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University of Southampton

FACULTY OF ENVIRONMENTAL AND LIFE SCIENCES

Health Sciences

Work system influences on nursing staff capacity for relational dementia care on Medicine for Older Persons wards: An ethnographic study

by

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Abstract

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Work system influences on nursing staff capacity for relational dementia care on Medicine for Older Persons wards: An ethnographic study

Emily Charlotte Oliver

There is a paucity of research studies that provide an in-depth exploration into the care for people with dementia on Medicine for Older Persons wards, particularly focusing on the provision of relational care and the effect of the work system on nursing staffs capacity to do so. The purpose of this study was to address this gap in the knowledge base.

This thesis describes a research study that aimed to explore the work system factors of Medicine for Older Persons wards and identify how these factors influence nursing staff capacity to provide relational care for people with dementia. Ethnographic research methodology was adapted to explore the culture of the three wards that participated in this study. A range of data collection methods were used including unstructured observations, informal conversations, semi-structured interviews and reflexive notes, followed by thematic analysis between January 2017 and March 2018.

The findings identify that the capacity for relational care does not sit with nursing staff themselves but relies to a great extent on the organisational context in which the nursing work takes place. Organisational priorities, temporal routines, and predetermined task duration shaped by organisational targets all have a significant impact on the way in which nursing staff organise their work. Organisational priorities do not include relational care and the time that nursing staff are able to spend building relationships with patients, particularly patients with dementia, is reduced as a consequence.

These findings echo what is already known in the evidence base, with more recent research by others (Featherstone et al. 2018) highlighting how routines dictate the care for people with dementia on acute admissions units and orthopaedic wards. However, through providing an in-depth picture of the mechanisms by which the nursing work system shapes the care that nurses are able to provide, this research suggests that routinised care is also predominating on specialist Medicine for Older People wards and impacting on the care experiences in the same way, despite the expertise that this workforce are thought to uphold.

The study has made both unique empirical and theoretical contributions but has also led to the development of recommendations for future practice. Most importantly the results provide evidence that any further research looking to improve relational care should start with the organisation. Nursing staff are aware of how to provide relational care, however, due to the organisational context in which their work is completed, they have no capacity to provide it. Relational care needs to be given the same priority as physical care, especially for patients with dementia and unless improvements to relational care is addressed at an organisational level, it is unlikely that nursing staff capacity for relational care for people with dementia will improve.

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Research Thesis: Declaration of Authorship

Print name:	Emily Oliver

Title of thesis:	Work system influences on nursing staff capacity for relational dementia care on Medicine for Older Persons wards: An ethnographic study.

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature:		Date:	15/08/19

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First and foremost, I will be forever grateful to my supervisors Professor Jackie Bridges and Professor Ruth Bartlett who have guided me not just academically but clinically, professionally and personally over the last 5 years. I have been so lucky to have two individuals with a wealth of knowledge and expertise, who have openly shared these with me, and who have given me opportunities that I would never have dreamed of. Both Jackie and Ruth have been invaluable right from the very beginning of my work up until this final submission in keeping me on the right path, whilst also allowing me to find myself, both as a researcher and a clinician. I feel we have made connections that will not end here and I hope that I will continue to work with them to ensure that their guidance will follow me throughout my career.

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Definitions and Abbreviations

Acute Care: Acute care is a level of health care in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery.

Allied Health Professionals (AHP): The broad range of health professionals who are not doctors, dentists or nurses such as physiotherapists, dieticians, occupational therapists.

Care Quality Commission (CQC): The care quality commission (CQC) is the independent regulatory body of all health and social care services in England.

Dementia: An umbrella term for a set of symptoms caused by brain disease or injury, such as memory loss, difficulty communicating and loss of ability to participate in activities in daily living.

Foundation Year 1/2 (FY1/2): A Foundation doctor (FY1 or FY2 also known as a house officer) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.

Health care assistant (HCA)/Health care support workers (HCSW): Non-qualified nursing staff in the UK who assist in patient care and practice-related duties as directed by and under the supervision of a registered healthcare professional.

Insulin: A hormone produced in the pancreas by the islets of Langerhans, which regulates the amount of glucose in the blood

Intravenous Medication (IV's): Solutions (usually medication) administered directly into the venous circulation via a syringe

Intravenous pump: An infusion pump that infuses fluids, medication or nutrients into a patient's circulatory system.

Medicine for Older Persons (MOP): A Clinical Service Centre within hospitals providing care to those over 65 who are acutely unwell or have experienced a stroke.

Multidisciplinary Team (MDT): A group of health care workers who are members of different professions e.g. Psychiatrists, Social Workers, etc.

National Health Service (NHS): The National Health Service for the UK is free at the point of use and publicly funded through national taxation.

Nurse in Charge (NIC): A registered nurse responsible for the management of a patient care unit.

Next of Kin (NOK): Nearest relative or the first person to be contacted in an emergency.

Older People or Older Person: A person or people over the age of 65 years old, as per the World Health Organisation (WHO) (2013)'s definition.

Registered Nurse (RN): A person trained in the scientific basis of nursing, meeting certain prescribed standards of education and clinical competence.

Rounding: A structured process where nurses on wards carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.

Rounding sheets: A document that records the tasks that nursing staff complete when repositioning a patient

Senior House Officers (SHO): Senior house officer (SHO) is a junior position for graduate doctors who are under special training within a certain medical specialty. A senior house officer reports to the head of department or consultant in-charge and performs a wide variety of clinical, clerical and teaching tasks.

Supernumerary: Staff who were working on the ward but were not included in the usual staffing numbers – usually student nurses.

UK: United Kingdom

US: United States of America

Vital Pack: Vitalpac is a mobile clinical system that monitors and analyses patients' vital signs providing clinicians with accurate, real-time information.

Vital signs/Observations (Obs): Clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions

***N.B:** When discussing the author's contribution to the research, the personal pronoun "I" will be used as it provides a level of reflexivity and engagement within the research.*

Chapter 1 Preface

1.1 Chapter Introduction

This chapter will provide the outline for this thesis. The chapter starts with an introduction into my personal profile which allows for a better understanding of my influences over the research. The chapter then goes on to state the purpose of this research, addressing the aims and objectives. The chapter will end with an overview of each phase of the study to assist with the understanding of the document and will then go onto outline each chapter.

1.2 Personal Profile

Prior to the discussion of the research study itself, I will give an introduction into who I am to enable the reader to have an understanding of any influence this may have had throughout the research. In any qualitative inquiry, the researcher's background, beliefs and social identities have a potential impact on the research process (Lathlean 2010) and I will therefore start with a personal reflection on these components and provide an insight into my motivations for conducting this research.

It was not too long ago that I started my career in nursing. I commenced my training for mental health nursing at the University of Southampton in 2011 and it was within the first year that my passion for older persons care was instigated. My first clinical placement as a student nurse, was on an organic dementia ward at a psychiatric hospital. The ward was relatively small, consisting of an estimated seven patients with one nurse and two healthcare support workers on shift at any one time. At first and understandably, I found the ward environment quite daunting - I had never worked in a clinical setting, let alone, with individuals who are living with cognitive impairment and due to the ongoing reports of "challenging behaviour" that I had seen, I was increasingly nervous about starting. Over time it became clear how quickly, you could build relationships with your patients and what a difference this could make. As with all placements, I was supernumerary, which gave me the time to spend real quality time with each individual, getting to know them and their families and spending my days participating in activities. I left that placement, thinking all aspects of nursing would be this like this and very much looking forward to my future career.

Following that first placement, I began to realise that nursing work was very different from what I had experienced and quickly became accustomed to the increasing target driven system, heightened with an increasing demand of patients with complex needs and met with the pressure of operating with short staff during most shifts. I left placements feeling guilty for not spending enough time with patients and somewhat exhausted from battling the negative attitudes of the staff towards their work, their colleagues and at times, the patients.

During my third year of my training, I was given the task of designing an audit for my final dissertation. I chose the topic of antipsychotic use for patients with dementia when admitted to hospital and suggested a quantitative audit looking at medication charts both pre and post admission. I thoroughly enjoyed thinking about methodologies as well as learning about policy and guidelines and thought that participating in something like this could lead to better outcomes from people with dementia at a more strategic level. I worked especially hard at this piece of work which eventually paid off – I was awarded the mark of a first class and it was at this moment that I decided to undertake my clinical doctorate straight from my undergraduate training.

Following a successful interview, in September 2014 I found myself undertaking a clinical academic doctorate titled compassionate care for patients with dementia in hospitals. For the clinical component of the doctoral training, I was placed on a Medicine for Older Persons ward in a general hospital – not somewhere you were likely to find a mental health nurse. As a naïve, newly qualified nurse now working towards her doctorate, I felt I was going to take on the world – providing outstanding patient care on the wards whilst improving practice, through research and at a national level.

Three months in, it was clear this was not my reality. I was quickly drawn into the task fixated notions of the hospital wards; meeting organisational demands as opposed to that of the patients. I found myself dictated by the tasks; trying to complete them all in the day to have some sort of sense of achievement at the end of my shift. Interestingly, it was this poor clinical experience that influenced the basis of this inquiry.

Luckily, due to my clinical academic role, I was able to take time out of the clinical setting and spent this time reflecting on the practices I saw, whilst also scanning the literature for a gap that needed addressing. It was during this initial search that I started to realise that the feelings I experienced daily were a widely reported phenomenon in nursing. I found numerous reports of nursing staff feeling overworked and undervalued in the literature, mixed with continued failings of care being reported, specifically with regards to dementia care. What I found most compelling was that the nursing staff stated they "wanted" to provide good care, it is unlikely for someone to enter a career in nursing without wanting to make a positive difference to the people in their care – so why in practice do we continue to see these downfalls?

After completing some scoping reviews, I found that the endless consensus from both the evidence base and my colleagues that there was a lack of time to work closely with patients due to work demand with the only suggested solutions being more money and more staff. I found it odd that this was just accepted by researchers and clinical staff – yes, I had worked shifts where the staffing levels were low but I had also worked shifts where the ward was fully staffed and yet we continued to face the same challenges. I knew that more time and increased staffing couldn't be the only solution to this problem and I knew that an increase in funding was unlikely. I started to question whether anyone had explored the current influences over nursing care and found that although some reviews were conducted in acute wards, the evidence base was limited in Medicine for Older Persons wards. The studies that were available had not explored the actual work system of the wards in any great detail and although aspects of the work system had been mentioned in isolation, there were limited reviews of the work system as a whole. The studies also tended to focus on the care being provided as opposed to the influence on the nursing staff themselves.

Following the literature search, informal conversations with colleagues and discussions with my supervisors, this soon became the focus for my research. It was not only the gap in the literature that prompted the core focus of this inquiry but a culmination of my personal ambitions, my professional experience and my passion to provide a high level of care for people living with dementia.

1.3 Study Aims and Objectives

The aim of this study was to explore what influence the work system had on nursing staff capacity for relational care with people with dementia on the Medicine for Older Persons wards. The study objectives are as follows:

1. To identify and describe the factors of the work system within Medicine for Older Persons wards that influence nursing work
2. To explore how work system factors influence nursing work
3. To explore what effect this influence is having on nursing staff and their individual capacity to provide relational care

1.4 Phases of the Study

This section will describe the order of events that occurred whilst undertaking this research study. The ethnographic study took place over a five-year period during the years of 2014-2019 and consisted of three main phases of data collection: observations, interviews and reflection. The way in which this thesis is written indicates the order in which each phase occurred and although this seems very succinct, in reality, different aspects of the study were not as linear. However, for ease of reading it has been written in this way.

1.4.1 Prior to data collection

Although this was a five-year project, it was not until the end of the second year that data collection took place. The first year of the research study was spent scoping the literature and trying to find the direction of the inquiry. Once this was decided, a Patient and Public Involvement group was assembled to help guide the research. This group consisted of carers for people with dementia who attend a carer's group with the hospital. This group met formally at the beginning of the research to discuss the topic, the current need for the research and the logistics of the proposed study.

Following this, the second year was mostly preparing and revising the ethics application. Eventually ethical approval was granted, and data collection could begin. The first month of data collection was spent building rapport with ward managers and members of the team on the proposed study wards, introducing them to the study and disseminating information literature. All of the individuals were very welcoming and made it clear that my research was very much needed in this environment which helped me to establish myself as an (albeit external) member of the team.

1.4.2 Phase One: Observations

The first phase of the data collection began in January 2017 and continued until September 2017. The purpose of this phase was to be immersed in the work of Medicine for Older Persons wards, observing the care given to people with dementia by nursing staff and identifying the features of the work system that were having an impact on nursing work. This phase took place over three wards and the observations occurred between 8am and 10pm, 7 days a week. The data were collected in the form of field notes, with reflexive comments recorded alongside to keep track of any personal influences, as well as identifying any underpinning themes that were witnessed. During this time, informal conversations took place with both the patients and the nursing staff to gain an insight into their experience, which also contributed to the data set. After 9 months and100 hours of observations the data were analysed thematically and used to inform and create the interview guide used in phase two as described below.

1.4.3 Phase Two: Interviews

The second phase of the study started in December 2017 following the initial analyses of phase one data. This phase consisted of interviewing nursing staff, both nurses (of all grades) and health care support workers. This phase continued until March 2018 when again it was felt that data saturation has been reached. It is worth mentioning that these interviews came at quite a difficult time for the hospital due to winter pressures, there was a greater number of patients being admitted and shifts were increasingly understaffed which was having a great effect across all aspects of the organisation. This put a strain on the recruitment numbers for the interviews. Nether the less, an overall data set consisting of 23 interviews was achieved. Once all the data were collected; analysis took place, again in the form of thematic, to understand nursing staff views on the influence of the work system. These results were them combined with the data collected in phase one to draw conclusions which were then related to the wider evidence base and relevant theory.

1.4.4 Analysis

Following the collection of both data sets, the secondary analysis phase took place in April 2018. In reality, analysis was ongoing throughout the study, however, a formal analysis stage at the end of the data collection ensured the conclusions drawn were based on the findings and the findings developed were true to the data.

1.5 Introduction to Individual Chapters

Chapter 2 provides the contextual detail to the study, introducing dementia care in hospital and the concept of relational care. This chapter also reflects on the current social and political context and examines the policy initiatives that focus on relational care for people with dementia in hospital.

Chapter 3 focuses on the current evidence base surrounding relational care for people with dementia and comprises the literature review for this study. This chapter provides the details of the meta-ethnography which was undertaken to explore what is currently known about the influence of the work place on nursing work in hospitals. This chapter highlights the gaps in the current knowledge base which include a lack of studies exploring specialist older persons wards, a lack of studies that focus on people with dementia and a lack of studies that analyse the work system as a whole.

Chapter 4 outlines the ethnographic approach taken, and the methods of data collection used within this study. This chapter also outlines what actions were taken to ensure that the study was ethical, as well as identifying how the findings can be generalised.

Chapters 5-8 illustrate the findings of this research. These chapters reflect on the data from both the observations and the interviews to provide an in-depth understanding of the Medicine for Older Persons wards and explore each objective individually. These chapters focus on the factors of the work system of the wards studied, how these factors influence nursing capacity for relational care with people with dementia and how this affects nursing staff.

In Chapter 9, the findings from the previous 4 chapters are discussed further and their theoretical and empirical significance are explored. The findings are discussed with relation to other empirical studies as well as in relation to theoretical context including theories of marginalisation and high demand-low control environments. This chapter will also highlight the unique contribution that this study has made, as well as identifying the strengths and limitations so that the weight of the claims made can be assessed.

Chapter 10, the final chapter of this thesis, highlights the implications of this research for policy, practice and research with recommendations made for consideration from the reader. The chapter will end with a summary of findings and a final concluding statement.

Chapter 2 An introduction to relational care for people with dementia in hospitals

2.1 Chapter Introduction

This chapter will introduce relational care for people with dementia in hospital focusing on both UK policy context and the wider literature. The chapter will start by giving an introduction to the prevalence of people with a diagnosis of dementia in hospitals. The chapter will then identify a definition for relational care by drawing on theoretical frameworks within the evidence base. This will be followed by a discussion and critique of the policy context surrounding relational care, specifically for people with dementia, within the United Kingdom.

2.2 Prevalence, projections and a statement of the problem

As a consequence of the increasing average age of the population, it is estimated that there are now 35.6 million people living with a dementia worldwide (Alzheimer's Society 2018). There are approximately 850,000 people living with dementia in the UK alone and this number is expected to increase to 1 million by 2025 and 2 million, by 2050. (Alzheimer's Society 2018). Dementia is much more prevalent in older persons, with a risk of 1 in 14 over the age of 65 and 1 in 6, over the age of 80 (Alzheimer's Society 2018). There are national concerns that this significant growth in the numbers of people living with dementia will have negative effects on the UK economy and the families facing dementia (DH, 2015).

The rising prevalence of dementia has led to a greater influx of patients with dementia throughout hospital settings (Department of Health 2009), (Thompson and Heath 2013), (World Health Organisation 2012), with an approximate 1 in 4 hospital beds occupied by someone with a diagnosis (Department of Health 2009). A survey conducted by the Alzheimer's Society in 2009 revealed that out of 1,1,36 nursing staff, 97% of respondents stated that they are always caring for someone with dementia at any given time (Alzheimer's Society 2009) and this will have only increased in recent years. Due to this increasing prevalence of people with dementia in hospitals, providing high quality care for this patient group is now a world-wide public health priority (World Health Organisation 2012) and several countries, including England, Scotland and Wales, have launched national strategies on dementia and dementia care (Department of Health 2009, Scottish Government 2011, Welsh Assembly Government 2011).

Despite the increase in patients with dementia into hospital settings and attempted government strategies, many reports suggests that hospitals remain ill equipped to provide a high standard of care (Park, Delaney et al. 2004). Older people living with dementia usually have three or more physical comorbidities (Mukaetova-Ladinska, Teodorczuk et al. 2009) and as a result, their diagnosis of dementia is generally not the primary reason for admission, nor is it a care or treatment priority (Timmons, O'Shea et al. 2016). The fact that dementia is not a priority is often reflected in patient's care trajectory. It is well evidenced in the literature that patients with a diagnosis of dementia have poorer outcomes than those with no cognitive impairment (Alzheimer's Society 2009) with hospital admissions usually associated with further cognitive and functional decline, increased likelihood of discharge to a long-term care setting and higher mortality rates (Sampson, Blanchard et al. 2009, Manning, Timmons et al. 2014).

People with dementia who are admitted to hospitals do not just have poorer outcomes but research has suggested that they also receive a poorer quality of care, particularly with regards to the nurse-patient relationship. Ongoing work over the last 30 years has demonstrated that providing relational care for older people in hospital remains elusive, with research suggesting it is still difficult to objectify and universalise what exactly it entails (Zeitz, Kitson et al. 2011). The relational aspects of care in hospital for older persons have received particular scrutiny in recent studies with reports identifying ongoing failures (Hall and Maslow 2008, Lakey 2009, Francis 2010, Maben, Adams et al. 2012).

2.3 A theory for relational care

Since the beginning of the 21st century, the terms "personhood" and "person centred" have been the foundation of guidance for nursing care. The increased focus on this approach, particularly in regards to older persons, has influenced a range of care environments over the last 30 years including long-term care (Henderson and Vesperi 1995), learning disability (Williams and Grant 1998) and even more particularly, dementia care (Kitwood 1997). Despite this assumed level of influence that person-centred care holds within nursing, more recently there has been a renewed focus on the nurse-patient relationships, with a shift away from the idea of person-centred care and an increased emphasis on relational care. Critiques have now argued that patient centred care is evangelical, as it expects professionals to know what it is like to be their patients, which is unrealistic. Others have claimed that the term "patient centred care" is often used in healthcare, however, there is often little understanding of what it actually entails (Sidani and Fox 2014).

As a result of the critiques of person-centred care, there has been a recent movement away from this concept, into a more collaborative, relationship centred approach to healthcare. Relational care is often defined as the backbone of nursing (Kinnear et al, 2014) and it is key to shaping service user experiences of health and social care (Bridges, Flatley et al. 2010). The importance of the nurse-patient relationship is well established within the literature with many theorists stating it is central to humanising and improving health care, as well as creating positive patient outcomes and increasing organisational performance (Peplau 1952, Altschul 1971, Travelbee and Travelbee 1971).

