks that were considered to be more urgent, nurses said they could not often return to complete the basic care needed by older patients because they then had to prioritise their time.

I really didn’t interact with him that much [an older patient]. I think I just cared mainly for the patient with the central line and I think that was it. (09:1:H2)

It’s priority nursing – don’t wash some patients if you can’t do everything else, such as the medications and the orders . . . only shower if possible – some patients . . . that’s getting worse over the years and the governments [are] closing beds so there’s a shorter length of stay. (013:1:H2)

It’s just, with only three staff members on, it just separates you, and you have basically one person who is left to look after everything else and if something goes wrong, or you have another job to do, it just totally throws the ward into confusion. (03:1:H2)

Things happen all the time you run out of time. Someone might fall, someone might get ill or you have to get them ready to go to the theatre immediately, or things [are] changing all the time, so you don’t give the care. (012:1:H2)

These nurses discussed how interruptions on the ward prevented them from providing care for older patients. However, they admitted they used time accessible for patient care for their social time at the desk.
4.4.2 Substituting time needed for care of older patients

Time available for nursing care of older patients’ holistic needs was reported by nurses to be substituted for time needed for social interaction. Social time was found when nurses restricted their time in patients’ rooms by avoiding or not speaking to, attending or responding to older patients, or by appearing to be too busy. The reason provided by nurses for this behaviour was that they felt they needed to have social or ‘excitement’ time to help them in coping with their work strain. They discussed how they economically organised their time for patient care around being able to take ‘this patient care time’ to socialise.

Nurses expressed a need for social time in order to help them cope with their work on the shifts. They discussed finding some ‘excitement’ through social activities with other nurses, doctors and allied health practitioners. On many wards nurses were observed to complete the routine or formally required care (medications, treatments and charting) and then return to the ward desk during their shift for this social interlude. In some instances their conversations were noisy and could be heard throughout the ward. The time taken for social meetings was often lengthy and could last as long as one hour; for example, one social session lasted from mid-morning to the lunch period, with all nursing staff on the shift participating.

_Nurses need some excitement. You can’t just give the basic care [every day], you’ve got to have some excitement as well. Lots of things impact on that basic care! Being busy all the time impacts on being able to give the care you want to give. You can run out of time for the care._ (01:I:H2)

There seemed to be some differences between the nurses’ knowledge about an appropriate level of care and the actual care that was implemented. In the following excerpt of this same nurse’s work, the patient time was substituted for time needed by her older patient, who in this interaction complained he was hungry during the morning whilst restrained in a chair. The man was agitated by the noise at the nurses’ desk, which was less than three metres from the door of his room.

_The patient’s room was in front of the nurses’ desk and there were two medical officers, a clerk and four nurses interacting at the desk. They were all laughing and talking loudly together. Medication administration was the only task the nurse carried out during the morning observation for the older patient. The older_
man’s room was directly opposite the nurses’ desk, and he sat restrained in his chair. This man complained he was hungry and thirsty during the morning.

(01:O:H2)

Nurses interviewed for this study believed they needed social time away from their older patients in order to find satisfaction in their work. Incongruence was found between nurses’ knowledge about what care should be provided and their actual behaviour, as they often used time needed by older patients for quality care for their own social interaction.

4.4.2.1 Avoiding older patients

It emerged that sometimes nurses did not speak to, attend or respond to patients when they were in their rooms. Time for social interaction was found when nurses substituted time designated for patient care by using such avoidance strategies. Nurses stated they felt caring for the older people to be a chore as it was hard physical work that they did not enjoy.

Um, that I don’t enjoy looking after the aged and the incontinent patients and I don’t enjoy that as well, and I find that frustrating and, like, I don’t really like aged care . . . It’s a really heavy kind of nursing and you do lots of lifting and it’s not good for your back and health and, um . . . (013:I:H2)

Although some nurses articulated they had difficulty providing care for some patients for a range of reasons, they did not openly reveal, however, their awareness that time spent socialising was time which they could have used for essential patient care. Nurses were aware that staff were avoiding or distancing themselves from the older patients.

It’s important not to ignore them like some [nurses] do. (08:1:H2)

Inconsistencies were found between what care the nurses knew should be provided and the actual care they implemented on the wards. The nurse quoted above was concerned by how other nurses distanced themselves from their older patients, but in actuality this nurse did not come near her older patient during the morning observation, and when she did it was only for a short time and for a routine task. There appeared to be differences in nurses’ accounts as described in the preceding theme, knowing about care and their actual actions.
No-one interacted with the older man during the morning observation, except to give him a medication. He sat on his own at his bedside. (08:O:H2)

During the following observation, the registered nurse left her older patient alone during the afternoon (from lunchtime to dinnertime) and no interaction was recorded. No other nurse came near the patient, and this was not uncommon during the observational time spent on the wards. As in a previous observation, this older man complained during the afternoon of feeling hungry and thirsty – he had not received assistance to eat his lunch, and eventually the catering staff had removed the tray. Also, during this session he indicated that he needed to go to the toilet, but no-one came into his room for some time because the nurses from the morning and the evening shifts and other allied health practitioners were socialising at the nurses’ station. The nurse in this observation spent half an hour talking to the staff at the desk after the verbal report for the evening shift, and then went to afternoon tea without checking on the needs of the older patient beforehand.

The RN did not come near the older patient during the observation. (04:O:H2)

In their interviews, some nurses reported that other nurses tried to evade talking to the older patients who, they felt, may have been lonely and needing interaction for their cognitive stimulation.

Talk to them and tell them what you are doing and isn’t a nice day, and just have a conversation. Whether you are getting any feedback or not is not the thing; that you are actually talking to them is important, not to ignore them like some do, and that must be dreadful because they are still able to understand and they’ll be brighter and they might laugh. (08:1:H2)

On this ward, quite a lot of people come in here and they are okay, and then after they have been here for a couple of weeks . . . they get quite drowsy and E . . ., for example, came in and she was wandering around but the last week and a half, she has spent in bed. It’s just, I don’t think it reflects on any clinical skills, but as with any other ward, it is very under-staffed and you don’t have that time to interact with the patients, which is probably the most important thing. (03:1:H2)

Nurses were knowledgeable about the importance of interacting with their older patients; however, they did not often demonstrate this in their observed behaviour.
Staff were observed coming into older patients’ rooms but then not speaking or even looking at the patients. These nurses would act in a predictable or systematic way, and so their behaviour looked like a tightly choreographed ‘bedside ballet’. The next observation demonstrates the pervasiveness of this behaviour across the nursing and medical disciplines.

The specialist, nurse and intern stood talking to each other at the end of the bed. They did not greet the patient. They did not have eye contact with her but instead were turned towards each other, looking at the charts from the foot of the bed. The specialist spoke to the intern and told her “to replace the K+ [potassium] and chloride.” They started to leave . . . The patient called out, “what was your name?” The specialist said “Doctor B.” (06:O:H1)

Nurses spoke about the time required for care of older patients, which they found impossible to deliver because of hospital constraints. The feelings expressed by these nurses resonated with other interviews, where nurses described their inability to change the way their work practices were being implemented on the busy wards.

But they need time for care . . . if you take the time . . . and have the time, which is hard in the hospital. (01:1:H2)

These findings suggest that there were differences between what the nurses reported and the observations of their work. For example, this same nurse was found to interact with an older patient only once during the morning, and this concerned taking a medication. The older man sat in the single room alone while the nurse sat out at the nurses’ station for over an hour, talking and laughing with other nurses and health practitioners.

The nurse came into the patient’s room to give the patient his medication. No other conversation occurred. The communication between the nurse and the patient was focused on the task. The nurse did not introduce herself or greet the patient. She had a commanding tone to her voice, “A . . . sorry to interrupt, but I have a tablet here for your urinary infection. Your doctor ordered it.” The nurse then left the room and returned to the nurses’ station. (01:O:H2)
In the following observation, the nurse is giving out medications and has not attended to the patient’s complaints.

_The older woman complained several times to the RN that “her bottom was burning.” The RN did not attend to her complaint and instead continued with the task of administering the medications, then she left the room._ (05:O:H2)

The nurse did not record this patient’s complaint in her charts for this shift. On a review of the patient’s medical records a break in the integrity of the patient’s skin was noted in the nursing report three days later, and treatment was then initiated. The nurses understood that older patients who are immobile would be at a higher risk of developing complications such as pressure ulcers if they are not regularly repositioned. From their scientific knowledge nurses would be aware that one of the prime indicators for a risk of tissue damage can be pain caused by an impaired sensory input. During the time of the observation this patient had continued to complain aloud about her discomfort to the registered nurse, the assistant in nursing and the enrolled nurse who were in her room.

_Nursing report: The patient was showered and left self-sitting on shower chair; walking with supervision. Needing to toilet frequently. Confused at times. Has red broken area on bottom. Hydroderm applied and patient needs encouragement to stay out of bed._ (05:R:H2)

During this next observation, the nurse is not attending or relating to the particular functional needs of the older patient. She has woken the man, but did not offer to take him to the toilet and instead gave him his breakfast tray.

_This older man is confused and has been woken up and sat in the chair for his breakfast. The nurse has left the room. He stops eating . . . He then stands up looking agitated and indicates that he wants to urinate but does not know where the toilet is. He is unsteady on his feet and holds onto the window sill._ (011:O:H2)

The patient records for this person showed that two days later this man had to be sedated for agitation. The charts noted that he was ‘getting upset’ because he could not find a toilet. He had become increasingly agitated since that time. The staff during the observation had not attended to the cues the man had communicated – he was restless and upset when he wanted to urinate. The nurses had not been toileting him regularly, as was requested on his care plan. This man was reported as being unsteady on his feet,
having bilateral cellulitis and now acute confusion (delirium). His records showed that he had fallen from his bed the day before and cut his head because of his agitation over trying to find the toilet, and this had led to the medical officer requesting regular toileting.

*Nursing report: The patient climbed over bed rails to go to the toilet and had removed his IV. Patient confused at times and agitated and very loud and unable to settle.* (011:R:H2)

The nurse participants in this study communicated that, apart from using avoidance and not speaking to the older patients, they knew if they appeared to be too busy their patients would not ask for care. However, some of the nurses indicated they felt some disquiet about their lack of competent or ethical behaviour.

*Pushing the older patient away and saying, “I haven’t got time, go away, I am busy,” but they come up to ask you where something is that you or I haven’t even got, [that] I imagine they’ve lost. You knew the older person who would probably suffer the most at the end of the day was that confused person because everyone tries to push them aside, ignore them, sedate them, use chemicals to restrain them, and I think that’s horrible.* (06:I:H2)

Distancing behaviour and escape–avoidance tactics did not appear to be an occasional occurrence on the wards but an acceptable and commonplace practice. Similarly, by appearing to be too busy the nurses also used a ‘go slow’ tactic; that is, they deliberately took a long time to respond to the older patient’s needs. This tactic may have arisen because some nurses admitted they did not like to provide care for older patients. The nurse in the following observation demonstrated a lack of empathy for her older patient during the lengthy observation, which had included the administration of a medication and assisting the patient with her evening meal. In this part of the observation, the patient had been requesting pain relief for over an hour and a half. During this time the nurse used a ‘go slow’ tactic by not answering her buzzer. On two occasions the researcher had to go and find the nurse to inform her that the patient’s pain was increasing and that she was becoming more distressed. When the nurse came to the patient’s bedside, no assessment was undertaken regarding the location or intensity of her pain. The nurse had called an evening medical officer to order an analgesic medication for the patient. However, her lack of motivation or understanding was shown in the way she did not advocate on behalf of the patient in order to inform the
medical officer about the increasing severity of the patient’s pain. If she had done so, he may have visited the patient and assessed her pain level himself, and perhaps ordered her an injection instead of an oral preparation. The oral medication that was finally administered to the frail older woman would have taken at least thirty minutes or more for absorption because of her ageing systems (Louis & Meiner, 2006).

The immobile debilitated aged woman lies in the bed quietly and stares at the bed table and tries to move herself [she has not been repositioned now for over two hours] and then calls out in a small voice softly, “Sister!” The patient continues to call out: “Oh, oh, can I have something to drink? . . . Oh God, the pains will never stop, please.” The patient starts to call out in a loud voice that is high-pitched, “Oh, oh, oh, oh . . .” [At this point, the researcher placed the buzzer within the patient’s reach and twice went to find the nurse when she did not respond to the buzzer.] When the nurse came into the room she walked to the patient’s left side and turned the buzzer off. Then she bent over very close to the patient’s ears and held the patient’s hands and said, “We’ve paged the doctor and he shouldn’t be too long.” The patient then says, “I can’t bear it; tell him to hurry.” The RN says, “Okay,” and leaves the room [not having assessed the pain or offered any comfort measures]. The patient is now groaning more frequently: “Oh, oh, please, no more, no more, oh dear God, uh, uh, uh.” The RN returns again with another nurse and tells the patient she has paged the doctor. [Again, no assessment of the pain or comfort care was provided for the patient.] “Will it last long, nurse? . . . he’s so long [the doctor] . . . If only they’d come, please, please help me, surely some have to suffer worse.. Oh, oh, oh, I can’t stand it, it’s too bad, oh, oh, oh, if only you people had to suffer, oh, please hurry, oh, tell her to come back, oh, oh, oh, please, please, please, please, not again.” (04:O:H1)

By being too busy, by going slow, by not responding and by the use of distancing and avoidance tactics, nurses in this study demonstrated a lack of competent care and valuing of their relationship with their older patients.

4.4.2.2 Devaluing the relationship with older patients

The rationale provided by many nurses for not providing adequate care for their older patients was that they had no time; however, during observations the nurses were
mainly completing scheduled tasks for the wards. The nurse in the subsequent observation did not respond to an older patient’s communication of discomfort as she attempted to move her buttocks across the bed. Moreover, nurses on the previous shift had charted in the patient’s medical records that the woman had ‘reddened and sore’ buttocks.

The patient tried to move her body across the bed, and as she tried to sit forward slightly she groaned, “Ooooh.” She grimaced as if in pain as she moved her buttocks across the sheet. The nurse did not comment or look at the patient’s face when she made this noise. The nurse did not respond to this situation or assess the patient’s buttocks. (013:O:H2)

A professional relationship with older patients was acknowledged by the nurses as an important part of competent practice, although many maintained that it was often impossible to achieve this because of a lack of time on the busy wards. Throughout their interviews, nurses disclosed that they knew what actions were necessary to protect older patients from complications during hospitalisation, but in actuality their behaviour did not always mirror their value system. Nurses expressed concern when they felt they (or other nurses) did not manage to provide the standard of care required by their older patients.

Um, I ’spose knowing why people came into the clinical setting in the first place and what we can do to prevent them from coming back in again, I don’t think we look at that enough, [to know] what is going on with the older person, to protect them more. (02:I:H2)

The findings showed that there were many observed examples where patients’ needs did not appear to be central to nurses’ concerns. For example, the older patient in the following interaction was sedated and did not move himself in his chair during the three hours of the observation. The attendant nurses did not demonstrate (in their behaviour) that their focus was on the care of this man, who was paralysed down one side of his body.

The patient's head nodded/jerked forward a couple of times. The nurse checked the infusion pump, kneeling on the floor at eye level with the machine. This was at the patient’s left side. The nurse adjusted the nasal prongs. Another nurse entered the room and said, “He’s drowsy.” She lifted the tubing on the Indwelling
Catheter Bag (hourly measure) and charted her observation on the chart. She did not speak to the patient. There was an unpleasant odour in the room from the patient’s breath. He touched his mouth with his right hand and tangled his thumb in the loop of the naso-gastric tube twice while the nurses were in the room. The nurse did respond to this, but only when it was brought to her attention. She then said to the patient, “A . . . try not to pull on your tube . . . you’ll be in trouble if you pull it out.” (02:O:H1)

Care that did not leave patients feeling satisfied and comfortable occurred when the nurses were not fully informed about each patient’s individual needs. Nurses implied that because of the problems on the ward and their stress at being overworked they could not be expected to know about each patient’s history or care plan.

*It was a very quick report. They didn’t tell me what was wrong with her . . . and I don’t have time to go and read up in her notes, so I guess the next plan of action is to then look at the care plan or I ask the . . .* (013:I:H2)

Some nurses labelled the older patients as lazy and appeared to have allowed their views to influence their judgements about how deserving these patients might be of nursing care.

*Yeah, I think with the oldies, they are a lot, it’s easier for them to get depressed and in a rut, it’s a lot easier for them, I find, they get almost lazy, because they have someone coming in looking after their total needs.* (013:I:H2)

Nurses also reported that they felt the hospital, as a bureaucratic organisation, was an ‘inflexible place’ that impacted on their ability to find time and provide appropriate care for their older patients. In addition, negative attitudes towards older patients permeated nurses’ interviews.

*But yeah, I, nursing is disappointing I feel the way it works . . . the whole [hospital system] – the way its structured and tiered.* (013:I:H2)

*Caring for oldies – they aren’t really my cup of tea. Um, like I said, I prefer a bit more technical, kind of theatre and stuff . . . it becomes very frustrating cleaning somebody up constantly, going backwards, you don’t feel like you are achieving anything . . . Yeah, it is quite frustrating to care for the oldies.* (03:I:H2)
‘Spose I’m guilty of being one of those people – because oldies, I’m really not a fan of working with oldies because you don’t see so much progress. (03:I:H2)

Having ageist attitudes included some nurses seeing older patients in less than positive ways.

Some patients are manipulative . . . they won’t do things for you . . . even though you’re doing the best for them, so you have to try and find ways to get them to do things. Yeah. (014:I:H2)

These ageist views included beliefs that older people were of a lower status than other members of society, and so providing care for them was therefore associated with this stigma.

I think there is a real stigma, and there is a real ageist thing about working with older people. I feel very positive about older people, but I think that I am in the minority because I think a lot of people [nurses] feel negatively about it. (02:I:H2)

At times nurses resolved their conflict about not having time to provide adequate care to their older patients by rationalising that they are sometimes too old to benefit from this care. Some nurses even questioned how deserving older people were of care that would rehabilitate them.

But, um, I’d say yeah, most of them would be elderly, somewhere between 70, 60 years of age, and so 70% are elderly patients . . . most of my patients would be over 90 and that’s going to be impossible. I really get quite frustrated [because] some of the candidates that are chosen for rehab are not really what could be termed rehabable’. It just becomes, sometimes it just becomes like a baby-sitting service. (03:I:H2)

Ageist attitudes can result in a lack of empathy for the older person, which some nurses admitted observing in the way other nurses treated them on the wards.

The oldies are absolutely treated like scum of the earth and it’s disgusting, but I can understand how it can get to be very, very frustrating for the people [nurses] that work with them. I think that’s the stigma as such, whereas I’m not, I don’t know, I don’t actually mind working here, but it’s just very slow, it’s not exactly a challenge. (013:I:H2)
In the next observation the nurse is continuing to offer care while the older patient is uncomfortable. The nurse ignores the frail older patient’s discomfort while she continues to raise the head of the bed. The patient’s position is lower down on the mattress, and when the angle of the head of the bed is increased it has forced her head forward, which causes her to cry out in pain. The nurse disregards the patient’s distress and tells her she will put it down when the tablets have been taken.

The registered nurse (RN) then begins to raise the head of the bed. The patient in a high tone of voice quickly says, “That’s too high, love . . . ahhhh! Ahhhh!” The RN does not respond to what the patient has said and continues to raise the head of the bed . . . The RN replies [with an emphasis on high], “Too high! I just want you to take these tablets then I will put you down again,” and she continues to raise the head of the bed. When the head of the bed is where the RN wants it, she tells the patient, “That’s it.” (04:O:H1)

The nurse in the following example is insisting that the patient takes her medication, which leaves the older woman feeling anxious and more resistant. The patient tells the nurse she does not want to take the capsule, but the nurse does not attend to the patient’s verbal communication and so proceeds with the task. The older patient’s vulnerability has placed her at risk of abuse, because she is totally dependent on the nurse for assistance.

The nurse now tries to push a capsule into the patient’s mouth. It is pressed up against the patient’s lips that are pushed flat. The patient says, “No, I don’t,” and she moves her head from side to side saying “no, no, no.” The nurse then says in a brusque loud tone of voice, with an emphasis on the word ‘want’, “Do you want go home? You want to get better?” (010:O:H1)

The nurses in these observations showed evidence of ineffective attitudes towards their older patients, which left these patients in discomfort. Some of these behaviours included avoidance, lack of attending and responding, rough, harsh speaking, brusqueness, slowness in responding, and insensitivity. The nurses disclosed ageist views in the way they found providing care for the older patients was a chore, unchallenging and associated with stigma.
THEME DISCUSSION: OPTIONALISING CARE

Choosing to optionalise their care included the nurses’ prioritising of patients and limiting of functional care needed by older patients. The nurses’ constructions revealed they preferred completing medical treatments or technical tasks. They also admitted that technical work interrupted them and used up their time, which meant they could not return to their older patients to complete their functional care. Interruptions are part of the routine of a ward, and nurses, in managing their professional role, learn how to accommodate this work within the time of their shifts. If technical tasks are favoured over the specific functional caring needed by frail and vulnerable patients it can place the older person at a higher risk of complications. Reasons given by the nurses for adopting technical work values were that these tasks were more challenging and interesting, and that they did not like performing functional care. Nurses appeared to understand what care they were actually providing and how they were implementing this care for the older patients, which for some was not at an appropriate standard (ANMC, 2005). Such behaviour does not meet the disciplinary expectations of the professional role, which notes that nurses are ethically obliged to provide a minimal acceptable level of care for dependent ill patients (ANMC, 2005).

