

# EXPLORING NURSING EXPERTISE IN RESIDENTIAL CARE FOR OLDER PEOPLE IN IRELAND.

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## **FOREWORD**

### **Nursing Homes Ireland**

Nursing Homes Ireland is pleased to partner with the All Ireland Gerontological Nurses Association (AIGNA), UCD and University of Ulster in this research. As in most other nations, life expectancy in Ireland has been increasing steadily in recent decades. This is a very welcome development for society and reflects improvements in quality of life, healthcare and treatment of conditions. Coupled with the changes in demography are increased challenges in the provision of health and social care services, particularly residential care. Census 2011 confirms the continuing trend of numbers growing older and living longer, revealing the population aged 65+ increased a significant 14.4% over the preceding five year period, and numbers residing in nursing homes grew 21.8%, from 21,553 to 26,265.

The results of this study can play a lead role in informing and educating key stakeholders and wider society as to the role of nursing expertise in residential care. As the research advises, “this study illuminates the ordinary, the invisible and taken for granted expertise inherent in the practice wisdom of nursing in residential care”.

Care of the older person is increasingly acknowledged as a nursing speciality requiring specific professional knowledge, skills and career structure however working with older people does not always enjoy the same status within nursing as other areas such as the intensive care unit or other acute care environments.

This research focuses on articulating the precise nursing expertise which contributes to excellent person-centred care for older people in residential care settings. This research further confirms the Excellence in Care throughout the nursing home sector as acknowledged and celebrated by the NHI Annual Care Awards.

One of the key findings emanating from this research states nursing expertise in residential care needs to be recognised beyond the context of residents and staff within nursing homes and be embraced by other members of the nursing discipline, society and policy makers. Significantly, it points to this lack of recognition as contributing to gerontological nursing not being properly valued. This study recognises the care ranges and skill mixes of gerontological nurses and contributes to dispelling the perception that nursing in residential care is unchallenging and of poor status.

The impact of an ageing population has a knock-on effect on nursing, resulting in increasing numbers of nurses required for the long term care sector and as a society we need to ensure that workforce planning addresses the challenges of attracting and retaining a high quality workforce in our sector.

NHI in partnership with others looks forward to leading and informing the ongoing debate in respect of care for our older population.



**Tadhg Daly,**  
**Chief Executive Officer, NHI**

# **All Ireland Gerontological Nurses' Association**

## **The Role of the Registered Nurse – critical to the future of residential care**

As the President of AIGNA it is a pleasure to endorse the research presented in this report and to add to the growing body of evidence that demonstrates the critical contribution that registered nurses make to the lives of older people in residential care settings.

There is a growing movement across the world to realign residential care for older people from a dominant biomedical model to a social model of care provision. A social model of care emphasises 'normality', focuses on ability, maximises opportunities for social participation and de-emphasises the artefacts of institutions and care. These characteristics are achieved by the facilitation of resident empowerment, person centred practice, environmental configuration and leadership that is creative and transformative. Whilst these characteristics of residential care challenge all of us to re-think models of care delivery, they also pose real challenges to registered nurses, who need to realign their role functions to ones of enablement, empowerment, facilitation and social connectedness whilst ensuring that the highest quality of clinical care is guaranteed. The role of the registered nurse in ensuring that clinical care to a highly vulnerable population is critical and needs to be understood by policy makers and managers alike. Instead of eroding the role of the registered nurse, a social model of care makes the need for expert gerontological nursing even more important. Given this, then understanding what expertise means in the context of nursing in residential care is a key issue.

This research adds to and extends existing research into the role of the registered nurse in residential care settings and demonstrates the breadth and depth of decision-making needed in order for residents to receive the highest quality care. It shows how the registered nurse needs to be able to balance a range of competing demands, values, strategies and regulatory frameworks in order to provide effective care services. Instead of leaving such work to the least qualified staff, the report highlights the need for expert nursing and for this to be of the highest quality possible.

AIGNA, as the voice of nurses in Ireland who work with older people will continue to build on the findings of this research and to influence decision-makers.



Professor Brendan McCormack  
*AIGNA President*

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# CHAPTER 1

## BACKGROUND TO THE STUDY

### 1.0 INTRODUCTION

This project was commissioned by the All Ireland Gerontological Nurses' Association (AIGNA) and Nursing Homes Ireland (NHI). Following on from previous work funded by AIGNA (Heath & AIGNA 2010), this research focuses on exploring nursing expertise in residential care facilities for older people in Ireland. Ireland's demographic profile is changing. As a shift in healthcare context has focused on sustaining older people in the community, older people in nursing homes demonstrate more complex health challenges (Tolsen et al. 2011), which require particular expertise from nursing staff (Hasson & Arnetz 2007, McGilton et al. 2012). Working with older people requires specific skills, competencies which are drawn from the art and science of nursing, the integration of self into the role and the use of evidence-informed practice. Although, expertise is often tacitly developed and not readily available in the nursing literature, it is imperative to articulate its precise qualities in the care of older people in residential care. Expertise involves the combination of relevant knowledge, skills and personal attributes. This combination leads to critical clinical reasoning which is 'the intellectual activity which synthesises information collected in the clinical situation, integrates it with previous knowledge and experience and uses it for making diagnostic and management decisions' (Newble et al. 2000: 156). In particular, competence in caring for health challenges such as dementia have been shown as essential for long term care facilities (Chang et al. 2010). This

is particularly relevant in the context of a 2012 Irish report which demonstrated many staff have experienced physical and psychological mistreatment by residents in their care (Drennan et al. 2012). Therefore, careful management of presenting conditions is paramount. A skilled practitioner can assess and detect subtle changes in the health status of older people and use reflective care planning to address emerging issues. However, it is important to note that expertise in nursing in residential care extends beyond the mere management of health conditions to promote person centred care.

Studies that have examined the role of the nurse in residential care for older people have attempted to quantitatively measure the work of nurses, leading to an incomplete understanding of the complexity of the knowledge and skill underpinning such nursing interactions (Heath & AIGNA 2010). This has resulted in the perception of nursing work in residential settings as a series of psychomotor activities and a failure to recognise the complexity of the knowledge, skill and expertise needed, including both the affective and cognitive domains of expertise. Consequently, findings in these studies negate the current distinct nursing contribution of the nurse in residential care for older people (Heath & AIGNA 2010) and further reinforce an existing poor image of nursing practice related to residential care for older people (Brown et al. 2008 a & b) as opposed to other nursing contexts, such as acute care (Henderson et al. 2008).



The imperative of this research is borne out by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People). The Health Act stipulates particular operational guidelines in the care of older people and recommends 'a high standard of evidence based nursing practice' (Government of Ireland, Health Act 2007 Part Two), which implies the imperative of applied competencies. Furthermore, the Act also recognises the essential experience of nursing in long term care of older people through specifying that when the person in charge is a nurse, they must hold 'a minimum of three years' experience in the area of geriatric nursing within the previous six years' (Government of Ireland, Health Act 2007, Part 3), while other staff must have appropriate qualifications. Paradoxically, the quality of these competencies in residential care has received scant attention and expertise in any domain of nursing demands recognition or it will be undervalued (Christensen & Hewitt-Taylor 2006). AIGNA has undertaken preliminary work in this area (Heath & AIGNA 2010), but further work was needed to explicate particular competencies and clinical reasoning engendered nursing expertise in residential term care facilities.

The objectives of this study were to:

- 1) Build on previous work undertaken by AIGNA in identifying the role of RNs in residential care settings for older people;
- 2) Articulate and demonstrate the expertise of RNs in residential care settings for older people;
- 3) Contribute to knowledge related to the discipline of nursing so that such expertise is recognised and valued;
- 4) Inform public policy in Ireland regarding the role of the RN in residential care settings for older people and inform decisions regarding ongoing role development as new models of residential care emerge.

# **CHAPTER 2**

## **LITERATURE REVIEW**

### **2.0 INTRODUCTION**

This section presents the literature related to older people in Ireland, residential care and nursing expertise. The search strategy commenced with a review of databases in CINAHL, MEDLINE and PUBMED by cross referencing the terms: nursing homes, long-term care, care homes and expertise in nursing in various combinations. This search resulted in a huge body of published literature which was initially scanned in terms of journal article title, abstract and article content. This process reduced the volume of literature relevant to this study. A snowball method was then used to review reference lists from relevant journal articles to identify possible supplementary literature. An additional review of publications and policy documents was undertaken within the websites of the Central Statistics Office (IRE), the Department of Health and Children, the Health Service Executive, the United Nations and the World Health Organisation. Finally, the UCD library was searched for books of relevance to the focus of this study and books of particular merit, which were not catalogued in the UCD library were either purchased or obtained through inter-library loans.

### **2.1 Older people in Ireland**

Reflecting a worldwide phenomenon, Ireland has an ageing population. In the 2011 census (CSO 2012), there were 535,393 people over 65 years of age in Ireland. Although this represents a 14.4 per cent rise from the 2006 census,

older people, as a proportion of the total Irish population, have demonstrated a moderate rise from 11 percent to 11.7 percent. Life expectancy in Ireland is increasing with females (81.6 years) living longer than males (76.8 years) (CSO 2009). Moreover, the 2011 census recorded an increase of centenarians from 289 in 2006 to 389. Within the population of Irish older people, ninety four per cent live in the community with the remaining six percent residing in some form of communal care<sup>1</sup> (CSO 2012).

Similar to global trends, population projections suggest that the Irish population may rise by 21 percent between 2006-2021, with those over 65 years increasing from 11 per cent to 15.4-16 percent (Morgenroth 2008, Layte 2009, CSO 2012). In particular, the numbers of those over 85 years is estimated to increase more than twofold from 48,000 to 106,000 in the same period (Layte et al. 2009).

## **2.2 Residential care for older people**

Residential care facilities are known by a diverse range of terms such as group homes, care homes, nursing homes, residential aged care facilities and long-term care for older people. The residential care models used can vary in different countries depending on issues such as historical and cultural factors, intergenerational solidarity and government budgets (CARDI 2011, Daly & Szebehely 2012). For instance, in the United Kingdom, nursing home care has been subject to discourses on whether this care constitutes a health or social care service (Heath 2010), while small group homes in the

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<sup>1</sup> Communal care is described as nursing homes, hospital care and other group living care provision (for example religious communities).

Netherlands, Sweden, Japan and the United States (Green Houses®) are increasingly popular (Verbeek et al. 2010). However, the best models are those which are flexible, have adapted to the ageing population and deliver individualised care. Moreover, recent commentators have emphasised the promotion of resident autonomy as a fundamental element of organizational care (Davies et al. 2008, O' Shea et al. 2008, Rodgers et al. 2012). Other advances in recent years have focused on what van Zadelhoff and colleagues (2011) term the deinstitutionisation of nursing homes from large hospital like domiciles to smaller, more homely environments. The advantage of such a transition in care delivery models is acknowledged in Ireland (Heath & AIGNA 2010) as supporting quality of life and a more normal living environment. Smaller, purpose built residential facilities have also been a recommendation in the recent Irish dementia care strategy research review (Cahill et al. 2012)

The need for residential care for older people arises from three areas (Spilsbury et al. 2011). Firstly, residential care may be a result of a post-acute episode, where the older person recuperates for a period of time. Secondly, admission may be due to the provision of end of life care. Thirdly, chronic illness may impose a reduction of functional and/ or cognitive ability to the extent that independent living or the capacity for a caregiver to provide substitute care becomes challenging. Other factors which can influence admission to residential care include age, gender, home support, developments in acute care and geographical supply and demand (Wren et al 2012) with need being different to actual demand (Wittenberg et al 1998).

As the world's population ages and life expectancy increases, it is likely that the demand for residential care will increase. In a recent CARDI report (Wren et al 2012), the number of older people requiring residential care in the Republic of Ireland is anticipated to rise by 12,270 by 2021, representing an increase of 59 percent since 2006. This compares to a projected 45 percent increase in Northern Ireland. Moreover, trends in residential care demonstrate an increased care demand required by residents due to greater levels of frailty (Cheek et al. 2003, Royal College of Nursing 2010). Paradoxically, working in aged care has been devalued and this has contributed to turbulence in the sector and in the provision of quality care for older people (Webster 2009, Heath 2010, Bass 2011). For example, a high rate of staff turnover is a problematic issue in residential care and can affect care quality (Redfern et al. 2002, Castle & Engberg 2006, Castle et al. 2007). Typically, staff hold altruistic objectives of providing quality care, often in line with policy ethos, but recognise they are hampered by the realities of practice, such as staff shortages, funding reductions, organisation of work and high dependency levels (Heath & AIGNA 2010).

### **2.3 Residential care in Ireland**

In 2011, of the six percent of Irish older people who lived in communal domiciles, 20,802 were described as living in nursing homes. Females (n=14,304), by far outnumbered male residents (n=6,498) (CSO 2012). The age cohorts in nursing homes increase with advancing years until 88 years of age and then decrease in line with decreasing general population age groups. However, fifty five percent of older people aged 100 years live in communal

care as opposed to 7 percent of 80 year olds (CSO 2012). Similar Irish study results have been noted (Wren et al. 2009) which indicated that in 2006 residential care was utilized by 0.8% of older people 65-69 years as compared to 33.7 percent of those 95 years and older. Such trends are comparable to other countries (Grundy & Jitlal 2007, Connolly & O'Reilly 2009).

Regulation of residential care can contribute to the promotion of a person centred care ethos (McGilton et al. 2012). It is also acknowledged, however, that regulation can on occasion overlook review of such care provision (Siegel et al. 2012). Residential care in Ireland is regulated by the Health Information and Quality Authority (HIQA). Established in 2007 under the Health Act (2007)<sup>2</sup>, HIQA is responsible for the registration and inspection of all private, voluntary and public nursing homes in Ireland to ensure compliance with 32 national standards (HIQA 2009). These standards are articulated in seven sections (rights, protection, health and social care needs, quality of life, staffing, care environment and governance and management). All inspections are publically available ([www.hiqa.ie](http://www.hiqa.ie)) and HIQA has the authority to make an application to the courts to deregister nursing homes who fail to comply with the national standards.

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<sup>2</sup> Health Act (2007)

Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009;  
Health Act 2007 (Registration of Designated Centres for Older People) (Amendment) Regulations 2010;

Health Act (2007) (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009;

Health Act (2007) (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010.

Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2012

Nursing homes in Ireland are a mixture of public, private and voluntary care facilities with an average 92 percent occupancy rate (Department of Health 2011). In recent years there has been a reduction of public nursing homes beds from 40 percent in 2001 to 28 percent in 2010, while the private sector has risen from 45 percent to 63 percent in the same period (Department of Health 2011). The type and numbers of nursing homes in Ireland is outlined in table 2.0.

**Table 2.0: Type and numbers of nursing homes in Ireland (Minister of State at the Department of Health 2012) (HIQA 2012)**

<b>Type</b>	<b>Numbers (Minister of State at the Department of Health 2012) (related to the end of 2011)</b>	<b>Numbers (HIQA February 2012)</b>
Private nursing homes	404	387
Voluntary nursing homes	48	64
Public nursing homes	121	123
<b>TOTAL</b>	<b>573</b>	<b>574</b>

There is some variation in numbers, particularly in relation to the type of nursing home, cited by the Government (Minister of State at the Department of Health 2012) and HIQA (2012). This may be due, in part, to a time lag in the correlation of numbers and discrepancies in the distinction between public and voluntary nursing homes.

In terms of expenditure, approximately 0.9 percent of the Irish Gross National Product is spent on long-term care for older people, and this is expected to rise to 1.8 percent by 2050 as the population continues to age (Standard & Poors 2010). This expenditure also represents 60 percent of the total budget on older people in Ireland (DOHC 2010). The cost of care in Irish nursing

homes is higher in public facilities due to a higher nurse-patient ratio. This is due to the fact that Health Service Executive (HSE) units have a higher proportion of maximum dependent older people (60%) as opposed to that of private nursing homes (35%) (HSE 2010). However, these figures need to be interpreted in light of the particular (and diverse) variables used in assessing cost and ratio. In terms of older people who are entering residential care, an application for financial support may be made in the context of Nursing Homes Support ('Fair Deal') Scheme (based on a care need assessment and a financial assessment). Residential care for older people in Ireland has been demonstrated to be more cost effective at intermediate and high levels of dependency (Bettio & Solinas 2009).

#### **2.4 The role of Registered Nurses in residential care**

Residential care facilities offer 24-hour expert care to meet a diverse range of older people's health, social and spiritual needs. Such needs range from palliative care, end of life care, supportive care and advanced care planning, physical and cognitive support and varying care models can govern the nurse's role (NHS & the National Council for Palliative Care 2006, Bass 2011). One particularly emerging area of care is palliative care, although such care can still be strongly associated with cancer (Casey et al. 2011). However, a palliative approach encompasses 1) improving the quality of life of those with a progressive life-limiting illness, 2) end of life care for those who are dying, 3) specialist care for residents with complex needs which requires expert input and 4) offering a support system to help families cope with the illness and loss (World Health Organisation 2002, 2004, Australian



Government Department of Health and Ageing 2004, HSE 2009). Palliative care transcends care related to physical symptoms to encompass a holistic approach through attention to four types of need-physical, psychological, social and spiritual (NHS 2006 & the National Council for Palliative Care 2006). End of life care may be viewed as the final period of life where social, psychological, spiritual and physical needs 'arising from an individual's death and mortality' are sensitively responded to (Froggatt et al. 2006:46). Thus, it is characterized by the immediacy of death. Such care requires a deep sensitivity from nursing staff and the ability to assist the resident towards a peaceful, 'good' death (Molloy & McQuillan 2012). Supportive care involves assisting the older person and his/her family through the care process from pre-diagnosis to death and bereavement (NHS & the National Council for Palliative Care 2006) while advance care planning is ongoing planning for possible health care decisions which may arise in the future (NHS & the National Council for Palliative Care 2006).