Many theorists have attempted to conceptualise the ideas of relational care and tested these ideas within nursing practice, however, only few have left a lasting impression. Previous debate has discussed whether there is actually a need for a model of relational care, with the argument being that it the basis in which nursing sits (Norton, McLaren et al. 1962). However, in the current healthcare climate, where the population is living longer and there is an increased emphasis on the management of the ageing population (Minkler and Fadem 2002, Nolan, Ryan et al. 2002) there remains the question of how success can be achieved, particularly with regards to nursing care. It has been agreed amongst theorists that relational care is, at its most basic level, what drives the interpersonal aspects of giving care and is about making connections between professionals, patients and carers, however, what makes relational care most difficult to define is that it cannot be attributed to tasks. Relational care is therefore, most noticeable in its absence, when connections are not made, relationships break down and quality of care reduces (Jacques 1993, McWhinney 1989)

Although theorists argue that there is a dissonance between person-centred care and relational care, the approaches are not dissimilar and the importance of patient autonomy is valued within both approaches. The difference however, is that relational care situates individuals within a matrix of social relationships (Clark 2002, MacDonald 2002) and emphasises the development of partnerships between patient and professionals, rather than a focus on the individual in isolation. Most of the literature distinguishes relational care from person-centred care in the following ways: the focus is on how the patients and health care professionals relate to one another, relationships are viewed as therapeutic and a medium of care, patients are active participants within the caring relationship and that interactions influence the course and the outcome of care (McGilton & Bowers 2008, Solkardis & Adler 2016). Although this approach is more focused on relationships, it continues to recognise the uniqueness of individuals but in addition, also values their "interconnectedness and partnership" with others (McCormack 2017) and doesn't dismiss the interdependence that people have on one another, which is something that the concept of person-centred care seems to neglect.

During the 1990s, the need for relational care was heightened following a desire for a new way in which care was viewed and delivered. Following the recognised failures of the healthcare system in providing a level of care that met the needs of individuals, the Pew-Fetzer task force was set up in the US, to establish a new approach to care that integrated psychological, social and biological factors (Tresolini and Force 1994). As a result, a new model for health care delivery was proposed named ‘relationship-centred care’, which reflected the ‘importance of interactions amongst people as the foundation of any therapeutic or healing activity’ (Tresolini and Force 1994). The Pew-Fetzer task force focused on three dimensions of relationship centred care: patient-practitioner, community-practitioner and practitioner-practitioner (Tresolini and Force 1994) concentrating on collaboration, reciprocity and the communication between health care professionals and patients.

Following on from the work of the Pew-Fetzer task force and in the 1990’s, through the work of Nolan, a potential practice framework for relational care was developed. The *Senses Framework* created by Nolan in 1997 is perhaps one of the most quoted frameworks for relational care within the evidence base. Nolan (1997) believed that previous theories for relational care did not have a clear direction and thus the senses framework *(see table 1)* was developed in order to address these limitations, providing more direct goals for both patient and staff. The term senses was purposely chosen to reflect the subjective nature of important care factors experienced by both those providing the care and those receiving it. Nolan suggested that if all these senses were experienced then the result would be an improved nursing workforce and consequently a higher quality of care for patients (Nolan 1997).

Since its development in 1997 the framework has been subjected to extensive empirical testing. In 1999, Davies et al, highlighted its value in the acute care setting, stating that although the factors that create these senses may vary between contexts and amongst individuals, the senses themselves remain prerequisites for successful relationships and high quality care (Davies, Nolan et al. 1999). Following on from this study, Nolan himself, conducted an extensive literature review in 2001 to identify exactly what each sense involved (as shown in Table 1). Since the development of this, the senses have been subjected to further empirical study involving focus groups and workshops with different practitioners, carers and older people to ensure that it captures the factors in relational care that individuals find most important, in which it has continuously proved it success (Nolan, Ryan et al. 2002).

Table 1: Senses Framework for patients		
Senses	**Client Group**	**Description**
Security	Older persons	Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort
Continuity	Older persons	Recognition and value of personal biography. Skillful use of knowledge of the past to help contextualize present and future
Belonging	Older persons	Opportunities to form meaningful relationships, to feel part of a community or group as desired
Purpose	Older persons	Opportunities to engage in purposeful activity, the constructive passage of time, to be able to pursue goals and challenging pursuits
Fulfillment	Older persons	Opportunities to meet meaningful and valued goals, to feel satisfied with one's efforts
Significance	Older persons	To feel recognised and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'

Moving on from Nolan's work, in 2010, an appreciative action research study conducted by Dewar and MacKay articulated the strategies used by staff on the acute ward that enhanced compassionate, relationship centred care for older persons on the acute care ward. The study found three core care processes that were important for staff, patients and families: "knowing who I am and what matters to me, understanding how I feel and working with me to shape the way things are done" (Dewar & MacKay 2010). Although these concepts appeared new, their foundations match the work of both Nolan and the Pew-Fetzer task force, with a focus on collaboration and reciprocity and particularly with regards to the senses of continuity, belonging, and purpose. These three senses focus on knowing the person as an individual, allowing them to feel part of a community and providing opportunities to engage in pursuing particular goals, all of which allow for a greater knowing of the individual and allowing them to "shape the way things are done" (Dewar & MacKay 2010).

Similarly, in a systematic review and synthesis of qualitative studies focusing on quality of care, Bridges et al, (2010) found that relationships with the staff were the key feature of the acute care experience for both the patients and their carers'. The review found that older people in hospital often feel worthless, fearful and as though they have lost control when relational care is not provided and suggested that it was this that determined whether individuals would have a positive or negative experience of care (Bridges et al, 2010). As an outcome, the study highlighted the importance of relational aspects of care, specifically the need to create communities "connect with me", maintain identity "see me" and ensure shared decision making "include me" providing an experience-based framework for nursing practice. Again, these concepts are not far removed from the concepts identified by Dewar and MacKay and from Nolan, again focusing particularly on the seeing patients as individual, forming meaningful relationships and providing opportunities to guide the way in which their care is provided.

There are clearly several different theories regarding relational care, however, as evidenced above there are similar foundations that underlie the concepts within them. The senses of continuity, “see me”, belonging “connect with me” and purpose “include me” all align with MacKay’s core care process of “knowing who I am and what matters to me, understanding how I feel and work with me to shape the way things are done” (Dewar & MacKay 2010). Beneath these foundations and undoubtedly the underpinning for relational care is interaction, which was highlighted by the Pew-Fetzer task force who focused on the communication between health care professionals and patients. Relational care can therefore be found in the interactions between staff and patients and the ability of staff to recognise the individuality of each participant and acknowledge the contribution that the individual can make. These significant interactions that focus on understanding personal biography (see me/continuity), creating meaningful relationships (connect with me/belonging) and providing opportunities for contribution (include me/purpose) are what this study will focus on as an indication of relational care.

2.4 Policy context

As explained in the previous section, within the evidence base there has been a renewed focus on relational care, particularly for people with dementia and the foundations of high-quality care is now the nurse-patient relationship. Although this is what the evidence base is now stating, it is important to examine how the UK healthcare system views relational care and what effect this could be having on the ways in which nursing staff work[1]. This section will focus on the key policy documents within the UK that have had, or are having an influence on the way in which people living with dementia are cared for within the hospital setting and analyse how relational care is documented within them. These papers, (as identified in Table 2) provide recommendations for healthcare professionals within the UK, suggesting evidence-based approaches and interventions that NHS organisations are required to use to inform dementia care provision within their hospitals:

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[1] This is particularly pertinent within this research as the study took place within a NHS Hospital. NHS hospitals are closely regulated by national governments due to being funded through public funds.

Table 2: Key Policy Documents that have influenced dementia care in hospitals in the UK.	
Document	**Key Recommendations**
NICE/SCIE (2006)[2] Guideline on supporting people with dementia and their carers' in health and social care	• Ensure that care provided is person centred and tailored to each individual • Acute care trusts should plan and provide services that address specific personal and social care needs of those who use their services. • Ensure health and social care professionals are properly trained in both communication and person-centred care
The National Dementia Strategy (2009) Living well with dementia	• Provided advice and guidance to health and social care commissioners and providers in order to improve dementia care. • The report focused on three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. • 17 key objectives to ensure improvement in quality of services provided to people living with dementia
Prime Minister's Challenge on Dementia (2012)	• Focused on three key areas: Driving improvements in health and social care, creating dementia friendly communities that understand how to help and improving research.
State of the Nation Report on dementia care (2013)	• Assessed the progress of Prime Minister's Challenge since 2012 • Highlight that further improvement was needed in: diagnosis, assessment and treatment, research and care of people with dementia
Prime Minister's Challenge on Dementia 2020 (2015)	• 18 aspirations to be put into place by 2020 to ensure England leads the way in dementia care and support as well as being the best place in the world to undertake research into dementia.

The development of National Institute for Health and Care Excellence (NICE) and Social Care Institute for Excellence (SCIE) guidance on supporting people with dementia and their carers in health and social care offered set of clinical guidelines and best-practice advice on the care of people with dementia both in the community and in care settings, focusing mainly on diagnosis but also paying some attention to post-diagnosis care.

The main underpinning principle throughout the guidance was that of person centeredness and within this, the importance of building relationships and increasing communication. The document refers to the use of dementia care mapping as a tool to evaluate the care and suggests this should be

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[2] Since the development of this thesis, this NICE guidance has been updated. The decision was made not to include this policy document as it was not published at the time of data collection and therefore had no influence over the care being provided: https://www.nice.org.uk/guidance/ng97.

used to ensure that there is a person-centred approach to care. There are also further recommendations that state that person-centred care should be encouraged as a way of managing behaviour that challenges and should be at the forefront of staff training, however there are no recommendations to how this could be achieved.

Throughout the document, there is little emphasis placed on relational care. The policy document does recognise the importance of and refers to a “good therapeutic relationship” between the staff, patients and carers and the document also states that the quality of relationships with service providers is the most important factor at every level of service delivery. Despite this and similarly to relational care, the policy provides minimal guidance specifically based in the acute hospital facility with the recommendations provided failing to provide tangible measures for hospitals to abide by. The guidance was influential in setting the standard for dementia care in the UK, however, there was little advice on who would make these changes, how they would be implemented, how to measure their effectiveness and with no allocated funding to do so.

Following on from the NICE guidance in 2006, the Department of Health developed *Living well with Dementia,* a strategy aimed at providing guidance to health and social care commissioners and providers. The report contained 17 objectives that, if implemented, were thought to improve the quality of services for people living with dementia, with Objective 8 focusing specifically on the care in general hospitals. The strategy proposed the appointment of a senior clinician, who would take the lead for quality improvement in dementia care in each hospital trusts, as well as the development of an explicit care pathway for the management of this patient group throughout their admission trajectory. Similarly, to the NICE Guidance in 2006, the term patient centred care was referred to and there was emphasis placed on the importance of relationships between nursing staff and patients, however, once again there were little guidance and a lack of tangible suggestions in place to ensure achievability.

Although the guidance in this strategy was more distinct and measurable in some areas, there were inconsistencies with regards to the guidance surrounding relationship centred care with more emphasis placed on person centred care. In addition, there were insufficient funding regulations to ensure its implementation. Despite additional money being allocated to commissioners of services, primary care trusts were subsequently unable to demonstrate how the national dementia strategy funding was spent and what improvements were made (House of Commons All Party Parliamentary Group on Dementia, 2011).

The next significant strategy aimed at improving dementia care in hospitals was the Prime Minister's Challenge on Dementia (2012). A programme set out to improve both care and research focusing on three key areas: driving improvements in health and social care, creating dementia friendly communities and increasing research capacity. Of the 18 aspirations, six were focused on awareness raising of communities, organisations and businesses; one focused on diagnosis; another on prevention and risk reduction; eight on research and only two on post diagnostic care and support.

There was a greater emphasis placed on relational care, particularly for use in care homes and domiciliary care. One of the key commitments (Commitment 4) aimed to improve standards of care, with 10 organisations setting commitments to deliver high-quality relationship-based care. Although the guidance had improving relational care as a commitment, the targets were again vague and unmeasurable with more emphasis placed on diagnosis than post-diagnostic support. The guidance was also tailored to the care home sector as opposed to the hospital sector and recommendations were not transferable based on the difference between the two settings.

In 2013, the success of this agenda was assessed and the State of the Nation Report on dementia care and support in England was published by the Department of Health. This report stated the areas that needed further rapid improvement, again highlighting the need for earlier diagnosis, better assessment, more research and an improved management of care, however, with little advice on how to do so.

In 2015, the Prime Minister's Challenge on Dementia developed in 2012 was built upon. The Prime Minister's Challenge on Dementia 2020 set out another 18 key aspirations to be achieved by 2020. These aspirations outlined what needed to be put in place to ensure that England was leading the way in care and support for people with dementia, their carers' and families. This time, three out of the eighteen aims were aimed at post diagnostic support, specifically in hospital care:

- All people with dementia to have meaningful care post diagnosis, which supports them and their family carer
- All health and social care staff to receive training on dementia appropriate to their role.
- All hospitals and care homes to become dementia friendly

A recent government review of the aspirations in 2018 reported success in some areas but a lack of improvement in others (Public Policy Exchange 2018). Again, research into diagnostics was reported to have increased, accompanied by an increase in diagnosis, however, what remains is a lack of post-diagnostic support. The review highlighted that there had been a reduced use in antipsychotics by around 10% in hospitals, however, the question of whether care and support had improved is yet to be answered.

2.5 Relational care in hospital

Despite the continued reports and the ongoing policy drive, research studies conducted within the last 10 years have continued to highlight the same themes with regards to relational care for people living with dementia. There is a wealth of studies within the literature that suggest that hospital wards are not a suitable setting for older persons (Maben et al. 2012, Tadd, et al. 2011) and in particular people with dementia. Substantial evidence in the literature suggests that the problem lies within the “impoverished environment”(Nolan, Ryan et al. 2002) in which the care for older persons takes place. Challenges such as high levels of complexity in patients, combined with low staffing have been blamed for failures of quality care and nursing staff in in UK NHS settings consistently cite environmental factors, specifically time constraints, as the biggest barrier to effective relational care, followed closely by a lack of staff (West et al. 2005, Lakey 2009, Esmaeili, et al. 2015, Jones, et al. 2015).

One of the first detailed reports was the *Counting the Cost* report published by the Alzheimer’s Society in 2009 (Lakey 2009). The purpose of the report was to provide evidence that there was a need for a greater governmental focus on improving hospital care for patients with dementia. The data were gathered in the form of surveys with a response of over 2000 nursing staff including health care support workers, nurses and nurse managers. The report provided demographic data with regards to people with dementia in hospital, suggesting that older persons wards have the highest proportion of patients with a diagnosis, estimated at 1 in 3 beds (Lakey 2009). The report also provided evidence of poorer outcomes for people with dementia when admitted, including an increase in the prescription of anti-psychotic drugs, increased length of stay and increase in mortality.

Although the report did not focus on relational care explicitly, one of the key areas for concern was the provision of person centred care and the interaction with nursing staff. 68% of respondents stated they were dissatisfied with the recognition of the person with dementia as an individuals, combined with 62% of respondents being dissatisfied with the opportunities for social interaction (Lakey, 2009). The report not only outlined the concerns for patients but also highlighted the challenges as reported by nursing staff – 23% of nursing staff responded that communication was a challenge and 89% of nursing managers suggested that nursing staff did not have enough time to spend with patients. Although there are questions of the bias of these results due to the methods used to collect data, the study does provide an insight into the challenges that nursing staff face when caring for people with dementia in hospital, the study was conducted in the form of a survey and therefore the realities of the ward were perhaps missed. The study also provided no further exploration as to why these challenges occurred and therefore recommendations to improve practice were elusive.

Following on from the *Counting the Cost* report, an ethnographic study was conducted exploring the experiences of patients and nursing staff of the care received by older people with dementia in acute hospitals (Cowdell 2010). The focus of the study was care in general, however, Cowdell (2010) did review the interactions between staff and patients. The findings highlighted how interactions were dominated by the delivery of tasks such as personal hygiene or nutrition and were often patronising in tone. The study also made reference to the contextual factors of the acute care ward, alluding to how they may affect the quality of care. Factors such as having set targets that needed to be met which overshadowed individualised patient care, as well as strict routines which caused a lack of flexibility in nursing work. Although the study did provide a general overview of the care on Medicine for Older Persons wards, it lacked precision in its focus and therefore recommendations were again quite elusive. Cowdell (2010) suggested that further research was needed in this poorly understood subject area, noting the ambiguity of the findings.

In 2011, Tadd et al, conducted an ethnographic study on four hospital wards across England and Wales to explore the experience of dignity in the acute care setting for older persons. The study consisted of 617 hours of ward observations as well as interviews with frontline/senior staff members and recently discharged older people and their family. The findings of the study related to four overarching themes: whose interests matter, right place-wrong patient, seeing the person and influences on dignified care. The themes highlighted the dissonance between the patient’s interests and that of the systemic and organisational factors, identifying that the acute care ward was not a suitable placement for older people in its current state due to environmental, staff skills and organisational processes. The primary focus of the study was that of dignified care and the findings outlined that dignified care for older persons was variable across the wards with no clear pattern as to why. Similarly to other research within the literature base, the study did not directly focus on relational care and more importantly, people with dementia. Although it can be predicted that a lot of the organisational/environmental factors have a similar effect, the difference in the care for people with dementia cannot be understated, highlighting the need for a study that focuses on this patient group.

In 2013, Following on from the work of Cowdell (2010) and Tadd et al (2011), a study that explored multi-professional perspectives on workforce preparation to care for confused older patients in general hospitals by Griffiths et al (2013) found that staff had inadequate training with regards to confused older adults which led to provision of sub-optimal care on the wards. Griffiths et al (2013) interviewed 60 members of the multidisciplinary team to discuss their preparation to care for confused older adults within hospitals. The findings suggested the professionals were unaware of the volume of people who would present with confusion in the hospital environment, explaining that the training they had received had not prepared them for this patient group. The study focused on the effect this had on the professionals themselves which is unique as previous studies tended to focus only on patient outcomes. The findings highlighted themes such as reduced confidence, reduced job satisfaction and reduced psychological wellbeing – all of which impacted on the care received by patients.

Although this study provides interesting insights into the care for confused older adults in hospital, the findings focused on the multidisciplinary team as a whole and therefore it is difficult to distinguish which responses were from the nursing team as opposed to the medical team. Unlike Cowdell (2010) the results focused on confused patients as opposed to patient with a diagnosis of dementia and therefore people with delirium could have been included (Mukadem and Sampson 2011) which could pose a different complexity than people with a dementia in isolation.

In 2014, Clissett et al, conducted an ethnographic study exploring the responses of healthcare professionals to the admission of people with cognitive impairment onto the acute care ward. The study highlighted the complexity of caring for people living with dementia on admission to an acute care ward, describing it as a “disruption”, especially for health care professionals. Within the observations, health care professionals were seen to be managing these disruption through embracing the personhood of the individual, protecting self without jeopardising personhood and suspending the personhood of the older patient - all of which were seen as a way for them to gain back control.

Although this study provides a helpful insight into the way in which health care professionals react towards older people with cognitive impairment, this report did not specifically focus on people with a diagnosis of dementia and a lot of the findings were in reference to people with mental health problems, which cannot be assumed is the same. The wards in which the study was conducted included both general medical units and orthopaedic wards and therefore do not provide an in-depth account of specialist wards for older persons. Similarly to Cowdell (2010), the research was helpful in explaining what staff were doing in response to a disruption in care but details were missing in terms of why this was their reaction and specific details about the context in which this was happening were missed.

In 2014, a similar literature review conducted by Dewing & Dijk that focused on the current state of care for older persons in general hospitals highlighted the continuation of these failures to provide high quality care.   The review of global literature focused on providing person-centred care and reported that factors such as nursing staff attitudes, task fixation, inadequate training, and lack of time all contributed to the failures on the acute care ward. The report did allude to the concept of relationship centred care, with comment being made to the therapeutic relationship between the person with dementia and staff and how this had a positive effect on wellbeing, however, this was not discussed in any detail. The report did, however, suggest that in the acute care ward the idea of person-centred care may be possible, suggesting that different models of care should be explored in greater detail and more systematically.

Similarly, this study did make reference to people living with dementia suggesting that staff found it more difficult to provide a high quality of care to people who were confused, however, this was not the focus of the inquiry and was therefore not explored in any detail. The study findings therefore evidence that nursing staff find the care for people with dementia is different from the care for older persons and therefore again, prompting the need for an inquiry with a specific focus on this patient group.

In 2015, a qualitative study by Porock et al (2015) explored the experience of hospitalisation from the perspectives of people with dementia, their care givers and other patients on the wards (co-patients). Non-participant observations of care was supplemented by 39 interviews with family care givers and co-patients following discharge. The findings illustrated how disruption from normal routine was the core problem facing all those involved – disruption for the nursing teams caused by the behaviour of people with dementia, disruption for the caregivers both inside and outside of the hospital, disruption for the people with dementia who were in an unfamiliar environment and disruption for co-patients who were sharing the space with a person with dementia. This study provides a detailed insight into the experiences of patients and care-givers on the ward but failed to explore the reasons as to why participants had this experience with a lack of focus on the staff themselves. The recommendations for the study suggest that there needs to be an adequate change to the system in which the care was taken place, however, due to it not being the focus of the inquiry, provided no indication into what changes should be made.

A very recent review of the quality of acute care for persons with cognitive impairment (Naef et al, 2018) found that there was continued discrepancy between best practice of inpatient services and the quality of care experience by patients. The study found that the interventions aimed to improve compassionate care were weak in description, lacked methodological quality and had no evidence of effectiveness that merited routine implementation. Naef et al, (2018) suggested that due to the increasing complexity and multifaceted approach to care, quality of care should be more systematically evaluated allowing for particular interventions to be better suited to the environment in which they are being delivered. To be able to improve relational care, a systematic review of the impact of the ward on relational care is needed to understand what interventions are needed to make improvements.