There have not been many studies made of the care nurses give to older patients in hospital; nevertheless, research has indicated that time constraints and variable conditions on the wards affect the standard of care being provided (Kilstoff & Rochester, 2001; Kilstoff & Rochester, 2004; Kramer, 1974; Lynam et al. 2003; Nystrom, 2002). Nurses’ perception of a lack of time for optimal care was supported in one study conducted by Williams (1998), who found that nurses used four phases of ‘selective focusing’ (self-focusing, needs-focusing, patient-focusing and quality-focusing) to cope with time constraints. These nurse participants identified four contexts of time that described the ‘pace of work and workload’; these were labelled as abundant, sufficient, minimal and insufficient time. An interesting aspect of these findings was that nurses believed conditions for the delivery of quality nursing care were rarely possible. When nurses had time the standard of care was good, and when time was limited the care needed by patients was not given. The results also indicated that ‘quality-focusing’ was not an everyday event due to the perceived limitations on the wards, and although some patients may have received quality care, other patients only received compromised care when nurses experienced high levels of work stress. This
research showed that it was not clear if the patients who received quality care were those most in need of it. Latimer’s (2000) study conducted approximately fifteen years ago found that nurses, even though they felt some ‘guilt’ and ‘frustration’, rationalised their decisions to complete the more ‘routine’ or medical type of work which met the ‘nature and purpose of the hospital’ instead of the care patients, including the older patients, wanted or needed.

Nurses have a theoretical understanding of what is an appropriate level of professional care, but the standard of care actually implemented may be quite different (Hegney et al. 2003; Kilstoff & Rochester, 2001; Kilstoff & Rochester, 2004; Lynam et al. 2003; Nystrom, 2002). The constructions of the nurses in this study indicated they needed social time to give them some excitement. They used tactics to find time for social interaction by avoiding older patients, not speaking, attending or responding and by appearing to be too busy. Thompson, Melia and Boyd (2000) noted that nurses may feel some types of care – such as ‘chatting’ or ‘sitting’ with the older patients – wastes their time, and so they may introduce ‘minor sanctions’, such as not speaking to them when in the rooms or limiting care. Older patients need interaction because this process orients them to their hospital surroundings and reduces the risk of cognitive impairment (Eliopoulos, 2001). If nurses make an effort to converse with older patients during the day, this interaction can assist in the prevention of delirium (Registered Nurses’ Association of Ontario, 2004). The results from one study that provided a ‘snapshot’ of patterns of care found that 13% of nurses’ time during the shift was spent on personal or social time (Fitzgerald et al. 2003). The question for patient outcomes, then, is how much of this substituted time affects nursing performance and the implementation of care for older patients. Williams (1998) found that nurses believed quiet periods of time on the wards were time they had earned in lieu of the overwhelming burden they carried in continuing to work under the busy and stressful ward conditions. Time taken at the nurses’ desk for socialisation is time nurses are not utilising for implementing the complexity of care needed by increasing numbers of acutely ill older patients admitted into hospital with co-morbidities. There appeared to be some incongruence between nurses’ knowledge about what care should be provided and what care they were actually implementing.

A nurse’s perception of time is influenced by the interaction of personality, culture and environment. All these aspects impact on the decisions nurses make about
how they can more efficiently manage their time on busy ward environments, in order to complete their workloads and not substitute patient time for social interaction (Tappen, Weiss & Whitehead, 2004). Essential care required by vulnerable patients should not be limited or denied so that time can be taken to find support through socialisation with other staff on the wards. However, the nurse participants indicated they often felt unsupported and unappreciated by their managers and by the hospital administration. This is a situation which was found to result in negative outcomes for both patients and nurses (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Social support is one coping strategy nurses feel they need, in order to deal with this stress in the workplace (Caan, 2000). The availability of social support in the work environment is seen by nurses to be of critical importance; increased availability can lead to nurses feeling more satisfied and providing an improved quality of patient care (AbuALRub, 2004). This was supported in the findings from an Australian study, conducted by Joiner and Bartram (2004), which showed that social support was negatively associated with work stress. These authors highlight that nurses need to engage in informal workplace discussions because these social interludes may have a stress-reducing effect, but not to the detriment of the trust implied in the professional relationship between nurses and their vulnerable older patients.

In a critical exploration by Peter and Morgan (2001) of Baier’s (1985) work on the concept of professional trust as including obligation, it is argued that it is not plausible to expect nurses necessarily to like all their patients. However, nurses should consider their obligation in implementing the codes and principles that guide their practice, in order to ensure the wellbeing and trust of all patients, including those older patients (ANMC, 2005). These professional standards of care, therefore, direct the moral responsibility or obligation’ of nurses in maintaining a patient’s health and in reducing discomfort (ANMC, 2005; Peter, 2002). When nursing practice is not framed by this morally based care it can engender anxiety, tension and distress in the older patient (Hagerty & Patusky, 2003). The reason for this is that older patients are more vulnerable and have a high prevalence of functional disability and are more at risk of adverse events (Fink & Foreman, 2000; Hart et al. 2002).

Failing to value the importance of functional care based on a caring relationship with older people can, therefore, result in abuse and coercion (NRB, 1999), because nurses’ values have a great influence on older people’s dignity and autonomy and the
management of their care (Jacelon, 2002). Not knowing about or relating to their older patients means that nurses may be implementing care that is not individualised or patient-centred. Defocused care may not be at an appropriate or safe level and, therefore, may not be framed by the professional (ANMC, 2003) and ethical codes of practice (ANMC, 2002). When nursing care is incompetent and borders on being unsafe, both nurses and patients feel stressed and dissatisfied (Bartram et al. 2004; Fagerberg & Kihlgren, 2001; NRB, 1999). Comments from nurses in the present study indicated some inconsistency between their understanding about the inappropriate standard of care being provided for older patients and the consequences of their actions. Nurses reflected a devaluing of the therapeutic values implied in their relationship with older adults and, in some cases, indicated ageist and neglectful attitudes.

It is important that older hospitalised patients are not ignored or neglected. Poor management of their care can result in further functional decline and adverse events (Hart et al. 2002; Needleman et al. 2002). Negative outcome occurs because acutely ill older patients often have many complex chronic conditions and so require a higher level of quality care to meet their multi-dimensional needs, including not only physical but also psychosocial (Miller, 2002; Needleman et al. 2002). The nurses in the present study, however, admitted that optionalising care was justified because of their perception that they did not have time to spend providing the intensive functional care often needed by their older patients. Functional care was believed to be more optional than usual ‘these days’ on the unresourced wards.

Overall, this section has presented nurses’ understandings about how they optionalised their care of older patients. Nurses indicated they were knowledgeable about what comprised competent care for the older patients. In their shared meanings they were aware of the level of care they were actually providing and of how it was being implemented on the wards. However, it was evident from their constructions that there was some incongruity between their knowledge about the expected care and the actual care being implemented. As their articulations show, there also appeared to be a degree of inconsistency between their knowledge about care needed by older patients and the consequences of their actions if this care was not provided. Nurses did not assume ethical responsibility for the optionalisation of care for older patients and instead believed the cause lay outside of their own personal control, and so they relieved their own stress by finding fault with others.
4.5 Blaming

Nurses interviewed for this study knew they were not providing an appropriate standard of care for older patients and rationalised their behaviour by blaming the context of the health care system, themselves and other nurses, and the older patients. These nurses indicated that they felt frustration and stress because they were not able to provide what they believed to be a professional standard of care in the economically constrained hospital system. Many nurses not only recognised that they were not giving appropriate care but also admitted that other nurses were not either. Some nurses blamed their older patients for not telling them when they needed care. Their collective acceptance of their less than desirable behaviour may have reduced their dissonance and offered them a cognitively comfortable position to operate from. Furthermore, nurses believed they were too helpless to effect any change to the status quo because of the ongoing budgetary restrictions operating in the market-driven hospital organisations.

4.5.1 The context of the health care system

There was an overwhelming feeling articulated by the nurses that years of government cost-cutting had impacted on the staffing and resources available in the health care system, which then affected their ability to provide a satisfactory level of care for vulnerable older patients. They complained that this economic climate had no flexibility to accommodate the health needs of ill people, and that these services should be available as health should not be costed like a commodity.

*Um, basically I think it all comes down to money . . . it’s a monetary thing.*

*Um, I mean, I understand that beds need to be closed and sometimes you have patients that are sick . . . people get sick and there’s no money [in the health care system] and you can’t . . . put money on that . . . no flexibility.*

(014:I:H2)

*There’s not enough money in the system . . . I may be out of line saying this, but the government’s very much interested in the money that we spend, the cost-cutting, the reductions. The don’t spend the money on providing the facilities and the staff that are needed to properly care for the people who need it the most, who pretty much are your oldies. They’re the ones that need the help more, the caring and more time.*

(04:I:H2)

*Well, the problem in nursing is a lack of money and the politics.*

(01:I:H2)
These constructions implied that there was some incoherence operating in nurses’ work areas, where years of funding shortages had led to reduced and, to some extent, punitive standards of care for those who most needed it – the critically ill patients, including those who are old.

4.5.1.1 Hospital and nursing administration

Nurses blamed not only the health care system but also the hospital and nursing administrators, who they believed had been relatively ineffective in making decisions that could have improved conditions on wards. Nurses perceived that the organisational objectives for efficiency and economy had hampered their ability to perform their professional role, which then prevented them from providing the quality care needed by the most needy, usually the older, acutely ill patients. Nurses voiced their anger and frustration about the less than desired practices being enacted on the wards.

I can go to a hospital administration meeting in a management position and go back six months apart and they’re talking about the same thing. Nothing happens. It just drives me nuts. They’re all running against a brick wall anyway. I mean they [nurses on the wards] are not giving the care they really want to give. They are worried about the budgets, etc, long hours, overtime and all that sort of thing, and, you know . . . they are not really doing the care . . . what they really want to do for a patient. (01:I:H2)

I think it would help them a lot to have more time with the [older] patients. Especially with the, sort of, chronic conditions like you know [they have], we have a very dense CVA that’s got no response, it’s very hard. You need to give them more care. I can feel that the system, the care [nursing] program falls down, it all seems to fall back on the nurses and we are already stressed out, in my mind, already carrying two-thirds of the weight anyway, which would be another burden. More dumped on us, more lumped on us, you know? . . . It decreases the quality of the care that we give. (04:I H2)

Nurses reported that they were frustrated by the perceived ineffectiveness and lack of interest of hospital and nursing administrators for the standard of nursing care. Furthermore, they felt their hospital organisations had their own objectives – to improve patient throughput – which was often to the detriment of quality caring practices. The
logic of how the beds, patients and staffing were being costed was seen by many of the nurses to be just about economic constraint and too little about caring for older patients. Nurses felt that they had to accept the ‘uninhabitable’ conditions on the wards.

*I feel that nursing at the floor level [is not interested in how funding issues have affected the role of the clinical nurses]. There’s not enough money in the system . . . and there’s too much attention spent on the supervising administration role in the hospital [not on the quality of patient care on the wards] . . . Misappropriation of resources, which are limited, I guess, and I just feel the whole kind of thing does grate me.* (04:I:H2)

*I mean, yes . . . every ward now has to run around and budget, I mean, and everyone is out of budget.* (01:I:H2)

*You just can’t run a ward . . . on a budget . . . The staff are frustrated because they just can’t get the equipment they want. So, I mean, they’re caught right in the middle. Yes. Well, the biggest problem is our lack of staff. That’s just not allowing us to give the standards of care.* (01:I:H2)

Nurses believed that there was a lack of interest in the quality of patient care being provided on the wards. As well, they believed there could have been more consultation with them in relation to how registered nurse positions were being replaced in the hospital.

*Originally there was one per staff here allocated to this ward. They’ve culled it from the nursing [position] to a wards man, whereas that should have been another whole position created. We’ve got staff and the funding and, of course, the excuse they always use is the [lack of] funding, you know.* (04:I:H2)

Blame was allocated not only to the hospital and nursing administration but also to the Nursing Unit Managers (NUM), who the nurses felt were mainly concerned with administration issues and not quality patient care. The NUM role superseded the Charge Sister role, which in the past had concentrated mainly on clinical supervision, such as the coordination and continuity of nursing care. Because of the health care system’s change to this position, many nurses believed they lacked support at the ward level for implementing professionally based care.
The NUM role used to be about the working, coordinating, delegating and managing. Whereas now it tends to be, like, they [administration] take the NUM away and the numbers drop for the [permanent] staff that have been allocated to the ward . . . which occurs because the NUM is now no longer available on the floor. The NUM is not attuned to the needs of the floor now, and then subsequently what then happens, senior registered nurses, you know, are left running hither and thither . . . so there’s been a real compromise in the quality of care that’s given . . . (04:I:H2)

Nurses continued to share their stress about the hard nature of their role. They reported their concerns about the organisational problems on the wards, which they believed were caused by a lack of clinical management over the years. This situation, they believed, had resulted in a loss of registered nurse positions and a decrease in the level of care being provided. Hence, nurses’ constructions alluded to the tensions they felt about being misunderstood and not receiving support and recognition from their nurse managers. In their articulations, they expressed feeling helpless because their practices were being influenced by other staff on the ward. They also implied that the work they were performing on the wards was similar to that undertaken by other health professionals but that they were not receiving the same recognition, status or reward.

*We do a lot of other things, such as physiotherapy, social work; we’ve got a medical role. So we have to be a jack-of-all-trades as well sometimes, you know, and I don’t think we get recognition for that all the time.* (03:I:H2)

*Oh, very much so, you know. Ahh, I feel like I’ve been misunderstood, I feel that I’ve been prejudiced against, you know, I feel that I’ve been just dismissed and have to accept it . . . But I feel that you don’t get, at times, the credit that you are due because of the gender, the discrimination and prejudices . . . the attitude to your role within nursing [collective of nurses on the ward not supporting the professional role values of other nurses], and the sense of [others health professionals] wielding power over others [nurses].* (04:I:H2)

Part of feeling undervalued concerned the fact the nurses did not believe they were being sufficiently renumerated for their contributions.

*Two are sick and too many patients and they’re over worked and, um, you know, and that leads to people leaving . . . and low pay on top of that, and it*
would be great if you could have one to two patients per nurse. Then you would be able to spend quality time with them as well as continue to care properly and do everything. Short-staffed everywhere you go. (013:1:H2)

I also think as nurses we have huge role for what [little reimbursement] we get paid for as nurses. (03:1:H2)

In the preceding and other interviews, nurses made transparent their belief that their moral responsibility to their patients was impossible to fulfil in the present hospital environment. They expressed they were overwhelmed by the lack of resources and support on the wards, which meant they were overworked and felt frustrated about how to competently perform their professional role under these conditions. Additionally, nurses felt that other nurses and staff exercised some power or control over how they were able to perform their professional role.

### 4.5.2 Themselves and other nurses

Nurses also blamed themselves and other nurses when they felt they were not providing a professional standard of care for older patients. They felt powerless within the hospital system to make changes to the way care was being provided. Throughout the interviews, many nurses articulated that they knew quality functional care was important for the older patients, but they admitted that they were not using their knowledge and skills in delivering a safe and competent level of practice.

... you can’t even give the care. (04:1:H2)

No. I just find that any medical area like where we have the 31 beds open and you are really busy... it was fairly trying for everyone, it is very frustrating and you knew the person who would probably suffer the most at the end of the day was the aged patients. (06:1:H2)

In the following observation, there is some disparity with the constructions shared by the preceding nurse about her concern for the care needed by older patients and her actions. In this observation, the nurse had not been to see the older patient who was left sitting on her bed and who needed to find the toilet.

The patient got out of bed and walked unsteadily towards the bathroom. She said out loud, “I’ve got to go to the toilet.” The patient was assisted to the bathroom area [by the researcher]. The registered nurse (RN) was standing at
the nurses' desk, talking socially to the other nurses, when she was informed about the patient needing her assistance. She replied, “Oh, all right, I’ll be there soon.” Five minutes later the nurse arrived at the bathroom to supervise the older patient and then to bring her back to her room. The nurse was speaking in a joking but blunt way with this older woman. The tone of the nurse’s voice was not low or gentle, but loud. (06:O:H2)

Nursing colleagues were portrayed as being part of the socialised problem on the wards in relation to the lack of acceptable care for the older patients. The nurses blamed themselves for not giving care but often included other nurses as well.

_I think, as nurses, I feel there is an awful lot we can do as far as our role is . . . and I think to say that, you know, you do [need to] use your, really, not basic nursing skills, but you [need to] use your real nursing skills when you care for older people. Because I didn’t feel that I was using those skills in acute care wards, that I had, and my knowledge and so forth because we were so busy, and we were so restricted to dealing with what was happening there then, that you don’t have time._ (03:I:H2)

_It’s very hard to give more care._ (04:I:H2)

_I mean, they are not giving the care . . . what they really want to do for a patient._ (01:I:H2)

Nurses sometimes blamed other nurses for their lack of care and called them abusive, but, nevertheless, they had chosen not to speak out about it. When nurses behave compliantly and enact less competent care they compromise their professional value system. By not resisting the undesirable practices, these nurses were abrogating their moral responsibility to prevent harm to vulnerable patients. A lack of moral identity implies an inability on the part of nurses to assume responsibility for unsafe or incompetent care. In many observations in this study, there was a range of care provided to older patients; some nurses were closely interested in the older people, while others were inattentive and demonstrated a lack of response, disrespect and even abuse.

_I just thought, God, we are just so bad. In the way we care for older people . . . I think that it is about giving good patient care because it is not just going in their rooms and emptying a catheter bag or taking someone to the toilet, but they [nurses on the ward] are locking them [older patients] in and leaving them there._ (03:I:H2)
4.5.3 Older patients

Nurses alleviated their conflict about not providing a professional standard of care not only by blaming themselves and other nurses but also by blaming the older patients. Several nurses related that they did not give care to the older patients because they did not ask for assistance. The meanings implied by some nurses, therefore, concerned whether it was worthwhile for them to use their time to ask the older patients whether they had a problem. Nurses complained that they could not force patients to have care.

*I feel that I have to [give her care] for lunch, and if she doesn’t want anything done to her then I can’t force her to have it or have a wash or whatever.* (012:I:H2)

*Well, yeah. They need O2 and they refuse O2 and that’s due to the confusion and that’s probably because they are hypoxic and, yeah, what can you do, then you can run into all kinds of problems, yeah, it’s a problem.* (010:I:H2)

Nurses believed that preventive care actions were not routinely being provided; instead, they blamed older patients for not telling nurses about their actual problems. In failing to implement safe and competent practice, the nurses were not working according to their standards of professional practice.

*But if you take the time and have the time, which is hard [to do] in the hospital, and say, right, they’re not drinking, and you go and see if they are a bit sore. But you’ve got to have the time to ask them if their heels are sore, most of the time they won’t tell you. They just see you running backwards and forwards. Yes, how often do they tell you? I had someone last night that had chest pain. And I said, “Why didn’t you tell me?” and he said, “I didn’t want to tell you.”* (01:I:H2)

Some nurse participants blamed older patients for not informing them if they were having any health problems. They admitted they knew they were not practising competently, and they also understood that this lack of care could result in complications for the older patients, however they felt personally unable to prevent these practices on the wards. These nurses’ behaviour was in contrast to the observed interactions presented in the major theme, optionalising care, where even when older patients attempted to inform the nurses of problems they were experiencing with either
verbal or nonverbal communication (which included complaints of chest pain, burning sacral area, hunger or the need to use the toilet) some of the nurses chose to use avoidance tactics. Additionally, it was also demonstrated that when actual or potential problems had been reported in patients’ records, and when care regimes were recommended in the care plans, the care was not always given during the shift.

4.5.2.1 Powerlessness to provide quality care

Nurses’ constructions included feeling frustrated and helpless to change the incoherent work conditions on the ward. They blamed the health care system, hospital and nursing administration, and ward management for their inability to provide the standard of care they believed was expected of them in their professional role. Failure to take charge of ‘how’ care was being provided on the wards demonstrated nurses’ loss of moral integrity, which they felt was compromised because they were abandoned by the system, administration, ward managers and other staff. Nurses admitted they were irritated and worried because optimal care was not being given, older patients were not being assessed properly and they were being discharged ‘quicker and sicker’, only to return for readmission.

You don’t have time to spend to assess all that . . . then you know they’re sent home and then brought back very soon. (013:1:H2)

The Nursing Unit Managers (NUMs) were also blamed for not wanting to be involved in supporting nurses by actively agitating the administration for changes on the wards with regards to current nursing practices. Nurses felt this inaction occurred because managers did not want to jeopardise their own job security. Moreover, there was a sense in nurses’ meanings that they did not feel they could approach their managers, and so a lack of coherence and trust compromised communication channels between ward nurses and those in administrative positions. The nurses in this study allocated blame to the health care system, hospital administration and ward management for this perceived lack of support. They reported their disappointment and loss of faith, not only in others but also in their responsibility as nurses.

But, yeah, I, nursing is disappointing . . . I think that not one of my perceptions is that it’s due to the fact that, you know, the old thought was that nurses were the doctors’ handmaidens, so in a lot of these nurses in administration, they sort of wanted to get away from the hard grind of the
patient load, the care, dealing with incontinence, confused, demented, sick patients. It’s very physically taxing, emotionally and its psychologically draining. They are invariably looking for a way to move up. So I feel its lost its, you know, the priority has been shifted the wrong way a bit. I feel it’s too top heavy and we’ve got too many, you know, administrators, who maybe they’re not, you know, I think all these problems in the system do . . . the lack of addressing the problems in nursing, the policies; it’s what it does to you as the caregiver, the carer. Oh, I don’t think it really affects them [nursing administration] that much. I think it affects the givers of care rather than the receivers. (013:I:H2)

Nurses intimated that although they felt powerless, they wished someone else would speak out on their behalf to address these problems and the conflict they were experiencing in their work environments. They articulated their sense of discontent in not feeling that they could personally change the work conditions they perceived on the hospital wards. The NUMs were seen by the nurses to be unconcerned about nurses’ stress over the undesirable work practices.