In Ireland, a recent study demonstrated how the nurse's role in residential care is articulated and also how it could be expanded for future development (Heath & AIGNA 2010). Using a questionnaire survey, focus group methodology and a review of the literature, findings demonstrate the residential care nurse's role being expanded in terms of leading and co-ordinating multi-disciplinary teams, becoming nurse prescribers, expansion in relation to palliative and end of life care and the development of additional roles such as clinical nurse specialists and advanced nurse practitioners. The

impetus for such expansion is based on improvement of quality of care to older people which is supported in the literature (Mezzy et al. 2005).

Yet, as discussed previously, commentators have observed difficulties in retaining registered nurses and one solution has been to recruit additional staff of lower grades, who have limited education or experience in responding to complex care needs of older people (Jones et al. 2007, deBelis 2010, Heath 2010, 2012). The blurring of roles between nurses and care assistants has further exacerbated this debate. Certainly this lack of boundaries contributes to a perceived invisibility of nurses within care delivery and a poor opinion of the residential care nurse's competencies by colleagues in acute care (Karlsson et al. 2008, 2009) as care work may be viewed by those outside the residential care domain as task based and lacking a tangible 'connection to affective and relational dimensions of the work' (Daly & Szebehely 2012: 139). However, studies have demonstrated that poor quality in nursing homes is associated with low nurse staffing levels (Bostick et al. 2006, Wagner & Rust 2008, Harrington et al. 2012)

This perspective is supported in recent research (Heath & AIGNA 2010) in Ireland which notes a lack of understanding of the multiple aspects in nursing care for older people in residential care. Furthermore, the invisibility of nurses' work with older people can tacitly support an agenda of reducing the complement of registered nurses in residential care settings (RCN 2004) despite studies demonstrating the complexity in the therapeutic engagement of such nurses (Lopez 2009). For instance, with regard to the delivery of care,

registered nurses consider themselves accountable for care provision while health care assistants stated ultimate responsibility for residents' care was with the registered nurse (Perry et al. 2003, Parquay et al 2007). Health care assistants tend to learn on the job and accumulate experience, can be task based, are orientated towards one client group and generally, one setting. Moreover, health care assistants do not have the same experience range as nurses, lack professional ethical standards, codes of practice and professional accountability (Heath & AIGNA 2010).

As older residents' dependencies are generally considered moderate to high in residential care, comprehensive care by suitably competent staff, such as registered nurses, is fundamental to quality services (Horn et al. 2005, Castles & Engberg 2008, Kim et al. 2009). However, quality of care is not necessarily about increasing the numbers of registered nurses (where there is an existing satisfactory ratio), but a consideration of other factors such as reducing agency staff, the culture and organization of care, physical environment and resources, skill mix, resident dependency needs, reducing high turn overs and potentialising the experience of nurses who work in residential care (Casey et al. 2011, Munyisia et al. 2011, Spillsbury et al. 2011). The role of nurses in residential care requires particular expertise in caring for older people, demanding a combination of knowledge and experience, yet opportunities for further education can be limited (Heath & AIGNA 2010). One particular valuable trait is that of leadership which has an important impact on practice improvement and contributing to expertise development (Jones et al. 2007, Arbon et al., Manley et al. 2009, Chenoweth

et al. 2010, Bass 2011). Targeted continuing education and practice development are fundamental for nurses in long term care and can assist in retaining nurses, developing and valuing their expertise and stimulating best practice for quality care outcomes (Cheek et al. 2003, Phillips et al. 2008, Brown Wilson et al. 2012).

## **2.5 Nurse-older person relationships**

Another blurring of roles occurs in the context of the long-term relationship of the older person and the nurse. Such sustained interactions often lead to close relationships where both nurses and residents can describe each other as being “like family’ members’ (Casey et al. 2011: 1825, Gannon & Dowling 2011). This departs from the professional, distanced relationship of many other health professionals’ encounters with patients, which tend to be episodic and of a relatively short duration. Nurse-resident relationships are built on principles of mutual positive regard and sharing of self and have a tangible impact on nurses in residential care. For example, one study of 28 nurses who worked in aged care revealed that the participants have debriefing sessions after a resident’s death to work through issues (Phillips et al. 2008). Furthermore, nurses and other care staff in residential care retain individual memories of the older person long after death as an enduring connection remains. This suggests that ‘Once a resident is memorialised they attain a symbolic immortality which individualises them’ (Dempster 2012:236).

## **2.6 Residential care nurses and residents' families**

Increasingly, it is acknowledged that staff in residential care need to work collaboratively with the resident's family to promote well-being (Bauer 2006). Families are essential stakeholders in residential care and can be a resource for helping older people to achieve their potential for quality of life (Bauer 2006, LeSage 2012) particularly in the context of a continued link to a person's personal preferences and past history. An essential element in staff-relative relationships is a democratic, reciprocal communication basis as both nurses and family members have a significant role in helping the resident to adjust to residential care living (Ellis 2010). Furthermore, fostering relationships with families can help family members maintain a sense of involvement and self-worth and there may be a perception by families that their involvement is positively correlated to the quality of care delivered to their relative (Bowers 1988). Often, admission to residential care may have been a difficult choice for families and residents and the continued involvement of families can promote a positive experience. However, some difficulties can present in terms of degree of involvement and also the degree of power relinquished in care delivery, which can lead to the rhetoric of close involvement but the practice of peripheral or tokenistic relative participation due to their comparatively ambiguous position (Bauer 2006). Thus, families need to be included in nursing home policy and nurses' expertise includes the negotiation of participative relationships in the context of the macro sphere of representation on residential care governance committees to the micro sphere of individualized care planning and relative's involvement in such

care. Such an agenda has the potential to also provide appropriate planning for residential care services for older people in the future (Heath 2010).

## **2.7 Person centred care**

Person centred care delivery has been proposed as an important element of nursing expertise (McCormack & Tichen 2001). In an Irish study on end of life care in residential and long term facilities (O' Shea et al. 2008), most participants described their care delivery as being person centred. However, the ethos of person centred care was hampered by issues of infra-structure challenges, staff shortages, ageist perspectives and capacity problems (O' Shea et al. 2008). Person centred care is immersed in valuing the individual by prioritizing personhood. Personhood is described by Kitwood (1997:8) as 'a standing or status bestowed upon human beings by others, in the context of relationship and social being'. The development of such therapeutic relationships enhances care and fosters continuity of care and can engender 'a sense of purpose for staff' (Brown Wilson 2012:10).

Person centred care negates the hierarchical, powerful position of professionals over patients and refocuses, instead, on person directed care and maximizing quality of life and autonomy (van Zadelhoff et al. 2011). For McCormack (2004), this means a professional ethos which recognises four dimensions: being in relation, being in the social world, being in place and being in self. These dimensions acknowledge that the interconnections of being in a relationship and that related interpersonal processes have an intrinsic worth for all individuals. Understanding life pathways is an essential

element of being authentic, particularly in relation to the production of individualized life plans (McCormack & McCance 2010). Thus, valuing life narratives is central to understanding the person and navigating individual priorities. Being in place reflects the negotiation of issues such as professional, organizational and cultural values and norms. Thus, making sense of a resident's values and his/her perception of the world is important to maintain a sense of the individual and to empower him/her in decisions of self (McCormack & McCance 2010).

One of the objectives of person centred care is the potentialisation of quality of life for older residents through humanistic dialogue (Clonginger 2010, McGilton et al. 2012). Improving quality of care in residential care services has been advocated as an essential element in a recent European level report (AGE Platform 2012), however, Cooney et al. (2009) observe that quality of life has been a relatively neglected area in research on residential care of older people. Multiple factors have been identified in older people's quality of life and these factors are dynamic, varying according internal and external influences to subjective interpretation and life experience (Bowling 2003, Murphy et al. 2009, Van Malderen et al. 2013). Older people in residential care are very dependent on others for quality of life (McGilton et al. 2012, Van Maldaren et al. 2013) and expertise in nursing care has the potential to enhance the resident's experience. In a grounded study of 101 older people in 12 nursing home sites in Ireland, Cooney et al. (2009) revealed that factors such as ethos of care, a sense of self and identity, connectedness, social relationships and networks, the availability of activities

and therapies all had an impact on quality of life for older people. Such factors were further mediated by the older person's ability to adapt, life experiences and health status as well as environmental factors such as the physical and social environment. The findings of quality of life in this study (Cooney et al. 2009) suggest that the implementation of principles of person centred care can significantly impact a resident's quality of life.

## **2.8 Expertise in nursing**

Oxford dictionaries describe expertise as expert skill or knowledge in a particular field (Oxford Dictionaries nd). Expertise in nursing is considered to involve the development of interdependent domains which move from technical rationality to professional artistry and the implementation of person-centred systems (Hardy et al. 2009, Petty et al. 2012) and practiced situational discrimination (Benner et al. 1996). Although subject to some critique (English 1993, Arbon 2004), early work by Benner (1984) provided insights into the ways which nurses gain competency and 'journey' from novice to expert. However, not every nurse attains the level of expertise (Altmann 2007) and competencies in nursing have been considered ambiguous (Watson et al. 2002, Rishel et al. 2008). For example, experience may make interventions more effective but may not impact on advancing nursing practice (Gerdtz & Bucknall 2001).

Benner (1984) used five levels of competency based on Dreyfus and Dreyfus's (1980) model, to articulate skill acquisition in nursing. Dreyfus and Dreyfus (1980) considered an expert as developing knowledge in context,



recognizing its relevance, being able to assess the context holistically and generating intuitive decision-making. Thus, an expert has a vision of what is possible, can use and adapt experiential knowledge to new situations and holds a depth grasp of practice based on tacit understandings. Expert nurses demonstrate and synthesize different types of knowledge by integrating ways of knowing from the domains of empirics, ethics, knowledge of self and aesthetics (Carper 1978). In fostering such attributes, the expert nurse sees not only what needs to be done, but how to achieve this using 'deliberate rationality' and intuitive practice (Benner et al. 1996: 43). Thus, an expert nurse is not rule bound but a rule maker in practice who can address complex, uncertain problems in practice (Lyneham et al. 2008) through 'fuzzy logic' (Kosko 1994). This encompasses intuitive reflection before action, reflection in action and reflection after the event (Schon 1987). Expert nurses are particularly attuned to reflection in action as their experience and knowledge enable innovative and entrepreneurial responses which meet the needs of the situation. However, defining and examining expertise has been challenging as many nurses recognise their practice as expert but articulating the context is difficult as it is inherently enmeshed and embodied in their professional identity (Lyneham et al. 2008, Christensen & Hewitt-Taylor 2006, Heath & AIGNA 2010).

Building on understandings by Benner and colleagues, the concept of communities of practice is useful in conceptualising the expert nurse in care of older people in residential care. Drawing from the work by Lave and Wenger (1991) communities of practice describe groups of people who have a

common interest and define themselves by the roles they play and the identities they assume within the community. Wenger (1998) indicates that particular qualities are demonstrated in communities of practice. Individuals 1) participate in a joint enterprise, such as looking after patients, 2) demonstrate mutual engagement (even in informal ways such as coffee breaks) and 3) have a shared repertoire. This is typified by peer to peer learning, which has application in the daily work of expert nurses who often facilitate colleague's learning and learn from colleagues. Reviewing expertise in the context of communities of practice also facilitates an understanding of the social process of knowledge sharing and utilisation within nursing practice. It is the recognition of expertise by colleagues and others which establishes the nurse as authoritative and trustworthy and essentially a valid source of support for clinical practice (Manley & McCormack 1997, Manley et al. 2005, Gabbay & LeMay 2011). This reflects the imperative that expertise is recognised due to the possession of specialised knowledge, extensive experience and reflection in action (Jasper 1994).

Heath & AIGNA (2010) identified two components of nursing expertise in the care of older people in residential care. Firstly, an expert nurse can practice person centred care through building up therapeutic relationships, caring, empathy, individualizing and cherishing the older person within the context of his/her life world. Secondly, it is the practice of nursing artistry, using the components of expertise articulated by Benner (1984) and Manley et al. (2005). Thus, expertise is a combination of professional artistry and practice wisdom integral to professional practice (Titcher & Higgs 2001). The unique

characteristic of nursing in residential care of the older person is that it allows the development of genuine and meaningful long-term relationships between staff and residents, which has the potential to enrich both parties' lives. This demands nurses to be highly motivated and innovative in the provision of care (Capezuti et al. 2007, Hasson et al. 2008) as well as the ability to teach, supervise and guide ancillary staff such as healthcare assistants (Heath & AIGNA 2010). Expertise has also been associated with specialised nursing roles in older person care, such as in the context of nurse practitioners in the United States and Australia and clinical nurse specialists in Ireland and the United Kingdom. Such roles have led to improved client outcomes such as decreased hospital admissions and timely interventions for older people (Arbon et al. 2008, Heath 2010). Within the domain of expertise, it has been suggested that staffing quantity over and above the minimum level is not a huge determinant of improved health outcomes. Rather, it is factors such as the expertise of staff which impacts positively on quality care (Arling et al. 2007, Heath 2010).

In an analysis of the literature, Manley and McCormack (1997) concluded that there were five domains of expertise in nursing: holistic practice knowledge, knowing the patient, saliency, moral agency and skilled know how. The facilitation of nursing expertise encompasses reflective ability, organization of practice within the context of optimum patient outcomes and the larger context, interpersonal relationships, autonomy and authority and recognition by others. Building on this and using emancipatory action research (Grundy 1982) and fourth generation evaluation (Guba and Lincoln 1989), more recent

work has built on Manley and McCormack's (1997) findings (Manley et al. 2005, Hardy et al. 2006) to demonstrate nursing expertise. Table 2.0 presents these domains and attributes in expert nursing practice.

**Table 2.1: Expertise in nursing: Domains and attributes (adapted from Manley et al. 2005).**

<b>Holistic practice knowledge</b>	<ul style="list-style-type: none"> <li>➤ Using all forms of knowledge.</li> <li>➤ Ongoing learning and evaluation from new situations.</li> <li>➤ Drawing from a range of knowledge bases to inform practice.</li> <li>➤ Embedding new knowledge and accessing in similar situations.</li> </ul>
<b>Saliency</b>	<ul style="list-style-type: none"> <li>➤ Discriminating cues to inform the situation.</li> <li>➤ Observation of non-verbal cues to understand the individual's own situation.</li> <li>➤ Listening and responding to verbal cues.</li> <li>➤ Regarding the patient as a whole to inform practice.</li> <li>➤ Ability to recognise the needs of the patient, colleagues and others in actions taken.</li> </ul>
<b>Knowing the Patient</b>	<ul style="list-style-type: none"> <li>➤ Respect for people and their perspectives</li> <li>➤ Respecting perspectives of the patient on his/her illness or life world</li> <li>➤ Willing to promote and maintain a person's dignity at all times.</li> <li>➤ Conscious use of self to promote a helping relationship.</li> <li>➤ Promoting the patient's own decision making</li> <li>➤ Willingness to relinquish 'control' to the patient.</li> <li>➤ Recognizing the patient's /other's expertise</li> </ul>
<b>Moral agency</b>	<ul style="list-style-type: none"> <li>➤ Providing information to enhance people's ability to problem solve and make decisions on their on behalf</li> <li>➤ Consciously working to promote another person's dignity, respect and individuality.</li> <li>➤ Conscious awareness of one's work and behaving impeccably.</li> <li>➤ Working and living own values and beliefs, while respect other's values and beliefs</li> </ul>
<b>Skilled know how</b>	<ul style="list-style-type: none"> <li>➤ Enabling others through a willingness to share knowledge and skills.</li> <li>➤ Adapting and responding with careful regard to individual situations.</li> <li>➤ Mobilizing all available resources.</li> <li>➤ Envisioning and articulating a plan through a problem/situation and inviting others to participate in the plan.</li> </ul>
<b>Additional understandings</b>	<ul style="list-style-type: none"> <li>➤ Being a catalyst for change</li> <li>➤ Being a risk taker, (taking risks which are informed by consequence of such action but enables the best outcome for the patient).</li> <li>➤ Fostering of interpersonal relationships</li> <li>➤ Recognition by others</li> <li>➤ Skilled companionship (Titchen 2001)</li> </ul>

Manley et al. (2005) further expand expertise using Higgs and Titchen's (2001) understandings of professional artistry. Professional artistry is 'the meaningful expression of a uniquely individual view with a shared tradition' (Manley et al. 2005: 26). It involves practitioner qualities, practice skills and creative imagination processes embedded in the domains of expertise (see figure 2) which combine to yield unique and dynamic responses to everyday practice challenges (Titchen & Higgs 2001, Manley et al. 2005, McCormack & Titchen 2001, Titchen & Hardy 2009). The development of these nursing expertise research studies has enabled the advancement of standards and accreditation for practice as the pragmatic constituents of expert nurses is made visible (Hardy et al. 2006). More importantly, these studies have provided tangible evidence, through portfolio development and critical, skilled companionship, of nursing expertise and its outcomes for patients, colleagues and the health service (Manley et al. 2009).

Another framework which has examined nursing expertise is that of skilled companionship (Titchen 2001) and this has been utilised to consider gerontological nursing (Webster 2009). Skilled companionship uses a particular framework to uncover how the nurse brings self to the relationship with the person being cared for (ontology of practice). It also considers the domain of knowledge and how such knowledge is generated (epistemology of practice) (Titchen & McGinley 2003). The illumination of expertise through a skilled companionship framework means an examination of three domains, each of which have inherent processes and strategies: the relationship domain, the rationality-intuitive domain and the facilitation domain (Titchen &

McGinley 2003). The examination and elucidation of each of these domains demonstrates skilled companionship as a blend of professional knowledge and self through professional artistry (Titchen & McGinley 2003).