Even more recently, Featherstone, Northcott et al. (2019) reported an ethnographic study (consisting of observations and observational interviews) exploring resistance to care from people living with dementia on acute medical units and trauma and orthopaedic wards. The results of the study not only described the types of resistance that were observed on the ward but also outlined the factors that contributed to this. Although not the main focus, the study highlighted how interactions between nursing staff and patients were limited and the approach to patient care focused on carrying out specific care tasks with the goal of completing the wider ward routine. These findings demonstrated that the reason for this poor relational care was the strict timetabled routines, particularly the tasks of mealtimes, medications and personal care, and suggested that this was actually the trigger for the cycles of resistance (Featherstone, Northcott et al. 2019). The findings also highlighted that there was a lack of continuity and the staff were unable to establish successful ways of working in order to support each individual patient.

Similarly to the previous studies mentioned in this chapter, the findings also failed to explore staff experience in any detail. Although the study did involve observational interviews with staff, there was limited exploration into staff experience of their work and the focus was the care itself, again suggesting a further gap in the literature that needs addressing. Although this study provided some evidence regarding relational care for people with dementia and the effect that the ward context has, the findings were limited to the acute medical unit and trauma and orthopaedic wards. Within the study report, Featherstone, Northcott et al. (2019) commented on the idea that specialist wards[3] should be more able to support people with dementia as the staff should be able to provide

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[3] Medicine for Older Persons or Dementia Specialist Wards

high quality care however, within the discussion identified that this was a gap in the literature that had not been explored in enough detail.

A study that has focused on specialist wards and the difference from started care for older people was conducted by Goldberg et al, in 2013. The study comprised of a randomised control study within a large general hospital in the UK, with patients admitted with confusion being allocated to either a specialist unit or “standard care” ward. A total of 310 patients were recruited to the study with finding indicating that although there was no significant difference in days spent at home or in health status, there was a difference in patient experience of care and with family carer’s satisfaction. The findings indicated that further economic analysis was needed if healthcare settings were to invest in specialist units, however, identified that there was no evidence that increased staffing costs might be offset by the reduction in hospital use. In the current climate where economic factors are at the forefront of healthcare organisations, there needs to be a greater focus on how we can adapt what we already have to improve the care for people with dementia, within the resources that we already have. With 1 in 3 hospital beds on older person’s specialists ward being occupied by someone with dementia and relational care being the gold standard, more exploration is needed to explore what the quality is like for this patient group within these settings.

2.6 Chapter Summary

This chapter has provided an introduction to relational care for people with dementia in hospitals. The chapter has illustrated how the number of people living with dementia is rising and because of this the number of people with dementia being admitted to hospitals is increasing.   Providing a high quality of care for this patient group is now a priority within hospital organisations and both research and government policy has attempted to support that. There is a consensus within the literature that quality care is mediated through the relationship between staff and patients. Theory indicates that relational care is based on staff seeing patients as individuals, developing meaningful relationships with them and involving them in care decisions. Relational care is therefore based on the interaction between nursing staff and patient and it is these interactions that the study will focus on.

Although the UK policy context of dementia over the last ten years is substantial and recommendations for improvements have been made, it is clear that where care and post diagnostic support is concerned, there has been little progress. The focus on diagnostics has led to an increase in the number of people being diagnosed, however, providing effective post-diagnostic support, particularly a higher quality of care particularly in hospitals remains elusive. The current policy climate remains ambiguous with regards to relational care and although person-centred care is alluded too, it is more in terms of service organisation rather than approaches to the care itself. There are no frameworks mentioned within the policy context, despite the underpinning foundations to relational care mentioned in the sections above. The policy documents and guidelines provide sweeping statements that refer to the need for health care professionals to provide relational care, however, with little support or guidance on how to do so. Is it therefore no wonder that there continues to be ongoing reports of poor care, particularly with regards to the relational care.

This chapter has demonstrated that the current evidence base consists of a wealth of studies that explore quality of care as a whole, however, there are some limitations and so an important gap remains in the knowledge base. Firstly, the wards in which each of the studies took place are very varied and although some studies did focus on specialist older persons wards, these were often mixed with both acute and general medicine wards and therefore it is difficult to distinguish whether there are any differences between them. Most of the studies focus on what is currently happening with regards to quality of care with little exploration into the reasons why. Although an understanding of the care being provided is needed, the use of this to make changes is limited without an exploration into the reasons *why* care is being provided in this way. In addition, all of the studies had patient outcomes as a focus but failed to focus on employee outcomes and therefore the nursing staff voice is being missed. All of these factors that were not considered in these studies are gap in knowledge base that need addressing.

The following chapter will explore more explicitly what is known about the context of the hospital ward environments and the effect on relational care, specifically for older persons.

Chapter 3 The challenges of providing relational care to people with dementia in hospitals – A review of the literature

3.1 Chapter Introduction

The previous chapter has demonstrated that providing relational care for older people and more specifically, people with dementia is a priority for UK hospital organisations, however, from ongoing reports it is clear that this remains a challenge. The evidence from the literature suggests it is due to the ward environment and more significantly ward factors such as a high demand of work (Maben et al, 2012), organisational needs (Tadd, et al 2011), disruption (Porock et al 2015) and the routinised structuring of the nursing (Featherstone, Northcott et al. (2019).

Despite this, the impact of the work system was never the main focus of the study inquiry and therefore this section of the thesis will now review the literature that focuses specifically on the influence of the work system on relational care. In order to analyse the literature systematically, a meta-ethnography has been conducted which has allowed for a better understanding of the gap in the body of knowledge that this research has gone onto address.

3.2 Search Strategy

This review has followed on from the work of Bridges, Nicholson et al. (2013) who conducted a meta-ethnography with an aim to synthesise evidence and knowledge from published research about nurses' experiences of nurse-patient relationships with adult patients in the hospital setting. This original review was conducted between the years of 1999 and 2009 with findings relating to clinical settings and emotional impact. The review articulated how the organisation was having an effect at unit level and had a strong influence over nursing staff capacity to build relationships, stating that improvements should focus on optimising organisational conditions.

Although this review provided a good insight into the contextual factors effecting nursing capacity, the review did not focus explicitly on older people or people with dementia. The review did identify this patient group as having higher needs and stated that nursing staff felt unsupported and ill-equipped to provide a high quality of care within the circumstances, however, this was not explored in any detail. A review that helps to build the understanding of the barriers of the work system that impact on relational care for this group in particular is much needed, particularly within the last ten years where the population age is increasing and admissions of this age group into hospital is at an all-time high. As a result, this review has filled this identified need and explored the factors of hospital ward that affect nursing staff's capacity for relational care on hospital wards with older persons between the years of 2009 and 2018.

3.2.1 Meta-Ethnography

The methodology chosen for this review was a meta-ethnographic synthesis as described by Noblit & Hare (1988). In recent years qualitative methodologies have become more commonplace within healthcare research proving their worth for both service evaluation and improvement (Hannes and Lockwood 2011). The term meta-ethnography describes a synthesis method in which researchers select, analyse and interpret qualitative studies in order to provide robust evidence on beliefs and experiences of complex social phenomena. As a result of this, qualitative syntheses are becoming increasingly used to provide evidence that underpins healthcare policy and practice (Downe, Finlayson et al. 2016) and is a suitable method for this review.

The term meta-ethnography was coined by Noblit and Hare (1988); ethnographers who were primarily interested with working with metaphors, however, meta-ethnographic syntheses are not limited to ethnographic studies alone. Meta-ethnographies sit firmly within the interpretative paradigm and therefore the focus is understanding the world as it is from subjective experiences of individuals. This type of review therefore includes research formed of ethnographic, interactive, qualitative, naturalistic, and hermeneutic and phenomological inquiries (Noblit & Hare 1988). These types of studies focus on explanations for social or cultural norms, are usually based upon the perspectives of participants and rely on "thick description" (Geertz 1973) provided through qualitative methods.

Noblit & Hare (1988) outlined a seven-step process for conducting a meta-ethnography which informed the basis for this inquiry *(figure 1).* Noblit & Hare (1988) suggest that for a meta-ethnography to be successful, the question of focus must be specific and concise. The first step of the meta-ethnography process is to find a question that is focused and succinct. On review of the broad literature as discussed in Chapters 2 and 3 it has been decided that the specific question for this

1. Getting Started
2. Deciding what is relevant
3. Reading the Studies
4. Determining how they are related
5. Translating the studies into one another
6. Synthesising Translations
7. Expressing the synthesis

Figure 1 Seven Steps of Meta-ethnography

synthesis is: What contextual factors affect nursing staff capacity for relational care on older adult inpatient wards?

3.2.2 Deciding what is relevant – Initial Searching

The initial literature search was conducted in March 2015 prior to the commencement of the research, followed by a review in May 2018 to ensure no further studies has been published. Literature was identified through searches of both online databases and hand searches of reference lists of papers retrieved. The databases used were: CINAHL, Medline, PsycINFO and Web of Science.

All findings were limited to the English Language and must have been published between 2009 and 2018. As this study was a meta-ethnography, all studies had to use qualitative methods to explore experiences and as a result, must have reflected the perspectives of nursing staff (registered nurses/ health care support workers) and/or patients. The main focus of the article must have been the effect of contextual factors on the nurse-patient relationship and it must have been based on findings within a hospital setting in which older persons were present (i.e. not children's or maternity). Papers were excluded from the review if they were not research based or had not been published in a peer reviewed journal.

The titles and abstracts (where available) of items found during the initial search were scanned and relevant items retrieved. A total of 17 papers were yielded during this initial search following the removal of any duplication. Once this initial scope was conducted the papers were read in full and scrutinised to identify further items for inclusion. Once these were assessed and sorted through, a total of 10 articles were rejected due to a variety of reasons including: no use of qualitative methodologies for the inquiry, the paper was a discussion piece, or the core focus of the paper was not contextual features and the impact on nursing capacity for relational care. During this time, citations searches were also conducted in order to identify any literature that was missed in the initial search.

3.2.3 Reading the Studies and determining how they are related.

Following the initial search and further secondary review a total of seven papers were chosen to be included in this report, *(summary report found in Table 3).* During this phase of the review, repeated reading of the literature took place and recordings of the themes, concepts and metaphors were recorded. Following the first three steps of the meta-ethnography, the next step involved comparing the accounts provided in each study and reviewing the concepts that had evolved from

Stage 3. During this review, each theme or concept was compared to one another to identify any similarities, differences or contradictions.

3.2.4 Translating the studies, synthesising translations and expressing synthesis

Following on from stage 4, the meaning found in the themes were then translated to generate an explanation for the phenomena under inquiry. After the systematic comparing and translating of themes, the next step in the meta-ethnography was to compare the translations to find any commonalities and reach new interpretations. The last stage of a meta-ethnography was to convey the findings which is provided in the next two sections: Results and Discussion.

Table 3: Summary of Literature

Name	Country	Methodology	Main Findings
Baumbusch, Leblanc et al. (2016) Factors influencing nurses' readiness to care for hospitalised older people.	Canada	Six focus groups and an individual interview with 41 registered nurses from emergency medicine, geriatric medicine, general medicine, and tertiary mental health and care transition units.	Nurses have a valuable perspective on what influence their ability to care. The unique needs of individuals, inappropriate staffing, organisational contexts and professional esteem are all related to the care for older persons.
(Clissett, Porock et al. 2013) The challenges of achieving person-centred care in acute hospitals: A qualitative study of people with dementia and their families.	United Kingdom	72 hours of observations on the acute ward in two UK NHS hospitals and 30 interviews after discharge.	The concept of person-centred care needs to be valued both at an organisational and individual level. Health care professionals tend to miss opportunities to provide person centred care.
(Cowdell 2010) The care of older people with dementia in acute hospitals.	United Kingdom	125 hours of observation on three specialist older people's wards in an NHS trust and 18 interviews with both patients and staff.	Nursing staff do not tend to listen to the experience of patients. There needs to be a greater focus on cognitive and affective domains so nursing staff can gain an understanding of how the patient feels and their experience.
(Dahlke and Baumbusch 2015) Nursing teams caring for hospitalised older adults.	Canada	375 hours of observations and 24 interviews with nursing staff on two units. One unit was a medical unit in a community hospital and the other a geriatric unit in a tertiary hospital.	Skill mix and team dynamics had the greatest influence on nursing staff. Further education is needed to assist clinicians to think about team work focusing on roles and communication techniques.
(Dahlke, Phinney et al. 2015) Orchestrating care: nursing practice with hospitalised older adults.	Canada	375 hours of observations and 24 interviews with staff on two units. One unit was a medical unit in a community hospital and the other a geriatric unit in a tertiary hospital.	They are trying to manage the environments in which they work, mobilising older adults and stretching available resources to provide good care. There needs to be a focus on orchestrating this care and share their experience with others.
(Moyle, Borbasi et al. 2011) Acute care management of older people with dementia: a qualitative perspective.	Australia	13 audio-taped interviews were conducted with nursing staff from acute-medical or surgical wards in a large impatient hospital.	Nursing staff consider safety as a priority over dignity and well-being. A risk management approach to care was adopted which reduces person centred care.
(Parke and Chappell 2010) Transactions between older people and the hospital environment: a social ecological analysis.	Canada	43 hours of ward-based observations on emergency, medical and surgical units in a community hospital. , 11 interviews with patients and their care givers and 14 with staff.	Older adults are often not appropriate for the ward environment. Factors such as architectural features, bureaucratic conditions, chaotic atmosphere and hospital employee attitude also result in disempowerment.

3.2.5 Results

Of the original 17 studies that were found during stage two of the meta-ethnography, a total of seven studies met the inclusion criteria for this review and were identified as high-quality papers. The research was conducted in multiple countries including the United Kingdom, Canada and Australia. All the studies focused on older persons nursing within the older adult inpatient settings, either acute general medicine or acute older persons medicine wards. All the studies used qualitative approaches in the form of observations, interviews or focus groups.

The first part of the synthesis provided an array of factors that influenced nursing capacity for care, however, once these were translated and expressed it was clear that they fell under five main themes: societal and national context, organisational context, ward level context, staff context and patient context. These five themes will be described in detail below.

3.2.5.1 Societal and National Context

The synthesis findings illustrated how societal context at a national level influenced the ways in which nursing staff were working across the hospital wards. Three of the studies reflected this perception with nursing staff stating that there was a pre-conceived ageist attitude having an effect both on their personal and the organisational beliefs towards older persons nursing (Clissett, Porock et al. 2013, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016). This perceived attitude at a national level was identified as influencing the readiness of staff to care for older persons in hospital, with participants suggesting that older people were often seen as having a higher level of need and consequently being more difficult to care for:

> “An Organisational Leader explained, ‘we have pre-conceived notions about what it is to be old. And I think we come with that baggage as nursing and healthcare professionals” (Baumbusch, Leblanc et al. 2016)

This broader societal context appeared to be influencing the way in which the patients were viewed but was also identified within the two studies as having an influence over the perception of older persons nursing. The studies reflected that older persons nursing was not seen as having a high prestige within the hospital organisation, with nursing staff professional esteem being lower when working in this department compared to other specialities such as intensive care or trauma (Baumbusch, Leblanc et al. 2016).

The studies not only illustrated how attitudes at a national level were influencing care for older persons, but national policy was perceived by staff as affecting their capacity for care. One study identified that health care professionals do not know how to provide good relational care due to an ambiguous policy climate (Clissett, Porock et al. 2013) where person-centred and relationship centred care is discussed in terms of the organisation whereas it should be with regards to approaches to care. Similarly, Baumbusch, Leblanc et al. (2016) suggested that there was a need for recognition by policy makers that the hospital system needs to change to meet the needs of the patients, as opposed, to the patients needing to change to meet the needs of the system as described by Tadd (2011) as “right place, wrong person”.

3.2.5.2 Organisational Context

All seven of the studies identified that the organisational context was influencing the way in which nursing staff were providing care (Cowdell 2010, Parke and Chappell 2010, Moyle, Borbasi et al. 2011, Clissett, Porock et al. 2013, Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016). There was a consensus between the studies that the priorities of the organisation had a significant impact on nursing staff capacity for care with patient safety (Moyle, Borbasi et al. 2011, Dahlke, Phinney et al. 2015) and patient flow (Parke and Chappell 2010, Clissett, Porock et al. 2013, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016) being at the forefront of nursing work.

This synthesis has provided evidence that the organisational priorities can shape the care for hospitalised older adults. Baumbusch, Leblanc et al. (2016) suggest the hospital system provides care for all patients in the same way, despite the diversity of different settings. This was suggested in the other studies with participants in all seven studies suggesting that patient safety was one of the highest priorities within their organisations and stating that this influenced the ways in which nursing staff structured their work. Patient safety was explained as protecting patients from potential harm, whether that be from their illness, the environment or other individuals (Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016):

> “The safety factors... is foremost in our minds.. We’re very concerned to prevent any harm to these folk”(Moyle, Borbasi et al. 2011)
>
> “I have to control them if I’m working as a special, I’m here to keep them safe” (Moyle, Borbasi et al. 2011)

Similarly, to the priority of safety, nursing staff within the studies reported that timely discharge of patients was a high priority for the organisation. The nurses in the studies reported that they were unable to build relationships with patients as their time was spent getting others ready for discharge as this was the wards priority (Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016):

> “They’re looking at the length of stay and how the length of stay is increased and so they’re [the administration] looking at the numbers. There’s a rush to get [older patients] out” (Baumbusch, Leblanc et al. 2016)

> “When participants tried to advocate, recognising the need for older people to have more recovery time in hospital, they were met with the resounding response that the hospital’s priority was to get patients discharged” (Baumbusch, Leblanc et al. 2016)

> “Clinical leaders primarily focused on ‘patient flow’ (RN 6, Site 1)” (Dahlke, Phinney et al. 2015)

The synthesis findings illustrated how organisational priorities were infiltrating to ward level and affecting the way in which nursing staff provide care within the wards themselves. Clissett, Porock et al. (2013) explored this in more detail, suggesting that the organisational priorities had led to nurses becoming more focused on tasks and consequently individualised care was decreasing. In order to improve nursing capacity for care, the findings suggest that more priority needs to be given to the care itself rather than the completion of task and that the staff should feel empowered to use this approach to care delivery.

3.2.5.3 Ward Level Context

The findings of this synthesis indicate that nursing staff capacity to provide relational care was strongly influenced by unit level factors. Although all seven studies alluded to the idea that the acute care ward was not suitable for older persons, three studies in particular stated that the acute care ward was actually detrimental to older persons, suggesting a definite dissonance between the needs of the individuals and the way that care was provided on the ward (Parke and Chappell 2010, Clissett, Porock et al. 2013, Baumbusch, Leblanc et al. 2016).

There was a consensus amongst the studies that older persons did not “fit” within the ward environment. In their study exploring nurse's readiness to provide care for older persons, Baumbusch, Leblanc et al. (2016) coined the term “poor fit” to highlight the dissonance between the way care is provided within hospital settings and the needs of older persons. Similarly, in their study exploring interactions between nursing staff and patients, Parke and Chappell (2010) also described a “lack of fit” when discussing older persons within the acute care ward. These terms really highlighted the inappropriateness of the acute care ward for older persons within the studies suggesting that the environment is not physically or culturally ready to meet the needs of this population.

Physical ward environment

Six of the seven studies highlighted that the physical ward environment had a negative effect on nursing staff capacity for care (Cowdell 2010, Parke and Chappell 2010, Moyle, Borbasi et al. 2011, Clissett, Porock et al. 2013, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016). The nursing staff within the studies suggested that the concerns with regards to the physical environment were multi-facetted, however, can be grouped into the following themes: architectural restraints, allocation of resources and lack of person centeredness.

The findings of the study illustrate that the fundamental architecture of the hospital was detrimental to the care for patients. Three of the studies commented on the layout of the wards, with participants commenting on the fact that it was not purpose built (Moyle, Borbasi et al. 2011) with factors such as open corridors (Baumbusch, Leblanc et al. 2016) and exclusion due to bed location (Clissett, Porock et al. 2013) being detrimental to nursing staff being able to care.

> "The managing of the exit-seeking patients on the [unit] where they have exits at the end of the hallways as well as the front unit entrance, staff struggle with this all the time' [OL2]" (Baumbusch, Leblanc et al. 2016)
>
> "Now the ward was beautiful . . . can't fault that. When I went in, everyone knew what was happening, but she was in a room tucked in a corner at the end and forgotten" (Clissett, Porock et al. 2013)

Some of the studies suggested that the wards were too chaotic and busy for the patients, particularly people living with dementia (Cowdell 2010, Parke and Chappell 2010), commenting on the cluttered environments and the increased noise which were identified as disruptive to care and caused anxiety for the patients.