I’m really at a loss to actually know how to make things better because I don’t have a great deal of experience, but I just kind of figure that what’s going on isn’t really working . . . See, I’m not quite sure how to make it better, I just know that something needs to change because we are not giving the care we should be giving. (03:1:H2)

One reason nurses gave for not challenging or reporting their problems to their administrators or ward managers was fear of being seen as ‘trouble-makers’.

Because I know I’m not a trouble-maker, I wouldn’t have stayed in the game for as long as I have, and I just feel that, it’s just that that’s the fact and I just wish that someone would be gutsy enough to address the problems in nursing, the lack of funding and to be able to change things because you cant give the care you want to . . . (04:1:H2)

That’s why I’m still a nurse, cause there’s no way I’d go into politics. I don’t mind doing the out-of-hours managing in the hospital but not in-hours. (01:1:H2)
So, yep, my role in nursing is, I think, I mean, I think nursing, the thing about my nursing is I’m nursing my patients, I am not very concerned with the politics and things like that go on in nursing. (03:I:H2)

These nurses did not feel they could take control and make decisions about implementing appropriate care on their wards. They believed taking an active role would jeopardise their positions and would create difficulties with other staff. They did not feel the profession was supportive of its own members.

There seems to be another thing within the nursing fraternity is that, it's the only kind of professional vocation where they seem to devour their own. We've got to, willing to put you down or to justify your position of authority to remind you where you are but what's needed is there isn’t enough money or empathy and support. . . . I think all these problems in the system do . . . the lack of addressing the problems in nursing, the policies; it’s what it does to you as the caregiver, the carer. Oh, I don’t think it really affects them that much. I think it affects the givers of care rather than the receivers. You feel frustrated, you feel, yeah, frustrated and you feel a bit angry, you feel a bit angry you can’t do anything about it. (04:I:H2)

In some interviews nurses noted that they believed being outspoken about the conditions of their work detracted from their caring role. In this study, no nurses discussed ‘speaking out’ or using any forms of resistance to challenge the less acceptable work practices of other staff. The only area in which nurses discussed ‘taking action about their work practices’ concerned forcing medical officers to prescribe sedation for cognitively impaired patients. The work environment appeared to engender feelings of oppression for nurses over their powerlessness and the lack of recognition of their worth.

Everyone pushes them [older patients] aside . . . and I think that’s horrible. (06:1:H2)

[The older patients] are stuck in a system where they are being pushed around. (08:1:H2)

Nurses’ inability or reluctance to effect any change to the lack of care the older patients were receiving on the wards resulted in moral conflict for some of them. Their stress may have been partly decreased by the fact that a few nurses had chosen to work overtime or through their breaks in order to feel like they had contributed in some way.
The realisation they were not using their professional values created a degree of role conflict for the nurses, who felt that the only solution or ‘way out’ was to change their career or go to a different area of nursing.

Two are sick and too many patients, the nurses are overworked, um, you know, that leads to people leaving . . . (013:I:H2)

If you are not strong physically and dedicated, invariably there will be a high turnover rate because things are bad in the system. (04:I:H2)

Leaving hospital employment and returning to work in the community was seen as a path that would relieve the nurses’ conflicts and would allow them to work independently and utilise their professional values more fully.

Um, how do I feel as a nurse . . . ? I mean, I feel we have a really important role as health care professionals, mainly as obviously in the acute setting, is obviously, you know, caring for people in that setting, but we also have a large educative role as well. Unfortunately, I don’t think that we use those skills as much as we can do in the acute setting and that’s one of my reasons for moving into community. So I think we work very holistically in that sense. (02:I:H2)

This section has explored nurses’ understandings about their own practice and has found inconsistency between nurses’ knowledge and the consequences of their actions for older patients in hospital.

**Theme Discussion: Blaming**

Nurses recognised that they were not providing an appropriate standard of care for their older patients, and in their interviews related that this was because they felt thwarted by the funding problems in the health care system that had impacted on many facets of care provision. When nurses feel that the health care setting, hospital and ward contexts are unpredictable, they can lose their sense of coherence and confidence in the system (Ponte, Kruger, DeMarco, Hanley, & Conlin, 2004). Nurses’ sense of incoherence about the situation – in and outside the health care system – can make a difference to the quality of their patient care (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). According to Ponte et al. (2004), when nurses experience a lack of coherence in the workplace they can begin to feel isolated and unrecognised by their hospital administrators. Not
enacting their practices according to the minimal competencies expected of them professionally places nurses in a moral dilemma (ANMC, 2005). Nurses reported in their interviews that they felt too helpless to effect any change in the less than competent practices currently acceptable on wards. They were dissatisfied with not using their professional values in providing quality care, and so some talked about quitting the profession altogether.

Nurses believed they could not meet their own expectations or those of others, and so had relieved their role conflict by accepting to enact a less than satisfactory level of care. In order to deal with their cognitive dissonance, they resorted to blaming the health care system, the hospital and nursing administration, themselves, others and even the older patients. When individuals feel disagreement or dissonance cognitively with their lack of ethical action, they may look for ways in which to justify their behaviour (Festinger, 1957; Harmon-Jones & Mills, 1999). Blaming is one way in which personal involvement can be reduced, as it decreases stress and limits personal responsibility for not choosing to enact a professional value system (Kilstoff & Rochester, 2004). In this way, nurses were perhaps able to relocate responsibility for their perceived lack of competent care as they went about their daily activities on the wards.

Professional nurses, however, are morally accountable for their practice, and, according to Walker (1998, p. 9), this “moral responsibility” is “a socially embodied medium of mutual understandings and compromise between people over their responsibility for things open to human care and response.” Personal responsibility for patient care on the wards cannot be isolated from the roles and responsibilities held by other nurses; that is, all nurses working on the wards form part of the social life of the ward and are therefore equally responsible for the ongoing negotiation of their responsibilities for competent practices. As part of their professional responsibilities, nurses share understandings about role behaviours, and these shared meanings affirm ‘who we are’ and ‘what we do’. It is this construction by which we judge and are judged according to our professional codes of practice (Walker, 1998).

Blaming may have resulted from nurses’ sense of alienation. Over time, nurses’ moral or ethical outrage about poor quality practices has been ignored, perhaps because those in administrative positions have become desensitised, leaving the integrity of these concerns questionable (Walker, 1998). The findings by Woods (1999) showed that nurse participants maintained a commitment to ethical practice through differing levels
of involvement, which can include ‘pragmatic compromise, moral protests or covert or overt subversion’. Moreover, factors identified in Woods’s research that impeded the nurses’ professional practice are also closely aligned with the reported meanings of the nurses in the present study. These include: familiarity with the health care context, the perceptions and relationship with those involved, and nursing responses to working within ‘the system’. However, the nurses in Woods’s study who were morally committed maintained a level of professional involvement with their patients even in difficult circumstances, and an optimal level of care was provided. Having nursing ethics in this sense is not seen as an optional extra, but as an essential part of the disciplinary framework that guides responsible and competent nursing practice (Alligood, 2006b; ANMC, 2002; Weis & Schank, 2000).

4.6 Discussion of Nurses’ Constructions of Their Management of the Care Needed by Acutely Ill, Older Patients in Hospital

This chapter has presented an interpretive description from the constructions provided by nurses as they cared for acutely ill older adults in hospital. The interpretive description has emerged from interviews with these nurses, from observations of their interactions with older patients, and (where needed) from some comparison and confirmation with nurses’ documentation of their patient care. The first section of this chapter was concerned with understanding nurses’ knowledge about what they believed to be competent and safe care for their older patients in hospital. The major theme, ‘knowing about care’, included meeting all of the older patients’ needs and focusing on the person so that care would be individualised. Patient-centred care is essential to the development and reinforcement of caring behaviours and patient satisfaction (Kipp, 2001). The nurses in this study demonstrated that they were knowledgeable and capable of providing safe and competent care. This was evident from their articulation of the necessity of implementing care that was based on nurses’ ongoing clinical assessments, which provided information for making informed decisions about what care was or was not appropriate for each individual patient. Decisions guided by these ‘profiles’ allow nurses to more readily anticipate possible outcomes and implement proactive care actions (Ebright, Patterson, Chalko, & Render, 2003). Caring behaviours are framed by conceptual frameworks and a disciplinary body of knowledge, and these guide nurses in providing competent care that meets the holistic needs of the patient (ANMC, 2005;
Yam & Rossiter, 2000). Nurses continually emphasised the significance of undertaking a critical assessment not only of the physical needs of older patients but also of their psychosocial needs, so that they would know and recognise sudden changes in the patient’s condition.

Nurses were also aware they needed to provide functional care. This preventive care is based on the therapeutic relationship nurses develop during interactions with older patients. Quality caring practices that show valuing of the older person were understood by nurses to be required by their conceptual frameworks (Alligood, 2006a; ANMC, 2005). In developing a focused relationship, nurses discussed using different approaches, which included establishing trust through speaking with the older adults, keeping their word, providing extra care, looking after patients, being there for patients, acknowledging each patient as a person, understanding the patient’s routines, giving reassurance, using touch and humour, and judging the patient’s behaviour and coping skills. These methods build trust and respect between nurses and older people, and were seen by the nurses as important in developing a therapeutic relationship. These findings supported the first aim of the study, and clearly demonstrated the theoretical and clinical knowledge of the nurses.

In relation to the second major theme, ‘optionalising care’, nurses believed that the level of care they provided for older patients did not often meet their professional standards of practice (ANMC, 2005). They realised that not valuing and developing a relationship with older patients and not providing a competent level of preventive care could place these older people at risk of complications. Professional values are based on the theoretical approaches and disciplinary standards of practice, and this framework is central to the day-to-day practice of nurses. Therefore, it directs and shapes the constructions they have about their world and the clinical decisions or judgements they make (Alligood, 2006a; ANMC, 2005). Nurses explained that they could not provide care guided by these professional values because of time constraints on their busy wards. In order to manage their workload, they chose to optionalise their actions, by prioritising patients and limiting care. The reason for this, according to the nurses, was that they were constantly interrupted by medical treatments and technical tasks and, therefore, ran out of time. Because of this continual lack of time on the wards, they were often unable to return to their older patients to complete the planned functional care. These findings supported the second aim of the study and suggested that nurses
understood what care they were providing and how they were implanting this care for the older patients on the ward.

It was evident that even though nurses understood a certain level of care was needed by older patients, they nevertheless spent lengthy amounts of their time socialising at the ward desk. Their behaviour appeared to indicate that there may be some incongruence between their knowledge about what care should be provided and the actual care they were implementing. Furthermore, this social time at the desk was time removed from patient care and was obtained by using tactics such as avoiding older patients, by not speaking to, attending or responding to them when in their rooms, and by appearing to be too busy. Devaluing of their relationship occurred when care was not patient-focused and nurses were not informed about their patients’ treatments and condition. Not knowing about patients’ needs means nursing care may cross the boundaries of safe practice and result in risky or abusive actions (NRB, 1999). There was a sense in nurses’ reports that the basic or functional care needed by older patients has a lower status in comparison to the more technical medical work. Additionally, a stigma appeared to be associated with providing this functional or basic care for older patients. As well, nurses who did not want to provide this care also expressed ageist attitudes, which highlighted a lack of connection in their relationship with their older patients.

Ageist attitudes were apparent in some interviews when nurses described the older patients as being too old for quality care. Nurses admitted they knew about the expected standard of functional or basic care required by the older patients, but this level of care was not evident in the observations of their practices. These findings, therefore, addressed the third aim of the study, and showed that there was incongruence between the nurses’ knowledge about what care should be given for older patients and the care that was actually implemented on wards.

A provision of quality care assures a patient’s moral right to a caring relationship, and this includes the maintenance of dignity, wellbeing and personal worth (Lagana, 2000). Nurses disclosed that they could not provide this standard of care because of economic rationalisation, which had resulted in reduced resources and staffing in the hospitals, and increased pressure on nurses themselves. Hence, the third major theme, ‘blaming’, highlighted the way nurses believed that the health care system, hospital and nursing administration and the Nursing Unit Managers were
responsible for the lack of competent care being provided on the wards. Although no-one would dispute the fact that economic rationalisation in the health care sector has created difficulties, the problem has been occurring for over two decades now in Australia (Duckett, 2005; Duffield & O’Brien-Pallas, 2003; Francis & Humphreys, 1999). Nurses, even during times of stringent cost-cutting, still have a moral responsibility to ensure that older patients receive quality care that is mandated by the profession’s theoretical frameworks and standards of practice (ANMC, 2005; Neuman, 1995; Nicol et al. 2000; NRB, 1999). There was a sense in nurses’ interviews that they used blaming to deal with their stress about not managing their own time more efficiently during their shifts. Justifications for why they were not giving competent care appeared to allow nurses to deal cognitively with their own anxiety about not providing an acceptable standard of care.

The meanings shared by these nurses (and which emerged from the researcher’s own constructions) were that the workplace environment impacted negatively on the nurses’ professional and ethical behaviour. The influence of bureaucratic hospital institutions on the role of nurses has also been documented over the years in numerous studies, both international and local (Kilstoff & Rochester, 2001; Kilstoff & Rochester, 2004; Kramer, 1974; Rodney et al. 2002; Weis, Malone, Merighi, & Benner, 2002). A lack of trust in hospital management and feelings about being unsupported were expressed in many interviews by nurses who believed the constant atmosphere of cost-cutting, a lack of resources and inadequate staffing caused them to feel neglected and disregarded. In organisational theory, when employees experience feelings of disrespect it mirrors the core values that operate within the culture of that workplace, and this eventually shapes worker performances (Masterson, Lewis, Goldman, & Taylor, 2000). This was apparent in the present study from the way that nurses discussed how stressed they felt in their jobs and that they knew they were not giving quality patient care. As a rationalisation for their behaviour, many nurses blamed the health care system and the nursing administration. They did not trust those in administration, nor did they believe that management valued or recognised their work. Moreover, nurses felt the system was ultimately responsible for staffing shortages, mainly because of its inability to recruit, retain and recognise nurses as a vital resource. The majority of nurses in this study had undertaken an undergraduate bachelor of nursing degree with five nurses completing higher tertiary studies in palliative care, bioethics, gerontology and rehabilitation and
health education and promotion. Even though one nurse had specialist gerontological preparation, the impact of her expert knowledge and skills was not evident in the care practices on the ward. Most nurses, including this nurse, articulated that their professional agency was constrained working in the health care system. The impact of a lack of resources and support by management on the ability of specialist nurses to influence ward attitudes and behaviour is supported by Ford and McCormack (2000, p. 393) who note that even though nurses may have higher degrees in gerontology or clinical nursing, this does not necessarily mean that there will be a “demonstrable outcome or evidence of expert practice in working with older people.” Nurses described the difficulties they had working in the hospital system and the way that ongoing cutbacks had worn down their willpower to act as professional agents in trying to change aspects of their work conditions.

These workplace conditions resulted in the nurses feeling unacknowledged, even though they were dissatisfied themselves, with the standard of care they knew was being implemented. As well, they spoke about their sense of inability to change the work practices evident on many hospital wards. Hence, even though they were able to provide some rationalisation for the level of care they were implementing, the nurses’ constructions did not adequately explain the fourth aim of the study— the inconsistencies found between the nurses’ knowledge about their care and the consequences of their care practices for the older patients. In a study conducted by Peter, Macfarlane and O’Brien-Pallas (2004), nurse participants described the way they felt burdened by the heavy workloads and oppressive nature of their uninhabitable work environments and believed they were powerless to change the situation. However, Paley (2004, p. 364) draws our attention to the reality of the current state of many global health care systems, arguing that it would be difficult for any nurse to find a “morally habitable hospital environment anywhere” and that perhaps it is a rather “utopian” desire. He goes on to emphasise that in “modern organizational life, things like ambiguity, uncertainty and so-called ‘role conflict’ are endemic . . . and go with the territory.” The research by Peter, Macfarlane and O’Brien-Pallas (2004) found that nurses perceived their professional value system to have been marginalised by the more dominant medical values. In addition, these nurses described feeling unappreciated for their contributions and isolated from decision-making within the broader activities of
the hospital organisation. Nevertheless, the nurses still found ways to resist and influence their moral environment.

Nurses in the present study also complained about their hard work on the wards, felt a lack of recognition and believed that their moral responsibilities were incoherent in the context of their work environments. But they did not, as Peter, Macfarlane and O’Brien-Pallas (2004) describes, attempt to innovate and strategically work the system for themselves or find others to do so on their behalf. Furthermore, some nurses resolved their conflicts by adopting a passive or compliant position and not speaking out. A similar sense of powerlessness or helplessness permeated the present interviews, as none of the nurses suggested they felt they could in any way change the work values operating on their wards. Nurses’ socialisation on the wards may be one form of oppressive group behaviour, in that any resistance by nurses is weakened as it becomes more comfortable to conform – this then encourages feelings of insensitivity about their moral disquiet. When the work environment is morally incomprehensible and nurses cannot find any satisfying path for resolving their value conflicts, then, as some nurses reported, their only option was to quit hospital work or leave the career of nursing altogether.

4.7 Conclusion

The constructions of nurses outlined in this chapter illustrate that they understand the importance of knowing about their patients and forming relationships that were focused and therapeutic. Nurses noted that building a closer connection with older patients alerted them to sudden changes in those patients’ conditions. When they devalued the relationship, their focus was not on keeping their frail patients safe but on completing medical treatments and technical tasks. Nurses acknowledged they were not giving patient-focused care but felt constrained by the ongoing fiscal problems in the context of the health care system. Nurses dealt with this situation by optionalising their care, choosing to prioritise patients, limit care, avoid older patients and substitute patient care time for social time. Because they were giving care that did not meet their professional value system, nurses disclosed that they felt stressed, angry and frustrated and looked for others to blame. Nurses admitted feeling helpless to change the way their work was organised on the wards, and so they reduced their cognitive dissonance by finding fault with others, in particular the health care system, the hospital and nursing administration,
and ward managers. These rationalisations did not further nurses’ understandings about the inconsistencies between their knowledge and the consequences of their actions for older patients. As well, the sense of powerlessness articulated by many nurses (who felt they did not know ‘how’ to take action either as individuals or as a group, or to implement professional care for their older patients) is an aspect of these findings that needs further exploration. The educational preparation of professional nurses stresses their responsibility to advocate for quality care on behalf of their vulnerable patients (ANMC, 2005). One might ask why the nurses interviewed for the present study felt they could not influence a change process, either personally or through the actions of others. The next chapter interprets and reconstructs the shared realities of the nurses in this study, with regards to the ‘why and how’ of their actions in managing care for their acutely ill older patients. It makes use of Giddens’s (1984) Structuration Theory, which allows a deeper and more theoretical examination of nurses’ constructions about how they provide care in relation to the social context of the ward and hospital system.
CHAPTER 5

PROFESSIONAL AGENCY OF NURSES

5.1 Introduction

This chapter further interprets the incongruence found between nurses’ knowledge about the care that should be provided to older patients and the care they actually provided, and about nurses’ documentation of their care. The findings presented in Chapter 4 did not sufficiently explain why nurses chose to optionalise and limit their care when they understood that a lack of care might result in negative consequences for their acutely ill older patients. Nurses’ blaming of the constraints in the hospital system and the contradiction between reports of their actions and observations of their care on the wards need to be better understood. This process has been undertaken after a search of various sociological theories, in order to locate a theory that would take proper account of both system and social integration and the professional agency of nurses. Giddens’s (1984, p. 3) Structuration Theory was chosen because it is concerned with social practices that “constitute (or socialize) us as actors, and which also embody or realize structures.” It is thought, therefore, that this theory allows an interpretation of the ‘why’ of nurses’ behaviour in not providing quality care on the wards. Hence, this chapter will consequently use three main concepts of Structuration Theory: system integration, social integration and professional agency.

5.1.1 Key concepts of Giddens’s Structuration Theory

In Structuration Theory, the concept of ‘human agent’ is seen to be the same as ‘human actor’ and, similarly, ‘agency’ is the same as ‘action’. Both terms will be used at times in this chapter (Giddens, 1984). The ‘knowledgeability’ of an actor or individual is contingent on three embedded processes which Giddens (1984) refers to as ‘the stratification model’: reflexive monitoring of action (discursive consciousness), rationalisation of action (practical consciousness) and motivation of action (the unconsciousness) (see Figure 1). These three processes will be used in conjunction with
other components of Giddens’s theory to explore the actions and motives of nurses in the choices they made about their care of acutely ill older adults in hospital.

**Humans are Knowledgeable and Purposive Agents**

... who have reasons for actions and if asked can elaborate discursively upon those reasons (including lying about them (p. 3).