Expertise in nursing older people underpins excellent practice through the improvement of outcomes, quality of life and efficient and effective service provision (Webster 2009). Indeed, the expert nurse is considered fundamental to the success of programmes such as advanced care planning for end of life care and for the management of older people who are acutely ill in residential care (Lopez 2009, Jeong et al. 2007, 2010). Care assistants tend to deliver most of the 'hands on caring', but Heath (2010, 2012) cautions that, what on the surface may seem mundane, can for a registered nurse, be a complex processing of information which draws on knowledge, experience and expertise and a refined clinical judgement. Nursing in residential care has become increasingly complex and requires a skilled workforce (Cheek et al. 2003). However, Webster (2009) acknowledges that describing expertise in gerontological nursing can be difficult. It encompasses essential core nursing skills but also, knowledge of the ageing process, the impact of ageing on the older person and others as well as deep engagement in person centred care (Webster 2009). This role and expertise transcends descriptions in the literature or in the registered nurse's job description (such as the expertise in recognizing a hypoglycaemic episode in an older resident with diabetes) and Heath (2012) argues that the invisibility of such activities raises the question of how such challenges would be addressed in the absence of a registered nurse's input. It is the expertise of the registered nurse which impacts most prominently on positive care outcomes and protects against risk (deBellis

2010, Heath 2012). Risk can be multifactorial and can focus on, for example, assessing a resident's intrinsic risk (ie assessing a swallow reflex, assessing for depression) to broader influences on care provision such as environmental and organizational risk (Heath & AIGNA 2010). Most importantly, the articulation of expertise is fundamental to being valued, particularly in the context of financial rectitude where value for money is paramount (Christensen & Hewitt-Taylor 2006).

## **2.9 CONCLUSION**

The literature review has presented issues related to nursing older people in residential care and the conceptualisation of expertise in nursing. As the population of older people rises and life expectancy extends so will the demand for expert nursing in residential care for older people. Paradoxically, there is a real need to articulate what such expert care consists of as the literature demonstrates that nursing in residential care can be devalued and considered task orientated. This research makes visible the expertise of nurses in residential care and through multiple data sources enables an understanding of how such expertise contributes to quality of care for older people. Residential care inherently involves complex issues by virtue of the presenting reasons that an older person enters the residential care environment. Thus, it is imperative that societal and professional value is placed on meeting the multiple and complex requirements of a diverse older person population, particularly those in residential care.

# **CHAPTER 3**

## **RESEARCH DESIGN**

### **3.0 INTRODUCTION**

The methodological approach used in this study allows the generation of data from multiple perspectives. One limitation of qualitative research in nursing is that it tends to generate nursing perspectives at the expense of the patient's perspective (Morse & Chung 2003, Boscart 2010). Consequently, in order to develop knowledge of the nursing expertise in residential care in Ireland, a triangulated approach was taken to develop a descriptive, multi-case study design. Such an approach has the advantage of potentialising the understanding of complex phenomena in the social world (Yin 2009). Thus, each of the 23 case study nurses represented a context sensitive unit of analysis which contributed to the study findings (Patton 2001).

### **3.1 Sample selection**

The sample of case study participants was generated through self-selection through both the AIGNA and NHI membership and communication to each organisation's members. Potential participants were invited to contact one of the researchers to discuss the project, assess suitability for participation and agree a data collection date. Relevant documentation such as information sheets and ethics information was emailed a minimum of two weeks prior to the data collection and Directors of Nursing were requested to discuss and disseminate these to potential participating staff and older people. Self-selection included Directors of Nursing's volunteering his/her facility's



participation (subject to ethics approval), recruiting a case study nurse, nominated colleague and older person. In some cases, participants were generated by potential case study nurses volunteering themselves<sup>3</sup>.

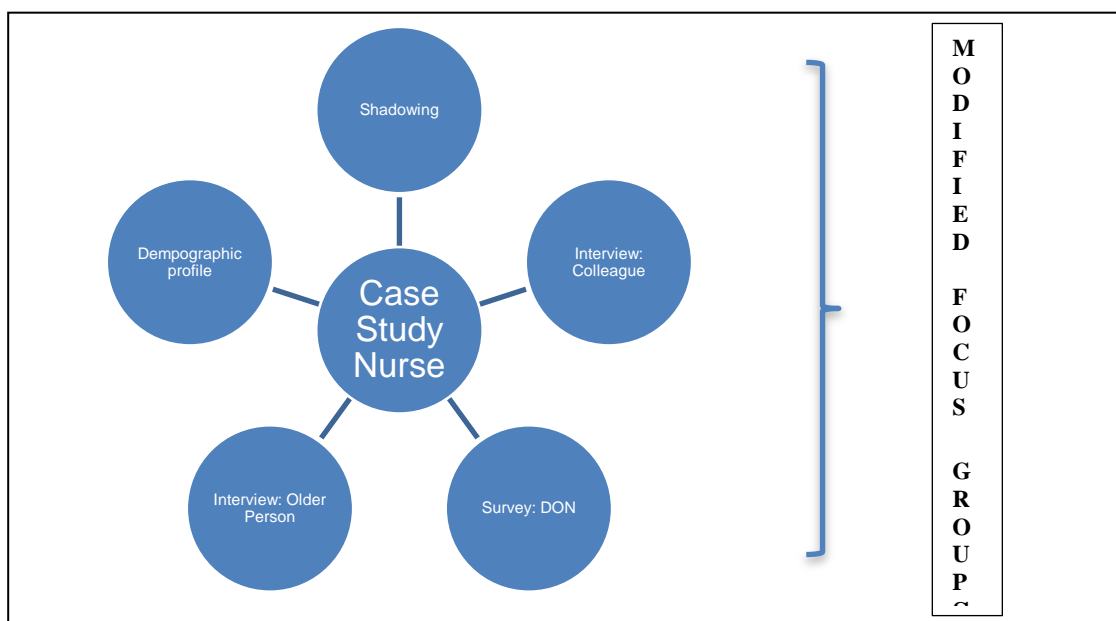
### **3.2 Data collection methods**

Data collection entailed the use of mixed methods, which have the advantage of building knowledge up through the use of multiple, complimentary data sources. This allowed the generation of depth data both from the outside in and the inside out. In this study, both qualitative and quantitative methods were used. Qualitative data generation has the advantage of depth exploration of complex phenomena and developing rich understandings whilst quantitative approaches describe occurrences and generate numeric data to describe or assess relationships between phenomena (Curry et al. 2009). This study was informed by data collection through several data collection methods, namely: a) work shadowing of each case study nurse, b) interviews: with one older person in receipt of the case study nurse's care c) interviews: with a nominated colleague of the case study nurse d) qualitative survey by the case study nurse's Director of Nursing (DON) e) case study nurse demographic profile and f) modified focus groups at the 2012 AIGNA Annual conference. While data collection methods *a* to *d* were context sensitive to the case study, data collection method *f* (modified focus groups), reflected professional discourses on what constitutes expert gerontological practice in residential care. Figure 1 demonstrates the data collection methods.

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<sup>3</sup> When case study nurses volunteered themselves, they were advised that permission for the study would have to be negotiated with the Director of Nursing for the facility and, if in a private/voluntary facility, be subject to the provision of ethics approval by the facility.

**Figure 3.0: Data Collection Methods**



### *Shadowing*

The use of shadowing as a data collection method in this study allowed the researcher to enter the natural environment of the nursing home and to examine the ‘culturally–context social processes’ (Paterson et al. 2003: 30), which constitute the daily practice of the case study nurse. Derived from institutional ethnography (Smith 1987), the shadowing method allowed the researcher to understand the case study nurse’s role and to uncover the subtleties of his/her daily interactions in residential care of older people. Although similar to participant observation, shadowing does not involve an active role in the setting being observed, but does involve co-creative, short term relationships realised through ‘sympathetic proximity’ (Gilliat Ray 2011:482). A major advantage of this method was its ability to generate important data within a real time, everyday context from the perspective of the person being shadowed (McDonald 2005, Quinlan 2008).

Although shadowing is generally associated with time periods of one day to an entire month, the shadowing period in this study involved 23 nurses for a period of two and a half hours between November 2011 to May 2012. All nurses were required to be registered as a nurse with An Bord Altranais (Irish Nursing Board) and have a minimum of one year's experience working in residential care for older people as a registered nurse. The Director of Nursing and the case study nurse from each care facility negotiated shadowing time periods with one of the researchers. All case study nurses were female and most shadowing periods occurred between 8.00am and 12.00 mid-day.

Shadowing involved close observation of the participant and the recording of continuous, copious notes, which detailed interactions with older residents, colleagues, relatives and others, body language and dispositions of the person being shadowed. If, during the shadowing period the case study nurse had a coffee break, the researcher accompanied her. This allowed additional insights from a community of practice perspective. In addition, during the shadowing period, the researcher asked questions related to clarity on activities being undertaken, knowledge of the older resident's life world or to illuminate tacit knowledge demonstrated in practice. This allowed not only the generation of knowledge related to the 'what' and 'how' of the case study nurse's role but also the 'why' (McDonald 2005, Quinlan 2008).

### *Interviews (Older People and Colleagues)*

In the interviews for this study, the objective was to facilitate rich exemplars of how the case study nurse's practice was experienced a) by older people in receipt of his/her care and b) by colleagues who work in partnership to deliver care. Older people who participated were required to have mental capacity and be in receipt of care from the case study nurse and were selected through the Director of Nursing approaching potential participants prior to the researcher's visit. Directors of Nursing approached the nominated colleagues, who were required to have experience working with the case study nurse. Nominated colleagues could be registered nurses or health care assistants.

Semi-structured interviews, with the aid of a topic guide, were used due to their ability to facilitate in-depth probing of the interviewees' experiences (Kvale & Brinkman 2009). The use of the semi-structured interview ensured that the relevant context was discussed through the use of pre-thought areas of questioning and the production of situated knowledge regarding the topic of interest (Mason 2002). Open-ended questions allowed for deep and thoughtful responses and provided the opportunity for increased latitude in participant responses, which when probed, led to an illumination of the experiences related to the role of the case study nurse (Streubert-Speziale & Rinaldi Carpenter 2003, Kvale & Brinkman 2009). A qualitative interview format allowed for the in-depth exploration of nuances, that is, the subtlety of meaning for the participants (Dingwall 1997).

Prior to each interview, a conversation occurred regarding the purpose of the study and how the interview would progress. When the interview commenced, the initial question was structured to facilitate the participant to relax and as the interview progressed, questions became increasingly refined to focus on the experiences of either delivering care with case study nurse or receipt of care from the case study nurse. Questions were responsive to each of the participant's narratives, while centering on the generation of data to address the research objectives. Finally, each participant was asked if they wished to include any other relevant area, which may have been omitted within the interview, or if they wished to elaborate on any part of the interview.

All interviews occurred between November 2011 to May 2012. A total of 46 interviews (23 with a nominated colleague and 23 with an older person in receipt of care) were conducted in a quiet area in each nursing home. The older person interviews were predominantly with female residents (n=18) with male residents constituting 5 interviews. Two participants were part of a married couple who both resided in the home. The option to continue to live as a couple was identified as enhancing their quality and enjoyment of life in acknowledging life histories. The older person interviews lasted between 30 minutes to 50 minutes. The nominated colleagues' interviews were completed with both nurse colleagues (n=12) and health care assistants (n=11). Nurse colleagues' interviews lasted 40 minutes to one hour.

### *Survey: Director of Nursing*

A qualitative survey was undertaken for each case study nurse by his/her DON (n=23). Qualitative surveys are useful in generating diverse views about the world as the respondent sees it (Fink 2003, Jansen 2010) and allowed the systematic collection of data regarding each case study nurse's practice. Using open-ended questions based on previous work (Hardy et al. 2009), the survey was divided into two sections. Section one, which contained six sub-questions, focused on illuminating the descriptive qualities of the case study nurse in the context of her expertise. Section two contained three questions which developed exemplars of how this expertise was operationalized in everyday gerontological nursing practice in the residential care facility.

### *Demographic survey*

Each participant completed a short survey that consisted of seven questions focused on personal and professional contexts, including age, experience, unit population of older people, training in care of the older person and highest level of professional education. The demographic details served to contextualise responses and to assist in the analysis.

### *Modified Focus Groups*

This method of data collection did not focus on any of the case studies per se, but did generate topic orientated discussion on the general nature and understanding of what constitutes an expert nurse in gerontological practice in residential care. The use of a focus group methodology is particularly advantageous in studies of an exploratory nature (Barbour 2007). The

modified focus groups took place at the 2012 AIGNA's annual conference. Conference delegates were invited to participate in focus groups pertaining to the research. A total of 115 delegates participated. Current self-described role descriptions and numbers in each role group may be reviewed in table 3.0.

**Table 3.0: Role descriptions and related numbers of focus group participants**

Nursing Management*	Clinical Nurse Specialist	Registered General Nurse	Practice Develop. Officer	Health Information and Quality Authority	Managing Director/ Person in Charge- Proprietor**	Other ***
62	3	30	4	2	2	12

\*Includes Directors of Nursing, Assistant Directors of Nursing, Person in Charge, Director of Care and Clinical Nurse managers.

\*\* Participants did not indicate that they were nurses, thus are categorised as self-described.

\*\*\*Denotes Social Worker (1), Administration (2), did not state role but stated private residential care (5) and public residential (4)

The modified focus group was divided into 13 sub-groups which had 8-10 participants each. Based on previous work undertaken by Manley et al. (2005), each group was asked to discuss one issue related to describing an expert nurse in long term care of older people and one exemplar or how such expertise was demonstrated in practice. Two moderators (the study authors) facilitated the session and encouraged each group to nominate a scribe to record the discussion. The moderators then traversed each group and listened to developing discussions and answered any concerns elicited by the group.

### 3.3 Analysis

The qualitative part (interviews, qualitative surveys, shadowing and focus groups) of this study used a content analysis approach to the data. Although there are variations of content analysis, this study employed directed content

analysis (Hsieh & Shannon 2005, Pistang & Barker 2010). This allowed the researchers to validate and extend existing research on the topic of expertise, specifically nursing expertise in residential care for older people. In this study, the pre-selected themes were constituted by the framework developed by Manley & McCormack (1997) and developed further by Manley et al. (2005) and Hardy et al. (2006). Analysis involved the use of a computerized qualitative data management system, NVIVO 10 © to interrogate the data to develop the themes. Often coding involved the data demonstrating more than one theme and thus the same excerpts could be coded more than once. Due to the multiple data sources, the following coding is used when presenting the findings.

**OP:** Older person interview

**NC:** Nursing Colleague's interview

**DON:** Director of Nursing survey

The data were firstly explored in relation to five data components for each individual case study nurse (n=23). These components were constituted by 1) the shadowing period, 2) the demographic profile, 3) the older resident's interview, 4) the nominated colleague's interview and 5) the Director of Nursing's survey. Using directed content analysis, Manley et al.'s (2005) themes were used to identify each case study nurse's expertise (saliency, holistic practice knowledge, knowing the patient, moral agency and skilled know how). The category which articulated qualities such as being a catalyst for change, being a risk taker, and fostering interpersonal relationships was given the title 'attributes'.



Two further themes were also generated. Firstly, within the data, there were often discourses, which spoke of the context of the nursing home, and the general qualities needed to look after older people in residential care. This theme of 'context of nursing home' allowed the idea of 'communities of practice' to emerge and located expertise within the complex organization of the individual nursing home. It also functioned to acknowledge that expertise in nursing is embedded in a social, political and environmental milieu, where the nurse is intricately interconnected with residents, relatives and colleagues and acknowledges overlaps of personal and professional realities. The second additional theme was identified within the older person's interviews. This theme focused on issues related to his/her admission to the nursing home and could then be mapped as a component of needs analysis related to the older person's experience of care from the case study nurse. Each case study nurse demonstrated multiple examples of nursing expertise within the individual themes.

The second stage of data analysis involved a review and consolidation of the individual case study data to develop robust exemplars of what constitutes expertise in nursing in long term care facilities in Ireland. The case study data were supplemented by data generated through a focus group which was convened at the AIGNA's annual conference. This allowed a general consideration of nursing expertise in residential care by knowledgeable stakeholders who all had a professional interest in care of older people.

The findings in this report are presented in two ways. Firstly, a combination and consolidation of all data sources is used to explore the themes described in the previous section. Secondly, as skilled companionship (Titchen 2001) provides an alternative lens to examine expertise, this framework is used to consider one case study nurse's expertise, illuminating her professional artistry.

The demographic profiles were analysed using SPSS and are presented in the findings as descriptive statistics.

### **3.4 Ethics**

Ethics approval was obtained prior to the commencement of the study. This comprised of several steps. Firstly, ethical approval was granted by the UCD Human Research Ethics Committee (LS 11-121-Phelan). Secondly, ethics approval was obtained from the Assistant National Director for Services for Older People for HSE facilities. Thirdly, private facilities and voluntary facilities submitted individual ethics approval. Copies of both HSE approval and private/voluntary facilities approval were also submitted to the UCD Human Research Ethics Committee (LS 11-121-Phelan), as requested, prior to data collection in the individual facility. The research observed the best practice standards as outlined in the *Code of Good Practice in Research* (UCD 2010).

Ethical processes for all methods of data collection are detailed below.