> "Many patients struggled with day-to-day life on the ward, finding the delivery of essential care stressful and the environment noisy, with bells and buzzers sounding" (Cowdell 2010)
>
> "It's a racket.… All the instructions are off the machine; it's hard to read. …now I'm upset and nervous" (OA#5) (Parke and Chappell 2010)

In contrast, participants in other studies suggested that the wards didn't have enough stimulation which resulted in the patients being bored and becoming increasingly restless:

> "One thing we did feel that was lacking, there was no music on the ward . . . It was deathly silence, there was nothing . . . there was no televisions in the ward . . . and there was no noise whatsoever, so everybody was just bored. They were literally bored out of their brains." (Clissett, Porock et al. 2013)

It was not only the architectural design of the hospital that was identified as being a barrier to care but resources were also seen as reducing nursing capacity. In their study that explored the orchestration of care for older adults, Dahlke, Phinney et al. (2015) highlighted the difficulty of resource provision with nursing staff suggesting that this was a barrier to their capacity:

> "Nurses also relied on one other for information about where to find supplies and equipment because it was a continuous 'struggle for [resources] throughout [the] shift' (RN 12, Second interview, MU" (Dahlke, Phinney et al. 2015)

Similarly, in Moyle, Borbasi et al. (2011) study, the participants identified that the allocation of resources was based on the level of risk on each ward as opposed to the patients need and therefore the nursing staff were continuously trying to locate resources for patients which wasted a lot of their time. Again, this was highlighted by Baumbusch, Leblanc et al. (2016), with the participants in their study suggesting that there were not enough resources for the number of patients that they were caring for:

> "One bathroom for over two dozen patients and a lack of functional call bell systems"(Baumbusch, Leblanc et al. 2016)

> "One Organisational Leader referred to the situation on these units as a 'resource disparity' [OL15]" (Baumbusch, Leblanc et al. 2016)

Another factor highlighted within one of the studies, in relation to the physical environment, was the clinical feel of the ward which was seen by participants as a barrier to providing person centred care (Clissett, Porock et al. 2013). The participants suggested that the ward should have more personal touches to increase a sense of identity for individual patients which is well citied within the wider literature (Downs, Small et al. 2006, Edvardsson and Nay 2009).

> 'In side room three sat Clarence hunched over his table. His knuckles were in his mouth and he seemed to be intently chomping on them whilst staring out the window. There were no cards or personal effects in his room: it was Spartan and smelt of bleach' This seems to be a description of an environment totally lacking in anything that might offer Clarence any personal comforts or a sense of identity" (Clissett, Porock et al. 2013)

The findings of this synthesis suggest that the physical environment of the ward provides an insight into the way in which older persons nursing is viewed and valued. Nursing staff within the studies felt that the wards were detrimental to the care of the patients and suggested that this highlighted the way in which the organisation cared for the patients:

> "It really shows how you value that population when they're in the oldest unit, the skinniest unit, the unit that's ugly" (Baumbusch, Leblanc et al. 2016)

Routine

In addition to the physical environment, the findings of this synthesis highlight that the routine adopted on the ward was also having an influence over nursing staff's capacity for care (Cowdell 2010, Parke and Chappell 2010, Moyle, Borbasi et al. 2011). Three of the studies identified that nursing staff had adopted a habitual way of working which reduced the likelihood of the individualised needs of patients' being met.

> "'They have to be finished by 12 so we can go to lunch' (Nursing assistant 3)" (Cowdell 2010)

> "Where you are looking after a large number of people by a small number of people, there's got to be a regime; there's got to be regulations; there's got to be systems to take care of it" (Parke and Chappell 2010)

There was, however, some contradiction within the studies with regards to nursing attitudes towards the routines. The findings suggested that some nursing staff felt that the routines were necessary, as there were "things that need to be done" (Parke and Chappell 2010) and it was the only practical way to ensure the tasks were completed. Other studies found that the nursing staff would challenge the routine contesting that individual patients' may not need certain tasks at a certain time (Cowdell 2010). Another interesting finding within the studies was the patients' response to the routine, Parke and Chappell (2010) found that the patients were aware of the routine and had an understanding that it was necessary for the hospital ward to function:

> "It is the only practical way to do it and to do it economically," (OA#7, 12:339). (Parke and Chappell 2010)

> I would have preferred to have my coffee and my breakfast maybe at 8:00, but it was convenient for them to serve it at 7:00. Well, you know… you can put up with it. (OA#5, 15:430) (Parke and Chappell 2010)

Despite the contrast in nursing staff and patient attitude towards the routine, the findings in the synthesis suggest that the routine was adhered too and as a consequence patient individuality was often disregarded (Cowdell 2010, Parke and Chappell 2010, Moyle, Borbasi et al. 2011).

High job demand

The synthesis findings provided an insight to the ways in which nursing staff view their jobs on the ward and as a part of this, a theme that was present within the studies was the concept of job demand. Within three of the seven studies, the participants discussed the high demand of the acute care ward suggesting that this had a significant impact on their ability to care (Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016). The high workloads that nursing staff expressed within the studies was seen as the reason for the task focused culture that was observed as an attempt to ensure the work was completed (Baumbusch, Leblanc et al. 2016).

3.2.5.4 Staff Context

The studies within the synthesis reflected that staff context also has a significant impact on nursing staff capacity to provide care. Similarly, to the ward level factors, staffing was a multifaceted concept and although number of staff was a predominant issue, other factors such as skill mix, team dynamics and the attitudes of staff also had an impact (Clissett, Porock et al. 2013, Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015).

Staffing Levels

As touched upon previously, many of the participants within the studies felt that the demands of work on the hospital ward were high and that the staffing levels did not often reflect this (Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016). The synthesis finding suggest that staffing is often based on the acuity of the patients, as opposed to their level of need and because of this, older persons wards often have the same level of staffing as other wards, despite the physical demands of caring being much higher. In addition to this, the issue of staff sickness and staff absence were also discussed, with one study stating that every day the team was at least one member of staff down (Dahlke and Baumbusch 2015). As a result of the poor staffing levels as explained by nursing, the findings illustrate that the staff were very task focused in an attempt to manage their workload which was detrimental to the care that the patients were receiving (Baumbusch, Leblanc et al. 2016).

> “You may have a nurse in a surgical unit that’s one to three, whereas in [geriatric medicine] where they’re needing much more, much more care and the more time you spend with them, they’ll get out quicker, but you’re having one nurse to five patients, maybe six, sometimes seven [N16]” (Baumbusch, Leblanc et al. 2016)

> “Older adults are heavy. [You] need time, patience to toilet them, give medications and they would like to chat with you’ (RN5, GU)” (Dahlke, Phinney et al. 2015)

Another factor touched upon on within this synthesis was the consistency of staff on the ward. Participants in two of the studies described how continuity of staff on the ward allowed for greater relationships to be developed with patients:

> “I think it may have been because they were there, they did longer shifts and . . . my mother was under their wing so they developed a relationship to her which, to her, is very important. Whereas the other staff that I saw . . . they hadn’t got such a close relationship with her.” (Clissett, Porock et al. 2013)

Team Dynamics and skill mix

Another factor within the theme of staffing that was illustrated in this synthesis findings was the concept of team dynamics and within this, the skill mix of the nursing staff (Dahlke and

Baumbusch 2015, Dahlke, Phinney et al. 2015). The dynamics between team members had a significant effect on nursing capacity for relational care with nurses and health care support workers having different expectations on each other's job role (Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015) . A general consensus throughout the study findings was that helping others in their role was effective in increasing staff morale and as a result, increasing staff capacity to provide high quality care. Within this team dynamic, effective communication was also seen as a necessity and vital to effective care. Ensuring that the team were communicating effectively was seen to reduce duplication of work allowing for more time to be spent with patients (Dahlke, Phinney et al. 2015).

> "The RN explained that she has been working to be accepted by the team by talking to the nurses" (Dahlke and Baumbusch 2015)
>
> I am working with nurses who will help me out. If there's an emergency going on they might start giving medications for my other patients. And so I feel obligated to help these girls out too. Because one day later on I might need help and they need help now. (RN 12, Site 2)" (Dahlke and Baumbusch 2015)
>
> "if you see a nurse that's really lazy, it make you feel like I don't want to do so much" (Dahlke and Baumbusch 2015)

As well as communication within the team, the findings suggested that the experience and skill mix of the staff was also very important, particularly when caring for older people with higher needs. The concept of education and training of staff was apparent in Dahlke and Baumbusch (2015), (Dahlke, Phinney et al. 2015) which focused on the orchestration of nursing teams. The findings of these studies suggested that experience and knowledge sharing between team members was vital to the delivery of effective care as it allowed for both the development of team relationships and provided an opportunity for staff to debrief about the challenges of caring for this patient population (Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015).

Other studies that didn't focus on staff in isolation, also highlighted the need for increased experience and training (Cowdell 2010, Moyle, Borbasi et al. 2011). Participants suggested that more training was needed to enable for a higher quality of care to be given to older people, particularly people living with dementia (Cowdell 2010). In contrast, participants in Moyle, Borbasi et al. (2011) study explained that although the training was provided, the knowledge gained could not be applied in practice, due to the realities of the acute care ward:

> 'Marvellous, absolutely amazing, but it's very difficult to apply these principles to an acute unit' (Registered nurse 4). (Cowdell 2010).

Nursing Staff Attitude

The synthesis findings also provided evidence that it was not just the level of staffing or the dynamics in the team but the attitude of nursing staff themselves which also affected the way in which care was delivered to older persons. The studies found that nursing staff attitude towards both the nature of their work and the patients themselves affected the way in which they provided relational care. Both Baumbusch, Leblanc et al. (2016) and Cowdell (2010) highlighted that nursing care for older people was not prestigious and was often viewed by nursing teams as quite unskilled which could have caused the work to be habitual and routinised:

> 'I don't think there's a lot of respect for nurses that care for the geriatric population' (Baumbusch, Leblanc et al. 2016)

The studies suggested that this lack of admiration for older persons nursing (as described in the societal context) has led to staff viewing their job as mundane resulting in them just ensuring what was needed to be complete was completed and not striving to achieve more than this. Similarly, to the negative attitude towards the job itself, another point of argument in the studies was that negative attitude towards the patients were influencing nursing care. Both Cowdell (2010) and Porock (2015) suggested that the nursing staff had negative views of older people, with patients who had a higher level of need being seen as disruptive which affected the level of relational care they received.

Within their study, Clissett, Porock et al. (2013) alluded to nursing attitude with their exploration into missing opportunities of care. Their observations of care on the acute care wards provided evidence that nursing staff often did not take the opportunity to engage with patients and in particular patients with dementia:

> "Tina stated that her father Eric tended to wake up in the middle of the night and, on one occasion, reported that he had found the nursing staff having a drink – an opportunity to invite him to join them for a while. However, they chose not to" (Clissett, Porock et al. 2013)

The missed opportunities observed in this study were regarded as detrimental to providing person centred care and demonstrated that the welfare of the patients being cared for was not as important as other tasks. Although this study did not explore the reasons why this was happening, the findings provide an insight into the attitudes of nursing staff on the acute ward regarding the priorities of their work which evidently was having a negative effect on the quality of care.

Negative attitudes towards older persons nursing is well citied in the literature so is it not surprising that this is a reoccurring theme. Although this negative attitude would appear to coincide with nursing staff beliefs at an individual level, it can be argued that actually this is a wider societal view. Much of the evidence base continues to identify ageism, particularly, in terms of desirability of nursing (McKinlay and Cowan 2003). Studies have found that nurses tend to favour the more complex nursing such as intensive care or surgery and are unable to see the "difference" they were making in older persons nursing (Nolan 2007). This undesirability and lack of complexity has led to older persons nursing revolving around residual care and consequently leading to the task orientated culture represented in the findings.

3.2.5.5 Patient Context

Although organisational factors were a recurring theme within the findings of this synthesis, five of the studies also provided evidence that it was the patients' themselves that were having an influence over nursing staff's capacity for care (Parke and Chappell 2010, Moyle, Borbasi et al. 2011, Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016). Diversity of the older generation, increased complexity of the patients being admitted, and unpredictability of behaviour were all factors identified in the studies as having a negative impact on nursing staff care.

Another recurring influence in the reports was the level of complexity that patients presented with. Many nurses commented on the fact that due to societal ageing, patients were now presenting with more complex cases and often have multi-morbidities.

> "The complexity of frail, older people in the community has continued to increase over the years, so that by the time individuals come into the hospital they can be quite unwell, and the level of intense care that's necessary to resuscitate them in the emergency department context, and then provide ongoing care, and then timely, appropriate, and safe discharge planning, that's huge" (Baumbusch, Leblanc et al. 2016)

There was, however, some ambiguity between the studies regarding whether it was the acuity of their illnesses that made cases complex or the demands of other physical needs such as mobility. The studies suggested that there was such an increase in diversity in this population which makes older persons nursing much more difficult (Baumbusch, Leblanc et al. 2016). There was a definite divide between patients who were acutely ill who had their own complexities and patients who required high levels of support with their activities of daily living who were also regarded as complex or in some studies “heavy” (Dahlke, Phinney et al. 2015). Nursing staff within the studies were observed to be prioritising patients with a higher level of acuity, however, this would then reduce the priority of other patients who had physical demands and needed more assistance with their activities of daily living.

> ‘We’ll have one [acute] patient that takes up so much time that you’re not able to take another patient for a walk. We have to juggle the acuity’. (LPN 1, GU). (Dahlke, Phinney et al. 2015)

Whether it was the increase in acuity or the increased needs with regards to activities of daily living, the nurses within the studies felt that neither the hospital nor the staff as individuals were equipped to care for patients who were more complex and as a result the quality of the care for the patients reduced.

Although not explored in great detail, some of the studies highlighted the increased difficulty for caring for people with dementia (Parke and Chappell 2010, Moyle, Borbasi et al. 2011). Nursing staff participants within this study stated that the complexities of each patient were exacerbated when caring for people with dementia, particularly with regards to aggressive behaviour or who may be unpredictable:

> Sometimes it can be really difficult to look after a person with dementia because they don’t settle, they just keep on wandering and they almost fall over… they don’t even want to listen to you at all. They take up so much time… (AIN, P9) (Moyle, Borbasi et al. 2011)
>
> We don't know what to do about the dementias and the mental issues with old people. We're pretty good with the physical things, but we don't know what to do, so ah, we kind of brush it off. (HE#14, 14:21) (Parke and Chappell 2010)

These synthesis findings reflect the increased complexity that nursing staff encounter when caring for people with dementia, particularly within an acute care ward in which nursing staff do not feel equipped to care for this patient group.

3.2.6 Assessing the contribution of literature from this synthesis and analysing the gap in the literature

As explained above, this meta-ethnography has provided a review of qualitative studies that focus on the nursing staff capacity to provide high quality care on older adult inpatient wards. The review has provided an overview of the factors that contribute to nursing staff capacity which have been discussed in detail above. The following section of this chapter will analyse the contribution of the literature to the body of knowledge and from this, identify where there are gaps which this doctoral study has addressed.

3.2.6.1 Lack of focus on people living with dementia and Medicine for Older Persons wards

Although all seven of the studies included in this review focused on older persons care, only three of the studies focused explicitly on people living with dementia (Cowdell 2010, Moyle, Borbasi et al. 2011, Clissett, Porock et al. 2013). The other four studies either made reference to people living with dementia when referring to the wider literature or failed to mention this patient group at all.

In their study, Baumbusch, Leblanc et al. (2016) discuss implications for people with dementia on the acute care ward, however, this was not the primary focus of their research. Similarly, Dahlke, Phinney et al. (2015) very briefly mentioned people living with dementia in their study, with reference to the importance of sharing of information and Parke and Chappell (2010) refer to people with dementia when discussing the wider literature, however, their inclusion criteria was participants without a diagnosis. Similarly, in their study exploring nursing teams and the care for older adults, Dahlke and Baumbusch (2015) made no reference to the care for people living with dementia.

The context of the wards in which the research took place also highlighted a gap in the body of knowledge that needed addressing. The majority of the studies focused on a mixture of wards (Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016) and it was therefore difficult to determine whether the results applied to specialist older persons wards in particular. Both Parke and Chappell (2010) and Moyle, Borbasi et al. (2011) avoided specialist older persons wards focusing on acute and surgical wards in isolation. In fact, it was only Cowdell (2010) that focused on specialist older persons wards in isolation highlighting the lack of knowledge about this particular setting within the evidence base.

As mentioned previously, the number of people being admitted to hospital with a diagnosis of dementia is increasing (Alzheimer’s Society 2018) and it is well citied within the literature that this patient group is one of the most vulnerable within the hospital environment (World Health Organisation 2012). The demographic data as mentioned previously in this thesis evidenced that most people over 70 are more likely to be admitted to specialist older persons wards and therefore an exploration into the care that this patient group receives, should be conducted within this setting. A study that focus on patients with dementia on Medicine for Older Persons wards in isolation and the care that they received was a gap in the literature that needed addressing.

3.2.6.2 Lack of focus on relational care

Two of the studies within the review failed to mention the concept of relationship centred care within their findings (Moyle, Borbasi et al. 2011, Baumbusch, Leblanc et al. 2016). Of the other five, four of them mentioned the nurse-patient relationship when discussing the wider literature, however, this was not the core focus within the results.

When discussing the wider literature, Cowdell (2010) made reference to the fact that staff see patients as “person-as-other”, meaning someone who is incapable of forming relationships, however, there was no reference to relational care within the findings. Dahlke and Baumbusch (2015) had a very strong focus on relationships, however, this was between team members and there was little exploration into relational care except to say the relationship between staff and patient is complex. Similarly, Dahlke, Phinney et al. (2015) also highlighted the importance of nursing relationships with individuals that they care for, however again, the results were focused on the relationships between nursing teams and there were no references to the relationship between professionals and patients. Parke and Chappell (2010) stated that the development of relationships between nursing staff and patients was dependent on certain characteristics of the older persons, however, there was no further exploration.

The focus of Clissett, Porock et al. (2013) study was that of person-centred care and therefore the framework used was underpinned by the nurse-patient relationship. In the concept of attachment, Clissett, Porock et al. (2013) highlighted how the continuity of staff allowed for greater relationships to develop which was seen as an indicator for a higher quality of care. Similarly, when discussing the concept of identity, the nurse-patient relationship was discussed with the findings highlighting that the warmth of the relationship between the nurse and the patients was the underpinning to making patients feel like individuals. Although relational care was underlying in the framework used, this was not the core focus.

From the previous chapters discussing relational care, it can be argued that there has now been a shift from a focus on person centred care to a focus on relationship centred care and we know from the evidence base that quality of care is based on the nurse-patient relationship. Due to the status that relationship centred care has with regards to dementia care, it is vital that more research is conducted that has this focus.

3.2.6.3 Lack of exploration into the reasons why

All seven studies described *what* was happening on the ward in terms of nursing capacity for care, however, failed to articulate *why*. The studies provided a description of the current state of care on the acute care ward, however, there was lacked an exploration into the reasons why the care was being provided in this way.

In their study exploring the challenges of providing patient centred care, Clissett, Porock et al. (2013) continued to discuss the opportunities that nursing staff missed when providing care for people with dementia. When discussing the attempts by healthcare professionals to engage people with dementia in activity, Clissett, Porock et al. (2013) stated that staff would often avoid engaging with patients outside of care tasks and therefore the opportunity to engage in activities were missed, however, did not explore or articulate why this was.

Similarly, when exploring the care for people with dementia on the acute care ward, Cowdell (2010) stated that the ward routine was followed by nursing staff in preference to meeting individual needs but again, there was no further exploration into why. The descriptive nature of studies was also evident in the work of Moyle, Borbasi et al. (2011) who's finding state that nursing staff tend to focus on acute needs and people with dementia are often viewed as low-priority. Although these findings provide an insight into what it is like for the patients on the ward, again, there is no further exploration into why nursing staff are giving people with dementia a low priority and unfortunately, without this understanding, it is difficult to make any changes.

Although general descriptions of what is happening on the acute care ward allow for the inconsistencies in care to be evidenced, it does not allow for interventions to be created that will help to resolve these inconstancies. Within the evidence base, a deeper understanding of not only *what* is happening on the ward but *why* things are happening in this way, is much needed. A more in-depth exploration into what is creating these inconstancies in care will mean that more specific interventions can be tailored to resolve the challenges faced.

3.2.6.4 Lack of multifaceted approach to understand the realities of the acute care ward

Although this synthesis has begun to illustrate that the impact on capacity for nursing care is multifaceted, the individual studies do not provide a systematic approach to the analysis of the acute care ward or provide enough detail to understand the reality of what it is like for nursing staff who work there. Two of the studies provided insights into how staffing factors affected nursing staff capacity for care but did so in isolation of other factors. Both Dahlke and Baumbusch (2015) and Dahlke, Phinney et al. (2015) focused on nursing teams and team dynamics and although this did provide a greater understanding of impact of this on care, it does not provide an understanding of the multifaceted factors that occur on the acute care ward.