... who exist in time and space

... and are positioned in the day to day flow of life during institutional time

... and in many ways within social relationships

**Knowledgeability and Capability of the Agent**

... depends on 3 stratified levels of consciousness (p. 5)

1. **Reflexive Monitoring of Action – Discursive Consciousness**

... when agents can articulate reasons for actions but degree of localized rationality depends on ability or competence to share knowledge; about reflecting on own actions, those of others and the social context (p. 5); in co-presence, observing the tacit rules of behaviour and evaluating the competency of others

2. **Rationalization of Action – Practical Consciousness**

... when agents can follow rules of convention but are not able to express those rules – influenced by “socialization and learning experiences” (p. 7)

3. **Motivation of Action – The Unconsciousness**

... what agents want – and is about a potential for action and not action itself; wants influence action (p. 6)

**Figure 1 Knowledgeability and Capability of Human Actors (Giddens, 1984)**

In structuration theory, ‘structure’ is associated with ‘rules and resources’ (see Figure 2). Giddens (1984, p. xxxi) sees “rules and resources recursively implicated in social
reproduction; institutionalized features of social systems have structural properties in the sense that relationships are stabilized across time and space.” In this way, Giddens’s (1984) theory is particularly useful for guiding understanding in this study in relation to two main aspects. The first concerns “the routinized intersections of practices, which are the ‘transformation points’ in structural relations”, and the second is “the modes in which institutionalized practices connect” system with social integration (Giddens, 1984, p. xxxi). These two elements assisted understanding about ‘how’ the structural constraints in the system influenced the practice of the nurses, and how their interactions on the wards, in the presence of other nurses (which Giddens refers to as ‘co-presence’) continued to reproduce practices within the hospital wards outside conditions of co-presence. The practices which then connect system with social integration are important aspects for this study. Giddens (1984) emphasises that even in a small society, there exists “at least some loose connection with wider ‘intersocietal systems’” (Giddens, 1984, p. 143).

A third aspect of Structuration Theory that will also assist understanding about how the care of older adults was managed concerns nurses’ capability as professional agents to choose how to ‘make a difference’. According to Giddens, everyone has the capacity to enact a ‘range of causal powers’ – that is, to get things done through the use of rules and resources, which can provide a ‘balance of autonomy and dependence’ and a basis for social power (Giddens, 1984). For Giddens (1984), professional agency is, therefore, about transformative power, which means that human actors are capable and purposive agents who can at any time decide to act differently.
Figure 2 Structuration Theory – Social Systems (Giddens, 1984)

5.2 System Integration and Social Integration

Giddens’s (1984) theory assists understanding in this study particularly of how nurses’ practices conducted in hospital institutions linked system with social integration. For Giddens (1984), institutions are defined differently from organisations in a general sense, as he sees them as the practices, which are embedded in time and space. Craib (1992) describes Giddens’s interpretation of an institution as similar to the concept of
‘marriage as an institution’. In this way, it can be seen that institutions are “patterns of relationships constantly structured and restructured in social practices” (Craib, 1992, p. 51–52). Institutional practices can simultaneously hamper and facilitate actions, and so it may not be sufficient for nurses, as found in this study, to simply revert to naming the organisational structure as the only constraining influence on their practice, as the reasons are far more complex. Hence, Structuration Theory will provide a useful framework for understanding how nurses are positioned in the wards and how their institutionalised practices continue to produce and reproduce the structural features of the wider social system of the hospital. Giddens (1984) notes that in order to do this, it is important to give some attention to the manner in which these institutionalised practices join system integration with social integration; that is, how institutional practices carried out in the absence of an actor or collective (system integration) are linked to practices which are performed between individuals in face-to-face encounters (social integration).

In examining the relations between ‘system integration and social integration’, Giddens (1984) stresses that it is not useful to employ the often cited terms of ‘macro’ (structural constraints that sets limits to free activity) and ‘micro’ (activities of a free agent). He argues that one should not have to choose between them – that there should be no division – and moreover that if we do so, we may be insinuating that one is more “fundamental” than the other (Giddens, 1984, p. 139). Hence, Giddens argues that we should not assume that ‘structure’ is only relevant to understanding “macrosociological issues” – as it is not ‘outside the activities of social agents’. Furthermore, he notes that an individual’s activity or practices in microcontexts has “strongly defined structural properties . . . as institutionalized patterns of behaviour are deeply implicated in even the most fleeting and limited of ‘microsituations’” (Giddens, 1984, p. 141). Giddens’s concerns were mainly directed towards how social practices, actioned in a variety of contexts, converged with one another so they played some part in the perpetuation of the system (see Figure 2). Giddens (1984, p. 28) defined integration as the “reciprocity of practices (of autonomy and dependence) between actors or collectivities.” He referred to system integration (see Table 9) as connections with those who are “physically absent in time or space” (Giddens, 1984, p. 28). Social integration (see Table 9) for Giddens (1984, p. 72), then, meant “systemness in circumstances of co-presence”, or face-to-face interactions. The use of time-space ‘distanciation’ in
Giddens’s theory is important for several reasons: it highlights how systems continue to be maintained by the connections existing between system and social integration (the stretching across time–space), it allows for the differentiation of different forms of society, and “it is integral to the generation of power” (Loyal, 2003, pp. 96–97).

<table>
<thead>
<tr>
<th>System Integration</th>
<th>Reciprocity between actors or collectivities across extended time-space, outside conditions of co-presence</th>
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<td>Social Integration</td>
<td>Reciprocity of practices between actors in contexts of co-presence</td>
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Table 9 System Integration and Social Integration (Giddens, 1984)

5.2.1 System integration

System in Structuration Theory means the “patterning of social relations across time–space, understood as reproduced practices” (Giddens, 1984, p. 377). Gregory (1989, p. 189) noted that in Structuration Theory this is what Giddens (1984, pp. 35, 37, 185) meant by ‘society’ as, “limitations of individual ‘presence’ are transcended by the stretching of social relations across time and space.” In this way, one can see that hospital values and practices continue to be produced and reproduced over time and space as institutionalised routines. Institutions can then be “conceived of as regularized practices which are ‘deeply layered’ in time and space, both pre-exist and post-date the lives of the individuals who reproduce them and thus may be resistant to manipulation or change by any particular agent” (Thompson, 1989, p. 72–3).

These structural constraints were seen by nurses in this study to place limits upon the feasible range of options open to them. This implies that the dominant medical orientation of hospitals influenced how the nurses were able to organise and manage their work on the wards. Nurses felt that the formal expectation for them to complete medical treatments and technical work as a priority was the reason for not having enough time to return to their older patients to complete the functional care they needed. From their disciplinary preparation, nurses understand that they are expected to utilise both technically and humanistically based functional approaches to their caring practices (Parker, 2006). Because they could not meet this professional expectation of their role, nurses instead blamed the constraints in the system that they saw as outside their control. In this way, nurses could provide a reasonable explanation for why they purposively chose what and how much care they would provide for their older patients.
Their intentionality in deciding how they allocated their time in the (social) system of the ward setting is integral to understanding how their behaviour then continued to reproduce the structural properties existing within their hospital settings.

5.2.1.1 Rules and resources

The structuration of (social) systems (see Figure 2), (comparable to nurses’ work patterns on the wards), means that they are grounded in the actions of knowledgeable individuals who utilise the ‘rules and resources’ in the social contexts in which their practices are being produced and reproduced (Giddens, 1984). A lack of impetus to attempt to change one’s behaviour can occur because individuals choose instead to follow ‘the tacit rules of behaviour’ (Giddens, 1984). These rules, which are understood tacitly, are elaborately intertwined in knowledge and practices (how to perform a certain action or how to continue to act) (Cohen, 1989). Rules can be either semantic, such as the qualitative and procedural meaning of practices, the locales and some or likely outcomes, or they can be normative, which refers to the same practices, locales and outcome from the position of the rights and obligations that establish their legitimacy (Cohen, 1989). Resources provide the means by which rules are actualised, as they have to do with access to power that can be used to influence the course of interactions with other individuals. There are two types of resources: allocative resources, the material features of the institution, and authoritarian resources, which concern how the social and time–space is organised, the production and reproduction of the body and the organization of life chances.

For Giddens, then, structures are “the generative rules and resources” (Craib, 1992, p. 44) – we know rules. We do not “formulate the rules that we follow, but this does not mean we do not know these rules – otherwise the work and other practices would not go on” (Craib, 1992, pp. 44–45). We interpret rules according to the circumstances in which we find ourselves. There are strongly and weakly sanctioned rules, but for Giddens (1984, p. 22) the rules that are of most interest for social theory are those concerned with the production and reproduction of institutionalised practices; “that is, practices that are most deeply sedimented in time–space.” It is not the more formal and strongly sanctioned rules, Giddens (1984, p. 22) says, that have the most power for directing an individual’s actions, but rather those routine procedures which
we do every day seem to “have a more profound influence upon the generality of social conduct.”

5.2.1.2 Duality of structure

The nurses interviewed, in utilising the ‘rules’ and ‘resources’ in their day-to-day work practices, unintentionally formed the structural properties of the institutions where they worked and, concurrently, the means by which the system was being reproduced (the duality of structure). The rules that function within institutional structures are, for Giddens (1984), ‘deep and embedded’, and so become part and parcel of the way these bureaucratic institutions are organised. For example, the time allocated for individuals to complete work expected by their institution is traditionally ‘specified and controlled’ and “formally sanctioned”, and so it is not ‘free time’ or ‘personal time’ for agents to do anything they want (Giddens, 1984, p. 156). Giddens (1984) believes that institutions maintain the discipline of their employees through the manipulation of time and space – in that each individual has his or her ‘proper place’ at any ‘particular time of the day’ to complete the work expected of them in their role.

This is certainly true of the traditional role of nurses in the hospital system, as their work patterns continue to be strongly controlled through dominant management structures. For example, the health care system has recently attempted to introduce ‘new’ models of nursing onto public hospital wards. These models were initially designed to support the professional value system in which nurses would have more control and autonomy over their caring practices (Kramer & Schmalenberg, 2003). However, the models that are currently being implemented have been mainly concerned with organising the work patterns of generally less experienced nursing staff into teams, so that specified tasks can be allocated and completed more efficiently (New South Wales Department of Health, 2005). These ‘new’ models when structured in this way, merely replicate the way tasks were delegated during the hospital apprenticeship system, which required nurses to learn ‘jobs’ quickly in a similar way to a factory production line (Kramer, 1974).

The tactics used to control the work patterns of nurses demonstrate how institutions partition the disciplinary time–space and work conditions for their employees, which for Giddens (1984), has at least two consequences. Firstly, institutions discourage the formation of groups of individuals who might demonstrate
their independent wills or oppose the needs of the organisation, and secondly, institutions directly control the activities of individuals (Giddens, 1984). The first of these measures can be seen in how hospital organisations attempt to introduce divisive strategies that maintain the lack of unity within nursing and the lack of support that nursing, as a caring profession, is able to demonstrate for its own members. For instance, this divisiveness is evident in the way hospital organisations have restructured the traditional role of the ‘charge nurse’ on the wards, who had been mainly concerned with the supervision of quality patient care and was replaced by a ‘nurse unit manager’ role that is focused mainly on administrative issues (Buchanan & Considine, 2002; Duffield, Donoghue & Pelletier, 1996). By this tactic, the nurse manager role has been far removed from being chiefly responsible for monitoring quality care practices (Buchanan & Considine, 2002). This disruptive course of action was highlighted by nurses in the present study who felt that even if they approached their nurse managers they would not necessarily gain any support regarding the standards of patient care on the wards. A further instance of institutional control over the practice of nurses is the current reduction of nursing roles in other areas of hospital management (Smith, 2006). This profound change has meant that nurses now have to answer to managers who are not members of their own discipline. Such strategies decrease the nursing profession’s autonomy or power as a group and reinforce its continual stratification and lower status within the health care system.

But, yeah, I, nursing is disappointing. I think that one of my perceptions is that it’s due to the fact that, you know, the old thought was that nurses were the doctors’ handmaidens. So a lot of these nurses in administration, they sort of wanted to get away from the hard grind of the patient load, the care, dealing with incontinence and confused, demented, sick patients. It’s very physically taxing, emotionally and it’s psychologically draining. They are invariably looking for a way to move up. So I feel it’s lost its, you know, the priority has been shifted the wrong way a bit. I feel it’s too top heavy and we’ve got too many, you know, administrators who, maybe, they’re not, you know [interested]. I think all these problems in the system do [impact on care] . . . The lack of addressing the problems in nursing, the policies; it’s what it does to you as the caregiver, the carer. Oh, I don’t think it really affects them [nursing administration] that much. I think it affects the givers of care rather than the receivers. (013:I:H2)
Structural properties operating in hospital organisations in this way tend to work against nurses coming together as a larger group or as individuals to protest about constraints on their practices, even though they are more likely to be the largest group of employees in hospitals. Moreover, through this lack of unity or direction, nurses continue to be caught up in the ‘busyness’ of their work role and so tend to follow unquestionably the ‘tacit rules of social behaviour’, which then maintains social order within the system.

A second and conspicuous group of measures used by organisational structures to control nurses’ work patterns is the way nurses are required to focus on completing formally sanctioned technical work, for which they are held liable. The introduction of medically based clinical pathways reinforces this ‘dominant medical orientation’ in hospitals, which then continues to influence the work patterns of nurses on the wards (Crowe, 2000; Knox & Gharrity, 2004). These type of ‘clinical pathways’ form part of patient-management systems that organise and sequence the medical treatments or technical care of patients so that it is more efficient and cost-effective (Crowe, 2000). The reality of these more medically oriented management strategies is that they are generally likely to be centred on treating the disease or the condition and do not consider the requirement and time needed for providing the nurse-initiated functional care needed by older patients (Knox & Gharrity, 2004). Consequently, the outcome of these pathway systems is that they defocus nurses from the provision of holistic ‘caring’ and focus them on ‘curing’. Moreover, it is in the interest of hospitals to make sure that this more technical type of work is completed and documented; a process that then continues to elevate its importance within the organisation. The fact that hospitals do not generally expect nurses to chart or record functional or personal care gives them a strong message that this care does not have the same status or value as technical tasks.

If organisational systems required the same level of accountability for functional care then these practices may be seen to be as important as medical treatments and other technical type of work and so receive a higher status. The influence of organisational structures on caring practices can be seen in the way most nurses in this study valued technological work and devalued functional care, which they described as repetitive, chore-like and physically hard. Moreover, nurses admitted that this type of care was the least desirable aspect of their role and an aspect for which they received little respect or recognition. Many nurses acknowledged that they preferred the “more challenging” and interesting technical or intensive work. This means that when ‘discerningly similar’
practices (such as those described by the nurses) are maintained over time and space, it lends them a ‘systemic form’ (Giddens, 1984). The nurses in this study stated that they felt helpless and unable to change the status quo on their wards, and they mainly blamed the system for this.

*I’m really at a loss to actually know how to make things better . . . What’s going on isn’t really working . . . I just know that something needs to change because we are not giving the [functional] care we should be giving.* (03:1:H2)

Structures can influence or constrain an agent’s behaviour, however, and Giddens (1984) maintains that individuals also constitute and influence social structure. This implies that there is a recursive or circular relationship between structure and action, and that it is this aspect of human agency that actually makes change feasible. As noted by Giddens (1984, p. 25), “agents and structures are not two independently given sets of phenomena, but represent a duality.” Structure, then, is the very “medium and outcome of the conduct it recursively organizes”, and so “the structural properties of social systems do not exist outside of action but are chronically implicated in its production and reproduction” (Giddens, 1984, p. 374). Hence, hospital institutions or social structures are not seen as separate from the actions or behaviour of the nurses, but rather are brought into existence by the very actions of these nurses who work in them – that is, by the continual repetition of their practices. This implies that although there may be structural constraints on nurses’ actions in the hospital setting, this is not to say that they are fixed and permanent or not open to even some small change through nurses’ own agency. It is this aspect of structure the nurses have not recognised – namely, that they could, as professional clinicians, individually choose to activate change in their own practices or behaviour on the wards.

The employment of Giddens’s (1984) concept of system integration in this section has demonstrated how nurses, in utilizing the ‘rules’, actually form the structural properties of the institution and the means by which their practices continued to be produced and reproduced outside conditions of co-presence. These practices, which then became institutionalised features of the system over time and space, provide some understanding of nurses’ feelings of helplessness and their lack of impetus to try to change what, to them, are predetermined or systemic constraints. However, Giddens (1984) would note that in their professional capacity they are knowledgeable agents and
understand that they are not meeting the standard of functional care needed by their older patients. By not accepting personal responsibility and by reverting to merely blaming the system, the nurses in the present study demonstrated they were not ‘keeping in touch’ theoretically with the disciplinary expectations for an appropriate standard of competent care. They were not, in their ‘practical consciousness’, directing themselves to move beyond a superficial reflection of their actions and their rationalisations in ‘blaming’ and towards a deeper theoretical level. Perhaps this was because they did not actually want to think about the fact that they did not ‘want’ to provide functional or basic type of care, and/or did not like older patients, or that they preferred technical care because it was more interesting and had greater status.

The nurses indicated that they felt both ‘dominated and dependent’ working within a system that did not value their professional role. However, by their actions, they continued to reproduce their practices across distance, which maintained social order within the hospitals. For Giddens (1984), this is evident in the reciprocity that exists between groups and collectivities and their relations of dependence and independence. However, this only partly explains why the nurses were not providing functional care required by older patients in preference to technical work. It is still not clear if the nurses were victims of the constraining influences of a medically dominant system or whether they were simply choosing to be incompetent. The nurses in this study understood they had to complete the formal work and knew they would be sanctioned if these ‘rules’ were not followed. However, although these regulations hinder some choices individuals make, Giddens (1984) would nevertheless note that agents still have some choice in how they act. Hence, explanations about how the systemic constraints forced the nurses to perform mainly technical work in lieu of functional care have their limitations, and one feels that the actions of the nurses still needs further interpretation. For, according to Giddens (1984), there are other factors at work. For instance, the enduring effects of the wider systemic constraints on the nurses’ practices, which were taking place across distance, outside conditions of their co-presence, needed to be understood in terms of the cohesive effects of their practices undertaken when they were physically present.
5.2.2 Social integration

Social integration refers then to “systemness” in circumstances of co-presence or “face to face” interactions (Loyal, 2003, p. 96). However, it is important to consider not only individuals’ actions but also the gestures and the positioning of actors during these encounters, because they are “both rooted in and motivated by the maintenance of ontological security” (Loyal, 2003, p. 96). Ontological security in Structuration Theory refers to individual’s desire to have “confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity” (Giddens, 1984, p. 375). Nurses in this study appeared to need to preserve their security or trust in how the social world of the ward appeared to them. The patterning of behaviour used by the nurses during their social relations may have offered them some ontological security or shared dependency because of their need to be accepted as part of the group. For example, on some wards, if nurses were not accepted by the main group they were at times not offered assistance with their work or invited to participate in social activities arranged outside the ward setting. Consequently, the large amount of time spent on each shift socialising at the desk was significant in regards to how nurses behaved towards each other and the values they learned through these social encounters. For Giddens (1984, p. 295), this process provides a “small society” of individuals, an event that draws them together as a collective “in circumstances in which adherence to group values can be publicly affirmed.” The normal manner of behaving, according to “the boundaries of the social life”, has to do with the “manipulative attitudes” that may be sustained in these collectives (Giddens, 1984, p. 4).

In order to understand how practices become institutionalised over time and space, Giddens (1984) recommended that one must examine how knowledgeable actors in their day-to-day activities both produce and reproduce these structural properties or rules and resources. This then connects what is going on in face-to-face ‘social’ situations with system integration. As well, Giddens (1984, p. xxxi) notes that one should study how these everyday habits or behaviours intersect or converge with one another, which he called “the transformation points” in structural relations. Giddens (1984, p. 282) talks about these time–space intersections as essentially involved in all social existence, and so a person’s activities are being “bound up with the repetitive character of reversible time – with paths traced through time–space and associated with
the constraining and enabling features of the body.” Nurses had chosen, unconsciously or consciously, to follow these ‘social rules’ that had become a habitual part of their routine in the ongoing flow or structure of ‘social life’ on the ward. The intersection of these embedded practices of devaluing older patients, socialising at the desk and maintaining the security of group behaviour generally continued during all shifts and in the space of the ward, whether individual nurses were present or absent, which then connected these social interactions with the system. In their interviews, nurses acknowledged that they needed to have time for social interaction. For Giddens (1984, p. xxxii) the “locales as settings of interaction” for “the routinized intersections of practices” are significant in understanding how these institutionalised practices actioned in co-presence with others continued outside conditions of co-presence. In this study, the locales of interaction tended to occur at the ward desk, and this setting was an important meeting-point for all the staff. Nurses articulated that they lacked time for patient care because they had to complete technical tasks, but, on the other hand, they also disclosed that they wanted to take time from patient care for ‘excitement’ through socialising.

*Nurses need some excitement. You can’t just give the basic care, you’ve got to have some excitement [time] as well. Lots of things impact on that basic care! Being busy all the time impacts on being able to give the care you want to give, you can run out of time for the care.* (01:1:H2)

Nurses claimed that they could not provide competent care because of time constraints. However, this was not borne out in observation of their practices, as they were seen to have time during their shifts. Giddens (1984, p. 4) noted that contradiction occurs when “the reasons people offer discursively for what they do may be different from the way they are observed to behave.” This is exemplified in the way the nurse in the preceding interview spoke about how the nurses on the wards ‘needed’ social time but could not give basic care because they were ‘busy all the time’, and that ‘lots of things impact on that’. The nurse is revealing her ‘tacit awareness of the rules’ that operate on the ward in what she is saying. However, she does not appear to wish to consciously reflect on the fact that, in following these rules and taking time for excitement at the desk, she is denying her older patients time for care. When nurses were being observed on the wards, they appeared to have time for giving basic care but chose intentionally to spend this available time for social interaction. The level of care they said they wanted to
provide for their patients could be seen to be a strong force for directing themselves to change their behaviour through reducing social time spent at the desk, but this did not occur. The nurse in the following interview, who explains that care can now be given on the ward because they have freed up time by closing beds, highlights another instance of incongruity between nurses’ articulations and the actual observation of their actions. The reality was that this nurse was observed to have spent large amounts of her time at the nurses’ desk socialising with other staff.