### *Shadowing*

- Prior to shadowing, one of the researchers confirmed that the case study nurse was familiar with the information sheet (via discussions with the Director of Nursing) and understood the purpose of the study. In addition, the researcher ensured that the case study nurse understood that she would be rendered anonymous and data were confidential. Case study nurses were advised that they could withdraw from the study without prejudice and written details of withdrawal were contained within the information sheet. Following demonstration of understanding, each nurse was invited to sign the consent form and complete the demographic profile.
- Residents who would be in receipt of care during the shadowing phase of data collection were approached by the Director of Nursing a minimum of one week prior to the study. The study and the method of shadowing were explained to the residents and oral consent was obtained and recorded by the Director of Nursing. Consent was obtained for those with mental capacity challenges by proxy of either the Director of Nursing or a family member. The researcher also discussed the shadowing method and recorded continued oral consent immediately prior to the shadowing period. Residents were advised that withdrawal was not possible after data collection as the shadowing process would already have anonymised their participation and it would be impossible to extract a single resident in the context of the shadowing data.

## *Interviews*

- Older people with mental capacity were approached by the Director of Nursing to elicit interest in participating in the study. One of the researchers met with the older person and discussed the study. Residents were invited to sign a consent form when full understanding of participation was elicited. The principles of anonymity and confidentiality were emphasised and that withdrawal at any point in the study would be possible without prejudice. Withdrawal details were contained in the information sheets. Residents were also made aware that the interviews would be recorded by the researchers and transcribed by a professional typist.
- Nursing colleagues were approached by the Director of Nursing to elicit interest in participating in the study. One of the researchers met with the nominated colleague and discussed the study. Nominated colleagues were invited to sign a consent form when full understanding of participation was elicited. The principles of anonymity and confidentiality were emphasised and that withdrawal at any point in the study would be possible without prejudice. Withdrawal details were contained in the information sheets. Nominated colleagues were also made aware that the interviews would be recorded by the researchers and transcribed by a professional typist.
- Directors of Nursing signed a consent form after full discussion on the purpose of the research. Issues related to confidentiality, anonymity and withdrawal were discussed prior to the commencement of data

collection in the nursing home and completion of the Director of Nursing Survey.

- Delegates who attended the AIGNA annual conference in 2012 consented by virtue of opting to participate in the focus groups.

Data were stored in a locked filing cabinet. Recordings were given individual codes, which were only known by the researchers. A professional typist transcribed the interviews and signed a confidentiality agreement. All participants were allocated a pseudonym and any references to places or names were removed from the transcriptions.

### **3.5 CONCLUSION**

This chapter has presented the methods and data collection in this study. In order to generate a comprehensive understanding of nursing expertise in residential care in Ireland, several data collection methods were employed. This allowed multiple perspectives to be correlated in a depth development of findings. The use of multiple sources of data underpins a more balanced perspective allowing findings to be holistic and contextualised.

# CHAPTER 4

## Findings

### 4.0 INTRODUCTION

This chapter presents the findings from the case study data and the modified focus groups. Information regarding the nursing homes and the demographic profile is presented followed by the findings from the themes generated through the data coding process related to the 23 case studies. The chapter concludes with an exploration of skilled companionship in relation to one case study nurse.

### 4.1 Facility and case study nurse details

Although the case participants were self-selected, there was a focus on generating data from a national distribution of nursing homes. Table 4.0 identifies the counties and related number of case studies included in the study.

**Table 4.0: Geographic regions of data collection and related case study numbers.**

<b>County</b>	<b>Case study numbers</b>
Cork	4
Kerry	3
Wexford	3
Sligo	2
Galway	2
Westmeath	1
Dublin	5
Kildare	1
Roscommon	1
Tipperary	1

Table 4.1 demonstrates that the case study nurses were employed in public, private and voluntary facilities.

**Table 4.1: Facility Type**

<b>Nursing Home</b>	<b>Number</b>
Public	6
Private	14
Voluntary	3

The Director of Nursing survey indicated that the bed capacity of the 23 nursing homes in this study ranged from 27 to 161.

*Findings from individual demographic profiles*

All case study nurses were female. The age distribution of the participating case study nurses may be reviewed in table 4.2 and ranged from 22 years of age to 60 years of age. The details in the demographic profiles were inputted into SPSS and are described in this section. Categories are reflected according to the individual questions and responses in the demographic profile.

**Table 4.2: Age groups of case study nurses**

<b>Age Group</b>	<b>Number</b>
22-30	8
31-40	5
41-50	5
51-60	5
61+ years	0
<b>Total</b>	<b>23</b>

Table 4.3 identifies the length of time the case study nurse had worked with older people as a nurse, while table 4.4 indicates the employment contract for the nurse. Most of the case study nurses worked with residents in a full time capacity.

**Table 4.3: Case study nurse's length of time working with older people**

1-3 years	7
4-6 years	3
7-10 years	6
10+ years	7

**Table 4.4: Employment Contract of Case study nurse**

Full-time	18
Part-time/job-sharing	4
Other	1x .73 contract

The case study nurse was asked to identify the number of residents currently in the unit where she worked (Table 4.5).

**Table 4.5: Number of residents in the unit\***

<b>Number of older people (residents) in the unit</b>	<b>Case study nurse</b>
< 10	1
11-30	11
31-50	8
51-60	2
61+	1

\*This was the area, section where the case study nurse worked within the nursing home. As some case study nurses rotated within such units, they indicated the total number of residents cared for.

Most case study nurses identified that they had engaged in specialist training on older person care (table 4.6). The level of education (training days or academic study) is identified in table 4.7.

**Table 4.6: Specialised education/training on older person care**

Yes	19
No	3
Did not respond	1



**Table 4.7: Level of specialized training**

<b>If answered yes to specialized training, level of training undertaken. *</b>	<b>Case study nurse</b>
Education Days	17
Certificate	8
Diploma	3
Degree	1
Post-graduate **	4
Did not respond	1

\* Some respondents ticked more than one box

\*\*Professional Certificate, Graduate Certificate, Graduate Diploma, Master's Degree, PhD.

#### **4.2.0 Reasons for admission to the nursing home**

The need for admission to residential care occurs in the context of an older person experiencing cognitive and or physical decline which makes independent living challenging. The older residents spoke of their personal accounts of being admitted to the nursing home. This could constitute an inability to care for him/herself as described in the excerpt below:

OP 5: A couple of years [as a resident in the home]. I wasn't able to manage at home.

Many of the residents spoke of complex health issues that led to their admission. The management of such complex health issues also constitutes part of expert care in gerontological nursing. A common catalyst which precipitated admission was falls:

OP 1: I fell too often, I was falling too much. I fell one time between the wardrobe and the bed...I damn nearly choked.

OP 12: I had a fall and I injured my left hip. And the point is that that has immobilised me.

Thus, knowledge of residents' gait, tailored care planning and working with the multi-disciplinary team formed an important part of risk management for many residents. For example, in shadowing 6, the case study nurse spoke with the resident about her history of falls and how the physiotherapist had helped to improve the resident's mobility, although the case study nurse indicated that the resident needed to be reminded to use the mobility aids and supervised. A second example of careful risk management was observed in shadowing 12, where a resident was assisted to position hip protectors and the case study nurse checked that the floor was fully dry following cleaning, thus reducing the risk of further falls.

Other negative sequel events could have also led to admission:

OP 16: But what really brought it to a head then was I didn't mind so much living alone but I got sick and then it came all of a sudden, one evening I remember I had a painter in all day and I was all right, even when he was leaving. And an hour after I got these shivers, I will never forget them, you know; the shivers were so strong they were nearly throwing me off the chair. And I kind of just tumbled into bed then but in the morning then I must have been very sick, I don't know I think I got some kind of a jumbled phone call from [son] XXX and he came and that is when I went to [hospital] XXX [and then the nursing home].

OP 13: And he [medical consultant] said the scans or x-rays or whatever they were showed that you obviously had a stroke at the top of the stairs and that is why you fell. And it also showed that you are getting mini strokes.

In many instances, during the shadowing period the case study nurse offered historical accounts of some residents' journey to admission to the nursing home. For example, in shadowing 2, the case study nurse detailed a male resident who was admitted due to a history of strokes, adding that she always tries to encourage his independence as the resident has ability but had 'given

up'. In another instance, the case study nurse (shadowing 13) spoke of a resident's gradual cognitive deterioration, which ultimately led to admission to care.

Admission could also be due to a loss or absence of the informal caregiver, who could assist the older person and compensate for challenges to independence:

OP 4: Well I am from [locality] XXX in [city] XXX and my sister who was there with me, I used to have a sister, XXX, got sick, she has died since and her anniversary is the 27th February next. It was some time ago. So there was nobody to take care of me.

OP 18: I wouldn't have been able to look after myself, none of my brothers and sisters were around anyway

However, one resident described how he felt the responsibilities associated with a high caregiving role were unfair and this was the trigger to his admission:

OP 11: I was on my own at home, I had lost my right leg and the best part of my right hand because of diabetes, I was totally dependent on having someone looking after me. Now, my youngest son took on the job and he done it too well...he was 24-7 with me, he literally wouldn't leave the house except to go shopping and I thought that was grossly unfair. The rest of the family were giving him a dig out but there were three up in the North married and I had three down in [county] XXX. So it wasn't feasible to be driving every night kind of thing.

Admission also impacted on the residents' psychological health as they struggled to adjust to leaving their home:

OP 23: It is another chapter in your life, you know, really and truly, you sort of say, here am I now, leaving a home, leaving everything and I am helpless.

OP 3: So I felt that coming here was going to be the end of my life...but apart from the first couple of months [when] there were buckets of tears, slowly but surely I realized that it wasn't the end of the world, I can do my own thing and I am left to my own freedom

Thus, the causes of admission to the nursing home were varied and complex which demonstrates the range of necessary expertise essential for nursing in the gerontological long-term care environment. It is the ability to direct appropriate care on many domains that demonstrates expertise. Expertise transcends mere management of the condition, but also careful attention to psychological, social and other presenting issues. This expertise is rendered particularly important in terms of building up helping relationships which are fostered over long periods.

#### **4.2.1 Context of nursing home**

When speaking of the context of nursing homes, it was evident that the staff of the nursing home valued their interactions with each other and this produced a positive outcome. Within communities of practice, engagement is central as knowledge is shared and there is personal satisfaction of knowing colleagues who understand each other's' perspectives and of 'belonging to an interesting group of people' (Wenger et al. 2002:9). Thus, the nurse does not practice within an ideological vacuum, but within a supportive network that focuses on resident care. Within this context, there was an intrinsic

acknowledgement of qualities that an expert gerontological nurse should hold, which enhanced practice:

NC 13: Initially you would have to have care, I mean you would have to be a caring person and an empathising person. A person who cannot really put themselves in somebody else's shoes... A job of nursing is a different job from working in the bank because you can just look after somebody and then they are gone, you don't have to have a relationship with the person.

This expertise was considered different from working with an older resident at home as diversity meant having adaptable skills to manage complex presenting issues:

NC 15: I mean...I was caring for my grandfather at home and it was totally different from being at home to a big environment like this, so many people to look after, so many little differences in care...

NC 18: Because they [residents] have different levels, some have dementia, some have Alzheimer's, some [residents] are just unable to cope at home and you need to be able to shift from one type of resident to another, you know...

This context, which was considered to be embedded in the ethos of the nursing home, resulted in positive experiences of care. In the examples below, older residents described how the context of the nursing home itself contributed to their experience of daily life and observations of care:

OP 20: I loved it from the very beginning I came in...and I am safe and I really love it [nursing home].

OP 12: In fact I would say, from listening to communications between them [care staff] all, they all respect one another as well as respecting me. They are a good group of people that are employed here.

Having an ethos which promoted resident involvement and decision making extended from having formal resident input to the daily practice engagement of staff with the residents:

DON 12: Residents in [nursing home] XXX have a residents' committee and they have a monthly advocacy meeting where they are afforded the opportunity to voice any changes they would like to see, also what they are happy about/unhappy about and any changes to their care can be communicated to the nurses in this way. Residents can also make decisions about their care in their monthly care plan update.

Although knowing is individual, knowledge is social and expertise is embedded in appreciating the collective nature of knowledge. Thus as Wenger et al (2002) state, others within the community of practice are needed to complement and augment the case study's own expertise. 'Others' included colleagues and the resident's families:

NC 1: But seeing the individual as themselves as well as being able to involve that family in that care as well and it gives...its providing the whole package...

DON 4: She [case study nurse] established a relationship of trust with the residents and their families which allows for better information gathering and sharing. [Nurse] XXX also uses information received from care assistants to develop her care plans.

This mutual dependency was also located in the data from the focus group which spoke of the expert nurse 'knowing when to ask for help and recognising each other's' [colleagues] skills so that optimum care is achieved'.

Often the case study nurse contributed to the effective running of services.

This could involve innovate solutions to address potential risk as described by the nursing colleague below:

NC 1: So [nurse] XXX has brought in that you have a second person and a second health care assistant so that something won't be over looked so that there will be that the whole care plan will be reviewed in that month.

This could also involve addressing usual practices in the home and introducing change for the benefit of the resident. This could be on an informal basis:

NC 7: We have clients here who can't eat dinners and that, I know it is a small example but we liquidise the dinners and it didn't look very appetising but [nurse] XXX came to them and said even if you separate the items on the plate and liquidise them separately, it would be a bit more palatable, because the point is you eat with your eyes as well. And the kitchen staff do that and I have found it helpful. It's a small example, but it does get you thinking.

Or it could involve more formal involvement in change to the usual social order and practices of the nursing home:

DON 11: She [case study nurse] is on the equality committee, is a safety representative and fully participates in all management meetings.

DON 5: [Nurse] is involved in the clinical governance committee in the home. She is a link nurse with the pharmacy, ensuring high quality medication management. [Nurse] XXX is developing her role as link nurse for 'end of life care' within the home.

The interdependence of the expert nurse with colleagues and residents and established ways of working were evident in all of the data sets, but

shadowing afforded the opportunity to observe this in action in the social world. This interdependence was observed in multiple interactions, where situated learning partnerships were evident through shared engagement for positive resident outcomes. This engagement was embedded in opportunistic conversations with residents and colleagues to the more formal meetings of 'handover and updates' as well as documentary records. In one nursing home, a targeted meeting was held regularly and each lead nurse discussed the residents they had responsibility for, inviting comments from colleagues and ensuring further care was organised according to need. It was evident from this meeting that the shared experience allowed situated learning to emerge within an interplay of robust discussion.

Within the data, the expert nurse could not be isolated from the contextual environment within which she practices. Observation of what constitutes an expert nurse, ways of interacting within practice and outcomes from such practice (resident and colleagues) were essentially immersed in context. Eckert (2006) argues that communities of practice are subject to two underpinning conditions: meaning which is shared over time and a commitment of shared understanding which leads to mutual understanding and mutual engagement. The expert nurse works within a defined community of practice. The data demonstrated multiple examples of how the expert nurse engaged in her practice related to the larger social order of the nursing home. This essentially provided insights into values, ways of doing things, attitudes and ethos.



#### 4.2.2 Saliency

Saliency involves the expert nurse demonstrating particular discriminate qualities to pick up on cues and respond to emerging issues in daily practice in a person centred, holistic way. In the excerpt below, the nurse colleague considers how the case study nurse reviewed the administration of a medication, which was regularly used but prescribed as a PRN medicine, in the context of its impact on the resident:

NC 10: There is the one example, she [case study nurse] felt that [resident] XXX did not need night sedation...she [case study nurse] felt that she [resident] is in bed, she is lying there, she is on and off sleep [at night], but she don't really sleep because in the day time she sleeps due to the medication. So she [case study nurse] said, 'no she doesn't really need that one [medication]', she said. 'Because if we are going to give that one she will become drowsy and won't eat'. She said 'no we are not going to do that for her [resident]...'

Similarly, an older person comments on how the case study nurse could observe the resident being out of sorts and not in his usual form.

OP 12: I remember one time her [case study nurse] saying to me, 'you are very quiet this morning and yesterday and normally you are very', she called it 'bubbly'. And I said, 'well I wasn't conscious of it.' And she said, 'are you ok?' And I said, 'I am firing on all cylinders'. But it just shows you the way she picked up on the fact I wasn't as outgoing as I normally would be.

Multiple examples of saliency were observed in the shadowing. One instance involved the delivery of care to a resident who was very ill and unable to communicate. While assisting with pressure area care, the nurse commented that the fabric of the nightdress was not suitable as it promoted perspiration and therefore could affect optimum skin integrity and also caused the resident

to be uncomfortable (shadowing 1). Care was taken to clean the skin and dry carefully while inspecting for any skin changes before changing the nightdress and repositioning the resident. As this occurred, the case study nurse was seen to examine the resident for any non-verbal facial cues of pain or wincing responses to the intervention. Throughout the process, the resident was gently informed of what was happening and spoken to in a way that promoted positive regard, respect and dignity.

Saliency also encompasses recognition of the impact of actions on others. A DON considers that this involves in depth knowledge of patients and families:

DON 1: An in-depth knowledge of patients, coupled with life story work and a relationship with families allows her to understand the needs of patients and families which assists her to know the cues that require action or non-action.

The ability to pick up on cues also extends beyond residents and families as a DON observes that the case study nurse offered support to a colleague:

DON 2: [The case study nurse] showing concerns regarding colleagues going through difficult [situation] outside [work]. Advised them who to speak to.

Cues could also present in ways which demanded holistic assessment of the resident. This could involve careful, individual and unhurried consideration of the resident to ensure that care can be focused in an individual way to meet presenting need, as described in the excerpt below. This allowed an intuitive response, which combined skills and knowledge:

NC 7: ...she [Case study nurse] is very understanding and she loves talking and interacting with each person. She

doesn't see the very baffled aggressive behaviour, she would look beyond the aggressive behaviour and she'd be looking at what might have triggered that behaviour and would then try to make staff aware so the agitation could be avoided the next time.