In their study, Baumbusch, Leblanc et al. (2016) did explore the multifaceted factors influencing nurse's readiness to care, however, the methodology used was interviews and focus groups and therefore it is difficult to gain an understanding of the realities of the ward in practice. This was similar to the research of Moyle, Borbasi et al. (2011) who also conducted face-face interviews with nursing staff, asking them to describe their role in the care for people with dementia, however, did not observe any practice. Although interviews provide an insight into the nursing staff perspective of their roles and the care they are providing, without observations, it is difficult to assess whether their perceptions are true. The literature exploring methodological approaches to healthcare suggest that although interviews can provide some insight into healthcare, observations allow for a greater understanding of the realities of the environment and allow for an increased clarity between what health care professionals say and what they actually do. An observational study that explored the different factors influencing nursing care would allow for a more detailed understanding of the realities of the ward, as opposed to an understanding of nursing staff perspective of that reality (Mulhall 2003).

In their study exploring the care for people with dementia on the ward, Cowdell (2010) did use both interviews and observations to provide an insight into what care was like for people with dementia in an acute setting. However, the study was iterative in its approach meaning that the analysis was not systematic, and the influences reported were quite sporadic. In contrast, Clissett, Porock et al. (2013) were more systematic in their analysis of the challenges of achieving person-centred care in acute hospitals, however, a person-centred framework was used meaning that the focus was on specific personhood domains as opposed to the focus being the contextual factors of the acute care ward.

The different factors that have been identified through completing this synthesis suggests a need for a study that examines the work systems factors, systematically and as a whole. Due to the complexity of the hospital ward environment which has been illustrated through the multiple factors identified in this meta-ethnography, a more systematic analysis of the work system is much needed to have a greater understanding of how different factors interact with one another in order to understand where the problems with nursing capacity stem from. Not only is there a need for a systematic study, but for a study that includes both interviews with nursing staff and observations of care. This will allow for an understanding of the dissonance between what is perceived by nursing staff and what is the reality.

3.2.7 Conclusions

The aim of this meta-ethnography was to build on the work originally published by Bridges, Nicholson et al. (2013) exploring nursing staff capacity to provide high quality relational care on acute care wards. As mentioned previously, meta-ethnographies are designed to systematically synthesise qualitative research and produce conceptually rich accounts from both clinicians and patients.

This literature review wanted to focus on the nursing staff perspective and therefore a review that focused on the synthesis of qualitative data was most appropriate, however, this is not without its limitations. In depth synthesis of literature can take years to complete and with the time constraints of a clinical academic doctorate and the fact it was conducted independently, it was not possible to be as thorough and therefore there is potential that some data were missed.

The literature that was found came from studies from within three countries. The three countries in which these studies were conducted all have first world economies, the population is predominately white, and all have publicly health funded systems. As a result of this, the sample may not be representative of all cultures and ethnicities and therefore the results may not be generalisable to other parts of the world.

When discussing the findings of this review it is important to reflect on the original study that this literature review was based on to compare. The review of the above literature provided findings not dissimilar to that of Bridges, Nicholson et al. (2013) who reviewed the literature between 1999 and 2009. The organisational setting at a unit level was the primary influence over nursing capacity for care which was also highlighted in the above review. Factors such as the nature of the clinical setting, difficulties between teams and a lack of time were identified in both reviews as having an impact on relational care.

A substantial difference in this review to that of Bridges, Nicholson et al. (2013) is that there is a lot more awareness of the societal context by nurses and researchers which was perhaps not as well understood in the past. The findings suggested that nursing staff felt patients were much more complex which was representative of society as a whole. There was also a greater influence on policies and guidelines which was not as apparent in Bridges, Nicholson et al. (2013) study. Despite this disparity in the findings, the similarities in the results cannot be contested, a concern considering some studies were published twenty years apart.

This review has provided evidence of the literature that is currently available in relation to the topic of this thesis. Although there is a wealth of literature that focuses on the acute care ward there have been some identified gaps that require addressing further. The finding of this meta-ethnography presents the different contextual factors that influence nursing capacity for high quality care, however, these factors are often described in isolation from one another or are not explored in a systematic way. In order to have a complete understanding of the different factors in the complex environments of hospital wards, it is necessary to explore the structure as a whole and identify how the factors link and relate to each other. This literature review has therefore highlighted the need for a study that systematically examines the complete work system and does not only identify the components that impact nursing capacity for relational care but identifies how they interact with each other.

This synthesis has evidenced that previous literature exploring nursing capacity for care have described the inconsistencies but have not explored further into the reasons why they occur. The studies explored within this synthesis have provided a description of the shortfalls, however, have not explored in any detail why they were observing these shortfalls in patient care. The evidence base is missing research that goes beyond explaining *what* is wrong and starts to identify the reasons *why*, providing a reality of what is it like to care for older persons on inpatient wards and in particular, people with dementia. Further exploration into the reasons why nursing staff work the way they do will allow for more tailored interventions that resolve the source of the problem as opposed to the surface inconsistencies that are being described in the current literature.

The findings of this literature provided evidence that contextual factors of hospital wards influence nursing staff capacity for relational care, however, the review has also identified the current gaps in the body of knowledge. The current evidence base has a wealth of studies that focus on the care for older persons and how contextual factors have an influence, however, tend to focus on different factors in isolation, as opposed to the work system as a whole. The evidence base is also lacking in studies that focus on relational care specifically for people living with dementia. The studies that have been discussed focus on acute care wards and not Medicine for Older Persons wards, where one would assume the level of care would be improved, however there is currently no evidence to prove it.

The evidence base is also missing an exploration into how contextual factors directly affect the nursing staff themselves, as opposed to just focusing on the care that patients are receiving. As identified previously in this thesis, nursing staff vacancies are increasing and therefore a focus on retention is needed. A greater exploration into the effect of the work system on nursing staff themselves is not just a gap in the body of knowledge that needs addressing but also an area of practice that is very topical.

From the findings it was clear that a study that explores the influence of the work system on nursing staff capacity for relational care, particularly on Medicine for Older Persons wards with a focus on people with dementia and nursing staff, is a gap in the literature that was well worth addressing.

3.3 Chapter Summary

In summary, this chapter has explained how the research question that underpins this doctoral study was found, through providing a description of a search and review of the current evidence base. The literature review has built on a previous meta-ethnography conducted between 1999 and 2009 by Bridges, Nicholson et al. (2013) that explored nursing capacity for relational care. This review consisted of seven studies conducted in the United Kingdom, Canada and Australia that explored contextual factors of the acute care ward and their effect on care. The results identified difficulties with team work, organisational structuring and the impact of policies and guidelines on nursing work.

This review of the research has highlighted the current gaps in the evidence base that need addressing. It is clear from the current evidence base that a high quality of care in acute hospitals for people with dementia is lacking. From the literature there is some consensus that care quality is dependent on both nursing attitudes and the context of the care environment, however at present, there are a lot of reports that state what is happening on the wards, identifying the problems themselves as opposed to providing an understanding as to why. Currently, there is not enough understanding about what is causing nursing staff to act in this way to create the problems that are occurring. Further exploration is needed to identify why nurses are acting this way and how exactly the features of the care environment directly impact on this, particularly for people with dementia and particularly around relational care.

There is a gap in the literature that has explored, in depth, the reality of how the work system effects nursing staff capacity relational care for people with dementia, particularly on Medicine for Older Persons wards. Each of the studies in this review, focused on individual components of the work system as opposed to looking at the work system as a whole in order to get to the root of the challenges faced. The review has also highlighted that there is a gap in the research that focuses on people with dementia specifically, as all of the studies included, focused on older persons in general.

Unlike previous research, this study has explored, in detail, the work system of a medicine for older persons ward and provided an explanation the influence this is having on relational care for people with dementia in this setting. What is unique about this contribution to the literature, is that the research has not just focused on the care itself but through its ethnographic approach, it has provided evidence of the reality of what it’s like to be a nurse in this setting, which has not previously been explored in the necessary detail.

The following chapter will focus on the methodology used to conduct this research. The chapter will also discuss the analysis and conceptual framework used to develop the findings, as well as explain the ethical considerations taken whilst conducting this study.

Chapter 4 Methodology

4.1 Chapter Introduction

This chapter presents the methodology used in this research study. Chapter 2 explained the current policy context in which dementia care sits and chapter 3 has highlighted the current gaps in the literature that focus on relational care within the hospital organisation, which has led to this inquiry.

This study used an ethnographic approach using qualitative methods in the form of observations and interviews. This chapter explains and justifies this methodology as well as describing methods for data collection and analysis. In addition, this chapter will discuss the ethical considerations, identifying the actions taken during this study. The chapter concludes by describing how the methods used have optimised the credibility and trustworthiness of the findings.

4.2 Ontology and Epistemology

Research is interpreted through a paradigm. Paradigms define the inquiry of a research study and influence the researcher's ontology, epistemology and chosen methodology. Ontology refers to the nature of reality and how individuals know what reality is. Epistemology describes what could be known and the relationship between the would-be knower and what could be known, and the methodology refers to the way in which the would-be knower goes about finding what can be known (Guba and Lincoln 1994). In simpler terms, ontology asks *what* reality is and epistemology asks *how* we know what reality is.

There are three main types of paradigms in research: positivism, constructivism and pragmatism. Positivists believe that there is only one single reality which can be measured and known, whereas, constructivists believe that reality is not set and needs to be interpreted. The third paradigm, pragmatism suggests that reality is constantly renegotiated and interpreted and as such either qualitative or quantitative methods can be used, dependent on which are best to solve the problem at hand. This research is shaped by the pragmatism paradigm.

There has been ongoing debate regarding the philosophical approaches associated with qualitative research and in particular, ethnographic designs. Realism is often considered as the more preferred epistemology for ethnographic research. Realism is defined as "the view that entities exist independently of being perceived, or independently of our theories about them" (Phillips 1987, p. 205), as such, reality is absolute and cannot be changed. This idea of realism being the underpinning for ethnography is due to the long exposure within a particular setting and the interaction with and between the research participants, however, Hammersley (2002) argues that this poses a problem for ethnographers. Hammersley (2002) is concerned that if knowledge is culturally relative, from a different cultural perspective, knowledge can be false and as a solution, has therefore suggested subtle realism as a philosophical approach to ethnographic work.

Subtle realism acknowledges that reality is there but recognises that attempts made to describe this reality are mediated from a range of factors including language and cultural expression (Hammersley 2002). Subtle realism assumes that the claim of knowledge does not change because the researcher has made the claim, therefore acknowledging that understanding a knowable phenomenon relies on different cultural assumptions and being aware that knowledge is never certain (Hammersley 2002).

Subtle realism allows comparison of different perspectives gained on a phenomenon from different methodologies that are specific to the goals that researchers may have (Mays and Pope 2000). Within subtle realism, the goal of inquiry is not to reproduce reality but to represent it, which is suited to ethnographic research. Due to the nature of ethnographic research, it is recognised that knowledge is created through interactions with the environment and the participants which is shown in this research through the use of informal conversations and interviews. The observations allowed for an understanding of the context under inquiry and this was then discussed with the staff who work within the context during phase two. The findings were created through not only the participants but the researcher who guided the interviews, reflecting on phase one, and then interpreted what was discussed during the analysis.

4.3 Research Aims and Objectives

The aim of this study is to explore what influence the work system has on nursing staff capacity for relational with people with dementia on the medicine for older persons ward. The study objectives are as follows:

1. To identify and describe the factors of the work system within medicine for older persons ward that influence nursing work
2. To explore how these factors, influence nursing work

3. To explore what effect this influence is having on nursing staff and their individual capacity to provide relational care

Data collection took place between January 2017 and March 2018.

4.4 Qualitative design and Ethnography

The findings of this study were collected using an ethnographic approach that incorporated qualitative methods in the form of observations and interviews. Ethnography derives from social anthropology (Gillham 2008) and is the study of social interaction (Reeves, Kuper et al. 2008). Ethnography investigates culture through in-depth study of certain groups (Spradley and McCurdy 1972) and attempts to understand how certain policies and practices shape the human experience (Denzin 2003). Ethnographic research is becoming increasingly recognised as valuable in health care settings and more specifically for making improvement within NHS services. This is due to its ability to access beliefs and practices in the context in which they occur and therefore increasing the understanding of behaviour surrounding health and illness (Morse and Field 1995).

The phenomenon under inquiry was explored using qualitative methodology. Qualitative research is a form of social inquiry and provides an opportunity to explore human experience (Denzin and Lincoln 2011). The first phase of the study was in the form of unstructured observations, which was fitting for the aim which was to observe patient care to understand how nursing work was structured. Unstructured observations provide direct access to what people say and do (Green and Thorogood 2009) and offer an increase in the understanding of people's behaviour.

The data collected during the observations were then used to form the basis for phase two of the study which took the form of interviews with nursing staff. The aim of this phase of the study was to gain a deeper understanding of the nursing staff perspective on relational care and what factors they felt were impacting their capacity to provide it. Interviews are a well-established research technique in social inquiry and are possibly the most common form of data collection in qualitative work (Doody and Noonan 2013). Interviews allow for a greater understanding of participant's views on the topic of inquiry (Wheeler 1996) and as nursing staff capacity was the core topic of this research, it was important to gain the outlook of this staffing group.

Ethnographic approaches and qualitative designs are being increasingly used in primary healthcare settings as a mean of understanding why patients and healthcare professionals behave in a particular way and allow a definitive focus on participant's feelings and experiences (Bryman 2001) (Bowling 2014) (Greenhalgh and Taylor 1997). The current surge in evidence-based practice and the recognised need for improved care for patients with dementia requires an exploration into current behaviours and beliefs of health care staff and a development of new strategies and interventions (Savage 2000). The growing number of qualitative inquires, similar to this study, are now being used to influence policy at both a local and national level.

4.5 Patient and public Involvement

As with most research studies into health care organisations, there was public involvement during the process. Collaboration with the public in the development of research studies can lead to improvements in the way that the research is prioritised, undertaken, communicated and used (Oliver 1995) and the active involvement of service users in research has become more important over the last decade with the positive impact on health care services becoming increasingly recognised (Brett, Staniszewska et al. 2014). As recommend by INVOLVE, the study was carried out with the contribution of members of the public, through the provision of feedback during the development of the study (INVOLVE 2017).

During development of the study, a patient and public involvement group was held and I spoke to members of a carers group run by the study hospital. The club attendees were carers of patients currently in hospital and the group aim was to provide a support network and discuss any challenges that they were currently facing. During this meeting, the outline of the proposed study was described, paying close attention to the background and methodology, in order to ensure its relevance but also pragmatism within the hospital setting. The discussion lasted for around an hour with informal conversations and question answering and time given so that the participants could provide suggestions on how the study could be improved. The points below describe the issues raised during the sessions and the amendments made to accommodate them:

1. *Information sheet may be too descriptive for people with dementia* – A summary sheet was created to summarise information for participants should they find the descriptive information sheet to complicated. The summary sheet is much briefer and in lay terms with large font and offers a much simpler summary of the study *(See Appendix N).*
2. *Concerns for nursing staff not providing consent* – It was explained that there were many opportunities for staff to reject involvement in the study and that on the day of observations each member of staff entering the bay would be given another opportunity to refuse to participate. It was also explained that nursing staff are used to being involved in research and being observed in their general practice so the study shouldn't place too much of a burden.
3. *It would be better to interview patients with dementia* – Although this was suggested this idea was rejected, as it felt inappropriate to formally interview a patient at what is already

a potentially difficult time. It was also not logistically possible on the acute care ward due to constraints of confidential spaces. It was felt that it was important to include patient's perspectives of care and it was therefore agreed that informal conversations with people living with dementia would be held during the observations and included in analysis. This felt a good compromise to include the views of patient and at the same time reducing any potential burden at an already stressful time.

Overall the patient and public involvement session was of great benefit to the study and provided validation that the research topic was relevant and worth investigating in the current healthcare climate. The suggestions made allowed a rethink and restructure of some parts of the methodology and improvements were made where necessary. Although there were no further formal PPI sessions which could be seen as limiting, the research and the findings, continued to be discussed with supervisory bodies, academic and clinical peers, as well as visitors who were on the ward during the time of observations. These ongoing discussions provided further validation that not only was the research beneficial but that the conclusions being made were generalisable, as many patients, staff and visitors stated that they had shared the same experience.

4.6 Setting

This study took place within a large NHS hospital setting in the South of England, employing 6,300 whole-time equivalent staff and providing acute services to an approximate population of 650,000. The data were collected from three different Medicine for Older Persons wards; two acute care wards and the other, a complex discharge ward. These wards were purposively selected as they have the highest proportion of patients over 70 and therefore, the greatest proportion of patients with a diagnosis of dementia.

4.7 Data Collection

This section will focus on the data gathered during this study that were used to generate findings related to the research aim. Data collection is the process of gathering information through several sources in order to answer a research question (Wheeler 1996). In ethnographic approaches to research, the data is usually derived from different sources and then compared in analysis in a process called triangulation (Morse 1991). Collecting data from different sources allows exploration into the phenomena from different perspectives, providing a more in-depth understanding and increasing the scientific rigour of the findings (Malterud 2001). The triangulation of different data sources allowing for different perspectives is underpinned through the ontology and epistemology as described in section previously.

To allow for triangulation, the data collected for this study were therefore derived from a variety of sources during a two-phase process. The multi-method approach ensured that conclusions were drawn and clarified from different perspectives on the same issues to allow for a reality to be constructed. The empirical and theoretical conclusions made in this study were derived from data collected through un-structured observations in phase one and semi-structured interviews in phase two. In addition, informal conversations, field notes and reflexive notes created during data collection were also used to support the findings. The phases of data collection and the methods used are illustrated in Figure 2.

Figure 2 Phases of Data Collection

Phase One – Understanding the patient's perspective

- Unstructured observations on the wards
- Informal discussions with patients with dementia
- Informal discussions with nursing staff
- Reflexive notes

Phase Two – Understanding the perspective of staff

- Semi-structured interviews with staff
- Reflexive notes

Although the phases were separate, the findings found from phase one were used to influence the questions asked during the interviews in phase two. During analysis the findings from both phases were amalgamated to draw conclusions from different perspectives, however, for ease of reading, the phases will be described separately. Data Collection occurred between January 2017 and March 2018.

4.8 Being an insider

Before providing a detailed description of the methodology used to collect this data, I believe it is also important to understand role as a researcher as the data was collected within a hospital organisation in which I had previously worked. My status as primarily a clinician within the trust and following that, a researcher conducting field work within the same setting caused ongoing internal tensions regarding the insider/outsider role. The term insider refers to a researcher that conducts research in a setting in which they are already a member and therefore shares an identity and experiential base with the study participants (Asselin 2003). There is ongoing debate in the literature arguing whether being an insider is beneficial to data collection or whether it can be detrimental to the research process - both of which will be discussed in this section.

There is no doubt that being an insider is advantageous in terms of acceptance. Researching in a field in which one is a member can allow for complete acceptance from the participants and can lead to an increased trust and openness. This in turn potentially enhances the depth of the data gathered and therefore allows for a greater understanding of the phenomena under inquiry. This was particularly useful in this study as I did not have a period of time in which the staff did not feel they were able to openly share their thoughts and opinions with me. From the very beginning of data collection, I was able to gather rich information about staffs true experience of what it was like to work on an older persons ward and care for people with dementia.

In contrast, being a member of the setting under investigation poses questions about the objectivity, reflexivity and authenticity of a research project. There are ongoing concerns that insider researchers are often too close to the project and too similar to those being studied and therefore their own personal experience can often influence the data collected. It is possible that preconceived ideas can guide the way in which the study progresses and eventually the claims that are made due to a heightened level of researcher subjectivity. Although I did not question my authenticity and objectivity during data collection, at times I did feel that staff did not provide enough explanation into what they were experiencing as they presumed that I already knew what they were going through. I often found myself having to ask staff to provide more detail during the informal conversations and interviews to ensure that I was not using my own preconceived opinions to formulate the findings and to ensure enough data was collected to draw conclusions.

Another argument against insider research present in the literature is the conflict that arises between roles. The dual role of a nurse and a researcher can often result in role confusion in which researcher responds to the participants or analysis the data from a perspective other than that of researcher. In addition to this, the dual role can often lead to a problem with loyalty in that the researcher doesn’t want to make claims that felt like they were against the setting they are studying. At times, I did find it hard to make claims that were negative about nursing work, however, I think this would have been the same if it was on a ward that I was unfamiliar with. It was not the negative claims against my peers that I found difficult but more the claims against the nursing profession as a whole. As the research study unfolded and findings were gathered, this guilt started to fade and I realised that it wasn’t claims against the nursing profession but actually about the context in which nurses work. I began to realise that this research was going to benefit the staff and actually the closer to the truth the data I gathered were, the more beneficial it would be to practice. Ongoing supervision throughout the research also allowed me to explore these feelings further and made me more aware of how these thoughts were impacting on the research.

Although the evidence base attempts to identify whether being an insider makes a better or worse researcher, I would argue that it in fact makes a different researcher. I understand that being a member of the setting being explored leaves me open to pre-conceived ideas and potential bias, but I also think it allows me to be more in tune with the participants. My background and knowledge of the field allows me to form a deeper understanding of the context in which nursing work is situated and perhaps provides a wider picture than what was being observed and discussed.