*We’ve basically chucked out seven beds and everyone’s breathing a sigh of relief because now we’re gone back to giving the time, we have the time to give the care and that’s very important. Satisfaction is also very important.*

(01:I:H2)

The intersection of staff socialising at the desk seemed to be an entrenched and unspoken, or institutionalised, ‘tacit rule of behaviour’. Substituting patient time for time at the desk was observed in many of the nurse–patient interactions. They stressed they wanted to give quality care, but this potential for action was not seen in the majority of their interactions with older patients. Instead, they appeared to be busy or used avoidance strategies with older patients who might take their time, so that they could complete routine or scheduled tasks and return to socialise at the ward desk.

*Yeah, choosing to eliminate some aspects of work for patients, so, um, yeah, I mean, it sounds awful but we all eliminate care . . . well, I do eliminate things for patients and I think, work . . . you know . . .* (014:I:H2)

Many nurses acknowledged that they intentionally optionalised or eliminated care because of time constraints, however they appeared to avoid thinking about or expressing the fact that social time was time that was available for providing basic care for their patients.

*Yeah, I mean, it sounds awful, but we all eliminate care.* (014:I:H2)

*Well, I mean, I know we are not giving the care.* (01:I:H2)

*So many things can’t get done or covered by the nurses and they [nurses] go home . . . well, things get missed and patients’ care is not optimal.* (013:I:H2)

Nurses’ behaviour demonstrated a lack of connection that devalued their relationship with their older patients. Their conduct, in rationalising actions in this way, may have
provided them with support and perceived solidarity as a group. This shared collective may then have satisfied their ‘wants’ by giving them strong reasons for not compelling themselves to actively try to change the status quo on the wards. Even if some nurses had wanted to act against this social convention on the wards, they may have felt it would be too difficult or unpleasant and could result in marginalisation or hostility. Nurses’ suppression of their anxiety in not utilising their professional value system may have provided them with a smoother and easier path to follow. Hence, they not only blamed themselves but other nurses also for not practising at an appropriate standard. In the following interview, even though the nurse admits the care was unsafe and unethical, she does not demonstrate any desire to have tried to change her behaviour. She has instead chosen to remain silent about her disquiet and, in so doing, is reproducing the conditions operating on the ward – as she observes, ‘the tacit rules of behaviour’ – that go on in the ‘day-to-day flow’ of the work setting.

*I think that it is about giving good patient care, because it is not just going on in their [the patients’] rooms – like emptying a catheter bag or taking someone to the toilet. But they [other nurses on the ward] are locking them [older patients] in [their rooms] and leaving them there.* (03:1:H2)

Unacceptable practices continued to be maintained in the workplace setting because nurses did not air their concerns. This then meant that nurses’ reproduced practices continued to connect social with system integration. They knew that they were not behaving professionally, individually or in ‘co-presence’ with other nurses on the wards. Agents’ inability to speak openly about work practices means that these rules which are used to structure social interactions as a collective “are much more fixed and constraining than might appear from the ease with which they are ordinarily followed” (Giddens, 1984, p. 23). If any nurses had wished to break from or ignore the social rules operating on the ward (that is, how the group wants to behave or the behaviour that is prescribed openly or tacitly), then this, could have disturbed the sense of safety that resided in the group’s ‘ontological security’.

During observations of nurses’ work it was evident there was a pattern of behaviour in the way they worked quickly to complete the formally prescribed tasks (medications and treatments and scheduled tasks) and then congregated for a large part of the shift at the desk or in the tearoom. As needed, from time to time they went off for short periods to complete routine or ‘formally sanctioned’ work and then returned to the
desk to continue their social interaction. In their constructions about the way they perceived their social world, nurses confirmed that they all followed the same informal rules in their behaviour. They seemed to talk about the other staff’s practices on the ward as ‘what they are doing’, as if this reduced their responsibility for the way the care was being implemented. There was a sense of safety in their day-to-day routines on the ward, as they ‘mutually monitored’ their own work and aligned it with that of other nurses. Nurses believed their behaviour was typical, and this was often confirmed in their discussions.

. . . because everyone else tries to push them aside. (06:I:H2)
 . . . I think some people try and bypass the elderly . . . (012:I:H2)
 . . . not to ignore them like some people do . . . (08:I:H2)
 . . . but you know we can’t do that (give care for the elderly) . . . (014:I:H2)
 . . . we can’t give the care . . . it’s (the same) everywhere you go. (013:I:H2)

Solidarity was achieved in the way the nurses provided a similar pattern of care to each other by substituting ‘patient time’ for ‘social time’. Even though they wanted this ‘excitement time’, it nevertheless made some feel uncomfortable. Nurses indicated that they felt they could not speak up or act against the sub-culture operating on their wards, which many understood was producing and reproducing ‘socialised practices’ over time and space. Their lack of will to think about their behaviour or empower themselves to change it and provide functionally based care could be because of repression.

5.2.2.1 Repression

Repression, for Giddens (1984, pp. 4–5), “is about those forms of cognition and impulsion, which are either wholly repressed from consciousness or appear in consciousness only in a distorted form.” He notes that actors can always discuss their intention and reason for acting the way they do, but they cannot necessarily do so about their unconscious motives. Unconscious motivation then concerns a person’s “potential for action rather than action itself” (Giddens, 1984, p. 4). For Giddens (1984, p. 6), these “motives tend to have a direct purchase on action only in relatively unusual circumstances, situations which in some way break with the routine”; that is, if they are unusual or different in some way. Motives do not force an individual’s choices but rather have a “generalized influence on action” – in the types of choices that people
make (Craib, 1992, p. 38). Repression provides further understanding about ‘why’ the nurses continued to act in the way they were on the wards. That many nurses expressed that they wanted ‘social time’ appears to have influenced the choices they made. In order to reduce their anxiety about their distortions of reality (that they favoured technical work or that it used up all their time) they rationalised their actions by blaming.

Nurses disclosed that they could not give basic care because they did not have the time. These nurses may have repressed thoughts that they may not have ‘wanted’ to find time to give care to older patients, even when this ‘time’ was actually available on the wards. This distortion may be part of nurses’ rationalisations for why they felt they had to optionlise the care needed by older patients. They admitted they did not return to complete this functional care when they found they were interrupted by technical or medical treatments (which they found to be more interesting and challenging). The use of ‘blame’ may have allowed them to dissociate from their ‘distorted wants’, which, as registered nurses, would not address their professional standards of practice (ANMC, 2005). Hence, using ‘blame’ provided many nurses with a less stressful and more palatable rationalisation for their actions. In this way, it can be seen that practices conducted in co-presence (social integration) are linked to practices maintained outside conditions of co-presence (system integration).

There is a sense in nurses’ statements that they have not stayed ‘grounded’ or ‘in touch’ with what they are doing while they are actually doing it, even though they know their care is not at a competent level. This ‘unconscious motivational pattern’ may be explained as an attempt by nurses to establish ‘modes of conduct’ that injected some kind of meaning and colour into the daily grind of work, which was highlighted in the way they talked about needing ‘social or excitement time’. As potentially knowledgeable practitioners, nurses have been able to articulate (discursively) that they know on some level that they had intentionally chosen to optionalise their care and that they are not using their knowledge and skills in their practice. However, they are unable (or do not want) to think about or acknowledge their real motives and the possible outcomes of their actions.

Social time at the ward desk may provide nurses with some trust or security in their actions, in that all staff behaved in this way – by following the ‘tacit rules’. Nurses were aware they had chosen the path of least resistance in choosing not to ‘speak out or
rock the boat’. Some felt that if they did it would upset their position in the hospital or on the ward, and they may have been ostracised by other nurses. Moreover, it may have been too uncomfortable to inform on the collective, in order to change the status quo, as it would have been paramount to admitting they were not a subjugated group within the system. Hence, if some nurses had raised any alarm about the way care was being optionalised on their wards, they would have been breaking the ‘solidarity of the collective’ and could be seen as almost equivalent to ‘not being a hospital nurse’. Membership in the ‘social’ collective put pressure on individual nurses to maintain the status quo. The need by nurses to be accepted by the ward ‘clique’ may outweigh the conflict nurses feel in not challenging the ward value system, and so they are able to maintain their ontological security. The inaction taken by nurses may assist them in dealing with or reducing their ‘personal tensions or moral conflict’.

5.2.2.2 Mutual tact

An aspect of nurses’ behaviour in keeping silent with the collective can be further understood by the use of ‘mutual tact’. For Giddens (1984), this enables agents to maintain security by ‘keeping face’ in their day-to-day interactions with each other. The nurses in this study knew their care and that of the other staff was not at a competent level, but they still did not try to change these practices. In maintaining ‘mutual silence’, the nurses may have ‘saved face’ by not embarrassing themselves or ‘showing their backs’. The reason for this type of behaviour, according to Giddens (1984), is that we have a ‘front and backspace’. In their frontspace, nurses could continue to perform their roles according to the routine of the wards, and in their backspace they were able to relax. For example, in their interviews, some nurses reported that they performed routine tasks and technical work and then took social time to relax in preference to finding time to provide basic care for their older patients. They appeared to be performing the formal expectations of their ‘role’ (with regards to how practices were being routinely provided) and so were able to keep ‘face’ in their frontspace, but they also shared in the social time by relaxing at the desk and so maintained their backspace. This behaviour ensured that nurses’ personal security or ‘face’ was not threatened. As Giddens (1993, p. 15) noted, “actors have a responsibility to protect other participants from blows to their self-esteem; they also have a right to expect that others will refrain from ‘assaults’ on their own self.”
The maintenance of their ontological security and mutual tact required the nurses to continue to provide the ‘routine’ or accepted actions of the collective. In Structuration Theory, as explained previously, you cannot analyse the actions of an individual apart from the social context. Instead, both agency and structure should represent a complementarity and be perceived more as a duality. An individual’s actions can then be understood in terms of “the complex of recurrent practices which form institutions” as “those practices depend upon the habits and forms of life which individuals adopt” (Giddens & Pierson, 1998, p. 77). In continuing to work in the way they were, nurses were repeating work practices and reproducing the socially accepted values of the ward, which then connected social with system integration. As Giddens (1984, p. 14) aptly says, “we create society at the same time as we are created by it.”

Even at an unconsciousness level, perhaps nurses knew they should not actively question these ‘social rules’ and so not confront other nurses about their practice. If they had broken these social rules, they would have placed themselves at risk of social sanction by other staff, for, according to Giddens (1984), rules enable actions but in following those rules individuals are also inhibited by them. Therefore, in abiding by these rules, nurses were maintaining the value system or rules of their ward by their ‘tactful behaviour’, which kept their ‘ontological security’ – and, ‘through mutual tact’, their ‘face’. This behaviour then becomes ‘morally sanctioned by the traditional practices’ that were perpetually recreated on the wards. Nurses form a (social) system through these ‘tacit rules of behaviour’, which are carried out during the repeated interactions they have with each other. As Giddens (1984, p. 2) writes, “human social activities, like some self-reproducing items in nature, are recursive.” These activities are “not brought into being by individual social actors but are continually recreated by them via the very means whereby they express themselves as actors” (Giddens, 1984, p. 2). Furthermore, actors, by adhering to their routine behaviours, reproduce “the conditions that make these activities possible” (Giddens, 1984, p. 2).

In their practices, the nurses were maintaining the structural properties of the hospital, and while the hospital’s existence does not depend on any individual nurse, it nevertheless would cease to function if it did not have nurses. Now, in producing and reproducing the mainly technical work practices on a ward in preference to the more functional or basic patient care, it is not a given that all nurses represent a unified collective. The reason for this is that “social reproduction must not be equated with the
consolidation of social cohesion” (Giddens, 1984, p. 24). This is evident in the way some nurses gave appropriate care (technical as well as functional), including the casual agency nurse who demonstrated actions that were competent, safe and patient-focused and addressed the professional standards (ANMC, 2005). The behaviour of these nurses implied that it is possible to motivate oneself to provide a high standard of care that addresses not only formal technical work but also functional care, even accepting that there are structural constraints within hospital wards. However, one must also say that the agency nurse was not part of the ward collective and so her work did not influence the way the collective practised, and because she was not permanently employed on the ward she may not have been affected by a need to maintain her ontological security with other staff. Whilst many nurses in the study recognised that their care was not professionally acceptable and articulated that they felt anxious, stressed, frustrated and even angry, they nevertheless believed they were unable to change the status quo.

“It’s priority nursing, don’t wash some patients if you can’t do everything else, such as the medications and the orders. (013:I: H2)

It is important, however, to emphasise that not all nurses interviewed felt uncomfortable with their practices on the wards. Some believed their behaviour was justified because of perceived ‘external’ constraints. They reported that they avoided their older patients to spend time with their peers socialising at the desk and did not acknowledge that a lack of functional care may have resulted in complications for their vulnerable patients.

5.2.2.3 Unintended/intended consequences of actions

As explained in the preceding sections, unspoken social rules on the wards guided the way the work was undertaken, which was concerned with getting the technical tasks done quickly and substituting time needed for functional care required by vulnerable patients for social time. According to Cohen (1989, p. 124), “modes of social integration involve consequences and outcomes generated in circumstances of co-presence so that the activities of agents in a given physical setting are interrelated in various ways.” To have reflexively monitored their actions and to have been motivated to implement the basic and weakly sanctioned functional care means that the nurses would have had to consider the implication or consequences of not providing this level of preventive care to their frail older patients. However, even though Giddens (1984) would note that individuals have choice, he nevertheless would agree that there will be
constraints (either social or systemic) on choice. For instance, an individual has a need for ontological security and is also constrained by structures, “in a causal sense, with action being understood as the effect of the overall impact of all the various causes” (Loyal, 2003, p. 68). Giddens (1984) does stress that a person’s activities cannot completely be explained or determined by ‘structural constraints’, as there is some choice, even if it is relatively small, in how one acts, as actions ‘can be otherwise’. However, in order to assist in understanding actions taken by the nurses in this study, one must examine more closely their intentions with regard to the decisions they made.

It was not clear if nurses had consciously thought about the consequences that their actions would have on the health of their older patients. As Giddens (1984, p. 10) notes, it is important to find out “if such knowledge is utilized by the author of the act to achieve this quality or outcome.” If this statement is true, he says, then one must further explore whether the “actions done are different from the intended” or the intentional aspects of this action (Giddens, 1984, p. 10). It cannot be fully known if nurses did think about the consequences of their intention to limit functional care. If they had consciously considered and were grounded or knowledgeable in the ‘here and now’ of their actions – about their care as they were implementing it – then they perhaps should also have been aware of the deleterious and cumulative effect their actions (or the lack of them) would eventually have on their older patients. Nurses did not specifically mention any situation when their lack of care had led to unintended consequences or negative outcomes for their patients. Hence, their constructions demonstrated that there were inconsistencies in their knowledge about the potential consequences of not providing functional care for older patients.

Nurses’ devaluing of functional care was evident in that they did not generally write up specific or detailed plans of the basic care required for patients, which then meant this care was not able to be followed up in the same way as, say, administering medications or intake of intravenous fluids. Practices that demonstrated a devaluing of functional or basic care were confirmed during a review of nurses’ reports and charts. For example, over the time of several shifts nurses had indicated in their reports that a frail older patient was becoming increasingly restless and agitated because of his need to reach the toilet. This patient was not observed to have been taken to the toilet routinely, which might have prevented his ‘anxious and agitated’ behaviour. Eventually, the older man became incontinent and, due to his deteriorating condition, the medical
officer was notified, which then resulted in an order for ‘regular toileting’. Even with this ‘medical order’ the nurses did not record a systematic toileting schedule in the man’s records. As a result, the patient became more ‘confused’ and finally climbed over his bed rails and fell, cutting his head, and subsequently needed an X-ray and suturing (011:R:H2). Nurses’ devaluing of the functional or preventive care needed by older patients was also found through other observations on the ward. For example, a nurse who was administering medications continually ignored an older female patient who was trying to inform the nurse that she had a ‘burning bottom’ that was painful.

*The nurse did not assess the woman’s complaint but instead continued on with the medication round and then left the room. The woman’s sacrum was observed to be bright red as she was moved some time later onto a commode chair for showering.* (05:O:H2)

Three days later it was documented in the patient’s notes that she had developed a pressure sore on her sacrum (05:R:H2). Whether intentional or not, these negative outcomes might not have occurred if the nurses on the wards had recognised the role of functional care in protecting older patients from harm in hospital. Part of a nurse’s theoretical knowledge is to understand that immobile frail patients need preventive care actions implemented systematically across all shifts in order to avoid complications (Neuman, 1995; Rogers, 1970; Roy, 1970). In the preceding example, the nurse would merely have needed to examine the woman’s sacrum, and, if the tissues were diagnosed to be reddened (erythema), to document a plan to reposition the patient one- to two-hourly to relieve pressure (Mott, 2005). A nurse can choose to provide competent care on his or her shift, although there is no guarantee that this level of professional accountability will occur on the following shifts by other nurses. Moreover, the consequences for not implementing preventive care by repositioning this older patient meant that the reddened area on her sacrum eventually progressed, over the following shifts, to result in a break in the skin integrity (decubitus ulcer). Although this ‘broken skin’ was not apparent during the actual time of the nurse’s shift, evidence indicates that sustained erythema, if not relieved, will eventually result in ulceration of the area (Mott, 2005). These examples illustrate that the further removed the consequences of an act are in time and space from the original context of the act, the less likely those consequences are to be intentional or connected directly to one actor’s actions (Giddens, 1984). The nurses may have also been unconsciously motivated to use ‘repression’ in favouring the
completion of the technical tasks in preference to functional caring. Nevertheless, nurses are held responsible for providing care that fulfils their standards of practice, and such quality caring depends on their competency in providing safe proactive care across all shifts to prevent further functional decline for vulnerable patients (ANMC, 2005).

The intentionality then to act with professional agency depends not only on nurses’ knowledgeability and ability to know that a lack of functional care will result in complications for frail and immobile patients, but also on the way they use their will to implement preventive care to protect patients from such adverse events. Most nurses in this study were able to demonstrate an appropriate level of knowledge and ability, but many admitted they knew they were not giving quality care for older patients. Hence, when the routine care on the ward is not of a competent standard it follows that there will be unintended consequences resulting. The constant production and reproduction of nurses’ institutionalised ‘incompetent’ practices on the wards, in face-to-face encounters, connected these social practices with system integration. For instance, inappropriate care on one shift in co-presence maintained the ‘systemness’ of this incompetent behaviour on other shifts, which eventually lead to deleterious consequences for frail older patients. According to Giddens (1984, p. 8), “acts have unintended consequences; and these may systematically feed back to be the unacknowledged conditions of further acts.” Hence the fact that these nurses were not prepared to try to change the ‘tacit rules of behaviour’ operating on wards meant that these actions were becoming more normal or routine. Perhaps the ‘ordinariness’ of their work was evident also in the way in which nurses continued their practices even though the researcher was present and sitting close to patients’ bedsides.

Social integration in this way has highlighted the influence of nurses’ interactions in conditions of co-presence, which reproduced the way care was being conducted and maintained on the wards. The repetition of these practices outside conditions of co-presence then connected what was going on in the ‘social’ to system integration. Nurses’ actions demonstrated that they appeared not to feel compelled to monitor their practices in the actual time–space and, moreover, that they kept ‘mutual tact’ in not wanting to share their concerns because of their ontological security in the shared collective. Consequently, these nurses were not only influenced by structural constraints, which forced them to comply with the strongly sanctioned ‘rules’, but they also felt pressured to maintain their security in the shared value system operating on the
wards as they understood them in order to keep ‘face’. To cope with their anxiety about providing medically oriented technical work in lieu of functional care, nurses may have used ‘repression’ of their ‘wants’.

Nurses reported they felt powerless to change conditions on their wards by speaking out about the lack of competent care, and so their decision to keep quiet may have meant that social practices on the wards were much more constraining and inflexible than might appear from the ease with which they were being enacted. However, even though nurses’ need for social interactions may have assisted them in coping with workplace conditions, it also meant that they were choosing not to provide the care needed by older patients in order to keep them safe from harm in hospital. For Giddens (1984), the unintended consequences of action are then seen in terms of ‘systemness’ and take their place in the range of factors that together contribute to the relationship between system and social integration and social order, accounting for the extension of social systems across time–space. In this way, although the structures in hospitals constrained nurses’ practices so that technical work was a priority, the fact is that the nurses, by the continuation of their social interludes on the wards, were also supplying the means by which the system was being reproduced on the wards when they themselves were absent. As Giddens (1984, p. 179) stated:

... there is no such entity as a distinctive type of ‘structural explanation’ in the social sciences; all explanations will involve at least implicit reference both to the purposive, reasoning behaviour of agents and to its intersection with constraining and enabling features of the social and material contexts of that behaviour.

The structural properties of the system, in controlling nurses’ work patterns, maintained a ‘disciplinary time–space’ for the nurses as employees. Completing sanctioned work allowed the nurses to meet the formal requirements of the system, and because they felt their work was not rewarded or renumerated they then looked for some ‘enjoyment and excitement’ on the wards, which was achieved through using patient time for social time. Time spent at the desk provided them with greater recognition and status with the staff, including allied health practitioners. In this way, social integration was connected with system integration.