Individualised care also involved being able to pick up on what the resident might present with and use expertise to address issues in a knowledgeable way:

OP 8: And I know she has [knowledge] because I see her with older people and what she is doing with them and that, so I know she has knowledge.

Saliency constitutes being able to discriminate the pertinent care demands of residents and to contribute to sharing this knowledge with colleagues. For example, in the excerpt below, the case study nurse identifies that skin folds may present a risk in obese residents and reflects on appropriate care with colleagues. Moreover, the identification of individualized care is recognised by the colleague as being typical of the case study nurse:

NC 15: Yes the kind of obese patients that we have, you would, kind of, do them in the morning, you might miss something underneath all their folds and stuff, you might miss that and she'd come back and she'd double check and she'd tell us where we went wrong and what we need to apply to the skin. She is very good like that, do you know.

Within the context of the focus group, saliency was considered to be knowing the skill of gathering information, and recognising the progress of sickness in an older person rather than picking up simple 'classic signs'. It also involved the use of appropriate pace with residents so that enough time is taken to look at the resident holistically and individually. Saliency was therefore

demonstrated by being able to discriminate what matters in a presenting encounter and respond in a seamless and efficient way

#### **4.2.3 Holistic practice knowledge**

The theme of holistic practice knowledge encompasses the integration of multiple forms of knowledge to respond to the individual presenting issues from each unique nursing interaction. This involves the nurse in a continuous learning cycle, and as each nursing experience presents new emerging challenges, these issues are addressed through the skilled combination of ways of knowing. Such ways of knowing allows the nurse to access experiential knowledge, integrate best practice evidence, implement the artistry of nursing and incorporate self into the situation. For example, in the excerpt below, the nursing colleague describes the decision pathway of the case study nurse. Knowledge is demonstrated by integrating the facts and being able to combine these in such a way that a solution is generated. The focus group summarised this as 'Knowing the skill in gathering the information [about the resident]'. This knowing would be based on attributes such as the 'initial assessment', 'recognising the progress of sickness in an older person', 'working in partnership with the older person', referring to past experiences, clinical judgment and theory' to identify the best approach in individual situations.

Holistic practice knowledge often involved an implicit focus on person centred responses, which integrated theory, research, experiential knowledge and

knowledge of the individual resident as described by the Director of Nursing in the comments below:

DON 7: The nurse uses research knowledge to make clinical decisions such as a choice of wound dressing, pressure area care and nutrition. She uses the knowledge of the residents to know how to deal with agitated or challenging residents, to recognise and diagnose illness and in the care of the dying.

Many of the data sources demonstrated how the case study nurse engaged in life-long learning and continuous professional development to ensure practice was immersed in the best available evidence (see for example the demographic profile results on training days and further academic education):

DON 8: Basis of training is RGN, but attends numerous in house training sessions, "An Bord Altranais' Category 1 courses eg Gerontology, wound care. As residents are long-stay, knowledge basis of medical history, preferences and life stories is good. Due to the increased needs of the residents in our facility, CPD [continuous professional development] is important and the CNS [clinical nurse specialist] often advice and we learn from one another and our experiences eg recently syringe driver in use.

What is important is that such knowledge is absorbed and translated to the unique environment of the nurse in long-term care. In the excerpt below, it can be seen that the expert nurse's input following a restraint course had a transformational impact on how practice realities were operationalised. Moreover, this was not only about educating colleagues, but the creation of formal care standards within the home through policy development:

NC 6: The restraint one, she [case study nurse] went off on a course in restraint and she came kind came back and said, a small thing anyway...that's a form of restraint. Small things you wouldn't realise, even just putting the bed table in front of the patient,..that is there, that is a form of restraint. Oh jeepers,

where we would all be a bit, oh right. And then [case study nurse] put all that kind of new restraint policy and consent form for cot sides and all those kind of things.

Holistic knowledge is important for being able to objectively review presenting issues, and demonstrates a critical review of such issues in the context of practice wisdom to generate cogent and realistic solutions:

NC 9: Yes she [case study nurse] would give you all the facts around the case that would be very classic now, you know, she will never be at a loss, she will cover the solution or her proposed solution, she won't be at a loss, she will give you all the facts of it rather than saying, 'oh I don't know, she is this'. She will never be vague about it. You will get all the facts, you will get it as it is, you won't get it exaggerated or dramatised. And she has a suggested solution most of the time, when it is possible. Even outside of her duty, off duty, she always has the solution to the problem, her suggested solution, yes.

Within the narratives of the older residents, confidence in the holistic knowledge of the case study nurses was expressed in care received. In the excerpt below, the older person discusses how the expert nurse advised on managing pressure areas, but more importantly, confidence was supported by knowledge of positive outcomes following such advice:

OP 3: Because I sat in an ordinary wheelchair yesterday getting my hair done, so she [case study nurse] tells me I should 'nt go for showers and stay out of the ordinary wheelchair I can't relax back and take the pressure off the bum. The ordinary wheelchair doesn't do that at all. She's sharp...she notices the differences... I can trust [name] XXX, no reflection on the other nurses, but I think [name] XXX is that bit more, maybe she feels she can give instructions but any time [name] XXX comes to see the wounds I know I am going to get a proper result or verdict.

The expert nurses' use of different types of knowledge was considered fundamental within focus group discussions. Issues such as the ability to weigh up situations, getting priorities organised and being adaptable to new practices and policies were identified as important. Moreover, the ability to weigh up situations in order to discriminate best approaches was considered essential and was underpinned by referring to past experiences, reflecting on practice, using clinical judgment skills and taking the responsibility to keep up to date.

Using holistic knowledge involved the ability to combine different knowledge types for optimum results in practice, which was recognised by the Directors of Nursing of the nursing homes:

DON 15: The [case study] nurse demonstrates personal practice knowledge, theoretical knowledge, procedural knowledge, organizational knowledge, reflective knowledge, especially in her area of expertise, which is palliative care.

DON 4: [Nurse] XXX would regularly attend training in different areas of gerontological care: [Nurse] XXX recently completed care of the Older person FETAC 8 plus a venepuncture course. This ensures up to date clinical skills, knowledge of residents and experiential knowledge is used in the care planning process. The selection of appropriate assessments and the development of planned care requires [nurse] XXX to use her skills to provide holistic high quality care.

In the review of shadowing notes, all case study nurses demonstrated multiple knowledge bases to inform practice and the use of on-going evaluation to direct new practices. However, in a review of shadowing 3, the researcher had made an annotation of 'symphony of care delivery', which

used the simile of an orchestra co-creating music. On careful reading of the notes, it was evident that this referred to the case study's holistic care. 'Constant negotiation of care with colleague and older person. Immediacy behaviours in tune [with] reflection in action' (shadowing 3). This referred to the integration of multiple activities while 'being' with the older person such as the application of knowledge of wound care, skin care and diabetes, immediacy behaviours, such as eye contact, tone of voice, body orientation and the equality of status afforded to the older person and the healthcare assistant all combined to present thoughtful and careful expertise in nursing which was intuitive to practice.

Holistic care is about a synthesis of knowledge, relational availability and the ability to unproblematically apply and adapt knowledge to new situations. In the data, this ability was described in all data sets and observed in the shadowing. Benner et al. (1996) suggests that holism is concerned with looking at the bigger picture and taking responsibility for directing care. Holistic care is about discriminating ways of knowing, which results in the best care pathway fit in a given situation.

#### **4.2.4 Knowing the resident<sup>4</sup>**

Positive outcomes for expert nursing care are exemplified through 'knowing the resident'. This involves respect for the resident and his/her perspective. In one of the shadowing exercises (shadowing 5), the researcher observed how other staff acknowledged the respect that the expert nurse demonstrated with

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<sup>4</sup> For the purposes of this study, knowing the resident is used rather than 'knowing the patient', which was the original term used by Manley et al's (2005) framework.



all residents, staff and families. This was observed in verbal and non-verbal actions. Most shadowing observations recorded a continued unhurried presence, with the focus of each interaction being on choice and dignity of the resident. Verbal communication in all of the shadowing periods demonstrated a focus on facilitating choice and prioritising the individual human uniqueness of each resident. This could be in the context of activity choices, menu choices, medication choices and choices related to religious activities. Choice was always considered central to person centred care:

DON 17: When addressing the residents care plan, the nurse discusses all care with the resident and encourages choice and reminds the resident that it is about them being a person and not what others may expect from them.

DON 19: Assessment, discussion and organization of the resident's care and day around their own choices. Verbal direction if followed and nurse acts on non-verbal cues also. Spiritual, social, physical choices are supported. Life history/story and understanding of residents prior lifestyle assessment and recreated to best ability in new environment. Consults with family (with resident) and peers to ensure choice is maintained. Utilizes consent policy as necessary.

NC 7: And [nurse] XXX is very for that [person centred care]... patient choice, like she would never say, 'come on [name] XXX you are getting up'. It is, '[Name] XXX would you like to get up, would you like a shower, would you like to stay in bed for an hour or two?'

Although choice for the resident often involved his/her acknowledgement of the expertise of the nurse, this was in the context of having expert information and explanation, rather than a restriction of choice as detailed below:

OP 12: ...But I am always conscious that she [nurse] reserves the professional right to alter what I am saying and I would prefer it that way. I mean I have a saying, it doesn't do nurses much credit but it says, if you own a dog, don't bark yourself. It means, of course as you know, the point is if there is a trained professional nurse available, why would I a [profession] XXX,

insist on my own limited knowledge of the problem?

Knowing the resident means essentially that life histories are appreciated, valued and, as far as practicable, are continued into the resident's nursing home life. This encompassed many ways of individualising the resident as detailed by the focus group:

Residents: individual assessment, care plans and policies. Staff education: communication, environment, life story work, respecting uniqueness, listening, promoting activity, holistic approaches. Promote person centred care. Being physically and emotionally present.

Families: Shared care approach- in communication and open door policy. Openness-getting to know family dynamics-acceptance, non-judgemental approach. Using technology for communication when not present.

Colleagues: recognizing each other's skills, sharing, openness and communication'

Others also noted the individualisation of knowing the resident. In the excerpts below, it can be seen that the expert nurses demonstrated an interest in the resident and that this was often observed by colleagues, management and the residents' themselves:

NC 7: She [case study nurse] would have conversations with them like if she know [sic] they had a farm, she would talk to them about crops. Like if the spoke about their life she would show an interest in that, yes.

DON 8: Recognised each resident is different is aware of residents' background, through discussion and life stories. Shows respect in the manner she communicates and holds herself. Treats residents' with dignity, 'knocks on doors', 'tone of voice', treats them as she would like to be treated.

OP 8: Oh yes she [case study nurse] always has time for you, she'd never go away from you or that, if you wanted to talk to her she would spend her time with you and talk to you.

OP 19: Oh and she'd [case study nurse] sit down on the chair with you. Sit down on that chair inside in the room and you feel she is interested in me

Verbal communication was respectful and often involved banter, which residents appreciated and reciprocated. In the shadowing 6, the following verbal exchange was noted:

OP 6: Ah...I am a contrary old bag...

Case Study Nurse: Well...I suppose you are from [county] XXX, you can be contrary 'cause you lost the All Ireland [national football championship]!

[Both laugh]

Knowing the resident also extended to intuition that something was not quite 'all right'. This type of knowing the patient is enriched through building up rapport and being able to decipher subtle changes, even when the resident themselves are not quite sure of the cause as detailed below:

OP 6: There was once or twice that I was down a bit and she [case study nurse] knew on the minute. She says, 'You are not right today, what is wrong with you?' And I said, 'I don't know what is wrong with me at all, I don't feel right'. And I couldn't say that I was really sick because I wasn't. I was just down and I couldn't get up, that was the way.

It was also apparent that the expert nurse needed to consider the perspectives of residents in terms of balancing rights of collective and individual life worlds while ensuring positive outcomes for all. One of the nursing colleagues describes how the expert nurse achieved a satisfactory outcome by negotiating a single room for a resident:

NC 6: Like small things of... there was a lady she was in a three bedded and she was kind of saying, those other women don't talk to me and I want to have the telly on and they don't want the telly on. This kind of thing. This lady is palliative and the other two ladies come in on respite and those two beds had different people in them and she was kind of in the three bedded looking at these different people coming in and out, you know. And she [case study nurse] was saying, stay here if you want or we have a single room if you want it. I know, a small example but she was delighted and she is in the single room now and she is, you know, happy out, you know.

Knowing the resident was evident in all shadowing observations as well as being articulated within the interviews, focus groups and Director of Nursing surveys. Knowing a resident in residential care is fundamentally different from most other nursing settings as it is built up over time and rapport is fostered with each resident. During the shadowing period, it was clear that the multiple domains of knowledge related to each resident were embedded in professional practice. This was constituted by knowledge of life histories, medical condition and family context all of which cohered to underpin the positive regard and inter-relations between the nurse and residents, the nurse and colleagues and the nurse and the resident's family. A predominant finding was the major focus on the resident in a person centred context rather than task or service need, which enhanced the quality of life experience for each resident.

#### **4.2.5 Moral agency**

The theme of moral agency is closely related to 'knowing the resident'. It includes the provision of information to allow residents to make decisions on their own behalf, working to promote the dignity, respect and individuality of others, working in a self-reflective way, committing to high standards of

behaviour and demonstrating value and respect for one's own beliefs and those of others. Within moral agency, the case study nurses were often spoken of as going the 'extra mile'. This could be staying behind to ensure the completion of work, rather than handing over to nurses from a different shift as detailed in the example below:

NC 16: And she [case study nurse] never leaves on time, if she is meant to be finished at 7:30, it is more likely closer to 8:30 and she is going out the door.

It could also be that particular emphasis is placed on the completion of care related activities when on days off. The case study nurse could demonstrate personal commitment to comprehensive care delivery:

NC 12: ...if she [case study nurse] is finished nights on Monday morning she is not going to be here for another week, she wants to make sure things are done. So you would be laughing...another list from [nurse] XXX.

NC 23: She [case study nurse] would yes, and she just rang back there to make sure everything was all right. She would often ring from home and say, 'oh I just forgot to tell you such and such'. And it would be on her mind if she didn't ring in. She wouldn't be happy leaving it until the next shift, even if there wasn't anything really major to say, she just wanted to make sure that you have this. She would be very conscientious that way.

Central to the expert nurse's care is the provision of information to enhance problem solving by residents. This was evident in all forms of data collection. Within the shadowing exercises, communication was observed in terms of providing explanation for residents and ensuring that explanations contained appropriate clarity. For example, being at the same eye level as the resident, speaking in a soft tone and a genuine respect for decisions were observed. The focus group data identified that giving time and using expert knowledge

to assist and/or enable the resident was important to facilitate decision-making and to support the input of a resident in his/her own care plan. Facilitating decision making for residents was also linked to mediating with other family members and members of the multi-disciplinary team:

NC 1: She [case study nurse] gave the patient the opportunity to decide what she wanted for her care and then eventually interacted with the family and the GP and decided on what to do so she gave her [resident] the decision on what to do.

One Director of Nursing observed that the case study nurse would never assume the older person would agree with proposed nursing activities and had an inherent right to decline care:

DON 9: I heard [nurse] XXX discussing [the] care plan with individual residents. She always approaches residents without the assumptions that they will agree with her provisional plan ie bathing etc.

Facilitating decision-making was considered a complex activity which drew on multiple ways of knowing. In the excerpt below the Director of Nursing articulates how the case study nurse promotes decision making by residents:

DON 15: This concerns her [case study nurse] to be self-aware and cannot be emanated from books, journals or lectures. Her experiential knowledge and intuition enables her to understand without [academic] rationale and [she] is confident in using it to promote residents' decision making. She uses her empirical knowledge, skills and assessment of each situation and draws from this to analyse the residents' capabilities, maximizing their return to independence and enhancing a quality of life.

Respecting the resident's dignity and individuality were central to the case study nurse's daily activities. For example, in shadowing 7, a health care attendant had styled a resident's (who had cognitive impairment) hair in pigtails. The case study nurse gently explained that this made the resident

look like a child and it was inappropriate. This resulted in the resident's hair being restyled. A nursing colleague, who commented on 'small' but important things which promoted dignity, identified another example:

NC 7: She [case study nurse] is always conscious that it is important to close the door...washing one part of the body and making sure the top half is covered...small things like that that you do. It makes a difference to the person, she would be careful of it.

Facilitating religious engagement was deemed important by the case study nurses, although this was not forced or overstated in the nurse's actions:

NC 9: As it happens, all of the ladies in there [unit] are Roman Catholic and she [case study nurse] is a Roman Catholic herself and she would be aware of those needs and she is practicing. I would know that from things she said, she was at Mass and she heard this or whatever. So she would have sensitivity there.

Dignity and respect was also suggested by the focus group as being inherently immersed in person centred care, good communication skills, the promotion of choice and intuitive knowledge. Moreover, dignity could be located in ensuring that nursing care of an intimate nature was sensitively addressed to minimise embarrassment for the resident by responding in a non-judgemental way:

OP 5: I have to wear pads. I have to admit that. I had bleeding piles and she [case study nurse] is so kind. Now that is a job that I said no mother in this world ever brought a daughter in this world to spend her time changing pads and putting cream on sore piles. They'd say 'that is an insult to my daughter' And you'd say that to her and she [case study nurse] laughs at you. She'd say 'we don't mind. That is part and parcel of the job, she said 'sure if you don't help then why do nursing? It is all part and parcel of it'.

The data suggested that the moral agency of the case nurse often extended beyond her predisposition to residents but also respected other colleagues' perspectives:

NC 9: She [case study nurse] has got a very respectful disposition. I have noticed that about her from the start. She treats everyone, not just the residents, all the staff and colleagues in a very respectful manner. I have noticed that about her. She is also very straight and honest, she is not...she is very sincere.