Unlike quantitative research in which participants are represented in numerical terms, qualitative researchers are unable to have a distant “researcher role” and the stories and experience of the participants are carried throughout data collection and analyses. As Rose (1985) explains, there is no such thing as neutrality in qualitative research whether you are an insider or outsider - there is only a greater or less awareness of one’s biases. I was careful to monitor my own influence on the research continuously through reflection, which I am used to doing due to my nursing background. Furthermore, I believe that through ongoing monitoring and reflection, my awareness of my bias has been to a high standard throughout the research. I argue that one of the main strengths of this study lies with how aware I was of the hospital system and the depths of the relationships formed with the research participants that allowed me to gather such rich data.

4.9 Phase One

As described above the aim of phase one of the study was to gain an understanding of the way in which the ward operates and start to identify the contextual factors that were impacting on nursing work and as a consequence patient care. This phase consisted of unstructured observations, informal conversations with staff and patients and field notes. This phase of the study occurred between January 2017 and September 2017.

4.9.1 Participants and Sample

To understand how the wards operated and how nursing staff work, it was vital to observe the care that nursing staff were providing for patients with dementia within a medicine for older persons ward. The participants for this phase were therefore patients on the ward who were over

70 and had a formal diagnosis of dementia. Twenty-two patients were approached and asked to take part, nineteen had capacity to consent and three were assessed as lacking capacity. A total of eighteen patients who had capacity consented to taking part in the study, with one declining. If the patients were assessed as lacking capacity, then the researcher contacted the next of kin after acquiring their contact number from the nursing team. A total of three consultees were approached, all of whom agreed to their spouse, relative or friend being included in the study.

Although a total number of twenty-one patients had consented (either from themselves or their consultee) to be included in the study, only twenty were observed. One participant who had previously consented had later changed their mind at the time of the observation and was therefore not included. Overall, a total of twenty participants were included in the observations, eighteen with capacity and two without. Of those twenty participants, eleven were male and nine were female. The age range of the participants ranged between seventy-two and ninety-six and all the participants were white British, which was representative of the hospital population as a whole.

4.9.2 Identification and recruitment of patients for phase one

Initially, potential participants who met the inclusion/exclusion criteria (Table 4 and 5) were identified by a research nurse who worked within the trust using *OCEANO*, a patient database within the hospital. The database allowed the research nurse to identify the location of the patients, their age and whether they had a formal diagnosis of dementia.

Once the potential participants for the selected ward had been identified, myself or the research nurse would then visit the ward and discuss with the nurse in charge which patients would be appropriate to be approached and whether they were end of life, critically ill or due to be discharged. There was also discussion regarding the participant's mental and physical wellbeing and whether it was appropriate at that time to try and recruit for the study. The research nurse would create a list of potential patients allowing me to select patients that would provide the most valuable data. The nurse in charge would then be asked again if it was appropriate for the patient to be observed and if the nurse in charge agreed, then then they were approached.

Table 4: Patient inclusion criteria for observations

Inclusion Criteria	Rationale
Patients over the age of 65.	The evidence base suggests that older persons are more likely to receive poor relational care in hospitals and this was the phenomenon under inquiry. In most western societies, an older person is described as a person over the age of 65 (WHO 2010).
Patients who have been diagnosed with dementia either prior to or on admission to hospital.	The study wanted to explore the experience of patients, specifically people living with dementia within hospital settings. Thus, only patients with a formal diagnosis of dementia could participate.
Patients who were able to speak English.	It was not feasible for this study to explore in-depth the experience of having both dementia and difficulty with speaking English as it was thought that this would be another research study in itself.

Once it was agreed that the patient was suitable to be approached, I would then introduce myself and form a rapport. I would take this opportunity to explain the purpose of the study and provide the information sheet *(See appendix A)* which outlined the study and provided answers to potential questions.

Table 5: Patient exclusion criteria for observations

Exclusion Criteria	Rationale
Patients who are end of life or critically ill.	To ensure that the study did not to place any un-due burden on patients/carers of patients at what could be an increasingly stressful and emotional time. Arguably, patients who are palliative, often receive an increased amount of care and therefore the results would not have provided a true indication of relational care within this setting.
Patients who are due to be discharged on the day of recruitment or day after.	This would reduce the likelihood of needing to go through the recruitment process again on the day of observation and not place any undue burden on the participants and nursing staff.

During this first approach and on building rapport with the patient, I was able to assess the capacity of the potential participant following the Mental Capacity Act legislation (Mental capacity act 2005). If the potential participant was assessed as lacking capacity, I would politely draw the conversation to a close and then seek advice from the personal or professional consultee as to whether they believed the individual would have liked to be involved in the research *(see Appendix B)* for full recruitment process for people lacking capacity). If, however, I assessed the participant as having capacity I would ask whether they would like to be involved in the study and allow them time to make their decision and return to the ward at a later time (within 24 hours) to gain their consent. If the participant agreed to participation in the study, the consent form *(see Appendix C)* was signed.

A log of the participants who were approached and either included or declined was maintained in the form of a participant recording sheet (*(see Appendix D)* to reduce any potential replication. The sheet included whether the individual was deemed appropriate to approach by the nurse in charge, whether or not they had capacity, whether they consented/declined or whether the personal/professional consultee consented/declined. It was agreed that participants would not be approached to take part more than three times, both to increase the sample size and to reduce any potential burden on the patients.

4.9.3 Identification and recruitment of nursing staff for observations

Due to the nature of staffing on the Medicine for Older Persons wards, an inclusive approach was taken for the observational phase of the study and therefore all nursing staff were included unless they stated otherwise. This setting tends to have a high staff turnover and a high level of staff sickness (Adams and Bond 2000) resulting in agency staff or staff working on different wards and therefore it felt unfeasible to obtain consent from all members of the nursing team.

Hospital staff are used to being observed and monitored in their professions and therefore it was deemed that transparent observations and an inclusive approach were ethically appropriate. Despite this, it was ensured that many measures were put in place so that nursing staff were aware of the study and how to “opt out” of participating. I spent a lot of time liaising with staff on the wards prior to the commencement of data collection to ensure they knew who I was and what the research was about. I also made it clear that if the staff did not want to participate, they should inform me at the time of the observations. During the observation period there were no instances of staff refusing to be involved in the study and all were happy to be observed and for notes of what they were saying to be recorded in the field notes.

4.9.4 Reflection on recruitment for Phase One

Although the desired number of participants were recruited during phase one, there were some challenges faced during the process. One of the most significant difficulties during recruitment was ensuring that participants met the inclusion criteria and thus had a formal diagnosis of dementia. The programme used to initially screen potential participants would often state "unspecified dementia" and as recruitment progressed it was evident that this could be used to describe patients who had mild cognitive impairment or possible delirium on admission which therefore made it difficult to determine who had a formal diagnosis. This problem then continued when recruiting on the wards as I found that members of staff were quick to identify patients as having dementia, however, when exploring further, the patient had no formal diagnosis in the medical notes and therefore could not be included in the study. On reflection, and if the same recruitment process were to happen again, it would be more appropriate to include patients identified as having "cognitive impairment" as this would have increased the sample selection and also reduced the time spent filtering medical notes to locate a formal diagnosis. This has however, raised a number of questions about identification and recording of a diagnosis of dementia in hospital organisations.

Another possible amendment that could have eased the recruitment process would be for participants to consent to the study verbally, without the need to sign a consent form. It was found that many participants were often very willing to join the study, however when asked to sign the consent form, became sceptical to write their name and signature on the consent document. Similarly, there was also difficulty to get consultees to sign consent forms, however, this was more a logistical problem as on a few occasions the consultee did not live close to the hospital and therefore could not come in to sign. Again, if any amendments were to be made to the recruitment process, it would be that both participants and consultees could provide verbal consent as opposed to needing written confirmation.

4.9.5 Unstructured observations on the wards

Unstructured observations on the ward took place during phase one (n=100 hours). The observations took place across the three selected wards, during selected times of the day to ensure a representative data set (see *Appendix E* for an example rota for observation). The observation sessions occurred between the hours of 8am and 10pm to reduce disruptions to patient's sleep. The observations lasted for two-hour periods allowing enough time for staff to become accustomed to the presence of an observer whilst also reducing the likelihood of observer fatigue (Aamodt 1991).

Following recruitment of patients, I found an appropriate position on the ward, in which I was able to observe interactions with minimal disruption to the healthcare process. Throughout the observation period, I also tried to reduce the likelihood of observer effect through observing from a discrete location and changing positions, whilst, ensuring that the interactions could still be heard.

Throughout the observations, a “participant as observer” role was maintained as described by Gold (1958). This type of role allowed me to have access to the setting by the virtue of having natural and non-research reason for being there. This role allowed me to become close to the participants being studied without being involved in the care itself and with the participants being aware that I was there for research purposes.

Although this role is advantageous in that it allows for a close relationship with participants and therefore encouraging in-depth understanding of the phenomena it can also be problematic. There is an ongoing risk that the “participant-as-observer” can become too identified with the participants (Gold 1958) making it difficult to remain objective and lose perspective of the focus of the research. Throughout the research, I was continually aware of my relationship with the participants and ensured ongoing reflection occurred throughout the process. The use of reflexive notes allowed me to keep track of my thought process and interpretation of what was being observed.

The data from the unstructured information was collected in the format of field notes. The field notes were descriptive of what I had seen and heard with some notes made regarding my own interpretation and reflection. The field notes were either written at the time of the event or if not appropriate (i.e. during a conversation) then later that day.

The focus of the observations was the work in which nursing staff were doing, what impacted or influenced their ability to do so and following this, the impact on the care for patients. I observed the routine of day, what tasks were part of this and how the staff structured their time whilst on shift. I also observed nursing staff attitudes towards their work and how this impacted on the way in which it was completed. I observed the care that patients were receiving and what was happening during this time. In contrast, I also observed what was happening when the patients weren’t receiving care and what the staff were doing instead. I ensured that a lot of detail was given to the context in which the observation was happening and therefore made notes on factors such as staffing, ward atmosphere, lighting and sound to ensure an in-depth description of the ward environment was provided. The focus of this research was the nursing staff and therefore activities of other members of the multidisplinary team were not recorded unless they had an influence on the work of the nursing staff themselves.

4.9.6 Informal discussions with patients with dementia

An “observer-as-participant” role allowed me to formally observe the care being provided but also participate in conversations with the participants which is how the views of participants with dementia were included. Appendix F provides a detailed observation procedure. An advantage of these interactions is that the data provided was first-hand from the patient with dementia which tends to be absent in many studies. A justification for using conversations during the observations, as opposed to interviewing patients with dementia at a later date, is that there is no need to recall experiences which could have potentially caused unnecessary distress.

4.9.7 Informal discussions with nursing staff

Similarly, to above, informal conversations with nursing staff also occurred during the observations. The topic of the interaction was mostly about what was currently happening on the ward, regarding time pressures and how this was impacting on care. Conversations also revolved around patients with dementia and how staff felt when interacting with this patient group. Often, I would find that staff would tend to offer cues into how their day was going through non-verbal communication, such as an eye roll or a sigh or a shrug of the shoulder and it was ensured that this was also documented.

4.9.8 Reflexive Notes

Reflexivity is a method used within qualitative research that allows researchers to validate their research practices, whilst also, being aware of their positionality and the way in they could potentially influence the research (Cutcliffe and McKenna 2002). Reflexivity is increasingly being recognised as a defining feature and integral part of the qualitative research process (Banister 2011), whereby the researcher can reflect on how their own actions, values and perceptions impact upon the study setting and this can affect data collection and analysis (Gerrish, McMahon et al. 2006). During data collection and analysis, I kept a reflexive journal which is considered an effective approach to maintaining reflexivity (McGhee, Marland et al. 2007). The reflexive notes not only acted as a source of data but also allowed for continuous monitoring of the research process. The data from the reflexive notes have been used as a source of data to form the results described in this thesis.

4.10 Phase Two

The purpose of phase two was to gain an understanding of nursing staff’s perspective on what I had observed during the observations in phase one. As mentioned previously, the data from phase one was used to construct the interview guide in phase two which allowed me to reflect on the conclusions drawn from this data set. Although not initially the purpose of phase two, the interviews also provided evidence of the thought processes of nursing staff which allowed for further insight into the way in which the hospital organisations and its culture had an effect on their work.

4.10.1 Participant and Sample

As mentioned above, the purpose of phase two was to understand the perspectives of nursing staff and therefore the participants in this sample consisted of nurses and health care support workers. One to One interviews (n=23) were conducted with the following staff *(see Appendix M for information of nurse banding)*:

Health Care Support Workers (n=10)

Band 4 Nurses (n= 1)

Band 5 Nurses (n =7)

Band 6 Nurses (n= 3)

Band 7 Nurses (n= 2)

All of the twenty three staff members listed above were women, which is expected in this setting, given the predominance of females in nursing (Health Care National Training Organisation 2001). The age range of the participants was nineteen to sixty-seven with most between the ages of twenty-five to forty-five. Of course, all nursing staff held a professional qualification and a registration with the Nursing and Midwifery Council. Not all healthcare support workers had a formal qualification, however, some held a health and social care awards such as NVQ2 or NVQ3. 20 of the 23 participants were White British and again, this was representative of the staff group as a whole.

4.10.2 Identification and recruitment of nursing staff for Phase two

A ward manager assisted me with initial recruitment of the interviewees to reduce any burden on staff and any potential of them feeling pressured to participate. Eligible participants were therefore identified by the ward managers using the inclusion and exclusion criteria found in Table 6 & 7 below. During the phase one observation period, I distributed information sheets *(see Appendix G*), invitation to interviews *(see Appendix H*) and consent forms *(see Appendix I*) to the ward managers on each of the three wards, who then circulated these to their nursing staff. Post boxes were provided on each ward for staff to submit their responses confidentially. The consent forms asked for staff emails allowing me to contact them to arrange a time and place to hold the interview.

Table 6: Inclusion Criteria for nursing staff for interviews	
Inclusion Criteria	**Rationale**
A member of the nursing team (nurse or health care support worker) on the ward.	To address the aims and objectives of the study and gain insight from first hand perspectives of staff.
Worked on the ward for longer than three months.	To ensure the data collected is from a participant that had a greater in-depth experience on the ward.

Table 7: Exclusion criteria for nursing staff for Interviews	
Exclusion Criteria	**Rationale**
Students nurses	To ensure that data collected represented the particular environment and factors that contributed to nursing capacity. Student nurses are often supernumerary, meaning they do not have the same pressures as nursing staff and would therefore be affected differently to members of the nursing team.
Agency Staff	To ensure that the data collected is up to date and from a reliable source that has spent a significant amount of time in the particular ward environment.
Nursing Staff that have recently been on long term sick leave, maternity leave or otherwise.	To ensure that the data collected is up to date and reflect the ward in its current state.
Nursing staff that have recently handed in a letter of resignation.	To ensure that perceptions are not altered and are in the interest of the ward.

4.10.3 Reflection on recruitment for Phase Two

Similarly, to phase one, I was able to recruit the expected amount of participants for the interviews within quite a short amount of time. This may have been due to my role within the trust prior to the start of the research, however, I tried to minimise this bias by sending invitations to interview to managers who then disseminated these to staff. Although this allow for some participants be identified and led to a handful of responses, it was not enough to reach data saturation.

Following this method, I then went on to attend ward handovers reminding staff that I would be holding interviews and if anyone was free that afternoon then they would be welcome to join. This method was much more successful, and I was able to recruit most participants this way, however, on reflection I feel that this was more because I had a previous relationship with the ward staff outside of research capacity. Many participants commented on the fact that they would like to “help me out” as opposed to feeling that the phenomenon under inquiry was worth investigating. Again, this relates back to the insider/outsider debate and whether this is beneficial or detrimental to data collection. As mentioned previously, ongoing reflexivity allowed for continuous monitoring increasing the validity and reliability of the findings.

4.10.4 Interviews with staff

One to one interviews with nursing staff were conducted during phase two of the study (n=22). Following initial recruitment from ward managers and attendance at handovers, I invited staff who had shown an interest, to interview (via email) at a time which suited them both in and out of shift hours. The interviews ranged in length from twenty minutes to forty minutes and took place on site, at the hospital. The reason for this chosen location was due to the current pressures on the ward. It was important to increase the likelihood of attendance and therefore having a location that would reduce time spent away from the ward was a priority.

The discussion was guided by the data collected and analysed in phase one and followed a semi-structured interview guide *(see Appendix J*). The use of this semi-structured technique allowed the interviews to remain informal and conversational. It also allowed for the staff to direct the way in which the conversation progressed and reflect on past experiences. The topics covered in the interviews included: the factors that influenced their work, the ways in which work was organised on the wards in terms of priorities and why and how nursing staff felt this was influencing their care and the ways in which they felt relational care for patients with dementia could be improved in the current hospital climate.

There is a wealth of literature acknowledging that interviewers are as much of the participant in the conversation as the interviewee and that the interview is often shaped by the context and situation in which they take place (Fontana and Frey 2000). Throughout the interviews, I was continuously aware of my competing role of both nurse colleague and researcher and therefore ensured that reflexive notes were kept allowing me to identify the way in I could have potentially influenced the interview content. The use of the reflexive notes during the interviews is mentioned below.

The interviews were recorded using a digital audio recorder which provided accurate reporting and limited the disruption of note taking (King and Horrocks 2010). The procedure of recording and transcribing interviews allowed for a more thorough exploration of what was discussed and permitted ongoing examination throughout analyses. A further advantage of tape-recorded interviews was that it allowed for others to peer-review the data collected; adding to the rigour of the study and providing an opportunity to listen to the tapes objectively in order to critique and improve my interviewing style (Morse and Field 1995).

Throughout the second phase of the study, I continued to have many discussions with my supervisory team to improve interview technique. It was decided that the interview transcripts were not shown to the interviewees, as this could have resulted in change of results due to staff reflecting on what was said and wanting to change their responses. (Thomas 2017).

4.10.5 Reflexive Notes

Similarly, to the use of the reflexive notes made during Phase One, reflexive notes were maintained during the interviewing phase of data collection. As mentioned previously, my role as both a nurse in this setting and a researcher meant that I had to be careful not to assume what nursing staff were saying and ensure that they would elaborate on certain things. Most of the nursing staff that were interviewed were aware that I worked within the hospital and therefore would often make assumptions that I knew what they were saying. To overcome this, during the interviews, I would ensure that I would ask them to describe this further. As stated above, it is now acknowledged that the interviewer is as much a participant as the interviewee and therefore regular reflections and repeated listening of the interviews allowed me to identify my influence over the conversation and adapt this over the course of phase two.

4.11 Data Analysis

Data analysis in qualitative research is the process of examining, categorising and combining the data to draw empirical conclusions and generate a hypothesis (Miles and Huberman 1994). As with many qualitative studies all the data were analysed thematically. I chose to follow the procedure suggested by Braun and Clarke (2006) who suggested a six-phase guide to thematic analysis as described below.

Although the analyses were completed using the same methods, the order in which it occurred allowed for the data from phase one to influence the data gathering in phase two (see Figure 3 for an illustration of data analyses). During phase one, the analysis was ongoing throughout allowing findings to emerge which then prompted further data collection. After completion of phase one, data were analysed formally prior to the beginning of phase two in order to create the semi-structured interview guide.

Once phase two was completed a further phase of analysis began with the results being combined with the data from phase one to draw further conclusions. During the formal analysis, the emerging findings were discussed with my supervisory team and reflected to staff participants to share any comments and add another perspective to the findings. Despite relaying the findings with others, I had the main influence in the analysis and therefore it should be noted that findings are framed by my personal values and background, as described previously.

4.11.1 Justification for use of thematic analysis

Most qualitative research studies use thematic analysis to interpret the data, especially those studies that use an ethnographic approach (Hammersley 2002). Thematic analysis allows for identification and reporting of patterns within data sets which allows for understanding of the phenomenon under inquiry.

Critics of thematic analysis claim that it is not in fact a method of analysis in its own right, (Boyatzis 1998, Ryan and Bernard 2000). This lack of credibility is most probably due to a lack of guidance in the method which has therefore led to vast variations in its use across different studies. Although lack of guidance has been identified as a critique of thematic analysis, it is argued that the flexibility allows for theoretical freedom allowing for a rich yet complex analysis of the data (Braun and Clarke 2006). To ensure that the themes are not seen as simply emerging and to provide evidence for the analytic process, I used the process of thematic analysis described by Braun and Clarke (2006).