In perpetrating these institutionalised behaviours, nurses were not only distancing themselves from their professional value system but also from their older
patients and their hospital’s administration. Distancing allowed the nurses to allocate blame to others external to themselves, which made it easier for them to deal with their personal conflict in devaluing the functional care needed by older adults. Nurses believed they were helpless in their actions, which then sustained them as an oppressed group – as victims of the system. However, Giddens (1984) assumed that knowledgeable agents would have some ability to exert even a small degree of control over these structural constraints. For the nurses to be able to wield enough power to make substantial changes in how care was being managed in the hospital wards – that is, to elevate functional care to a similar status to that of technical tasks – they would have to invoke structures through the use of available ‘resources’, and this did not occur because they believed they were unable to ‘make a difference’.

5.3 Professional Agency

Thus far this chapter has argued that structures are both enabling and constraining, for power constrains as well as being the means by which individuals can ‘do things’ (Giddens, 1984). In order to examine the potential of nurses to act with professional agency, it is first necessary to revisit some of the key concepts discussed in the preceding sections. In system integration, it was suggested that hospitals demonstrate their power by the use of constraints, which are evident in sanctions and rules (both allocative and authoritative). These structural constraints vary from situation to situation and may impose some limitation on an individual’s options. However, for Giddens (1984), these sanctions do not compel people to act as there is mostly always some degree of freedom to choose.

Nurses understand that they must fulfil the requirements of their organisation, but they also know they can act as individual agents and choose the way they assess, plan and implement the functional care required by their patients during the time–space of their shift. In Structuration Theory, for someone to demonstrate their purposiveness and capability, they must show how they reflexively monitor their actions, and this depends on a process of rationalisation (Giddens, 1984). Being reflexive, then, means that individuals can think about their actions after they have performed them. Rationalisation occurs when people know about their actions, how they are doing them and can, if asked, “supply reasons” – this concerns their practical consciousness in “keeping in touch” with their actions “as they do it” (Giddens, 1984, p. 376). The
process of “tacit understanding” concerns the individual, routinely and without any fuss, maintaining “a continuing ‘theoretical understanding’ of the grounds of their activity” (Giddens, 1984, p. 5).

The nurses in this study, as highlighted throughout this chapter, were not ‘keeping in touch’ with the professional requirements of their role. As professional agents, they could discuss the possible consequences of not providing an appropriate standard of care and, according to Structuration Theory, they could have decided if their actions were appropriate at the time or whether they would act differently next time. Giddens (1984) sees this as an important aspect of the potential of professional agency, as he does not see people as senseless machines but as knowledgeable actors who can think about what they do before they do it and act on the basis of their choices. Knowledgeability is reliant on three levels of consciousness, which Giddens (1984, p. 3) refers to as the “stratification model of the acting self” (see Figure 1) and which involve “treating the reflexive monitoring, rationalization and motivation of action as embedded sets of processes.” He notes that these aspects of consciousness are “set in” each other and depend on the competence of the individual, in relation to their “socialization and learning experiences” (Giddens, 1984, pp. 3–7).

To explore nurses’ ‘acknowledged and unacknowledged actions’, the level of discursive consciousness will first be examined through the process of reflexive monitoring. It is important to note that any separation of these aspects of consciousness, used during this discussion to explore the nurses’ discursive and practical consciousness, is relatively arbitrary. The reason for this is that any line between them can be seen as “fluctuating and permeable” – “both in the experience of the individual agent and as regards comparisons between actors in different contexts of social activity” (Giddens, 1984, p. 4). Discursive consciousness concerns the ability of individuals to reflexively monitor the conditions of their actions and the “purposive, or intentional, character of human behavior, considered within the flow of activity of the agent” (Giddens, 1984, p. 376). These conditions, according to Giddens’s (1984) interpretation, refer to the social and structural circumstances that shape actions.

Nurses reported that they had difficulty providing care within the constraints or conditions of the hospital system, and so in order to cope with their work on the wards they completed the formally sanctioned technical or medical work and then ‘purposively’ chose which patients and how much care they would provide. In their
face-to-face practices, they maintained the systemic nature of the ward structure by their repetitive social interactions. By continuing to substitute time for providing patient care for time to socialise at the desk, nurses were reproducing the structures in the ward system, which were continued outside their physical co-presence. These findings demonstrate that nurses were not acting with professional agency in that they were cognisant of their lack of competent practices and knew what standard of care they needed to provide and how this care should have been implemented on the wards. Giddens (1984, p. 3) asserts that human beings are knowledgeable and purposive actors who do not act with agency by ‘intending to do things’, and that agency is about their capability to actually ‘perform the action’:

> To be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked, to elaborate discursively upon those reasons (including lying about them).

This implies that for the nurses to be professional agents they must not only know about safe and competent care, but must also show this standard of care in their actions. As professional agents, nurses in this study therefore had power as individuals, or the means of intentionally choosing to get things done – they could choose to act competently or choose not to act. Through their reflective ability, they could have brought about some change, even at a ward level, by their own individual agency or by challenging other nurses. From their interviews it appeared that the way nurses were practising on the wards was seen by the collective to be the ‘ordinary way of behaving’, which confirmed the structures now embedded in the social practices.

> I just thought, God, we are just so bad in the way we care for older people. We are terrible, aren’t we? I think as nurses . . . I feel there is an awful lot we can do as far as our role is [concerned]. You [should] use your real nursing skills when you care for older people. I didn’t feel that I was using those skills in acute care wards that I had and my knowledge and so forth, because we were so busy and we were so restricted to dealing with what was happening there and then, that you don’t have time. (03:I:H2)

Reflexivity in this theory, then, concerns the conscious monitoring of one’s (purposive or intentional) actions and those of others, as the nurse above did. As well, she demonstrates that she can also monitor the social and physical aspects of the ward in which she is working. Nurses knew that competent care was not being delivered on their
ward by themselves or by other nurses according to their professional knowledge and skills, because of constraints in the system that they generalised as ‘a lack of time’. Nevertheless, they appeared to have passively accepted their lack of will to behave as agents in the ‘then and now’ in order to change these ‘conventionally accepted practices’, which continued the integration between ‘system and social’. Reflexive monitoring of activity is, according to Giddens (1984, p. 5), a “chronic feature of everyday action and involves the conduct not just of the individual but also of others.” There is an expectation that agents reflect on their own actions and that others will also do the same of their own actions (Giddens, 1984). Assessing one’s actions occurs during many different types of situations and with other people (in co-presence or during social relations) and “is the basis upon which the competence of an individual is evaluated by others” (Giddens, 1984, p. 4). However, even though nurses were monitoring their own practices and the incompetent practices of their colleagues, they still did not articulate in their discursive consciousness any incentive to change their own behaviour on the wards. Nurses continued to practice in the way they were when other nurses were not present, and even when they were aware the researcher was observing them.

_The oldies are absolutely treated like the scum of the earth and it’s disgusting, but I can understand how it can get to be very, very frustrating for the nurses._ (013:1:H2)

Nurses understood that their routine actions ‘fitted in’ with the practices of everyone else on the wards. However, they did not feel they could act in other ways.

### 5.3.1 Agency and power

The capacity to direct oneself ‘to take action’, according to Giddens (1984), is ‘transformative’ power. He noted that it is concerned with the capability of an individual to intervene in a series of events, which would then alter their course. In this way it is the “‘can’ act, which mediates between intentions or wants and the actual realization of the outcomes sought after” (Giddens, 1993, p. 110). It is this feature of actually realising their potential power in taking action to avoid negative outcomes for the older patients that seems to be lacking in nurses’ consciousness. Agency, then, is about having the capability to bring about change by making some difference or through the utilisation of some sort of power (Giddens, 1984). The nurses in this study had the
potential capability to choose to continue to meet the formal rules of the institution by completing technical care as well as manage the functional care required by older patients. Instead, they felt unrewarded and unrecognised, and so they continued to optionalise their care and blame the system, including their nurse managers, who, they believed, did not support them as professional colleagues and who mainly acted on behalf of the institution.

*You feel a bit angry that you can’t do anything about it.* (013:I:H2)

*Within the nursing fraternity is that, it’s the only kind of professional vocation where they seem to devour their own... they put you down.*

(04:I:H2)

*I’m really at a loss to know how to make things better.* (03:I:H2)

It was evident that nurses found the structures in hospital institutions to be dominant and powerful influences and not suitable as ‘resources’ on which they could draw. Giddens (1984, p. 54) speaks of “domination”, which “involves asymmetries of the resources employed in power relations.” He notes that “it is related to sanctions of coercion and inducement.” If individuals feel somewhat marginalised, Giddens (1984) believed, they could, even as subordinates in extremely bureaucratic institutions, exert some influence or control over their work conditions. Personal authority could occur through ‘responsible subversion’; that is, by intentionally choosing to act in certain ways, based on one’s experience or understanding of the social system and ethical practice. Nurses who decided to take control of their practices would look for opportunities in which they could enact a standard of care by “pragmatic compromise, moral protests or covert or overt subversion” (Woods, 1999, p. 426). To act ‘agentically’ means that nurses needed to be able not only to command themselves to act differently but also to recognise and be conscious of their own power to change the accepted way they and/or other nurses were producing and reproducing their work. Power is a two-way process, in that it is about the capability of the individual to either act or intervene in order “to make a difference”, but it is also about a person making a conscious decision to “refrain from such intervention which might change the state of affairs” (Giddens, 1984, p. 14). In this study, nurses did assume some control over their practices but this was about ‘irresponsible subversion’, as ‘time’ was found to satisfy their ‘want’ for social interaction but not to provide ethically based care. The majority of nurses were not empowered to act to change the constraints in the system or their
own social practices on the wards in order to provide quality care. Hence, this lack of
taking action to change work conditions continued the routine of nurses’ day-to-day life
on the wards, which then maintained the connection between system and social
integration.

To challenge the status quo, nurses would have had to claim the authority to do
so, but such action is not a simple matter. They would have had to reject the credibility
of the present ward conditions, and, in doing so, move outside the constraints evident in
the connections between both social and system integration. In capitulating their
professional values, most nurses knew they were not acting agentically but were not
motivated to empower themselves. Even so, a few nurses who had exercised their
transformative power by utilising ‘allocative resources’ or the material features of the
hospital environment were able to enact their professional role, but those who felt they
could not then continued to reproduce the structure. To behave ethically, according to
the disciplinary standards and professional values, means that nurses needed to move
outside their collective security and express their agency by advocating a standard of
competent care they know would protect older patients from adverse events.

5.3.2 Dialectic of control

In Giddens’s theory, the “dialectic of control” refers to “the two-way character of the
distributive aspect of power (power as control))”, which concerns those in relatively
subordinate positions utilising “resources in such a way as to exert control over the
more powerful in established power relationships” (Giddens, 1984, p. 374). For Giddens
(1984, p. 16), “power within social systems”, which is stable “over time and space
presumes regularized relations of autonomy and dependence between actors or
collectivities in contexts of social interaction.” Giddens (1984, p. 16) argues that “all
forms of dependence offer some resources” and, so anyone who is relatively subservient
can exert some pressure on the conduct of those who they feel are superior. However,
power which is part of action, according to Giddens, is never exercised absolutely. For
example, in the socialisation of the nurses at the ward desk there were those nurses who
had reflexively monitored the way they were all practising on the wards but resisted
acting against the solidarity of the group. By not empowering themselves and raising
their concerns, they were maintaining ‘mutual silence’, and saving ‘face’ by not
‘showing their behinds’ with the collective. The rationale for this type of behaviour,
according to Giddens (1984), is that we have a ‘front and a backspace’. The nurses in their public or ‘frontspace’ continued to perform the routine technical tasks and treatments and then took social time in their ‘backspace’ to relax in preference to completing the less desired functional care. However, they could have planned to exercise some power (by lobbying the other nurses) in this quiet ‘backspace’, but by keeping back from making their concerns public they ignored their ability to utilise some autonomy with those who were in a more superior position.

These nurses, if not directly through their own agency, could have drawn on the second type of resource available to them, that of ‘authoritative power’. Even though they felt powerless to seek change within the system from their manager or from their peers in the social context of the wards, they could, through their ‘facility’, have chosen to go to a professional organisation such as the state registration authority, the Nurses and Midwives Board (NMB) or the College of Nursing, in order for it to bring pressure for change to occur. The power that would then occur would come not from the individual, but from others acting with agency on their behalf. Nurses, therefore, are not devoid of power to act ‘in other ways’ and even in their subordinate position can access ‘authoritative resources’ such as their professional organisations to act on their behalf. Nurses often commented that they believed that those in authority in the hospital (including their Nursing Unit Managers) would not welcome their concerns. Nonetheless, even in their relatively inferior position, actors are “never wholly dependent, and are often very adept at converting whatever resources they possess into some degree of control over the conditions existing within the system” (Giddens, 1993, p. 243). Professional agency means that nurses must use their power to provide competent practices guided by knowledge that is based on both scientific and humanistic approaches to care. If safe care is not occurring, then, as a competent practitioner, it is required that one either raise concerns within the institution, or command oneself to go outside, such as to professional organisations like the Nurses and Midwives Board, the College of Nursing or unions. According to Craib (1992, p. 55), there is always the potential for people to struggle for greater autonomy of their practices, no matter how “unequal the power relationship might be.”
5.4 Conclusion

The objective of this chapter has been to undertake a further analysis of why nurses in this study chose to optionalise their care of acutely ill older adults. In rationalising their behaviour, nurses mainly appealed to constraints in the health care system. However, as has been discussed, the influences on nurses’ lack of professional agency are far more complex and cannot be explained merely by blaming to the system. Although they were knowledgeable and potentially capable agents, nurses recognised that they were complicit in the decisions they made to limit care for older patients. Moreover, it was evident that by continuing to practice in the way they were, nurses were reproducing the very same conditions that connected system with social integration. For Giddens (1984), agents cannot merely do what they like within institutional structures, as there are powerful pressures that impose limitation on their options. Nurses believed this to be the case, as most found their role within the hospital settings to be relatively ‘specified and controlled’. By following tacitly understood rules, nurses’ practices formed the structural properties of the institutions, which simultaneously became the means by which the system was being reproduced; this is what Giddens (1984) refers to as the ‘duality of structure’.

Utilising the embedded rules that function within these institutions implies that the process maintains the control and direction operating within these structures for the way nurses were expected to work. For example, medical and technical work is ‘strongly sanctioned’, and so nurses understood that it was important to complete it according to the orders and times specified. Nurses are aware that institutions demand that this work must be systematically documented, in contrast to functional care, which is only ‘weakly sanctioned’. Nurses in this study opted to complete the higher status and more interesting technical work, which, they claimed, took up the majority of their time and so prevented them from returning to complete the less desired functional care required by older patients. The lack of accountability for functional care meant that many nurses optionalised which patients to care for and how much care these patients would receive. However, it was not clear if nurses were acting with intention concerning the consequences of not providing competent care, as there were inconsistencies between what they were saying and what they were actually doing. Appearing to be unaware of the consequences of their behaviour during the time of their actions meant that complications in patient health did not become evident until later
shifts. Hence, individual nurses could not then be formally sanctioned for the occurrence of adverse events. These practices, perpetuated over several shifts by multiple nurses, then maintained system integration.

Nurses rationalised their behaviour by blaming the system that controlled their practices by the ‘partitioning of the disciplinary time–space’ around their activities. In this way, their actions and the constraints in the system were not independent of each other. As structure is the very “medium and outcome of the conduct it recursively organizes” (Giddens, 1984, p. 374). Nurses’ actions, therefore, became chronically implicated in the production and reproduction of the systemic nature of their work conditions. In this study, even though nurses believed they had no control over the relatively bureaucratic structures, they nevertheless demonstrated some subversive power in the way they manipulated the ward constraints in order to find some satisfaction for social interactions during their day-to-day life on the wards. In doing this, nurses not only met the formal needs of their organisation but also gave their work some ‘colour and excitement’ that was seen to be lacking in the unrewarding and uncaring system. Their behaviour on the wards normalised the neglect of the older patients, which came to be seen as the routine.

The reason for the nurses’ ‘mutual silence’ about the lack of care on the wards was that they did not want to embarrass themselves or the group by speaking out. Such behaviour, according to Giddens (1984), allowed them to keep ‘face’ in their ‘frontspace’, but they also shared in social time at the desk, which allowed them to relax in their ‘backspace’. The use of reflexive monitoring of their own actions and those of the other nurses meant that in their relationships with each other nurses were conscious of the fact that they ‘fitted in’ with the group behaviour. The accepted routine reproduction of their practices on the wards across time and space, therefore, provided the conditions that connected system with social integration. In this way social order was maintained through the reciprocity of practices conducted in co-presence across ‘extended time’ and outside the ‘conditions of co-presence’. Accordingly, it can be seen that the optionalisation of patient care is neither wholly the cause of the system or of the nurses, but rather the ‘duality of structure’, which connects the two and which impacts on the professional capability of the nurses to act otherwise.

Giddens (1984) maintained that, even within these forceful constraints that operate in the system and on the wards, agents can direct themselves to ‘make some
difference’ in how they practice, ‘as they are not robots’. For Giddens, agents can choose to maintain things as they are or to alter them in some way. However, this is an easy assumption to make as the constraints that reproduce the system outside conditions of co-presence and the pressures that maintain social practices in face-to-face encounters on the wards are both powerful forces that, over time, overcome the professional agency of nurses. Nurses understand their legal obligation to complete technical work and know that if they choose not to work in this way they will be sanctioned by their organisation. They also believe that they are in an impossible position on the wards, as they lack the will to act in any way that would break the social rules of the collective. These social rules are, for Giddens (1984), much more set and binding than might appear from the way they are followed. In this way, a group of nurses on the wards has a strong influence or hold on how others behave. If any nurses attempt to act outside the values and social life of this collective, according to Giddens (1984), they will find that they are restricted by certain ‘boundaries’, including the attitudes of other members of the group, which could result in alienation. However, perhaps it is not these ‘boundaries’ that restrain nurses from expressing their concerns about the way care was being provided on the wards, but rather an unconscious attempt to retain the status quo.

It is difficult to imagine a relatively subordinate nurse being able to have any real effect on the structures operating in such restrictive organisations. As Giddens (1984) notes, most of the time these forces will constrain an individual’s actions, as the structural properties in institutions generally are more hindering than enabling. Nevertheless, if the desire is strong enough, Giddens maintains, individuals who want to change systematic practices still have some potential to act autonomously no matter how unequal the power relationship. If nurses wish to, they could utilise their transformative capacity to actagentically as individuals or attempt to get other nurses to join them in changing the practices on the wards, or even choose to go outside the institution to garner the support of their professional organisations. Agentic behaviour is possible, as evident from a few exceptions where some nurses chose to empower themselves and provide professional care. These nurses had ‘chosen to act otherwise’, although there were some limitations to their options and these constraints would differ from one context to another. As this chapter has highlighted, there are opposing social forces operating, both within the system and on the wards, which constrain the majority
of nurses’ capability to act with professional agency. However, it is important to emphasise that nurses did not act in any covert way by trying to change their routine practices while they were being observed by the nurse researcher. Hence, it was not clear if nurses in this study fully understood the consequences of choosing to optionalise the functional care needed by acutely ill older adults, or even if they thought about the consequences of their behaviour. Perhaps they understood in the ‘abstract’ but ignored the ‘immediate’ situation. Even so, their inability to enact their transformative power became ‘circuits of reproduction’ for the way their social actions connected with system integration and continued to maintain social order within the medically oriented hospital wards.
CHAPTER 6
CONCLUSIONS AND IMPLICATIONS

6.1 Introduction

The broad purpose of this study is to understand and reconstruct the meanings of nurses about their professional role in providing care for older patients in an acute care setting. Specific aims included: firstly, to identify nurses’ knowledge about what comprised competent care for their older patients; secondly, to identify nurses' shared meanings about what care they actually provided and how they implemented this care; thirdly, to evaluate the congruence between their knowledge about providing a competent level of care and the actual care they implemented; and fourthly, to understand nurses’ constructions about the consistencies or inconsistencies between their knowledge and the consequences of their actions. This concluding chapter summarises what was found and outlines implications for the discipline.

6.2 Overview and Findings of the Study

The uniqueness of this multi-method study is that it showed that nurses were knowledgeable and potentially capable as professional agents but that many did not provide competent care for their acutely ill older patients. These results are significant because this study has not only incorporated nurses’ constructions concerning the care they knew should be provided, but that their understandings were also able to be further examined in relation to actual observations of their practices on the wards and their documentation of their care. This process has allowed for interpretation to take place of nurses’ knowledge about what they knew to be competent care and the actual care they provided. Previous research has tended to focus on nurses’ views about how they provide care and has often disregarded their actions (Paley, 2001).

Nurses claimed they wanted to give competent care but blamed the health care system for under funding of staff and resources. As well, they blamed the
predominantly medical orientation for the way work was conducted on the wards, which they believed used up their time and prevented them from returning to complete functional care needed by older patients. As discussed in Chapter 2, these reasons were common in the literature (Barnard, 2006; Daly et al. 2004; Hardy et al. 2002; Latimer, 2000; Locsin, 2001; Sandelowski, 2000; Wynne, 2004). Furthermore, reduced funding within the health care organisations had resulted in inadequate staffing, time and resources, which had led to nurses being unable to provide a competent standard of care (Buchanan & Considine, 2002; Fagerberg, 2004; Jackson & Borbasi, 2006; Lumby, 2001; Williams, 2001b). However, the findings from the multiple types of data collected in this study tell a somewhat different story. Although nurses’ constructions indicated that ‘medical and technical type of work’ used up all their time during a shift, observation did not confirm this. Moreover, in contrast to the literature as discussed in Chapter 2, section 2.4, which highlighted the inherent stresses evident in many hospitals that hampered nurses’ autonomy (Griffiths & Crookes, 2006; Jones & Cheek, 2003) and resulted in unpredictable and incoherent ward contexts (Aiken et al. 2003; Ponte et al. 2004), this study did not observe wards as such chaotic and uninhabitable places. These wards had the required numbers of permanent staff on the various shifts, and casual hospital staff were observed to be used on only two occasions. Thus, nurses’ explanations for their lack of time (as discussed in Chapter 4, section 4.4.1.1) could not be accepted as sufficient for their decisions to optionalise the functional care required by vulnerable older patients.