Moral agency was integral to the practice of each case study nurse. It is exemplified by a conscious effort to prioritise the resident's choice and respecting values, perspectives and decisions in a non-judgemental way. Resident's decision making was found to be underpinned by an implicit focus on giving understandable information, consultation with colleagues and relatives to address emerging issues. For example, in the excerpt below, the nursing colleague describes how the case study nurse would value discussions with the individual resident and if mental capacity was a challenge, confer with relatives. This would be undertaken in a contemplative way which allow a discrete balance of competing issues and choice of appropriate decision:

NC 7: [Nurse] XXX would be careful to discuss things with those who can make choices and for those who can't she would speak to relatives and us and the manager and look at the options. She never rushes into things but its sort of contemplative, like mulling it over.

Ultimately, it was the self-determination of the resident which was given precedence. Moral agency was also concerned with a focus on delivering the



highest possible care which maximised positive outcomes for residents, families and colleagues.

#### **4.2.6 Skilled know how**

Skilled know how is based on being able to adapt and respond appropriately to presenting situations and being able to mobilise diverse resources to generate the best care pathway for residents. It also involves being a resource for others and sharing knowledge while working co-operatively with colleagues and families to reach positive outcomes for residents.

Being able to adapt to individual situations involves a complex fusion of knowledge. Many instances of skilled know how were observed in relation to the delivery of resident care. This could be within the know how of completion of nursing activities as each nurse drew upon her nursing skills to deliver care. In the shadowing experience, skilled know how was observed in many areas such as wound care, medication management, pressure area care and end of life care. Each nurse conducted these activities using reflection before, in and after action with the researcher. In many instances in the shadowing period, the individual context for each resident was discussed with the researcher before an approach to the resident. One shadowing episode (shadowing 16) involved a discussion on a resident's skin care. The resident had very inflamed lower legs but the case study nurse had persisted in applying E45 cream and ensuring the care plan was known by colleagues. This had resulted in major improvement in the resident's skin condition and the nurse's careful inspection

of the skin and recording of condition was observed. In addition, this also involved a discussion on the level of pain and 'tightness' experienced by the resident.

Furthermore, such care was orientated to the resident as the case study nurse articulated a deep knowledge on individual preferences. For example, in shadowing 16, a gentleman with limited communication used particular hand signals which were very familiar to the case study nurse to identify his needs. Other small ways of knowing the resident were also observed, such as knowing the flavour of drink supplement preferred and leaving particular residents in bed because they like to sleep later. Within the responses from the focus group, skilled know how was seen to 'know what to do in a particular situation. [The case study nurse] uses theory and experience [to] grasp the right thing'.

Skilled know how was described by nursing colleagues who observed how the case study nurse delicately handles situations:

NC 1: I think she [case study nurse] handled that very well because this patient could be quite, like she has her own mind and likes to make her own decisions and some people can clash very easily but [nurse] XXX knew the right approach to take on giving her the decision on what to do. The outcome was good, well she is back with us now; she is still quite unwell but...yeah

Skilled know how also encompassed orientation and on-going teamwork with colleagues. A nursing colleague observes how the case study nurse uses her expertise in picking up subtle changes in a resident's status:

NC 11: When I came here onwards she is the boss and she is giving orientation to me and she is excellent for giving orientation, or doing things...she is always finding that first rather than everybody. They are...their vision is going bad so... these kind of findings she will do first time. She is doing the appropriate decisions.

Such know how could extend to almost anticipating the problem due to the deep and long term engagement with a resident. In shadowing 8, the nurse was observed interacting with an older resident who was restless. The case study nurse asked questions about urinary frequency and urinary pain. From gathering this information, she decided to test the resident's urine which screened positive for infection. Following this, a specimen was taken for analysis, a medical review advocated and an increased fluid intake encouraged. Similarly, in the instance detailed below, the nursing colleague remarks on how intervention was commenced before formal diagnosis:

NC 7: Yes we had a lady up there and I think, I think it was a urinary infection she was getting up a lot and not herself. She [nurse] seemed to anticipate it because she was in there trying to push fluids and opened the windows and freshen her up and it turned out that the lady was going on to get a bad UTI. So before any more obvious symptoms happened, yeah, she was kind of dealing with it doing the right thing to help her

Skilled intervention was also observed with residents who had cognitive difficulties. The shadowing period demonstrated instances of the management of challenging behaviour:

NC 13: She [case study nurse] said to leave him [resident] for half an hour and go back. And when we went back he was still quite aggressive and she said to leave him again for a bit because there was no point in even trying to do anything with him because he was so aggressive.

NC 14: Yes absolutely, yes...I just find with one lady who would be quite aggressive in the mornings, like this role play [introduced by the case study nurse] that we have started with

her quite recently, it is like a break through. She [resident] doesn't ...while we are working she [resident] is answering all the questions, even about her having her own little car she shares a room with her sister and just bringing that in and her car was this size.

The Directors of Nursing also supported proficiency in the management of challenging behaviour in the observations:

DON 7: ...she [case study nurse] uses the knowledge of the residents to know how to deal with agitated or challenging residents...

Skilled know how could extend to revisiting a presenting issue and using knowledge of nursing and the resident to develop a plan with positive outcomes:

NC 10: Three hours before and it is the one patient is complaining of very bad abdominal pain, the abdomen is tender and it happened, if it is the week...the weekend is bad. And we sent her into the hospital and they said there is nothing and they send her back to the nursing home. Again me and [nurse] XXX were working one weekend and she actually performed a rectal examination and she [case study nurse] told me she [resident] is really constipated, we will do something for that. And, you know, she is really constipated and we gave her a suppository as well, her bowel is empty and her pain and everything is gone and she is ok.

Throughout the shadowing period, there were multiple examples of the case study nurse envisioning and articulating an action plan and involving others to participate in this. In one instance, shadowing 7, an issue arose with a supra pubic catheter and this was discussed with the resident in depth and arrangements made for medical review. Further discussions with this resident involved the improvement in healing of her [resident's] pressure wound, the imminent arrival of a pressure relieving chair and a review of diet. This

demonstrated many forms of skilled know how, for example, the impact of diet on healing, the suitability of a vacu dressing for the resident's particular wound and the use of aids to relieve pressure.

Case study nurses worked excellently in a team based approach. In many instances, colleagues approached the case study nurse with care issues, that were responded to in a timely fashion:

NC 15: She [case study nurse] is very aware about all the residents and if I said to her, this morning I was getting so and so and there was a rash. She would go straight away down, if she is with somebody she would come straight down. And I might say to her half an hour later, 'oh did you see'... because we are all coming to her with... And she will say, 'no I went down, I went down'. And what is good about [nurse] XXX as well, what I find is if I say to her, [resident] has a rash on her back there. [Nurse] XXX will always come back and say, 'oh yes I looked at that, I think it is only'... And she will let us know

Assistance with planning could also entail using experience to help colleagues plan comprehensive care and supporting care delivery. In the excerpt below the case study nurse's help in discharging a respite resident was much appreciated:

NC 6: That way she'd be a step ahead and she'd be informing you, do you know, whatever, this person's home circumstances or what this person needs? Not that she is checking up on you but just making sure, especially if you haven't been there a couple of days, if you were on nights or you haven't been here or whatever, she'd be great at informing you, you know, and following you up and making sure you are doing your job and genuinely just informing you.

This finding was supported in the shadowing data. For example, in shadowing 20, careful review of skin status was observed in one resident. A proposed care intervention was planned and this was discussed with colleagues and

recorded in the resident's care plan. This was supplemented by consolidating this care plan in practice through partnership with colleagues and the resident.

However, the 'team' transcended typical understandings of healthcare teamwork, ie a multi-disciplinary team, to view relatives and ultimately, the resident, as prominent stakeholders in care delivery. In the instance below, information from family was obtained to address a falls challenge:

DON 2: Recently admitted resident had two falls. Nurse enquired to family regarding medication regime- turned out family were giving medications at different times. Medications reviewed and no further falls.

Skilled know how could also involve contacting family members when residents felt a little low. This activity acknowledged the social and historical connectivity older people had and its enduring importance in resident's life worlds:

NC 20: Oh yes definitely I do and they [residents] have often said, 'I am not feeling great today', or things like that, or 'somebody didn't come in to see me or whatever'. And she [case study nurse] has reassured them or maybe even rang the family and said, this person hasn't seen them in a while, would like to see you...their form isn't great, you know.

Subtle changes in social interaction could be identified and in the excerpt below, the case study's ability to recognise change led to gentle intervention:

OP 14: Ah yes because she [case study nurse] thought that I was spending a lot of time here in the room and it wasn't...I just didn't feel that good and I wanted to have peace and quiet and she said, 'you are spending too much time in the room now, you need to get out, promise me'. Yes I will. A change of scenery will do you good and you know, it did.

Many of the case study nurses had pursued additional education or had particular interests in specific areas of gerontological nursing care. Colleagues and DONs, who often drew on this knowledge on a regular basis, recognised this. One DON commented that the case study nurse was responsible for training staff and had completed 'train the trainer' programmes:

DON 1: She [case study nurse] is a train the trainer on a number of initiatives and has completed post-graduate education in infection control and HDip [Higher Diploma] in Gerontology.

Skilled know how could also underpin leadership in driving change for quality care initiatives while enabling colleagues through sharing information:

DON 18: [Nurse] XXX shares knowledge and skill with peers following formal education days. All new knowledge is discussed and put into practice if appropriate.

In many cases the case study nurses held responsibilities that contributed to the effective running of the service, essentially related to issues of quality care and safety:

DON 4: [Nurse] XXX is a member for the clinical governance committee on the [nursing] home. She is regularly involves in clinical and [nursing] home audits and in the development of appropriate plans.

NC 14: yeah, she [case study nurse] would be our manual handling assessor.

Skilled know how is an important part of nursing expertise in long term care of older people. This is particularly pertinent in the context of caring for older people over a prolonged period of time. The nurse in residential care is able

to build up a rapport with both resident and family which can be used to underpin decisions and care pathways. The case study nurses in this study demonstrated a well-developed capacity to work in teams and to foster knowledge and skills of colleagues and residents. Therefore, the application of skilled know how in practice resulted in enhanced care outcomes, efficient care plans and environments where residents enjoyed a good quality of life.

#### **4.2.7 Attributes**

This section will present some findings in the context of additional understandings of expertise located in the literature on nursing expertise. These are: being a catalyst for change, being a risk taker, fostering interpersonal relationships and recognition by others. Many aspects of the attributes may be identified in the previous detailed themes, thus this section will briefly focus on particular elements in the data which support the additional understanding.

##### *Catalyst for change*

Nursing knowledge is in a constant state of flux as it is influenced by various ways of knowing as well as macro-factors such as national policies, legislation and political and social factors. In the data, the case study nurses were observed to stimulate change in a number of ways. Although many of the Directors of Nursing described the case study nurse as being involved in change on a nursing home committee level, the case study nurse herself could stimulate change:

DON 17: The [case study] nurse has set up a dining committee and helps ensure dietary needs are met. She was also involved



in the transition to care process. She concentrates in health promotion and well-being in her role.

Being involved in change enables new ways of working which can be beneficial for both staff and residents. Manley et al. (2009) sees this as facilitating the momentum of development while leading democratically. In the excerpt below, the case study nurse introduces change, which is seen to have a positive impact, but this is done through a focus on bringing the staff together rather than an authoritarian leadership style:

NC 1: Yes the most recent thing, we were going through the change of... we got new drug kardexes and say if it was to be tried anywhere [nurse] XXX would always say, will we try it here first and see how it goes? So would had our new drug kardexes and when a nurse is doing her medication and she wears the red apron, so we tried that out here and it worked very well that and we have told the residents who can understand that, that nobody is to be interrupted if they are wearing the red apron because they are doing the medicine round. And the same with the relatives coming in, if you see a nurse in red don't disrupt her, and all the staff know. So we were the first to kind of try that out and it has worked and things are much smoother.

Change involves careful communication and dissemination of new ideas for discussion. This approach was identified as being a trait of the case study nurses:

DON 4: [Nurse] 4 works closely and communicates well with her colleagues in the care setting. She recently used her initiative to drive change and develop practice and recently developed a poster presentation about the use of reminiscence therapy in residents with dementia. This was well received by colleagues.

The case study nurse frequently used reflective practice to either review change or to initiate change. Change may be as minor as making a decision to advocate for earlier intervention for a resident:

NC 14: Yes I mean because the doctor has, I don't know how to put this, but he would have been in today anyway but she felt, you know, he'd be in in an hour's time and she [case study nurse] thought I am not going to wait until then, I am going to ring him. Definitely down there I would have noticed that she would definitely need something stronger to make her more comfortable.

Or change may involve a more structured approach which is led by the case study nurse:

DON 7: The nurse facilitates this when she feels that a resident could have received better or different care. She will ask the care assistants if they felt their actions were the best in the situation or what could they have done differently and also when introducing a new practice after a couple of days, ask the carers how they feel it is working and should it be changed?

Thus, initiating change is a component of leadership skills and requires skills such as know how, partnership, communication and evaluation to ensure a quality-based development of care.

### *Being a risk taker*

Being a risk taker involves taking informed risks in order to achieve optimum outcomes for residents. Manley at al. (2009) propose that this also encompasses challenging practices to improve care. This may be a challenge to current orthodox discourses and practices in areas of health, medicine and nursing. However, it is the balance of risk that is paramount, with patient

outcomes being the overriding concern and the realisation that rules need to be flexible. Often, this involved what the focus group termed thinking 'outside the box-the ability to be innovative and even using entrepreneurship to achieve best outcomes'. In the excerpt below, the case study nurse considers a lady with Huntington's disease who refuses food and drink via a PEG tube. The case study nurse personally ensures her safety during assistance with food and drink and respects the resident's wishes:

NC 11: And when the medicine for the elderly, they said rather than the feed, the big feed, then she [resident] don't want that. 'I don't want the tube into my tummy...I will eat'. Even though she is eating, her eyes are filled with tears because she is not able sometimes she is choking. The [nurse] XXX will stay by her bed and she is staying with her until she finished the feeding to prevent choking and things like that. If the movements are more aggressive, she will stop and she will wait and that is the way.

Bending the rules and taking a risk could also be seen in the case study nurse understanding the importance of meaningful things, people or animals in the resident's life-world. In doing so, the nursing colleague in the excerpt below details how a small risk, which was not in line with organizational policy, made a major impact on a resident:

NC 6: We had a palliative care gentleman and all he wanted to see was his dog. It was a small thing and [the case study nurse said] 'Bring in the dog, if we get in trouble...so what...bring in the dog'. This is what he wants, bring in the dog, so we brought in the dog and he died that night. You know, small things and they make a difference, you know.

Such risks are not, within main stream thought, acceptable, however, when coupled with knowledge of the resident, a true respect for self-determination and a deep appreciation of the potential outcome, the case study nurses could balance risk to identify and justify best outcomes for that specific

resident.

### *Fostering interpersonal relationships*

An important part of teamwork is fostering interpersonal relationships. However, within the long-term care environment, this extends to the development of enduring relationships with the residents and their families. Such relationships are based on positive regard, empathy and a willingness to work for the benefit of others. In all of the shadowing data, each case study nurse demonstrated positive methods of fostering relationships.

Fostering relationships between the resident and the case study nurse was seen as fundamental to optimum care outcomes. Data from the focus group highlighted areas such as 'engaging in life story work, giving residents 'TIME'-being available for the resident'. Furthermore, relationships were immersed in 'being friendly and approachable, empathetic, kind and the ability to have a laugh' (Focus group).

Fostering good relationships was considered essential for case study nurses and one Director of Nursing describes how the case study nurse achieved this:

DON 5: [Nurse] XXX leads by example in relation to respectful communication and care to the residents and their families.

Families were seen as central to the resident's well-being and most data sources identified the case study nurse's close communication with family members. This communication could be increased when the resident health deteriorated:

OP 10: Yes when I was sick she [case study nurse] used to ring him [son] everyday and vice versa.

This close knowledge of families also enhanced communication with residents. For instance in shadowing 16, the nurse was observed asking how a weekend went as a resident was out with family. The case study nurse was able to talk of family members as she had built up rapport over time with the family. As well as identifying positives with family interaction, this rapport with the resident and family was also considered useful in identifying negative issues:

DON 9: Uses intuition/knowing. Has good therapeutic relationships with residents and families. Very good to pick up on poor 'dynamics' within the families.

The sharing of self was seen as a positive enhancement of the relationship between the nurse and the resident. Often, residents could demonstrate knowledge of the case study nurse's personal life:

OP 23: And if she was out somewhere she'd tell me where they went for a meal and then I'd hear all about it. She got married you see, so that was great to see all the pictures

Getting to know families meant that there could be a more relaxed interaction which indicated a less formal environment which was more home like:

OP 14: She [case study nurse] knows my husband very well and she knows [daughter] XXX, my daughter in [town] XXX. My husband would be jeering [joking] her here sometimes and all, you know.

Interpersonal relationships were also fostered with colleagues particularly when genuine interest and concern was demonstrated. In the example below,

the case study nurse would make an effort to assist a colleague who might be under stress, but this was done discretely to maximise confidentiality and provide an opportunistic time to talk privately:

NC 17: Yes, go out of her [nurse] way to kind of find an opportunity to find the person [colleague] on their own or maybe if they were going to hang up their coat or on the way back from the loo.

Valuing the colleague and ensuring mindful attentiveness in authentic collegial relatedness therefore enhanced interpersonal relationships with colleagues. The examples below indicate how such mindfulness was used within the context of colleagues:

NC 21: With everyone, with us as well, not only with the residents but with us as well. If you ever had to speak to her she would always ask us, 'are you ok?' Just before I came up she went down to [care assistant] and as you know one of the ladies has gone out, she has been very active all morning, and she went and said, 'are you ok, do you need a break, do you want to go for a cup of tea?' Even though [care assistant] had had her break. She is very...she is very understanding.