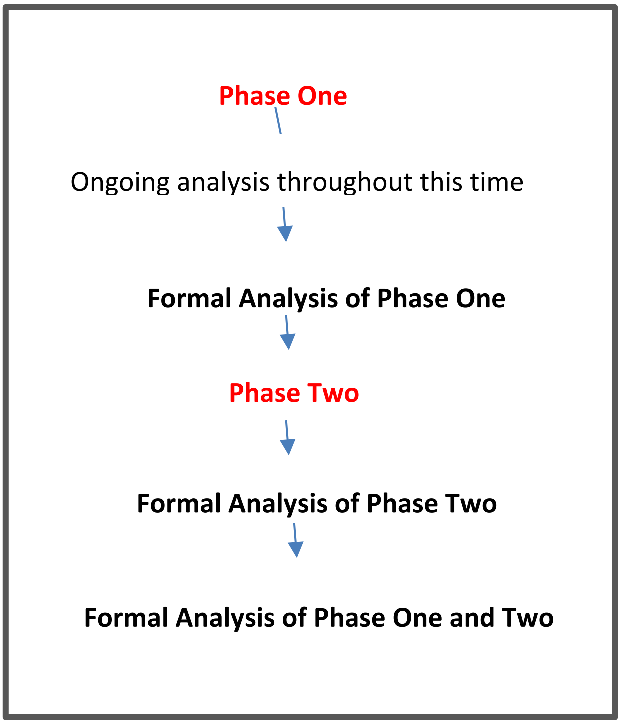

Figure 3 Phases of Data Analysis

4.11.2 Data Analysis Process

In qualitative research, it is argued that analysis must not follow a strict set of guidelines, as value lies in the flexibility of the work. However, in order for others to be able to understand how the themes evolved there must be a defined process for analysis. Braun and Clarke's (2006) six phase guide to thematic analysis will be discussed below in accordance to the research project. This will provide a detailed account of the analysis methods used, which (Ellingson 2013) advocates as it provides proof of the depth of analysis.

4.11.2.1 Familiarising yourself with the data

Throughout the study, I took responsibility for both data collection and data analysis. I undertook the field work and interviews as well as transcribed the data and conducted the analysis, meaning I was very familiar with the data set. Through undertaking the field work, I already had some preconceived ideas of emerging themes, however, chose to be “immersed” (Braun and Clarke 2006) in the data prior to starting to generate initial codes. Immersing oneself into the data involves “repeated reading” (Braun and Clarke 2006) of the data and reading in an “active way” (Braun and Clarke 2006) in which I chose to create a draft coding diary which allowed me to start identifying possible codes. To ensure complete familiarisation, I ensured that I read through the entirety of the data three times before beginning the formal process of initial coding.

4.11.2.2 Generating Initial Codes

Once familiarised with the data, I started to generate initial codes. Codes are used to identify features of the data that appear interesting to the analyst and make a contribution to the understanding of the phenomenon (Boyatzis 1998). It is worth acknowledging at this point that the codes themselves are not themes but contribute to the development of themes. Themes, however, tend to be broader and often encompass numerous codes.

The process of coding was assisted using NVIVO (Version 11), a software that allows for the storing, managing and coding of large quantities of data in in a systematic way (Yin 2015). The coding was theory driven as opposed to data driven as I was addressing a specific question and had a definitive line of inquiry. I read through the data and appointed codes to small parts of data whilst maintaining a coding log *(see Appendix K for examples*). Throughout this process I also used the function of “parent nodes” on NVIVO for codes which were seen as over-arching categories as this assisted in the identification of themes.

4.11.2.3 Searching for themes, Reviewing Themes, Defining and Naming Themes

I have chosen to condense the last three phases as I feel that although they are defined as different phases, in reality they occurred simultaneously. Following initial coding of all data, I started to identify over-arching categories and began re-organising the codes into potential themes. I used visual representation as suggested by (Braun and Clarke 2013) in the form of mind maps to understand how the themes related to each other and identify which were the main themes and subthemes. These themes were continuously reviewed with ongoing referral back to the initial codes to identify evidence for the themes and then changed accordingly. Once there was a comprehensive thematic map of the codes, I then started to define the key themes, finding parts of the data that support them. I ensured that the data was not just paraphrased under each theme but that there was clear justification for how this contributed and what relevance it had.

4.11.2.4 Producing a report

Once the themes were defined, the final stage was to produce the written report of the findings which has been completed in the making of this thesis.

4.12 Framework underlying analysis

Chapter 3 provided evidence that an in-depth exploration into the acute care ward in this current climate was missing and needs to be addressed and it is for this reason that I chose a work systems analysis framework to guide my analysis. The framework is actually an analytic tool used to identify human factors in healthcare, known as Systems Engineering Initiative for Patient Safety (SEIPS) model. The framework identifies different components of the work system that have an impact on the work being carried out and in this instance: relational care.

4.12.1 What is SEIPS?

Healthcare organisations are very different to other industries in that they are very complex systems, consisting of a magnitude of human, technical and social factors. The delivery of health care relies on a variety of people and stakeholders that interact with each other, combined with a variety of technologies and devices and occurring in a variety of physical environments and organisational settings. This complex system is often met with many conflicting values and objectives coming from the stakeholders, staff and patients and often mixed with considerable pressures and increasing change.

Due to this inherent complexity across healthcare systems, socio-technical approaches to analysis have become increasingly recognised as a way of examining and improving services. Socio-technical system is an approach to analysis that considers human, social, technical and organisational factors in order to understand how work is carried out and how it can be improved (Baxter and Sommerville 2011). This human factor approach to work system analysis in hospital settings allows for identification of the multiple systems elements and their impact on quality of care.

The Systems Engineering Initiative for Patient Safety (SEIPS) framework is a well-known approach to systems analysis. SEIPS is a model of work system and patient safety, which provides a framework for understanding the structures, processes and outcomes in health care and their relationships. Originally developed in 2006 and funded by the Agency for Healthcare Research and Quality, SEIPS was created to improve the design of healthcare systems following proposed application of engineering concepts to healthcare by the US Institute of Medicine.

Since its development, the SEIPS model has proved its worth across a number of health care settings as well as being used to frame both the design and analysis of health research (Gurses, Carayon et al. 2009, Draper, Karmel et al. 2011, Shekelle 2013, Singh, Morgan et al. 2015). A significant amount of research studies have used SEIPS to evaluate various health care settings including outpatient units (Carayon, Wetterneck et al. 2005), radiotherapy (Rivera and Karsh 2008) and intensive care units (Rivera and Karsh 2008, Gurses, Carayon et al. 2009).

As illustrated below, the SEIPS model consists of five components that create the work system: technology and tools, organisations, person, tasks and environment. These five components interact and have different influence over each other, and it is these interactions that produce the outcomes for both the employees and patients.

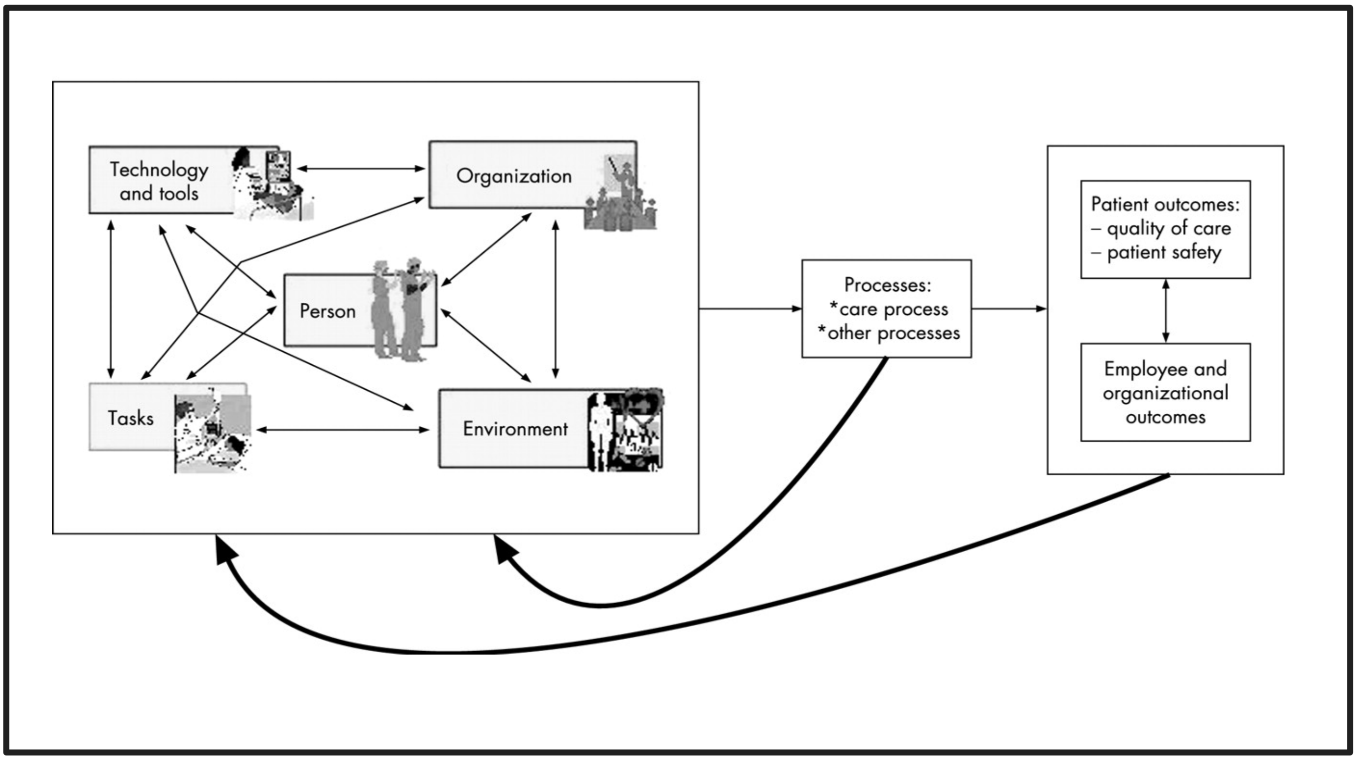

Figure 4 SEIPS framework

In the SEIPS model, the person is at the centre of the work system with the idea being that the other work system components should enhance and facilitate the performance of the individual. 'Person' in this model can describe either the patient or the health care worker or can simultaneously represent both. Tasks are the specific actions that are undertaken in the work process and the tools/technologies are what the person uses to undertake these tasks. The organisation component refers to the structures external to the person but that organise time, space, resource and activity for example shift pattern, organisational culture and resource availability. The final component – environment- refers to both the internal and external environment and includes factors such as physical space, noise as well as macro-level societal factors such as policies and economic factors.

4.12.2 How is SEIPS applied in this inquiry?

SEIPS is a sociotechnical system framework that allows for a richer analysis of organisations. The SEIPS framework provides an in-depth description of a work system considering human, social, organisational and technical factors. The outcome of using a framework of this type is a better understanding of how these factors interact and influence how work is done allowing for tailored interventions that are more likely to be successful. Although used in other healthcare settings, this model has rarely been used in the acute settings, particularly Medicine for Older Persons wards and to my knowledge has never been used to analyse relational care. I have also only found one occasion where the framework has been used in research consisting of qualitative methods as most appear to be in the form of surveys.

Throughout the analysis, there was ongoing reflection to the framework, and it was used to organise the data into different themes that correlated to components of the work system. The separate components allowed for identifications of different factors of the work system and their influences on relational care. It also allowed for a greater understanding of the relationships between the different factors and for identification of which was having the greatest impact on nursing work.

4.12.3 My Reflection on SEIPS

I chose to use the SEIPS model for this study as it provided an underlying framework for analysing the environment in which nursing work takes place. As demonstrated in the previous chapter, there are many varying components that affect nursing staff capacity to provide good relational care. There is, however, currently no detailed analyses of the individual contextual factors, how these relate to one another and how they affect nursing work, which I hope to provide from this research.

When considering a framework for analysis, it is important that the researcher is aware how the framework could influence their thinking about the data. I participated in reflexive analysis throughout both the data collection and analysis and had regular supervisory meetings to discuss the direction in which the study was going. Although the framework had specific components that my data could have fitted into, I was careful not to limit myself to these. I ensured that I was noting down all aspects of care that I saw and all the factors I thought influenced care delivery and worked out how they fit into the work system once the data was collected. I ensured that I did not disregard other factors that did not fit into the components and made my own themes for these.

From the start of the research I believed that this framework was suitable for my line of inquiry, however, I continuously reminded myself that the framework pays little attention to emotions. From my own experience (prior to data collection), I was aware how significant emotion management is in nursing work and therefore was careful not to disregard this just because it was not a component in the work system framework. During my research I was keen not to lose the emotional component of nursing work and as you will see from the results this has played an important part in the analysis and discussion.

4.13 Quality of research

One of the most significant challenges for qualitative researchers is the assurance of the quality or "trustworthiness" of their research (Finlay 2006). Due to the variability of interpretations within the data, the quality in qualitative methodological research has been subjected to criticism in terms of reliability and is frequently described as subjective assumptions that are supported by unscientific methods (Ballinger 2004).

In quantitative research, rigour is determined by a basic framework consisting of three concepts: reliability, validity and generalisability (Finlay 2006). Qualitative researchers, however, reject these positivist paradigm concepts, highlighting that the integrity and quality of qualitative methodology requires a different evaluation criterion specific to the aims of social inquiry.

There have been many proposals that have tried to identify appropriate qualitative criteria, however, the general consensus is that qualitative inquirers need to demonstrate that their research is credible and has an accuracy of representation as opposed to being reliable or valid (Agar 1986). I chose to follow the strategies identified through Lincoln and Guba's model of trustworthiness - a model based on four identified criteria: credibility, transferability, dependability and confirmability (Lincoln and Guba 1985). The strategies I used within this study to ensure trustworthiness, in accordance to Lincoln and Guba's model are outlined in Table 8 below:

Table 8: Strategies to ensure trustworthiness

Criteria	**Strategies**
1. Credibility: This criterion replaces the concept of internal validity in quantitative research. Credibility describes the degree to which the data makes sense (Finlay 2006).	1.1 Prolonged engagement in the field: Prior to the start of data collection, I had worked clinically within the field for two years and had already built a rapport with staff. During study set up, I met with the managers and ward staff to introduce the study and build further relationships with staff. The observations were conducted over a period of 6 weeks, occurring 3 days a week, allowing me to be submerged into the setting even more and thus increasing the likelihood of the participants becoming accustomed to the research. 1.2 Triangulation: As mentioned previously, I used a variety of methods of data collection to ensure an in-depth exploration into the phenomenon of this study. The combination of observations, field notes and interviews provided data from different perspectives which in turn increased the probably of producing credible results. 1.3 Regular discussion with academic supervisors: Throughout the study I had many meetings with my supervisory team and academic peers to discuss the study and ensure consistency and credibility. 1.4 Reflexivity: As another method of data collection, I produced reflexive notes around my field notes in phase one and during interviews in phase two in which I commented and reflected on my role as a researcher and my influence on the data to increase the credibility of the findings (as explained above). Observer effect: During phase one I attempted to reduce the impact of my presence on the research environment. In a high-pressured environment, it is unlikely that staff will be able to maintain a radically different behaviour for a long period of time (Cormack 1976), (Mulhall 2003)), however, during the observations, I decided to move positions and try to observe from places that were not in the forefront of the care.
2. Transferability: This criterion replaces the concept of external validity in quantitative research. The idea of transferability is to provide enough information for others to decide whether it is applicable to other settings (Finlay 2006).	2.1 In-depth description of context: Throughout phase one, I ensured that there was enough detail provided for others to judge the applicability of the results to other settings. Although the participants have remained anonymous in phase two, there is detailed information regarding their background including their level of experience and job role. The data includes both typical and atypical data and this has been stated in the results. The observations were collected until data saturation was reached in both phases which has provided a large data set for others to determine the data's transferability.
3. Dependability: This criterion replaces the concept of reliability in quantitative research. In qualitative research, dependability is ensured by the research providing enough information for others to follow the research process (Morse, Barrett et al. 2002).	3.1 In depth description of research process: This thesis document provides description of the research process. I have ensured that each of the research procedures followed has been described in detail and have commented on what I did during each process. 3.2 Regular discussion with academic supervisors: As described in point 1.3
4. Confirmability: This criterion replaces the concept of objectivity in quantitative research. Confirmability provides the opportunity for others to trace the researcher's construction of their interpretation (Wallendorf and Belk 1989).	4.1 Reflexivity: As described in point 1.4. 4.2 Triangulation: As described in point 1.2. 4.3 In depth description of research process: As described in section 3.1.

4.14 Ethical Considerations

Throughout this research my aim was to keep the best interests of participating patients and NHS staff at the forefront and therefore participants took precedence over the process of the research. The research nurse and I tried, at all times, not to place an undue burden on the participants at any point and ensured there was a minimal risk of harm throughout.

The study was proportionate and represented what was achievable when working within limited resources. Discussions with the NHS Trust's research and development team, my supervisory team, academic colleagues, and the hospital managers, occurred throughout the study to discuss any problems that occurred and to ensure that the decision made was in the best interest of the participants and the wards studied.

The study was granted approval by South Central - Hampshire A Research Ethics Committee and the Health research Authority on the 9th January 2017 *(see Appendix L* for approval letter).

4.14.1 Setting

Due to the pressured and demanding nature of the Medicine for Older Persons wards, the recruitment and data collection could have come at what was already a particularly stressful time for both patients and staff. The following measures were put in place to ensure that the study did not place an undue burden on the ward:

- Meetings with managers and ward staff were held prior to the commencement of data collection so staff were aware what it would entail. Posters were also placed within the ward areas as a reminder to staff, patients and visitors.
- It was made clear to staff and patients, both through written information and verbal explanation that there was no obligation to take part in the study and, they could withdraw at any time should they change their mind.
- Ward staff were not directly involved in patient recruitment and were only consulted at the end of the process to ensure it was suitable to approach the participant, thus reducing any undue burden.
- There was minimal conversation with ward staff prior to the start of each observation session to ensure that they were not spending clinical time discussing the research.

- The research nurse and I had information sheets in case someone enquired about the study. Both the information sheets and posters had my contact details for further information.
- My work as a clinical nurse allowed me to identify distress caused by recruitment/data collection when conducting the observations so I knew to end the observations if necessary.

4.14.2 Patients with dementia and consent

Despite the ongoing initiatives to increase involvement of people with dementia in research, there continues to be a gap in the literature of studies involving this client group (Hubbard, Downs et al. 2003). One of the focuses for the study was to explore the care for people with dementia specifically and therefore it was important to ensure that the views of people with dementia informed the research. In light of this, the decision was made to only include participant if they had formal diagnosis of dementia.

As previously mentioned, both myself and the research nurse were able to assess capacity and had previously worked as clinicians with patients with dementia. If the participant was assessed as not having capacity a personal consultee was contacted to provide advice on whether the person would like to be involved and then I would decide based on their judgement. The consent process did not end here and throughout data collection, I continually assessed the capacity of the participant and if there was a suspected change, then acted accordingly. If the personal consultee advised that the participant would like to be involved in the study, I continued to assess whether the participant was comfortable with me observing and stopped if the participant became agitated or showed signs that they were not happy with my presence.

4.14.3 Not obtaining consent from staff during phase one

Due to the high staff turnover and shift pattern on the ward, it was not feasible to obtain written consent from all of the nursing staff prior to the observation phase. Therefore prior to the start of data collection, I spent time on the ward ensuring that staff were aware of the study and the protocol for declining participation. Staff were informed that this was an inclusion study and it would be necessary to inform me at the time of the observation that they did not wish to take part. The wards were provided with a schedule of the observations, so they were aware when the research was taking place so they could decline participation. The staff were made aware that if they declined to take part, then the observations would still occur, however, any interactions between them and the patient would not be recorded. Posters and information sheets were also disseminated on the wards to increase the awareness of the study.

The observational phase was not intended to be covert in nature, meaning participants were to be aware that the study was taking place. If members of staff entered the ward and were not aware of the study, I took this as an opportunity to publicise the project, which in turn, gave staff the opportunity to decline participation. As mentioned previously, both myself and the research nurse had information sheets at all times when on the ward so were able to disseminate these to patients, staff and visitors when necessary.

4.14.4 The role of the researcher

As I had worked previously as a clinical nurse within the hospital, it was important to have a clearly defined role when conducting the observations and interviews. I made it clear that there was to be no involvement in providing patient care and the staff on the wards were made aware that I would only intervene in an emergency whereby the participant was putting themselves or others at risk.

In addition to this, prior to the start of each observation session I would ask the nurse in charge if any patients were at risk of falling so I could alert staff if the patient was to get out of bed. There was one instance during data collection, where I overheard the nurse in charge say I could act as a member of staff to keep an eye on an observation bay and in this instance, I had to define my role again and explain what I would and would not be doing.

4.14.5 Confidentiality, Anonymity and Data Protection

Throughout the study there was strict adherence to the Data Protection Act (1998) with regards to participant's personal data (Redsell and Cheater 2001). The study limited the need for personal data as much as possible throughout and had the safety of the participants at the forefront of the research.

For the observation phase, access to personal data (outside of the direct care team) was not necessary. The patients who were eligible for the study were identified by the research nurse who had previous access to the Oceano database through their clinical work. Whilst recruiting on the ward, if myself or the research nurse assessed a patient as lacking capacity, we would then ask someone from the direct nursing team to access the notes in order to acquire the next of kin's number for a personal consultee.

During both the observations and interviews, no names or personal data were recorded and this has been the same for publication. The participants were made aware that although no names were recorded, the data may be identifiable, however, this was unlikely. They were also made aware that I may decide to publish some direct quotes from the interviews and had to agree to this when they consented to being interviewed.