It was critical, therefore, that a deeper investigation of nurses’ practices on the wards be undertaken, and so through the use of Giddens’s (1984) Structuration Theory (Chapter 5) a very different picture emerged of the incongruence between what nurses said and what they did. Consequently, this analysis indicated that, aside from hospital constraints, other factors that were influencing nurses’ professional agency needed to be considered. Giddens’s (1984) theory was chosen to guide this understanding because of two central aspects: firstly, the ‘routinized intersections of practices’ in institutions, which he referred to as the transformational points in ‘structural relations’, and secondly, the modes in which such ‘institutionalised practices’ were linked with social integration. As discussed in Chapter 5, section 5.2.1, Giddens (1984) maintained that institutionalised structures are constraining, in that an individual cannot just choose to do ‘anything’. Hence, institutions such as hospitals do not provide ‘free or personal
time’ for nurses to do whatever they want either, as there are set ‘systems or structures’ in place, which clearly direct how work is to be completed, right down to the ward level. For Giddens (1984), institutions in this way, uphold the discipline of their employees through the manipulation of ‘time and space’ and the type of work that is required.

The nurses in this study fundamentally understood how these ‘institutionalised structures’ influenced their work role; that is, they knew that ‘technical tasks’ must be completed as a priority. Conversely, it was also evident that nurses were aware that they could make choices in relation to when and how they provided functional or basic care. Hence, although these dominant ‘structural properties’ within the hospital systems directed the technical and medical work patterns of nurses, they also provided them with ‘conditions on the wards’ for making decisions pertaining to how they would manage their ‘other’ time during their shifts. As presented in Chapter 5, section 5.2.1.2, nurses’ lack of functional care on the wards was not merely caused by a lack of time but because the structures within the system elevated the importance and priority of medical ‘curing’ work over the functional ‘caring’ role of nursing, which was comparatively ‘invisible’ and ‘unrecognised’. In this way, nurses recognised that quality caring was less important to the needs of the organisation, and so by their day-to-day actions on the wards nurses prioritised the ‘technical work’ (such as medications, wound dressings and other treatments) over their functional caring role. Nurses thus ‘normalised’ their behaviour, which then continued to produce and reproduce these systemic practices. With this in mind, it is easier to understand why nurses in this study used ‘institutional constraints’ as the main reason that they were unable to provide the standard of care needed by frail older patients.

To blame hospital constraints offered some nurses cognitive relief for their lack of competent care, however the findings also indicated that there were nurses who felt uncomfortable with the way they were practising. One of the reasons offered by these nurses for not ‘speaking out’ emerged from their perception that there was no support within the hospital systems, particularly in relation to the nurse managers on the wards. In Chapter 5, section 5.2.1.2, it was noted, that according to Giddens (1984), institutions used controlling tactics, one of which was to discourage the formation of large groups of individuals who might be able to wield some authority to protest about workplace
conditions. A second tactic was to control the activities or work patterns of all individuals who work within the organisation.

The first of these two measures can be seen in the way institutions have implemented divisive structures that weaken the ability of nurses to act as a group to object about the way care is being provided on the wards. Nurses in this study did not feel they could approach their ward supervisor, perhaps because of the change to this position, put in place by economically focused hospitals. For example, where wards were once managed by a charge nurse who supervised nursing practices, they are now chiefly managed by nurses who are concerned primarily with meeting fiscal objectives and not necessarily the continuity of quality care for patients (Duffield et al. 1996). According to a report by Buchanan and Considine (2002), this structural change has profoundly affected the work of these managers and has reduced the support they can provide for staff on the wards. It is remarkable that even though this organisational strategy occurred about twenty years ago, the nurses in the Buchanan and Considine project still believed it continued to impact on their clinical role. Nurses in the present study also used this structural change in hospital management systems as a reason for why they could not approach their Nurse Unit Managers on the wards for any support about their concerns. A further example of this type of ‘strategic divisiveness’ can be seen more recently in the way these health care organisations have sidelined senior nurse managers and nurse unit managers and replaced them with ‘generic’ non-nurse managers (Leembruggen, 2006). In this system, nurses are increasingly expected to report outside their specialty to administrators in each hospital division such as medicine and surgery. The result of this institutional structural manoeuvre, according to Brett Holmes, the general secretary of New South Wales Nurses’ Association, has led to further disempowerment of nurses in hospitals and has “pushed them back into a role where they were not given the opportunity to be heard properly” (Smith, 2006, p. 9).

It is incontestable for Giddens (1984) that institutional structures constrain action, however he further clarifies this statement by noting that individuals also constitute and influence ‘social structures’. Thus, although the nurses in this study implied that such constraints imposed limitations on their ability to act with professional agency, it was clear that their clinical decisions were not only being hampered by a lack of time or under-resourcing on the wards, but also because ‘functional caring’ was not seen to be as important by the economically and medically oriented hospital
administrations, ward managers or by the nurses themselves. In other words, hospital ‘structures’ influenced nurses’ constructions about their relative helplessness, the higher status of technical work and the lower status of functional care. As discussed in Chapter 5, section 5.2.1.2, the use of Giddens’s (1984) theory made it evident that nurses’ favouring of technical work over functional care plainly demonstrated that they were well integrated into the hospital system.

The intentionality of nurses in optionalising and limiting the functional care of older patients in face-to-face situations, according to Giddens’s (1984) theory, becomes ‘the institutionalized features of the system over time and space’. The present findings not only demonstrate this ‘integration between social and system’ but also show that nurses’ ‘daily patterns of behaviour’ on the wards are not practices which they are ‘personally moved’ to try and change. The reason for an agent’s lack of impetus to change behaviour, according to Giddens (1984), may be that they are following the ‘structural or tacit rules’ of the system. Furthermore, nurse would have an implicit understanding of how such ‘rules’ operated, because they would be closely ‘intertwined into their knowledge’ about ‘how’ they were expected to practice. The structural rules provided the nurses in the present study with the ‘know-how’ or values about regarding what work was important and what was not. In this way, nurses were able to console themselves about their lack of competent behaviour by blaming the ‘legitimised’ technical work and medical treatments that used up their time.

To blame the ‘structural constraints’ totally for nurses’ actions only partly explains what was happening on the wards. As noted in Chapter 5, section 5.2.2.3, Giddens’s (1984) theory suggests there are ‘other things’ that could have some bearing on how people decide to act. Nurses, as professional and knowledgeable agents, would have had a degree of freedom to choose how to practice, even taking into consideration the supposed restraints operating in the hospital system. The significance of this aspect, following Giddens’s (1984) theory, is that structures can both enable and hinder practices, and this was plainly understood by the nurses in this study, who not only knew they had to complete technical tasks but also were conscious that they had some personal autonomy in choosing to optionalise their functional care.

Lacking agency, nurses made purposeful decisions not to complete the functional care needed by the older patients, perhaps because they knew it would not be formally accounted for in the same way as medical treatments or technical work.
Moreover, the lower status and weakly sanctioned nature of this ‘basic or preventive’
care was reaffirmed continually on the wards by the ward manager, who, whilst acting
chiefly on behalf of the institution, did not supervise this care or require it to be charted.
This resulted in nurses normalising their ‘neglect of the older patients’. The hospitals
had implemented systems or structures which strongly sanctioned the medical and
technical tasks and, through nurses’ daily routine practices, this work continued to be
reinforced as more important. Hence, nurses’ actions strengthened the existing
‘structures’ and connected their own socialised actions with the system.

Powerlessness and helplessness were offered by the nurses as justifiable reasons
for being unable to control the relatively fixed ‘structural rules’ which specified that
they must complete ‘legitimate’ technical work as a priority. Nurses did not feel they
were appreciated or rewarded for this work and so they looked for ways to compensate
themselves. This study has revealed that nurses found ‘enjoyment’ during their shifts by
taking time to socialise with other staff at the ward desk, time they could have used to
complete functional care needed by older patients. In order to have this ‘time’, nurses
used ‘avoidance’ or ‘distancing’ tactics, which discouraged older patients from
‘bothering’ them or expecting them to spend time providing care at the bedside. Nurses’
rationalisation for substituting patient time for social time was that it allowed them to
cope with the frustration and stress they experienced working on the wards. Chapter 5,
section 5.2.2.1, discussed the interpretation provided by Giddens (1984), which noted
that by their actions nurses may have been trying to add some ‘colour’ or interest to
their daily routines. Even though there were constraints on their practices, nurses were
nevertheless able to find ways in which they could indulge themselves.

Time taken for socialisation was time the nurses could have used to demonstrate
their professional agency by providing care needed by vulnerable older patients. However, through their behaviour they were not only finding some ‘enjoyment’ and
pleasure but also perhaps were increasing their perceived status by being seen ‘doing’
mainly technical work and by being able to meet and chat with allied health
professionals. Hence, the nurses achieved some control over the constraining and
unsupportive hospital structures that impacted on their work role. The significance of
these institutionalised ‘social meetings’ for Giddens (1984) is that they publicly affirm a
group’s values. The intersection of these behaviours then became the transformational
points in the nurses’ structural relations – social events which drew them together and provided boundaries for ‘how’ they should conduct their ‘social life’ on the wards.

The manipulative attitudes sustained in these collectives, according to Giddens (1984), must not be underestimated. Participating in this shared collective may have provided the nurses with support and solidarity as a group, and this could have been a strong motivational reason for not ‘rocking the boat’ and speaking out about their incompetent practices. Hence, as discussed in Chapter 5, section 5.2.2, if any of the nurses had tried to deviate from this it would have disturbed the group’s ‘ontological security’ (Giddens, 1984). The nurses’ socialised behaviour meant that they had to ‘mutually trust’ that no-one in the group would report what was happening on the wards. Group pressure maintained ‘silence’ by stifling any effort by members to raise their concerns. However, even though this may have been unbearable, it still seems difficult to accept that some nurses did not attempt to express their unease publicly by some means. Nurses could have changed their behaviour when other nurses on the ward were not present in patients’ rooms. Instead, it appears that some nurses may have felt that their behaviours were acceptable, as they did not alter their actions even in the presence of the researcher, who was sitting near to where they were interacting with the older patients. Nurses seemed to be unwilling to reflect on their own behaviour or on the consequences of their actions, even whilst being observed by the researcher, an ‘outside’ person. From this it might be construed that it could take some degree of effort to implement strategies on the wards that would shift nurses’ entrenched way of acting.

Agentic behaviour, therefore, was found to be lacking in these nurses, as they chose not to spend time providing the care required by the older patients. Furthermore, this finding was in contrast to the discipline’s expectation of professional competency as described in Chapter 2, section 2.5.1. For instance, person- or patient-centred care was found to be central to the disciplinary philosophy of ‘holistic’ care and the development of professional relationships with frail patients (Fitzgerald, 2006; McCormack, 2003; Schmidt, 2004). In particular, this therapeutic ‘connection’ has been cited frequently for its importance in guiding quality ethical practices based on mutual negotiation with older and more vulnerable patients (Frey & Norris, 2006; Hagerty & Patusky, 2003; Thomas et al. 2005). Furthermore, this professional knowledge frames nurses’ practices so they can better organise and manage the technical and functional care needed by acutely ill older patients in order to protect them from additional
physical decline (Gill et al. 2004; Hart et al. 2002) and readmission (Fink & Foreman, 2000; Street, 2004).

Nurses’ knowledgeability and likely capability to provide competent care was not found to be a problem. However, most chose not to provide an appropriate standard of care for the older patients, as outlined in their national competencies (ANMC, 2005). One could not doubt, from the findings in Chapter 4, section 4.3.1, that nurses had a general understanding of the importance of preventive care. This was clear from their descriptions of the importance of knowing about the history and present condition of older patients, in order to be alert to any sudden changes. As well, nurses were aware in their constructions throughout Chapter 4, section 4.3.1.1 that older immobilised patients were at a higher risk of adverse events in hospital and so needed preventive functional care. In this study, the descriptions provided by nurses about ‘quality and holistic caring’ were based on theoretical learning, as highlighted in Chapter 2, section 2.5, which discussed the importance of utilising both scientific and humanistic approaches (Parker, 2006). It was noted in this section that even though scientific and technical knowledge are essential to nursing practice, it is also necessary to point out that humanistically based caring has greatly influenced much of nursing’s theoretical and philosophical development (Walker, 2006). Hence, in the discipline of nursing, it is well recognised that humanism includes ‘functional’ and ‘other’ care that considers the dignity and respect of the ‘whole’ human being and therefore situates the ‘individual’ as central to what nurses ‘do’ in their practice (Walker, 2006).

Theoretical learning did not frame the care provided by nurses in this study. By their behaviour, nurses showed that they were not ‘keeping in touch’ with what they were supposed to be doing professionally – to provide an expected standard of care for frail patients. A lack of agency, for Giddens (1984), means that individuals are not ‘grounded’ in the here and now of their actions – that they are not consciously thinking about what they do. The nurses lacked self-direction, which, for Giddens (1984), may occur when individuals do not reflect on their actions at a deeper theoretical level in their ‘practical consciousness’. Such behaviour may have occurred, because the nurses did not want to think about the fact that they did not actually ‘like’ or ‘want’ to provide basic or functional care, which they described as ‘chore-like, physically hard and repetitive’. They may have wanted to have social time and so they ‘distorted or repressed’ unpleasant thoughts about their unethical behaviour from their
consciousness. In this way, the nurses may have relieved their disquiet about the consequences of their actions in not providing competently based care required in order to address older patients’ functional needs.

Everyone has some power ‘to choose to act otherwise’, according to Giddens (1984), however the nurses rationalised their lack of professional behaviour by blaming. Following Giddens’s (1984) theory, the nurses could have empowered themselves to behave in other ways by which he means that agents can use their ‘allocative’ (the material features in the environment) or ‘authoritative’ (others act on their behalf) resources. However, the majority of nurses in this study did not choose to take this path. With Giddens (1984), a possible reason for nurses’ lack of agency may have been that they were maintaining their ‘mutual tact’, which is concerned with the way a group of individuals ‘save face’ by protecting each other from sanctions or embarrassment. Nonetheless, some nurses acted agentically by utilising the ‘allocative’ resources in order to provide safe and competent care. In comparison, those nurses who did not ‘break solidarity with the group’ and did not draw on their transformative powers in order to change the lack of care by their daily practices, continued to produce and reproduce the structural conditions on the wards which connected their social behaviour with the system.

One cannot just accept that nurses’ lack of agentic behaviour in this study was caused simply by constraints in the health care system; other aspects also came to bear on how nurses were deciding to practice. Through the use of Giddens’s (1984) theory some of the complexity that impacts on nurses’ potential capability to provide competent care has been investigated. Even though Giddens (1984) would not deny that there are structural properties within organisations that impose restrictions on how individuals are able to act, there are opportunities in which a person can demonstrate their transformative power and professional agency. It is important, then, that in understanding the findings of this study, one should not rely entirely on the capability of individual nurses or small groups, and certainly not on the ‘good policy’ of hospitals for a greater balance between technical and functional caring. Perhaps the reality is that ‘functional caring’ will never be realised as a main value while hospital institutions continue to be driven by market imperatives, even though positive patient outcomes would save the health care system money because older and more debilitated patients would not be readmitted for more costly and extended care (Fink & Foreman, 2000;
Foreman et al. 2001; Grimmer et al. 2004). Hence, as shown in this study, such economically and medically oriented institutions maintain a fairly restrictive hold over the authority and work patterns of nurses with divisive and controlling management strategies.

The perpetuation of these tactics, as has been shown, has successfully ensured the ongoing subordination of nursing (the largest group within these ‘structures’) and has discouraged any supposed threats by this ‘group’ to the social order where medical values predominate. If professional practices are to gain any status or value in hospital institutions, functional care must be considered as an equal component of the health care package and not ignored. Even though there are wards in which quality care is not devalued, it still remains that this is not the general policy operating in most fiscally minded hospital organisations, where the importance of medicine and technology is deeply embedded in the ‘structural relations’. Hence, in using Giddens’s (1984) theory, a more systematic exposition has been achieved of the ‘how and why’ of nurses’ practices in managing the care of acutely ill older patients in hospital. Moreover, by understanding how these practices continue to produce and reproduce hospital structures, then there is a greater “potential for changing them” (Hardcastle, Usher & Holmes, 2005, p. 223).

6.3 Reflections on Method

The philosophical approach used for this significant study was guided by Guba and Lincoln’s (1994) constructivist paradigm of inquiry. The utilisation of this type of inquiry provided an opportunity to question the understandings of nurses about how they constructed their world from their ‘emic’ or insider point of view. Thus, some insight was achieved into the different perceptions or meanings held by each nurse. In this way, ‘reality’ can be seen as being relative to each individual and, as such, it can alter not only with the course of time but also because of our unique experiences. Hence, the five axioms used in this constructivist approach proved its appropriateness for this study, allowing for a consideration of the nurses’ multiple constructions of their world.

In relation to the first axiom, Lincoln and Guba (1985) noted that ‘realities are whole’ and so one should not attempt to separate them from their contexts. In order to comply with this axiom, several forms of data collection were used in this study to
capture the various nurse participants’ perspectives about their caring role and how they practised in the natural context-rich setting of the hospital wards. The study addressed the second axiom by taking into account the assumption that the ‘inquirer’ and the ‘object’ of inquiry interact to influence one another. For example, the researcher assumed the role of interviewer in discussions with each nurse about how they understood their practices, and in the participant–observer role the researcher was able to interact with the nurses as they worked. A third important axiom in constructivist inquiry concerns the possibility of generalisation. The implication of this statement is that because the realities of nurses are developed from specific contexts and personal experiences, they may not be able to be generalised. However, the realities of these nurses may share some attributes in common with the experiences of other nurses in different work settings who may be able to appreciate this fact and take it into account (Lincoln & Guba, 1985).

The fourth axiom stipulates that it is impossible to distinguish causes from effects, as all “entities are in a state of mutual simultaneous shaping” (Lincoln & Guba, 1985, p. 38). This study abided by the axiom in the way the researcher imposed a ‘purposeful structure’, which emerged from interactions with nurses and which led to a mutual shaping of meanings. In this way, issues were able to be raised during the process and from the ongoing exploration, ‘analysis, critique, reiteration and reanalysis’, until some shared understanding was achieved with the nurses being interviewed (Schwandt, 1994). All commonly held constructions were evaluated with regards to how they compared to each other and the extent of their credibility and relevance. In following this process, the final axiom was able to be fulfilled. Thus, this constructivist inquiry was value-bound, because the meanings of nurses were reconstructed by the intent of the researcher in order to make sense of their complex experiences and perspectives (Lincoln & Guba, 1985).

The powerful nature of this constructivist study, therefore, lies in the fact that it was designed to comply with these five axioms through the incorporation of a multi-method approach. The varied forms of data-collection methods included interviews with nurses, extensive observations of their practices and a review of their documented actions in patients’ records. The use of these different approaches allowed for some variation between the data collected from interviews with nurses in relation to their knowledge about the actual care they believed should be provided and what care they
were observed to be providing in the time–space of the wards. Moreover, the inclusion of data from patients’ records provided a further insight into nurses’ realities of their work on the wards.

These three methods are of considerable importance in furthering understanding about nurses’ practices, for, according to Paley (2001), this is not the usual case for the vast majority of empirical studies, which seem only to report the views and perceptions of individuals and tend to ignore what they actually do. According to Leonard (1995), the reason for this reluctance by researchers to explore a research problem using very different methods may be because it requires additional time and work on their part, but possibly a more critical ‘disincentive’ is that researchers may have to deal with the incongruence that may present between the findings obtained from each of the multiple approaches. But it is important to note that although valuable insights were obtained from the discrepancies obtained from this data, this was only possible from within a constructivist framework. However, rather than seeing that these multiple methods would pose a problem, this researcher found that they would provide greater reassurance that all the data collected examined the nature of nurses’ constructions about how they perceived they managed their care of older patients. The use of additional methods provided unique insights into nurses’ actual practices, and this strengthened the interpretation of the findings. Hence, in this study, it was important to use these three data collection methods, as, according to Lincoln and Guba (1985), they are significant in a constructivist study because they provide some validation of consistency when triangulated.

Following the initial analysis of the data collected from these multiple methods (Chapter 4), it became apparent that there was some incongruence between nurses’ knowledge about what care they felt should be provided for older patients and the care they were actually implementing. Additionally, the analysis also indicated that there were inconsistencies between nurses’ knowledge about their care and the consequences of their actions. A further examination of the data was undertaken using Giddens’s (1984) Structuration Theory. The use of this theory was of considerable importance because it provided a framework that not only allowed for a more in-depth interpretation of nurses’ shared constructions about their practices and their actual actions but also “re-orientates ‘the social’, returning it to its central, constituting position in discussion about nursing practice” (Purkis, 1994, p. 317).
6.4 Implications

The findings obtained in this study suggest several important strategies to improve the quality of nursing care of acutely ill older patients in hospital. In saying this, it is vital to emphasise that this study does not provide all the answers for the inconsistencies found between the care the nurses knew they should give and what care they were actually providing. However, the critical aspect of this study is that it has allowed for a deeper investigation of this incongruence through the use of Giddens’s (1984) Structuration Theory. From this process greater illumination has been directed to ‘how’ nurses’ reproduced practices on the wards continued to maintain those very same constraining structures, which they blamed for their lack of professional agency.