NC 21: I mean...we had someone there recently who came in and wasn't well and when he came in [nurse] XXX asked him are you ok and he was saying he was but she knew by him he wasn't, you know. And finally around 12:00 she persuaded him to go home

In conclusion, the development and fostering of interpersonal relationships occurred in the context of reciprocity, positive regard and a genuine interest in the person (either resident, colleague or family) as an individual. This represents an important part of nursing expertise in long term care and is essential in order to support other attributes.

### *Recognition by others*

All case studies and the focus group data detailed instances of the case study nurse's expertise being recognised by others (residents, family and colleagues). There were many accounts from nursing colleagues which highlighted appreciation of expertise. One nursing colleague recalls that she recognised the case study nurse's expertise from the time she received orientation to the nursing home:

NC 14: Well when I first started here I shadowed [nurse] XXX for my first week or two, she...she is a great leader. If there are any problems I always go to [nurse] XXX if I need a bit of help or to ask questions. She is very easy to communicate with and approach.

Each Director of Nursing provided reflective statements which highlighted the acknowledgement of the expert nurse's skills. The two examples detailed below indicate recognition of the case study nurse's deep and extensive engagement in care of residents:

DON 1: An in-depth knowledge of patients coupled with life story work and a relationship with families allows her [case study nurse] to understand the needs of patients and families which assists her to know the cues that require action or non-action.

DON 15: Her [case study nurse] aesthetic knowledge acknowledges the importance of the art of nursing. It is expressive and viewed through all actions. These practices are encountered everyday and can be 'small' yet complex. She clearly demonstrates the complexity of 'basic' tasks and nursing expertise rather than delegating or taking them for granted. Consequently, these 'small' practices separate nursing from other healthcare professionals.

Recognition by others also included statements by the residents themselves. This is arguably the most important recognition as the residents are the

centre of care provision. For this reason, a number of comments (which were not exhaustive) have been presented to provide and insight into how the residents recognised the expertise of the case study nurses:

OP 1: ...she is fussy, but she's the best, she's the best, she's the best...that's a fact.

OP 2: Now you have Nurse [name] today, she is one of the real powerhouses... she is great.

OP 4: Excellent at delivering care. She's not wanting in any way...She is not wanting in any way, she is patient, she is kind, she communicates and most of all she listens.

OP 8: I find her very nice and very good and she is always very cheerful, that is one good thing about her, she is always very cheerful and cheers you up.

OP 10: I think she is tops, really lovely and really kind.

OP 11: It is just that she doesn't panic, she could come across serious cases there, and I know...I haven't personally seen but I know that she would deal with it in such a way that the person would be dying and he'd almost be happy when she's leaving them [because the care was so excellent] ...she is so professional.

OP 15: We love her, everybody loves [nurse] XXX, I wish there was more I could say, I just couldn't say enough about her.

OP 21: She is very, very nice and no matter what I would ask for she would help me. She helps me any way she could.

Recognition by others was demonstrated throughout the data. The case study nurses were acknowledged for many reasons which considered their expert nursing skills, their personalities and their ability to genuinely care for the uniqueness of the individual.

### **4.3 Skilled companionship**

The skilled companion framework (Titchen 2001) offers an alternative way of



elucidating expertise in practice. Within the findings, there were many instances where skilled companionship was evident. As stated previously, the domains of expertise are not mutually exclusive, thus there is overlapping in thematic development. Acknowledging this, the development of the theme skilled companionship in this study offers an alternative lens to develop similar aspects of expertise. This section departs from presenting findings from all of the 23 case study nurses to use the principles of skilled companionship in data gathered pertaining to one case nurse study, which is anonymised further by the removal of the numerical code.

As stated in the literature review, skilled companionship is a conceptual framework for person centred care (Titchen 2001). It comprises four domains: relationship, rationality-intuitive, facilitation and therapeutic use of self. Each domain has discrete processes and strategies.

#### **4.3.1 Relationship domain**

Within this domain are four processes: Mutuality, reciprocity, particularity and graceful care. These are examined using data from the interviews (older person and nursing colleague), Director of Nursing and shadowing observations.

*Mutuality* involves the resident and case study nurse working together in a genuine relationship. This implies a partnership in care where the resident is recognised as an equal and active stakeholder. Within the shadowing period all care choices were negotiated. Resident choice was persistently promoted

both in verbal and non-verbal communications. Furthermore, it was clear from the data collected that mutuality was important in the case study nurse's day to day activities, even when illness could present a barrier to partnership in care:

NC: ...particularly when the residents get sick or something, it can be difficult to inform them of options, but she [case study nurse] always informs them...they get good care about them and explain to them the situation and options so that they can decide.

DON: [Nurse] XXX communicates well with the residents. She assesses residents' needs through direct discussion with them.

OP: She would just sit down beside you and she would talk to you. She doesn't talk to you as a patient or somebody who has one screw missing up here, she talks to you as an adult person that is quite capable of making their own decisions and doing the right thing

Thus mutuality is interlinked in recognising the resident as a distinct individual human being, with a right to choice. Relationships are based on the case study nurse offering her knowledge to the resident, tailored to his/her need and within a partnership context, which fosters individual decision-making and choice.

### *Reciprocity*

Mutual exchange of knowledge, concern and care between the residents and the case study nurse was evident in the data. In particular, the nurse invited a sharing of life worlds. Asking about family and visitors, but also sharing elements of her own life achieved this:

OP: She [case study nurse] opens up to me... and her mother and father, they seem to be a very kind couple. I don't know where they went, the sister and herself, and the mother and the

father, the four of them went together [on holiday].

Throughout the shadowing period, the case study nurse projected unconditional positive regard and empathy for the residents. There was a sharing of self with the resident which was mirrored by similar reciprocal closeness from the older person. This sharing also extended to the sharing of information with the relatives as detailed by the nursing colleague:

NC: ...even on the phone when they [relatives] ask about relatives or they are coming to visit, you know, she [case study nurse] is nice to them... Like...two weeks ago, one lady she died, and last a few days, maybe five days, they are coming and they stay here and she went to ask them, first of all she looked after the lady, the resident, to get her the best comfort which we could to help her. And then she asked the family about cup of tea, explained about everything...she understood the situation, she called the doctor.

The excerpt demonstrates how knowledge is shared in the context of meeting information needs. As the resident entered end of life care, the needs of both the resident and her family were prioritised and medical assistance sourced.

### *Graceful care*

Within the data, it was clear that the case study nurse used all aspects of self to ensure residents felt personally valued. Graceful care involves being genuine with the resident, unhurried, being emotionally and physically present, sharing of self, using humour and valuing the resident. In the excerpt below, the older resident describes a typical interaction with the nurse which demonstrates graceful care. It was evident that there was a running banter which was used between the nurse and resident which both enjoyed:

OP: Yes. It [referring to respect] is all done very quietly and respectful and no gushing or anything. She [case study nurse] just comes in, a big smile on her face and she would say, 'And how are you today love?' 'Well' I said, 'now that I have seen you I am not too bad at all'. 'You wouldn't be telling me a whopper?' [said by the nurse] I said, 'would you believe it?' She roars laughing...she thinks that's an awful funny statement to make... we used to say when we were small, don't be telling me a whopper. That was telling me a lie

Consequently, the way of being (ontology in action) was projected as generous, approachable and caring. Graceful care was observed in looking after an older lady who could be 'difficult'. The case study nurse was considered to be able to attune to the resident's needs:

NC: Like [resident] XXX, the lady, you know her, is really difficult to work with her because, you know, one day she wants to die, other days she is like 20 years younger and things like that, you know, and it is very hard to cope with and manage her so I think she [case study nurse] knows how to speak to her.

Within the shadowing period, interactions between this resident and the case study nurse were observed to be focused on positive regard for this resident. The case study nurse ensured that she gave time to the resident and spoke gently in a way which valued the relationship. It was also evident in the interaction that the resident responded with great regard for the nurse and during one observed interaction, following the resident's request being met, the resident held the case study nurse's hand and said 'Thank you love'.

### *Particularity*

This involves 'knowing where the resident is at' and can be elicited by observing the situation and responses, picking up on cues and clues specific to the context of the resident's lives. This is immersed in uniquely knowing the

patient from a medical, social and emotional context, including the experience of illness.

Within the context of the interview the older resident emphasised how the case study truly knew her:

OP: There are days, I am telling you something, I am like an antichrist, the back is at me, the kidneys are at me, I want to go to the toilet and I haven't the energy to put the two feet under me. She [case study nurse] doesn't take a bit of notice [of the bad mood], she would look after you. I know that if I, and I say this quite confidently and truthfully, that if I had a choice that somebody told me that I was going to be in bed for six months and I wanted someone to care for me I would pick her.

Within the shadowing period, small but individualised actions were noted. For example, knowing that a particular resident liked milk with medications, while another resident only liked 'Miwadi' [orange drink]. Shadowing data demonstrated obvious knowledge of families and the context of older person's life history. There was also genuine interest in the current life world of the resident. Such knowledge represents the 'what', 'why' and 'how' knowledge and how such knowledge is created in practice representing epistemology in action (Titchen and McGinley 2003).

#### **4.3.2 Rationality-intuitive domain**

This domain has three processes: intentionality, saliency and temporality. This section considered these processes as the prerequisites for relationship and facilitation domain (Titchen and McGinley 2003). The case study nurse was able to act with intention by using the skilled companion strategies. The

use of saliency translates to knowing what is important for the context and using appropriate strategies to address this. In articulating the process of temporality, a deep engagement with time in the sense of appreciating the past history of residents, the current status and having the ability to plan care, anticipating outcomes was observed. One method of demonstrating the rationality-intuitive domain is the completion of comprehensive care plans for residents. The care plan represents a written record of the individual resident's nursing plan with detailed knowledge in many domains such as social history and medical history. Using a care plan allows thoughtful review of the individual resident with implicit planning for historical and emerging needs, anticipatory care and goals for addressing needs. As such, the case study nurse was observed completing the care plan while reflecting on the particular resident. The Director of Nursing also highlighted care planning as a way of documenting, operationising and evaluating residents:

DON: [Nurse] XXX uses her experience and knowledge of the residents when developing and reviewing residents' care plans.

Knowing what matters is an essential component of nursing expertise. In the following example, the depth knowledge of the needs of the resident is made visible through recounting the case study nurse's care. This resulted in the resident knowing that her care needs were being addressed with particular and careful attention:

OP: I am not exaggerating when I tell you that girl [case study nurse] at 4:00 in the morning she would go down and make tea for you, she'd get medication for you, she'd be up and down and up and down all night and make sure that you are all right. And she leaves the door too, and she'd have a chair outside the door so she can see scant ways how I am. So if I was here and I was supposed to be asleep I can see that she is out there, she is watching to see that I am all right. That is concern, that you

don't find.

Another example of knowing what matters is that of helpful communication. The case study nurse used particular strategies with both the residents and colleagues to project respect and dignity for each individual. An observation by a colleague indicated that the case study nurse could break the traditional distant persona of patient-nurse relationship for the benefit of the resident in order to enhance the caring relationship:

NC: It is not a problem for her to be familiar to them [residents], to hug them, you know, to be really nice to them, because some nurses are too official but she is not, she is very friendly.

In articulating temporality, one example demonstrated taking action at the right time and at the right pace. The nursing colleague describes a situation where the case study nurse observed a mood and physical change (restlessness) in a resident and advised the nursing colleague to 'keep an eye' on the resident. As symptoms progressed the family were called, which from the case study nurse's knowledge, calms the resident without the need for pharmaceutical intervention.

NC: She [case study nurse] does do things like that or if we have a problem with someone, you know... Like if someone is very restless and does do these things, you know, we have this kind of problem with the resident. Like we have a man, sometimes he is in a bad mood and he is shouting and she does, she informs the family. For example, she found he is very good when his daughter is coming and talking to him so he is better.

This approach of temporality was also observed in the shadowing period as the case study nurse spoke with the clinical nurse manager of a resident who

was agitated and wandering. Various strategies were discussed and one decided which the case study nurse implemented with success. A particular point of note in this discussion was the case study nurse being an advocate for avoidance of pharmaceutical intervention and that this should be a reluctant last mode of intervention.

### **4.3.3 The facilitation domain**

The facilitation domain is concerned with reflecting on practice and has four processes: consciousness raising, problematizing, self-reflection and critique. Facilitation involves role modelling, working through 'craft knowledge' (Titchen & McGinley 2003), making-sense of practice pathways, receiving and sharing feedback as well as promoting creativity.

Within the context of shadowing, there were many opportunities where the researcher enquired about actions and activities. This allowed a continued depth insight into what, why and how the case study nurse's practice was organised, delivered and evaluated. This included direct questioning during the shadowing period on how work was organised in terms of activities, working in partnership with the care attendants, backgrounds of residents and rationales behind various practices and interactions. For example, one resident was due to attend an external facility on the day of observation, but the nurse picked up on the resident being flushed looking and a little listless and recorded a mild pyrexia. Further questioning on level of fatigue, experience of pain, dietary intake followed and a discussion on missing that particular day to the external facility ensued. Reflecting on this, the nurse



drew on her ways of knowing both the general presentation of the resident and empirical nursing knowledge pertaining to the signs of infection.

Within the context of the nursing home, the nurse was able to engage in reflection from an organisational viewpoint through participation in a clinical governance committee. This allowed best practice to be located in policy while also reviewing the policy in the context of the evidence and requirements of the specific nursing home:

DON: [Nurse] XXX is a member of the homes clinical governance committee. She is involved in reviewing areas such as falls, incidents and complaints on a quarterly basis. [Nurse] XXX uses her professional judgement in everyday discussions around residents' needs and evaluating outcomes.

Elements of facilitation could also be seen in the case study nurse's approach to care as observed by her nursing colleague. This could mean taking a careful approach to individual resident choices, while accepting that they have the right make risky choices:

NC: ...she [case study nurse] is careful and she has to consider what is good for the residents... because residents can make bad decisions about themselves...

Another aspect of facilitation is role modelling. Within the nursing home, the Director of Nursing reported that the case study nurse implicitly used this:

DON: [Nurse] XXX leads by example in relation to respectful communication and care of the residents and their families. She is particularly talented in the area of end of life care, where she shows great professional, clinical and emotional judgement.

The case study nurse demonstrated the facilitation domain in many aspects of her work and this is supported in the various data sources. There was also

a self-recognition of continued engagement in further learning both through further role development (as cited by the DON), additional training and experiential learning. The use of skilled companionship also encompasses a facilitative use of the 'self' domain where know how and self are combined into the provision of individualised care which is dynamic and individualised to each resident, through relationships based on partnerships, presence, a genuine endeavour to care and positive regard. This practice synthesis results in professional artistry (Titchen 2009), which is ultimately concerned with the promotion of flourishing in human beings.

#### **4.4 CONCLUSION**

The findings have illuminated many complex elements in the domain of nursing expertise in residential care in Ireland. The multi-layered components blend together and cohere in a seamless way. The findings in this study make explicit the deep engagement of these expert nurses and also demonstrate the outcomes of care through data generated from the residents who participated in the study, the colleagues who work alongside the case study nurse and the Directors of Nursing in the nursing homes. The findings ultimately explore how the case study nurses practiced their craft. The data has shown that the case study nurse's expertise is focused on both ontological and epistemological relationships with residents (and indeed families and colleagues) and how such expertise is entrenched in mutuality, commitment and reciprocity.

## CHAPTER 5

### DISCUSSION AND CONCLUSION

#### 5.0 INTRODUCTION

Research has demonstrated the necessity to recognise and support residential care nursing practice expertise (Tolsen et al. 2011, McGilton 2012). However, within residential care of older people, the role of nursing expertise is often rendered invisible (RCN 2004, Hardy et al. 2006, Heath 2012). A focused reflection on the 'ordinary' can have a transformative effect and illuminate new understandings of what may, on the surface, appear to be mundane encounters. This process is demonstrated in Patrick Kavanagh's poem below, where the 'taken for granted' is suddenly viewed as extraordinary:

#### **Canal Bank Walk (Patrick Kavanagh, 1960)**

Leafy-with-love banks and the green waters of the canal  
Pouring redemption for me, that I do  
The will of God, wallow in the habitual, the banal,  
Grow with nature again as before I grew.  
The bright stick trapped, the breeze adding a third  
Party to the couple kissing on an old seat,  
And a bird gathering materials for the nest for the Word  
Eloquently new and abandoned to its delirious beat.  
O unworn world enrapture me, encapture me in a web  
Of fabulous grass and eternal voices by a beech,  
Feed the gaping need of my senses, give me ad lib  
To pray unselfconsciously with overflowing speech  
For this soul needs to be honoured with a new dress woven  
From green and blue things and arguments that cannot be proven.

Similarly, this study illuminates the ordinary, the invisible and taken for granted expertise inherent in the practice wisdom of nursing in residential care. The argument for reducing numbers of registered nurses in nursing

homes can focus on enumerating care as tasks, rather than the depth and integration of different forms of knowledge (Heath & AIGNA 2010, McGilton et al. 2012, Siegel et al. 2012) which constitutes 'extraordinariness'. In particular, previous research in Ireland has recommended that nursing expertise in residential care for older people is made explicit (Heath & AIGNA 2010). This is particularly an issue in a growing older population generally and specifically a residential care population in nursing homes which demonstrates increased care complexities (CSO 2012). In response to these recommendations, AIGNA and NHI commissioned research to explore expertise in nursing in residential care. This study used 23 case study nurses working in residential care in the Republic of Ireland. This research adds to the existing body of knowledge of literature on expertise in nursing care, in particular related to residential care of older people, because it offers a multi-dimensional way of examining expertise. Thus, like the movement of light in a prism, expertise is illuminated through the production of data from different sources. Often literature related to care experience, particularly in qualitative research, considers care from the point of view of the nurse and, although important, can be subject to a secondary experience of care quality (Boscart 2010). Therefore, it is valuable to have concurrently examined the expertise of case study nurse from the point of view of first hand observation through shadowing, through the lived experience of a colleague who works with the case study nurse and the older person.

Using directed content analysis, the qualitative case study data were explored using Manley et al.'s (2005) framework for nursing expertise. This resulted in

the development of the case study nurse's expertise in relation to saliency, holistic practice knowledge, knowing the patient, moral agency and skilled know how. Two further themes emerged: admission to the nursing home and the context of the nursing home. Following this, the data from each case study were combined to develop each theme. This involved the integration of data from the focus group held at the AIGNA in 2012. The final phase of data analysis encompassed the use of a different nursing expertise framework (Titchen 2001) to interrogate data related to one case study nurse. The use of Titchen's (2001) framework of skilled companionship functioned to illustrate an alternative lens within which the case study's expertise was located. Personal integrity (Hardy et al. 2006) is considered paramount to nursing expertise and underpins the concept of skilled companionship of the expert nurse and his/her relationship with the resident (Pearson et al. 1997, Manley et al. 2005). This results in care delivery underpinned by professional artistry (Titchen & Higgs 2001).

### **5.1 Admission to nursing homes**

As the population ages in Ireland, the need for nursing homes will increase (Wren et al. 2012). Admission to residential care is primarily determined by older people's age and gender, the level of dependence and disability within the population and the availability of either formal or in formal care in the resident's home and community (Wren et al. 2012). As demonstrated in the data in this study, admission could be precipitated by a clinical deterioration in the resident's status, leading to increased needs which pose a risk to independent living or which impose a major challenge to a caregivers' ability

to provide adequate care in the community. This concurs with studies which identify the catalyst for older people's admission to residential care is predominantly due to a change in the individual's health (Bowman et al. 2004, Connolly & O'Reilly 2009). However, increased life expectancies and a focus on keeping people at home for as far as practicable (DOH 2012) translates to a continued trend in high care demand within residential care.

Admission to the nursing home, which was predominately described by the interviews with older people, demonstrated both the complexity and diversity of care requirements of the residents. The complexity of residents' health needs was evident in the case study nurses caring for the older residents, who seamlessly adjusted care to each individual's unique needs. Thus, the care expertise of the nurse in residential care required attributes such as a skilled knowledge of the management of diverse health conditions and person centred care delivery. Such care ranges from life story work, 'really' knowing the resident, advocacy and empowerment, managing skill mix, medication management, knowledge of ageing and disease pathways and complications as well as the ability to weight up the co-presenting features and consequences of co-morbidities. In addition, it is recognised that admission to a nursing home is a stressful event (Melrose 2004). Thus, understanding and helping older people and relatives to psychologically adjust to an altered living environment is a fundamental part of the transition to nursing home care (Ellis 2010). When such a combination of skills is considered, the expertise of the residential care nurse in this study emerges through the data and although nursing in residential care can be devalued, (Bass 2011, Tolsen et al. 2011),

this study contributes to dispelling the perception that nursing in residential care of older people is unchallenging and of poor status.

## **5.2 Context**

As nurses work within a social system, the presence of an environment conducive to care excellence is a fundamental factor in both developing nursing expertise and in supporting nursing expertise. Therefore, expertise within this study was considered to demonstrate social dimensions. Many factors affect the context for expert nursing care, which is immersed in an ethos of person-centredness. The context theme is enmeshed in the cultural milieu of residential care, which demands support for person centredness (McGilton et al. 2012, McCormack et al. 2012).

Siegel et al. (2012) identifies such macro factors such as socio-cultural, public policy/financing/regulation, nursing/professional and organizational, as essential for the promotion of person centredness. However, many regulatory systems, where they exist, do not always focus on person centered care (McGilton et al. 2012). Undoubtedly, since the establishment of the HIQA in 2007, a macro perspective of care standards has resulted in independent, statutory review of nursing homes. The presence of regulatory systems in residential care has impacted on the competencies of nurses (McGilton et al. 2012) and has positively impacted not only on the experience of residents, but also on promoting a recognition of the diverse attributes required for quality care provision (Flynn et al. 2010). This diversity ranges from having person centred care as a core of service delivery, to dietary suitability and

buildings' specification. For example, it was noted in this study that although the case study nurses delivered person centred individualised care, such care could be compromised by being delivered in hospital-like buildings, which reflected a physical environment of institutional care. Moreover, one Irish study identified the ethos of care as fundamental to enhancing quality of life in residential care (Cooney et al. 2009). Acknowledging this, the experience of data collection in this study has demonstrated an explicit departure from a focus on task orientation and service priority to an appreciation and promotion of individualized care, quality of life and, ultimately, human uniqueness.

From the meso-perspective of the specific nursing home, a process of both personal participation and reification (shared experience around which participation is organised) occurs to produce a practice logic (Wenger 2010). Thus, there is a joint enterprise, an interaction process based on mutuality and the production of a shared repertoire (Wenger 2000). Considering expertise within the lens of communities of practice allows the component of shared practice to emerge. It recognises that learning is situated and mutual within the stated domain of the nursing home resulting in collective competence. This shared learning is one which can be between residents and the expert nurse, relatives and the expert nurse as well as between colleagues. Each individual nursing home, although subject to the macro-structure of regulation (for example HIQA) and contemporary research and practice, has individual ways of being such as the inherent values, ways of doing things, power relations and communications. Consequently, in this study, each nursing home demonstrated a shared repertoire of resources



which evolved from sustained and historical interaction. As Wenger (2009) points out nurses who share lunch breaks and conduct discussions on care constitute a shared repertoire of knowledge of patients. Similarly, on the occasions where the shadowing period included sharing a tea break with the case study nurse and colleagues, informal discussions often occurred relating to care provision.

The expertise of the case study nurses was seen to be drawn on by colleagues, relatives and residents. There were many instances in the data of new innovations being introduced by the case study nurse, which resulted in what Wenger (2000, 2010) considers a way of negotiating if the community will accept this as a new element of the community's competence. This creates an experience of 'knowlegeability' and encompasses the production of a particular case nurse identity within the community of the nursing home. However, in this study, learning was not a unidirectional, hierarchical process within communities of practice, but a reciprocal, peer engagement, which facilitated the case study nurse's participation in and orientation to the nursing home (Eckert 2006). Thus, the case study nurse was often seen to inspire by example but demonstrated a readiness to learn from others. Consequently, the nursing home was a place wherein the case study nurse could flourish and contribute to other's flourishing.

### **5.3 Expertise**

The general literature on expertise in nursing demonstrates a multifaceted, complex and helping mutuality between the nurse and the care-recipient

(Morrison & Symes 2011). Such reciprocal relationships are evidenced in this study through a pluralism of knowledge resulting in integrated, meaningful expert care. Various frameworks which examine expertise propose a combination of elements, which intrinsically cohere to provide holistic, humanistic care with positive outcomes on a variety of dimensions (see for example Carper 1978, Benner et al. 1996, Manley & McCormack 1997, Titchen 2001, Manley et al. 2005). Accordingly, expertise in nursing not only consists of propositional knowledge, personal knowledge and professional craft knowledge (Titchen & Higgs 2001) but results in excellent person centred care, which is essentially delivered intuitively. This 'diagnostic reasoning' (Ritter 2003: 137) is ultimately characterized by the ability to adapt unproblematically in the context of both certainty and uncertainty and involves a degree of (measured) risk taking (Morrison & Symes 2011). As a result, the aspect of intuition cannot be ignored because of difficulty in its articulation (Lyneham et al. 2008, 2009). Intuitive related expertise has been demonstrated in multiple ways in this study in the context of drawing upon multiple knowledge bases, intuitively acting in promoting helping relationships and having such care delivery recognised by others. Being able to discriminate cues is considered fundamental to establishing meaning and responding to current issues as well as anticipating possible future issues (Hoffman et al. 2009).

Case study nurses were observed to tacitly direct and redirect care as appropriate to the individualized presenting situation. This involved being competently able to manage idiosyncrasies, by employing fuzzy logic' (Kosko

1994) in the everyday practice of nursing in residential care. Such logic transcends rules, standards or routine practice care to the ability to simultaneously integrate multiple knowledge sources and determine appropriate care. It was particularly evident that this involved all aspects of Manley et al.'s (2005) framework. A particular advantage of generating the older person interviews, the nursing colleague's interviews and the data from the Directors of Nursing was the ability to correlate the shadowing data with the experience of the receipt of care (older person) and experience of co-working (nursing colleague and Director of Nursing). Moreover, the demographic profile added to the provision of a contextual background of each case study nurse, in terms of length of experience working with older people and specialized training and education in the domain of older person care. It is noted that contrary to Benner's (1984) model, where expertise is considered time bound and occurs after five year's experience, the case study nurses in this study demonstrated expertise within a shorter timeframe. Some of the nurses had 1-3 years (n=7) or 4-6 years (n=3), yet this did not reduce the level of expertise observed or experienced. This concurs with Rishel et al. (2008), who concluded that nurses' expertise is immersed in a situational context rather than related to length of experience.

This study also concurs with other research which demonstrates the high time commitment by nurses in residential care in relation to communication (Munyisia et al. 2011). Nursing homes are complex communications environments, which involve a flow of discourses between the case study nurse and residents, the multi-disciplinary team, colleagues and residents.

Communication was observed in all data sources and underpinned helping relationships which prioritised individualism and resident choice. The promotion of choice, which was replete in the data, supports the notions of 'personhood' and person centred care. Moreover, the case study nurses' communications network was observed to have multiple foci, such as with the residents, multi-disciplinary team, fellow direct care colleagues and residents. In some instances, the researcher was also informed of local communication with surrounding communities, particularly related to fund raising and political lobbying.

The impact of the nurse in this study was observed in the ability to combine all of Manley's et al.'s (2005) characteristics of expert care, thus, clinical judgement (Tanner 2006), was the result of genuine engagement with the resident, colleagues and families. The case study nurses' data was replete with instances of authentic presence (McCormack & McCance 2010) or 'relational availability' (Boscart 2010) which promoted positive regard for each resident and a firm focus on individualism and partnership in care. However, person centred care needs to be supported in multiple domains to ensure the capacity of the expert nurse is potentialised (McGilton et al. 2012). The case study nurses all demonstrated the ability to carry out their role effectively and to collaborate with colleagues while demonstrating leadership. The case study nurses in this study also demonstrated leadership in the context of using a person centred care approach within each nursing home's skill mix. This concurs with research related to person centred care in residential care facilities (McGilton et al. 2012).

The outcomes of expertise include enhanced quality of life experienced by the resident, efficient and effective care delivery and the ability to practice as role models and leaders in care. This highlights the person centred dimension of residential care, where it is the discovery of the resident's life world that is deemed important as well as the technical component of care. Without any exclusion, all 23 older people spoke of the positive experience that was experienced from the case study nurse. Often this was embedded in simple activities such as 'giving time', listening, and a simple smile or touch. Alternatively, it could be immersed in discourses which demonstrated high confidence in the ability of the case study nurse to address individual complex care presentations over and above nursing colleagues' ability. Such actions were embedded in the holistic delivery of care, where genuine interest in the person and confidence in nursing ability was also highlighted. Moreover, quality of life was promoted by a mindful assessment of each resident's capabilities and support for maintaining capacity.

While nursing expertise in residential care has been demonstrated in this study, it needs to be recognised beyond the context of residents and residential care nursing colleagues to other members of the nursing discipline, society and indeed within political discourses. The lack of validation of such expertise can be immersed in ageist assumptions wherein caring for older people does not appear to generate the same kudos as other practice settings within nursing (Siegel et al. 2012). Only then can nurses in residential care be valued and this value needs to be immersed in an appreciation of nursing expertise in working with older people.

#### **5.4 Limitations of the study**

- The effect of being observed may have impacted the case study nurse's actions in that, in being observed, the usual activities could be altered (Hawthorne effect). The researcher made some attempts to limit this by engaging in conversation with the case study nurse to reduce any anxiety regarding being shadowed. Some case study nurses commented that they forgot about the presence of the researcher after a period of time. Moreover, in conducting care, many discussed the usual practices of daily routine which were observed as typical in the shadowing period and such routine made it difficult to alter usual practices to any great extent.
- Resident interviews were only undertaken with residents with mental capacity and those approached by the Director of Nursing. It may be that the experience of expert care in those with mental capacity challenges is experienced differently. In addition, it could be argued that approaches to potential older person participants could be biased towards those with positive experiences.
- Most of the older people who expressed an interest in participating in the study were semi-independent. This raises a similar issue in that residents who have greater care requirements may experience care differently.
- This research did not include the experience of expertise from the perspective of the resident's relatives. This component of data is likely to add to understandings of expertise in residential care of older people, particularly in the context of an acknowledgement of the

importance of relative's input in residential care and the building up of long-term relationships with resident's relatives.

- The construction of expertise in residential care would also be enhanced from data from independent advocates, which is a recommended service in Irish nursing care homes.
- In relation to the sample, self-selection of nursing homes occurred. It is likely that nursing homes who were confident in having high care standards volunteered to participate. Thus, those who may have struggled with attaining standards would not have an impetus to participate. This was somewhat validated by the fact that the case study nurses, nursing colleagues and some of the Director of Nursing surveys included references to very positive HIQA reports.
- Reviewing the formal statutory evaluation (HIQA inspection reports) of care in facilities for residential care of older people may add to describing nursing expertise in residential care of older people. This review would examine the individual case study nursing home's HIQA inspection report and would allow additional insight into the areas of context, cultures and communities of practice.

## **5.5 CONCLUSION**

In conclusion, nursing expertise in nursing needs to be acknowledged (Manley et al. 2005). Unless, this occurs, such diverse knowledge fusions will inevitably remain invisible and, consequently, valueless. This is especially the case in residential care where nursing can be devalued and there can be a perception that expertise in nursing can be substituted. This is a fallacy as

such perspectives negate the intrinsic, individualized and holistic care inherent in expert practice in residential care. Without explicit and external value in nursing expertise in residential care, it is easy to reduce care to simple and uncomplicated service provision. However, such a position also supports ageist discourses, wherein expert nursing care is somehow not a pre-requisite to such service provision. It is therefore challenging to promote the imperative of nursing expertise and a nursing leadership role in residential care.

Tolsen et al. (2011) cautions that there is often a requirement for quality care to be measured and a focus on cost containment, but workforce planning (ie skill mix) for residential care demands appropriate nursing expertise. Understandings and beliefs of society, policy makers, other members of the multi-disciplinary team and the discipline of nursing need to value nursing in residential care (Christensen & Hewitt-Taylor 2006), particularly as the presence of expert nurses is associated with enhanced resident outcomes (Mezey et al. 2005, deBellis 2010). Thus, this valuing of expertise should not be negated, especially through arguments related to issues of cost containment within residential care.

## **5.6 RECOMMENDATIONS**

1. One of the most important aspects arising from this study is the imperative of establishing the value of expertise in nursing in residential care of older people. Consequently, nursing colleagues in settings outside nursing, society and policy makers need to appreciate such value



and expertise.

2. Within a cost containment agenda, the value of expert nursing care needs to play a more explicit role in the multiple discourses within society, policy on residential care and the nursing discipline. Service planners need to take account of the depth of care delivered by expert nurses and quality of life outcomes related to person centred care when calculating skill mix. This should complement quantitative based measures of skill mix.
3. The consolidation of the expert nurse's role in residential care needs clarification, particularly in the context of skill mix, scope of practice and leadership. This should include the national adaptation of the person centred practice approach, building on the existing work of McCormack & Dewing (2010) and McCormack et al. (2011).
4. Additional research into expertise in nursing practice can enhance the findings of this study. Such research could include relatives/family members and include a dimension of costing expertise in relation to both experienced quality of care (by residents) and quality care outcomes.
5. Gerontological nursing needs greater recognition as a speciality in its own right at all levels of nursing education. The undergraduate nursing curriculum needs to acknowledge the speciality of gerontological nursing and post-registration education programmes need to be standardized to ensure the expertise of registered nurses is maximized.

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Brendan is Director of the Institute of Nursing and Health Research and Head of the Person-centred Practice Research Centre at the University of Ulster. His internationally recognised work in person-centred practice development and research has resulted in successful long-term collaborations in Ireland, the UK, Norway, The Netherlands, Canada and Australia. His writing and research work focuses on person-centered practice, gerontological nursing, and practice development and he serves on a number of editorial boards, policy committees, and development groups in these areas. He has a particular focus on the use of arts and creativity in healthcare research and development. Brendan has more than 110 peer-reviewed publications as well as 6 books published. He is the Editor of the "International Journal of Older People Nursing". He has co-authored 'Practice Development in Nursing' which has now been translated into two languages, 'Practice Development in Nursing: International Perspectives' and 'Person-centred Nursing'. Brendan's co-authored book (with Prof Bridie Kent), 'The Clinical Context for Evidenced-Based Nursing Practice', won the prestigious Capstone International Nursing Book Award for 2011 which recognises the excellence of one outstanding book published by Sigma Theta Tau International. Brendan is President of the All-Ireland Gerontological Nurses Association [AIGNA], Chairman of the charity 'Age Northern Ireland' and a Fellow/management committee member of The European Academy of Nursing Science. In 2011 he was awarded the status of 'Senior Distinguished Research Fellow' by the University of Ulster, in recognition of his research achievements.