Hospital constraints blocked nurses’ access to empowerment structures, which appears to have led to their perceived helplessness and lack of autonomy to control the conditions impacting on their care. At present, these constraining hospital structures implement all types of covert controls that hamper the autonomy of nurses to make decisions about their own professional practices and to participate in sharing and ongoing development. For example, because their work patterns are relatively fixed, nurses are often unable to contribute in team meetings, in which they can share their expertise in a similar way to those conducted by other health allied groups. Instead nurses are more commonly directed to attend ‘hospital organised workshops’, which emphasise what they do not know or what the hospital deems they should know. Further institutional constraints and influences can be seen in the limited time provided for nurses at the beginning of shifts in which to share patient-care experiences. Nurses are expected to attend brief reports, which are generally dominated by the value placed on medical and technical care, with only scant attention directed to nursing-initiated functional care needed by frail older patients. Institutional structures limit opportunities for nurses to take a more autonomous and empowered role in maximising their expertise and skills. The result then leads to the continual reproduction of practices on the wards, which connects social with system integration and maintains the perpetuation of a hospital’s existing social order.

It is clear that if nurses are to provide quality caring practices that are meaningful to them, health care organisations will need to change their overriding goals towards efficiency of output. The market-driven values inherent in these medically oriented contexts situated the nurses in this study in an unenviable and constraining
position. The result of this influence meant that competitive hospital management structures specify and control ‘how’ nurses practised on the wards. Nevertheless, even under these restraints there were exceptions in this study in which some nurses were able to demonstrate their professional agency. However, most nurses felt their practices were limited by fiscal structures within the hospitals that promoted policies of quick throughput and high acuity patients, rather than the conditions needed for them to provide the quality of care needed by older patients.

Health care organisations, perhaps because of their fiscally directed ethical stance, tended to privilege technical and medical work over the functional caring role of the nurses. The result of this orientation to how work is managed means that nurses may be more concerned with prioritising these tasks because they are held responsible and accountable for their completion on the wards. Hence, such calculating manoeuvres in these institutions have resulted in highly legitimated technical work being privileged over the more weakly sanctioned functional nursing care. The increase in these structures therefore led to a greater emphasis on medical or technological concerns and not to the best approach to maintaining the competent care needed by older patients. An obvious response of the health care system would be to require nurses to chart their functional actions, but this could encourage staff to find other ways to optionalise this care, resulting in an ongoing reproduction of the same systemic behaviour. The continuation of these practices means that vulnerable older patients do not receive the quality of care they need, which results in further functional decline and adverse events.

The policy throughout the health care system is to promote shorter stays, which means that older patients are discharged ‘quicker and sicker’. If their care has not been of a high standard, this places them at a higher risk of readmission and a longer overall period of institutionalisation. Health care organisations appear to have disregarded the ability of quality nursing care to reduce the risk of complications for older patients. It is unclear why professionally based functional care is not supported by hospital management, especially when one considers the increased costs incurred from caring for more debilitated patients on readmission. Organisations thus continue to reinforce their devaluation of the caring role of professional nurses, which perpetuates the status quo. The most obvious response to this situation would be for nurses to take more control in monitoring their caring work, but this involves issues of professional agency. Nurses are capable, they do have the ability to act with agency but the reality is that
they too often choose to collude in their own feelings of helplessness and oppression. Older patients should not have to receive care that is not at an appropriate standard. Nurses, to act as competent agents, need to resist the influences operating in hospital institutions which impact on their professional role and personal ability to provide quality care – care that is centered on the holistic needs of the older person. It is important that nurses understand that these institutional structures are both enabling and constraining - as power not only constrains but also provides the means for individual nurses to ‘do things’. Nurses can draw on their theoretical, scientific and humanistic knowledge and professional values to guide them in intervening in some form of compromise. Personal authority can occur through responsible subversion, where empowered nurses can decide to practise ethically through an understanding of the hospital social system.

A professional commitment to competent care for older patients includes not only nurses’ legal but also their moral responsibility. In their professional work life, nurses are constantly challenged about their practices and need to find a balance between the conflicting service demands of the organisation and their professional conduct. Often, it is the more routine or normalised practices which occur in the social life on the ward which create the greatest ethical dilemmas for nurses. To demonstrate their purposiveness and capability to act responsively, nurses must show through the process of rationalisation, how they reflexively monitor their actions. Critical reflection allows nurses to avoid blaming others for their lack of care through undertaking a systematic analysis of their own actions, how they are doing them, and be able to if challenged, provide reasons for acting as they do. Older people have a right to quality care and this care should not be optionalised by nurses in order to meet the more dominant medical requirements of organisations. Individual nurses need to utilise their professional knowledge and transformative power in taking action, or hospital management systems will continue to deplete their power as a group. It seems incomprehensible that hospitals do not wish to engage nursing more as a profession and take advantage of the critical thinking skills and valuable expertise of this group. Professional organisations should move beyond the ‘blaming’ of government economic policies to consider how they can raise awareness of nurses, and provide them with the ‘political know how’ with which to operate as powerful players in these health care settings.
The discipline, therefore, needs to draw on the significant findings in this study and alert itself to the divisive institutional structures, which continue to weaken the control of nursing over its caring role. Furthermore, the context of competition and the scarcity of resources operating in most of these hospitals has continued to cut the power of nurses over their own practices at the local or ward level by replacing nurse supervisors (charge nurses) with nurse managers. The more traditional position of the charge nurse was concerned primarily with monitoring and supervision of clinical decisions and the provision of a high standard of care. These nurses held a high degree of responsibility for patient care, and generally their role was supported or championed by the medical profession. When it was substituted for a nurse unit manager’s position, it was assumed that other nurses in leadership roles, such as the clinical nurse consultant or the clinical nurse specialist, would undertake the supervision of patient care. However, these expectations soon diminished as these nurses became more involved in the management objectives of the organisation, which included participation in medically based research projects and as team players with medical specialist groups. These management strategies have meant that hospitals have ‘leached’ nurses from clinical positions, where they may have better supported the role of staff nurses in their provision of quality patient care. The profession needs to monitor the aged care content in undergraduate curricula so that it prepares registered nurses, who, as managers will be committed to monitoring the quality of care needed by older adults. There also needs to be a heightened call for more nurses prepared as gerontological specialists.

A more recent tactic used by health care organisations to further reduce the authority of nurses relates to how they have recently replaced nurses in administrative positions with non-nurse managers. Greater levels of authority over clinical decision-making about quality patient care will be moved from nurses back under institutional control. Organisational structural shifts such as these, which force nurses to report to administrators outside their own specialty, need to be redressed, or the importance of technical tasks will continue to dominate the functional care of patients on wards.

Hospital management that marginalises nursing practices must be forced to re-evaluate the significance of quality nursing care if these practices are to be assigned the same high regard held for medical treatments and technical work. Nurses are in the best position to co-ordinate the standard of care required by those patients who are most debilitated. However, in order for institutions to allocate a higher status to nurses, they
need to appreciate the structural conditions that influence the nursing role and identify programs that will prevent the continual downgrading of functional care required by acutely ill older patients. The professional status of nurses can be increased through measures that reclaim their control over the way care is organised on wards. For instance, hospitals can elevate the presence of nurses on wards by highlighting the value placed on nurse-initiated and -managed patient rounds and case-management meetings. Nurses can be better acknowledged by being nominated to chair important multi-professional hospital committees in preference to medical staff. An important point for hospitals to consider is that if nurses in this study had worked in organisations that elevated their status and promoted supportive structures, such as a clinical nurse supervisor to ensure quality patient care, they might not have substituted time needed to provide care for older patients for social time at the desk.

Organisations that implement structures that constrain the way nurses are able to practice, erode nurses’ sense of professional responsibility and consciousness about the consequences of incompetent practices. Moreover, organisations should not, as they commonly do, only give limited recognition to the theoretical learning of professionally prepared nurses. In such environments, nurses lose their capability to provide quality care and their capacity to support each other. Hospital organisations need to reconceptualise caring practices and raise the professional status of nurses by recognizing the professional knowledge and expertise nurses bring to their clinical role. Individual nurses through a process of rationalisation, need to critically reflect on their own actions in order to increase understanding and knowledge of their actions and how they can change them. Through reflection on practice, nurses can in partnership with expert specialist gerontological nurses, empower themselves to change the social conditions operating on the wards that influences actions and behaviours.

6.5 Recommendations for Future Research

The present study suggests several ideas for further research:

- Future research should focus on examining organisational structures which control and punish nurses who resist. Interventions / strategies need to be identified which would support the advocacy role of nurses and their actions to resist in situations of ethical concern.
• Research needs to be undertaken which would examine the re-implementation of the clinical supervisor’s role in supporting quality caring practices for older adults.

• A recommendation for research which would explore management structures which are being implemented in hospitals, which appear to be constantly working covertly and overtly to subvert the professional status of nurses and their ability to influence policies which impact on the quality care of patients, including older people.

• A further recommendation would be for national research to be set up which would report on the social structures operating within hospital contexts and how these structures impact on the ‘empowerment, emancipation and enlightenment’ of all staff who care for older adults. This national study would be chaired by gerontological nurse experts. The objective of this research would be to share concerns and develop coordinated actions which are interdisciplinary in nature and which, when implemented, would promote greater balance and equity between medical treatments and humanistic based nursing care. The findings from research such as this may:

  o Raise the critical awareness of staff towards current practices being enacted on hospital wards.

  o Identify a team of clinicians across Australian health care settings with aged care expertise who would support practices based on gerontological principles and positive health outcomes for older patients.

  o Alert all practitioners to the importance of ensuring the social and health needs of older patients are addressed during hospitalisation.

  o Develop standards which would guide the practices and care planning of all staff so that humanistic based quality care is acknowledged universally as the legal and moral right of all acutely ill older people in hospital.
REFERENCES


Buchanan, J., & Considine, G. (2002). *Stop telling us to cope! NSW nurses explain why they are leaving the profession*. A report for the NSW Nurses Association. University of Sydney, Australian Centre for Industrial Relations Research and Training.


APPENDIX A

INTERVIEW SCHEDULE

The following set of questions will be used to guide interview discussions with the nurses. This is not a complete list of questions nor is it presented in the order to which these questions might be asked.

General prompting questions:

- Think about a significant experience you may have had when caring for an older patient.

Follow-up questions will depend on the responses received and are likely to include some or all of the following aspects of nursing management:

- How did this particular interaction with the patient come about?
- What information did you use to help you during this interaction?
- Tell me about how you managed your care or interventions for this patient for example:
  - What assessments did you make?
  - What conclusions did you draw from your assessment?
  - What decisions did you make? What was significant in this situation?
- How might your past experiences have influenced this interaction?
- Are there any other factors, events or activities that influence the way you interact with your older patients?
APPENDIX B

GUIDELINE FOR PARTICIPANT OBSERVATION OF NURSES INTERVENTIONS WITH AN OLDER PATIENT

The principal issue of interest is how nurses act and how they communicate their decisions and actions to patients. For this reason during the participant observations of nurse-patient interactions/interventions, particular note will be taken of the following:

- Who initiates the contact?
  - What information or explanation is provided to the patient by the nurse?
  - How are the patient’s questions answered?
  - To what extent are the patients involved in the nurse-patient interaction?
  - What is the duration of the interaction or intervention?
  - What justifications or explanations are provided prior to or during specific interventions or procedures?
  - If the patient shows signs of anxiety or discomfort or uncertainty or distress – then how does the nurse respond?
APPENDIX C

NURSES’ INFORMATION LETTER

Study Title: A STUDY OF THE NURSING MANAGEMENT OF OLDER ADULTS IN HOSPITAL

Investigator: Kathleen Kilstoff RN PhD Postgraduate Student, Centre for Research in Healthy Futures, The University of Western Sydney, Richmond Campus.

Telephone: H (02) 99745763  W (02) 95145143

Supervisor: Dr Jane Cioffi, Faculty of Health, The University of Western Sydney, Richmond Campus.

Telephone: W (02) 45701929

The purpose of this research is to explore nurses’ management of older patients in acute hospital settings. The study is being undertaken by myself, Kathleen Kilstoff as part of my PhD studies. You are invited to participate in this study if you have at least two to three years clinical work experience in nursing adults, including older patients aged 65 years and over. The study will consist of short interviews, observational sessions and a review of patients’ records. There is no foreseeable risk of harm to your or to your patients. There are also no immediate personal benefits to you for participating in this study. If you agree to take part in the study, your participation will involve the following:

- two to three short individual interviews (of approximately half an hour each), where you would be asked questions about how you relate to your older patients’ needs.

- observation of three to four episodes of direct patient care in which you are involved (for example, clinical management);
• providing a brief explanation of the study to selected older patients under your
care and obtaining their written agreement for being included in observations
whilst receiving nursing care.

I will conduct all the interviews and if acceptable to you they will be tape recorded. I
will also carry out all the observations. As far as is possible interviews and observation
sessions will be arranged at a time which is convenient to you and your patients. To
assist you in discussing the study with potential patient participants, a copy of a
Patients’ Information Letter will be available, and if required, I will also be available to
answer any questions that may be raised. You may postpone an interview or observation
session, or withdraw from the study at any time without providing an explanation – by
informing the nursing unit manager or myself. If you choose not to participate in the
study, this will not affect your employment in any way. All interviews will be
transcribed. You will have an opportunity to review, amend or edit interview transcripts
following transcription. Your name and any reference to the ward or the hospital will be
removed from all documents and a code will be allocated following data collection. All
information collected will be treated in confidence. Information may be used in
publications but your anonymity will be maintained. All study data will be stored in a
locked cabinet in my office and will only be shared with my doctoral supervisor and the
confidential typist. At the end of the study all interview tape recordings will be stored in
a locked filing cabinet in the Centre for Research in Healthy Futures, UWS. All other
data files (rendered anonymous) will be stored for safekeeping in the Faculty of Nursing
for the required period of five years and then destroyed. You will be able to access the
findings of the study by contacting my supervisor or myself. You can contact me at any
time to ask me any questions that you may have about the study.

Complaints

The University requires that all subjects are informed that if they have any complaint
concerning the manner in which a research project is conducted it may be given to the
researcher or if an independent person is preferred, to the Executive Officer, Human
Research Ethics Committee, Research and Consultancy Unit, University of Western
Sydney, Hawkesbury 2753, telephone 02-45701688.

PhD Candidate: __________________________

PhD Supervisor: __________________________
APPENDIX D

NURSES’ CONSENT FORM

NURSES’ CONSENT FORM TO PARTICIPATE IN A RESEARCH PROJECT

I ____________________________ of ____________________________ Postcode ____ have been invited to participate in a research project entitled:

A STUDY OF THE NURSING MANAGEMENT OF OLDER ADULTS

In relation to this project I have read the Nurses’ Information Sheet and have been informed of the following points:

- Approval has been given by the Medical Research Ethics Committee of Manly Hospital.
- The aim of the project is to explore how nurses relate to older patients [over 65 years of age].
- There are no immediate personal benefits to me for participating in this study.

I understand that the procedure will involve:

- observation of episodes of direct patient care given during a shift in which I am involved
- one or two individual interviews (of approximately half an hour each and which will be tape recorded), following observation sessions where I would be asked questions about my management of care for older patients;
- providing a brief explanation of the study to selected older patients under my care, providing them with a Patient Information Letter and obtaining their written agreement for being included in observations whilst receiving nursing care.
1. All interview and observation sessions will be arranged at a time that is convenient to me and to my patients.

2. There are no possible adverse effects or risks to me or my patients with regards to participating in this study.

3. My involvement in this study may be terminated at any time if I feel I do not want to participate.

4. If the results of the study are published, my identity will not be revealed.

If I have any problems or queries about the way in which the study is being/was conducted, and I do not feel comfortable contacting the researcher, Ms Kilstoff on 95145143, I am aware that I may contact the Coordinator of Research Administration, on 99769504. I can refuse to take part in this project or withdraw from it at any time without affecting my medical care. To withdraw from the study I may contact the Manly Hospital Ethics Committee through Manly Medical Administration on 99769664, or the researcher Kathleen Kilstoff on 95145143.

After considering all these points I accept the invitation to participate in this project.

SIGNATURE       WITNESS
(of nurse/volunteer)   (Please print name)

DATE:       SIGNATURE (Witness)
APPENDIX E

PATIENTS’ INFORMATION LETTER

Study Title: A STUDY OF THE NURSING MANAGEMENT OF OLDER ADULTS

Investigator: Kathleen Kilstoff RN PhD Postgraduate Student, Centre for Research in Health Futures, The University of Western Sydney, Richmond Campus.

Telephone: H (02) 9974 5763 W (02) 9514 5143

Supervisor: Dr Jane Cioffi, Faculty of Health, The University of Western Sydney, Richmond Campus.

Telephone: W (02) 4570 1929

My name is Kathleen Kilstoff and I am a postgraduate student in the Centre for Research in Health Futures, The University of Western Sydney, Richmond Campus. As part of my PhD studies I am undertaking a research project, about how nurses manage the care of older patients in hospital, who are 65 years of age or older and who speak English as a primary language. I hope that the information from this study will improve nursing care for other older patients.

In order to understand how nurses care for older adults I will need to observe them when they are providing care at the bedside. I therefore need your permission to observe what the nurses do or say when they are with you. I may need to do this on three to four occasions. My presence should not in any way change the care that you would normally receive from the nurses. You can ask me to leave at any time if you feel the need for privacy or do not wish me to be present.

In addition to observing what nurses say or do when they are with patients, it would also be useful for me to understand what they write about the care they provide. I may therefore need to read your patient records. The information that I would need to take out of your records would relate only to the nurse’s assessments and written
discussion related to your care. It will not involve any personal details about you or your medical history. If you would rather not take part in the study, please let the nurse know.

All information I collect is confidential and will be seen only by my supervisor and myself. Your name will be removed from all the information and a code given instead. The results of the study may be published, but these will not identify you or any other participants or the hospital. If you have any concerns about the study please feel free to contact me on the telephone numbers provided above.

Complaints

The University requires that all subjects are informed that if they have any complaint concerning the manner in which a research project is conducted it may be given to the researcher or if an independent person is preferred, to the Executive Officer, Human Research Ethics Committee, Research and Consultancy Unit, University of Western Sydney, Hawkesbury 2753, telephone 02-45701688.

PhD Candidate: __________________________
PhD Supervisor: __________________________
APPENDIX F

PATIENTS’ CONSENT FORM

PATIENTS’ CONSENT FORM TO PARTICIPATE IN A RESEARCH PROJECT

I __________________________ of __________________________ Postcode ____ have been invited to participate in a research project entitled:

A STUDY OF THE NURSING MANAGEMENT OF OLDER ADULTS

In relation to this project I have read the Patient Information Sheet and have been informed of the following points

1. Approval has been given by the Medical Research Ethics Committee of Manly Hospital.

2. The aim of the project is to explore how nurses manage care for older patients [over 65 years of age].

3. The results obtained from the study will not be of direct benefit to my medical management.

4. The procedure will involve the researcher observing how the nurses care for me. This observation session will include the interactions nurses have with me for a brief period on one or two days. As well the researcher may need to review what the nurses write about in my medical records. The information that is taken out of my medical records would only relate to the nurses’ assessments and discussion about my care. It will not involve any personal details about my medical history.

5. There are no adverse effects or risks to me in regards to my participation in this study.
6. My involvement in this study may be terminated at any time if I feel I do not want to participate. If the results of the study are published, my identity will not be revealed.

7. If I have any problems or queries about the way in which the study is being/was conducted, and I do not feel comfortable contacting the researcher, Ms Kilstoff on 95145143, I am aware that I may contact the Coordinator of Research Administration, on 99769504.

I can refuse to take part in this project or withdraw from it at any time without affecting my medical care. To withdraw from the study I may contact the Manly Hospital Ethics Committee through Manly Medical Administration on 99769664, or the researcher Kathleen Kilstoff on 95145143. Participation in this project will not result in any extra medical and hospital costs to me. The results of any tests or information regarding my medical history will not be published so as to reveal my identity.

After considering all these points I accept the invitation to participate in this project. I also state that I have/have not participated in any other research project in the past 3 months. If I have, the details are as follows

SIGNATURE (of patient/volunteer) WITNESS (Please print name)

DATE: SIGNATURE (Witness)
DEFINITION OF TERMS

This section introduces the definitions of the major terms used in Chapter 6 (Giddens, 1984).

- **Allocative resources**: Material resources involved in the generation of power, including the natural environment and physical artefacts.

- **Authoritative resources**: Non-material resources involved in the generation of power, deriving from the capability of harnessing the activities of human beings.

- **Discursive consciousness**: What actors are able to say or to give verbal expression to about social conditions.

- **Duality of structure**: Structure as the medium and outcome of the conduct it recursively organizes; the structural properties of social systems do not exist outside of action but are chronically implicated in its production and reproduction.

- **Knowledgeability**: Everything which actors know and believe about the circumstances of their actions and that of others.

- **Ontological security**: Confidence or trust that the natural and social worlds are as they appear to be.

- **Practical consciousness**: What actors know and believe about social conditions including the conditions of their own actions but cannot express discursively, no bar of repression as with the unconscious.

- **Rationalisation of action**: The capability competent actors have of ‘keeping in touch’ with the grounds of what they do, as they do it, and can if asked explain or supply reasons for their activities.

- **Reflexive monitoring of action**: The purposive or intentional character of human behaviour.

- **Structuration**: The structuring of social relations across time and space.