During the observations there was no need for anyone outside of the direct nursing and medical team on the ward to know which patients were involved in the study. Neither I, nor the research nurse, directly informed anyone that the participant was involved, except for the nurse in charge who had a discussion with one of us prior to the start of the observations. For the interview phase, the staff posted their consent forms in a locked letter box provided and none of the other members of the nursing team were aware of their participation.

4.14.6 Data Storage

To limit the risk of jeopardising the data protection, all paper files acquired during observations were transcribed into electronic files within 48 hours of collection. Once transcribed into electronic files, the paper files were destroyed by being shredded and placed in confidential waste files within the university. Audio recordings were also destroyed as soon as they were transcribed as they were no longer needed.

All electronic files were kept in a locked file on my password protected laptop which only I had access to. Once data collection was complete, any personal data collected during the study, such as consultee contact information or names of staff were destroyed within three months. Due to the University of Southampton's policy, other data collected during the study was deposited in ePrints Soton for long-term secure storage for a period of 10 years.

4.15 Chapter Summary

This study explores the impact of ward system factors on Medicine for Older Persons wards and how these factors affect relational care between nursing staff and patients with dementia. This chapter has explored the methodology of this research study, explaining the methods used and commenting on the reliability of the findings. This study was underpinned by a pragmatist paradigm, in which the reality is changeable (subtle-realism) and co-constructed by the researcher and the participants. The research has been conducted using an ethnographic approach that incorporated qualitative methods in the form of observations, informal conversations, interviews and reflexive notes. The data have been analysed thematically and measures have put in place to optimise the reliability and validity of the findings. The wellbeing of patients and staff was at the forefront of this research and a range of strategies were deployed to assure this. The next four chapters will detail the results of this study.

Chapter 5 Setting the Scene

5.1 Chapter Introduction

The next four chapters present the results found from this research. This chapter focuses on the data gathered that provide a description of the Medicine for Older persons wards. This will then provide the context for the following chapters that will explore the data that answers the objectives of this study as described below:

1. To identify and describe the factors of the work system within medicine for older persons wards that influence nursing work
2. To explore how work systems factors, influence nursing work
3. To explore what effect this influence is having on nursing staff and their individual capacity to provide relational care

5.2 An Introduction to Medicine for Older Persons

This study took place within a hospital in the South of England between January 2017 and March 2018. The hospital was a large NHS site with a capacity of 1,200 beds that provided acute services to an approximate population of 650,000. Within the hospital there were eight wards situated beneath the Medicine for Older Persons umbrella. Medicine for Older Persons wards specialise in older persons medicine, providing services to those who are 70 and older and treat a range of conditions. Due to the age of the patients on this ward, the population with a diagnosis of dementia was high and on average, about 80% of the people across these wards had a diagnosis or a form of cognitive impairment. Data were collected on three of these wards, each of which had approximately 25 beds.

The vast majority of patients on these wards came in through accident and emergency, moved through into the medical assessment unit and were then admitted onto the wards if further treatment was required. The length of admission ranged from one week to over three months depending on a Persons social situation. Many of the patients on the study wards had recovered from their acute illness but were waiting for a care package in order to be discharged home. This was often a long process as barriers such as securing funding for care home placements and locating equipment such as wheelchairs, often caused delays. As a result of these delays, the study wards were occupied by both acutely unwell and medically fit patients.

Each ward was comprised of a team of doctors, including consultants, senior house officers, and medical students, as well as the nursing cohort consisting of one Band 7 manager, Band 6 nurses, Band 5 nurses (*Nurse banding described in Appendix M*) and health care support workers.

5.3 Shift Pattern

The wards operated as 24-hour care services and as such, the nursing staff had a varied rota pattern to ensure that all shifts were covered. The shift pattern consisted of both long and short day shifts and a night shift as described below:

Long Day: 7.30am – 20:00pm
Short Early: 7.30am – 14:00pm
Long Early: 7:30am – 16:00pm
Short Late: 13:00pm – 20:00pm
Long Late: 11:30am – 20:00pm
Night: 19:30pm – 08:00am.

Most staff on the wards worked a mixture of all shift patterns, including both days and nights. A typical shift pattern for full-time staff within a week, consisted of two long days, one short shift (early or late) and one long early or long late. If the staff worked nightshifts, their week would usually have consisted of three to four consecutive nightshifts or in some instances, these were spread across the week. There were members of staff who worked permanent nights and therefore worked three to four nightshifts per week, every week. There were also members of the team who worked part time and therefore their shifts varied based on how many hours they worked. Some members of the team also worked only short days and therefore worked five days a week as opposed to four[4].

5.4 Staffing

The nursing staff on the wards were either health care support workers, student nurses, nursing associates, registered nurses, sisters or managers. A detailed explanation of the different types of nursing staff is provided in Appendix M.

The three wards in which this study took place, operated on the same staffing levels. On a day shift (both early and late) the ward should have operated with one nurse in charge, managing two

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[4] This was rare and was usually due to health constraints.

nursing teams. The nursing teams should have consisted of one nurse or nurse associate and two health care support workers that cared for a cohort of eleven to twelve patients. At times there would be more staff on during a shift, for example on occasions there were additional health care support workers who may "float[5]" between the two teams or a student nurse who was supernumerary[6]. There were also occasions on shift when there were only three health care support workers on at one time and in this case, there would be one based within each team and one "floating" between. At times when hospital staffing was very low, the nurse in charge would also be lead a nursing team so there were only two nurses on shift at one time. This was not a regular occurrence and only occurred once during the observation period.

During the 14 months of data collection between January 2017 and March 2018, the hospital was going through a time of turmoil with regards to nurse staffing, which was reflective of the national state of nursing vacancies during this time period. At the time of data collection there was a national staffing crisis within the NHS, with an estimated shortage of 36,000 nurses (NHS England 2018). During this time period and for the first time in NHS history, the figures suggested that more nurses were leaving than joining the NHS with an estimated one in ten nurses quitting each year (NHS England 2018). NHS digital suggested that although some of those leaving were over 55 (the age at which nurses can retire on a full pension), just over half were under the age of 40. Due to this increasing staff shortage, the figures show that 2/3 of the workforce were agency or bank staff (NHS England 2018), a picture reflected on the study wards described here.

5.5 Ward Built Environment

The walls and floors of all three wards were white with yellow beam lights that ran along the corridors. The entrance to the wards had large, double doors with signs welcoming visitors to that particular unit. The walls of the wards were hidden underneath blue noticeboards, which were covered with posters that highlighted ward audits and provided information for both staff and patients. The wards had a central area in which there was a reception desk, seating and filing cabinets in which the medical notes were kept. There was always a patient board in this area that provided details of each patient on the ward and there were also computers and phones in this area, which staff were always able to access.

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[5] Float - The member of staff would not be under a team but would work between the two, helping where needed.

[6] Supernumerary status meant that they were part of the workforce, although, not included in the staffing numbers.

All three wards included a manager's office where the band 6 and 7 had a desk space, as well as a kitchen for staff to make drinks for both themselves and patients. On most wards, there was a treatment room where medication and medical equipment were stored. The wards had a linen cupboard in which patient gowns and bedding were stored, as well as another equipment store containing spare mattresses and mobility aids.

The wards consisted of bays for multiple patients and these bays were segregated into male and female. The bays consisted of four to six beds, depending on the size of the room, and had the beds across each side of the walls facing inwards towards each other. Between each bed space, there was a curtain that could be drawn for privacy by staff when providing or assisting with intimate care such as washing, or medical procedures. As well as bays, the wards had single rooms, which had individual patient beds. These single rooms were usually for patients that were immunocompromised[7] to stop the spread of infection or at the end of their life, as it allowed more privacy for them and their visitors. Most of the single rooms were large, with a bed in the middle and had a sink on one wall.

5.6 Ward Routine

Data gathered from the observations reflect that the nursing work was shaped by a routine. The routine dictated what task needed to be completed, who was to complete that task and the duration of which that task should last. This routine remained constant throughout the year of observations and was identical across all three of the wards.

During an early shift, the day would start with a nursing handover in which the nurses from the nightshift would explain to the oncoming staff what had happened during the night and whether there was anything to follow up on. All nursing staff (both registered nurses and health care support workers) would be present for this and overall the handover would usually last up to half an hour. The handover would take place in the relative's room, which was a smaller room off the side of one of the corridors and a place in which patients could not hear what was being said.

Once the handover was over the night staff would be free to leave their shift and the day staff would begin their tasks for the day. The nurses would start by checking for any patients who required insulin before breakfast. They would then check the vital pack, an iPhone that had an app installed to record patient's vital signs (pulse, blood pressure, oxygen saturations) and ensure there were no outstanding vital signs to be checked. Once these tasks were completed, the nurses

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[7] Patients who are immunocompromised have a reduced ability to fight infections and other diseases possibly due to underlying illnesses such as forms of cancer.

would then began their medication round. The health care support workers would start by stocking their trolley of wash bowls, towels and sheets and begin sitting patients up ready for breakfast.

Between 8:00am-8.30am the breakfast would arrive on the wards and a bell would be heard signalling that the trays were ready to be distributed to patients. The health care support workers would queue next to the food trolley and disseminate the trays one by one, to each patient. Once the trays were delivered, the health care support workers would focus on the patients that required assistance with eating and drinking and during this time the nurse would continue administering medication. From observation, it was evident that staff felt that most people with dementia needed assistance to eat which would result in the health care support workers assisting. Breakfast lasted, on average, half an hour and the end of this meal period was often signalled by the catering staff coming back onto the ward and collecting trays. For people with dementia who needed assistance with their food, their trays would usually be left until staff were able to help. The more people that needed assistance to eat, the more time was spent on this task and the more staff became concerned with the lack of time they had left in the morning:

> "The kitchen team have come onto the ward. "Breakfast" one of them shouts and the health care support workers leave what they are doing and come to line up to give out the food. The nurse in charge also drops what she is doing and says "I'm off to the bed meeting" – meals and the bed meeting are high priority as all tasks seem to be dropped for these two activities. The meals are delivered one by one and the patients receives a brief interaction, mostly centred on the activity of eating or small one line sentences "you alright?" "Here's your breakfast" "shall I open it for you?" "Shall I sit you up?" "are we keeping you up" "shall I move that table?" and then once the patients are in the correct position, they then leave to go back to delivering the meals. The staff go back to help the patients who need assistance "we've got four feeds in here – oh Christ!" ***FIELD NOTE***

Once the breakfast period had ended and patients who needed assistance with eating and drinking had finished their meal, the health care support workers would spend the rest of their morning assisting patients with washing and dressing. Although this seems like a straightforward task, the washing and dressing of a patient was complex and often consisted of performing many tasks at once. During this time, the health care support workers were also checking the skin integrity of the patients whilst providing a wash, as well as observing for any dressings that may need changing. This complexity was heightened when the staff were assisting a person living with dementia. People with dementia would often resist personal care – either verbal or physical resistance– which would cause the task to take longer as staff had to manage this resistance as well as performing other tasks.

Staff on the ward appeared very task orientated during the morning. The health care support workers knew which patients needed to be weighed and would often include this within the task of washing and dressing. Documentation played an important role during this time and all the food and fluid charts and rounding sheets[8] would be completed for the morning, ready for lunchtime. Bed linen was also changed during this time, as well as beds wiped, and bedside tables cleaned. The patients that were able to get out of bed, were sat out in their chairs. Again, this was often more complex for people with dementia, who were likely to have difficulty with mobility. As a result, this often required the use of equipment such as hoists and often required more than one member of staff.

During the morning, the nurses would usually have finished their medication round between 09:30am and 10:30am. The medication round, similarly to washing and dressing, would often be an amalgamation of tasks completed during the administering of medication. The nurses were continuously checking the patients to which they administered the medication - ensuring their catheters were draining properly and checking dressings, whilst simultaneously checking the vital pack to ensure their observations were stable.

> “She picks up the folder of the next patient and goes back to the trolley without making any interaction. She returns to the patient when she is ready to fill it in, “Hello, you alright? you look tired” she holds out medication “here’s your tablets” “I’ll pop them in”. There is little relationship being built but the task is being completed which seems to be her main priority. The nurse continues to hold each pill up and wait for the patient to take it, there is not interaction during this encounter. Once the patient has finished taking all of their tablets, the nurses then moves on to the next patient” **FIELD NOTE**

The medication round would also be a time for nurses to check the patient's documentation, checking there were no gaps, ensuring that they had had their bowels opened recently and filling out the food and fluid charts from breakfast. Nurses were continuously stock checking the trolley and seemed to repeatedly return to the clinic room to refill packets of medication. They were also seen to be completing pharmacy requests when stock had run out, as well as checking medication charts to ensure there were no gaps or missed doses.

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[8] Rounding sheets document patients repositioning throughout the day. The sheets contained columns for every two hour time frame and prompted nursing staff to record the patient’s skin integrity, as well as nutritional intake.

Once the medication rounds were over the nurses would again check the vital pack to ensure that there were no outstanding observations and complete any additional tasks that had arisen from their medication round, such as calling the pharmacy or requesting that the Doctor rewrite a medication chart that was full. When these tasks were completed, providing there was still time before lunch, the nurses would go on to assist the health care support workers with washing the patients, which would often go on until 12:00 when lunch was delivered.

Again, these tasks were made more complex when the care was for someone living with dementia. It was often observed that people living with dementia needed more support in order to understand the tasks such as taking their medication or having their vital signs recorded and consequently these tasks would often take longer. Simple tasks such as filling in the food and fluid charts were made more complex as the nurses were unable to ask how much the person had had to eat or drink. This increased complexity often led nurses to spend more time on these tasks which similarly to views of health care support workers, made nurses frustrated and concerned with the time they had left.

Although these tasks are described here in a linear way, many of these tasks were often occurring simultaneously. In addition to the planned work, the field notes reflect that unexpected incidents such as a patient fall or a patient deteriorating often occurred. If these events were to occur, this would then add to the workload of the nursing staff and they would not only need to attend to these patients but continue to complete the tasks mentioned above. There were often alarms ringing to signal that a patient had stood up and was at risk of falling; and if so, the nursing staff needed to attend to this. Intravenous pumps were continuously beeping; signalling that they had either finished or there was an obstruction and the staff had to ensure that these were switched off or fixed. The ward phone was constantly ringing with relatives asking for updates on particular patients or calls from other professionals trying to find out about a patient, both of which the nursing staff had to attend too. In addition, and perhaps most importantly, the patients were often asking for further assistance – another drink or assistance to the toilet and thus, the staff also had to manage these demands simultaneously.

During this time, the ward was also full of other members from the multi-disciplinary team. Within the busy periods on the wards there could be the nursing team (one nurse and two health care support workers), as well as two physiotherapists, one social worker and often three doctors in one bay. The doctors were also carrying out their medical rounds and allied health professionals (physiotherapists and occupational therapists) were assessing patients. As a result, nursing staff (particularly nurses) were also taking requests from these other professionals; all of which they had to complete as well as their own jobs. In addition to these tasks, there was also the ongoing need to ensure patients were being moved throughout the hospital system and therefore admissions and discharges were happening simultaneously throughout the day. Nursing staff (health care support workers and nurses) were also expected to each have a half an hour break during this time.

5.6.1 Late Shift

Twelve o'clock signified lunch time on the ward and by this time, without fail, all patients were washed, dressed and sat up or out in the chair, waiting for their lunch. Once again, the food trolley would come onto the ward delivered by the kitchen services, signified by a bell and the staff would line up to deliver the trays to patients – similar to the breakfast round, however, this time included nurses as well. Lunch appeared much more relaxed than breakfast and lasted on average of an hour. Again, similarly to breakfast, lunch did not just consist of helping patients with their meals but checking paperwork, repositioning patients and tidying the bed space, were all part of the lunchtime routine. Once the nurses had finished assisting with meals, they would then attend to the lunch time medication round which did not usually take as long as the morning round due to the reduced amount of medication to be dispensed. Each lunch time medication round lasted approximately thirty minutes to one hour.

Following the end of lunch and the medication round, there was, what can be described as a "lull period" between 13:00pm and 14:00pm. During this time, there did not appear to be any routinised tasks and staff often occupied their time by cleaning, checking their training schedules online and completing any further paperwork that was outstanding. Interaction between staff and patient was very limited at these times and so very little relational care was observed in the lull period.

At two o'clock tasks on the ward seemed to pick up again and the nursing staff would help patients to change position and assist them to the toilet if necessary. Unlike the morning round, the nurses were more involved in this repositioning and again this task usually incorporated tidying the bed space, attending to documentation and checking the patient for any changes to their condition. Similarly, to the morning however, was the increased complexity that nursing staff faced when completing these tasks with people with dementia compared to people with no diagnosis.

This field note highlights how nursing staff spent their time in the "lull period" between 13:00pm - 14:00pm, as discussed above, despite the reduced in tasks, the staff still did not prioritise interacting with patients:

> “The lunches are coming to an end – the next rounding time doesn’t start till 14.00pm so the staff have some free time before this. I can see 2 HCSW sat on the desks in the bay looking at the patients, I assume waiting for them to finish their meals. 2 HCSW are on the computers and one checking the rota. The nurses continue to do the medication. It is noticeably calmer on the ward and it is clear that there is less tasks that need to be done however it seems that the interactions with patients have not increased” ***FIELD NOTE***

> “From 13:45 – 14:15 there is no interaction with staff. Most of the staff are record keeping or spending time on the computer. Most of the patients are now asleep or have visitors at their bedside so there is no need for staff interaction” ***FIELD NOTE***

Once all the patients had been repositioned by staff, the nurses were usually occupied by filling in the care plans. Each nurse on duty had to complete a record about the physical care that patients had received throughout their shift, commenting on themes such as mobility, continence care, skin integrity and nutrition. This work would take the nursing staff up to an hour to complete all the paperwork for each of the patients in their care and often coincided with patients' vital signs being recorded again.

Visiting time on the wards started from 14:00pm onwards, which seemed to both alleviate and add work for the nursing staff. The nursing staff seemed to feel less need to be within the bays perhaps because they saw the visitors as observers and they relied on the visitors to alert staff of any concerns. However, visitors would also request to speak to nursing staff for an update which would often involve staff contacting other members of the professional team for more information. Between the hours of 15:30pm and 17:00pm staff were again entitled to take a half an hour break.

From 17:00pm onwards, the workload would begin to increase again and staff were seen to be busy with tasks. Between 17:00pm and 17:30pm the teatime meal was provided, again, following the same routine as the previous meals. Once the meal was over, the healthcare support workers went onto repositioning the patients and assisting them back into bed should they so wish. This repositioning round seemed to take longer than previous rounds as staff tended to ensure that any tasks left unfinished from earlier in the day were completed, the ward was tidy, and the paperwork was up to date and ready for the night staff to come onto shift.

During this time, nurses were administering their evening drug round which usually consisted of more medications than lunch time and therefore took a longer amount of time. This task also involved ensuring that the vital signs were recorded again and there were no outstanding patients to check. The nurses also spent this time ensuring paperwork was up to date and finishing any tasks (such as bladder scans or changing catheters) which the doctor may have requested earlier on in the shift. At 19:30pm the night team would come onto shift and it was time for the nurses on the day shift to handover, ready to leave for the day.

Similarly, to the early shift, the late shift did not always run as smoothly and sequentially as described here. As mentioned before, discussions with visitors remained a high priority for staff, answering phone calls from external organisations and family members, admissions and discharges, requesting tasks from professionals and ensuring patients' needs were met, were all additional tasks that nursing staff must have completed. Unexpected events such as patients becoming increasingly unwell, a patient falling or a patient dying, all had an impact on the routine of the day. In addition, the patients that had increased needs, such as patients on an end of life pathway, patients on a complex medication regime or patients receiving intravenous medication also placed an increasing demand on nursing staff time.

This time of the evening also seemed to add another layer of complexity to the routine as people with dementia would start to experience what is often described as sun-downing[9]. Sun-downing often presents itself as a higher level of confusion which can result in increased agitation. During this time on the shift, the nursing staff would often spend more time trying to assist people to sit down in their chair or lay in their beds, as a way of managing the risk of falls.

5.6.2 Nurse in charge

Although part of the nursing team, the nurse in charge followed a very separate routine from that of the other members. As mentioned previously the nurse in charge had the role of organising the shift and overseeing the tasks, as well as taking the lead in the admissions and discharges of patients. The day started with the nurse in charge organising the staffing for the ward and delegating the patients to each members of the team. From here and as with the rest of the team, the nurse in charge would then attend the handover of the patients in the morning making notes on both teams. Once the handover had ended the nurse in charge would then go onto organising the day ahead, including checking what patients were due to be discharged and getting things in place for this. The time before 08:30 was also used for checking the vital packs for any outstanding alerts as well as any outstanding documentation.

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[9] Sundowning is a symptom of Alzheimer's disease and other forms of dementia. It's also known as "late-day confusion." If someone has dementia, their confusion and agitation may get worse in the late afternoon and evening.

At 08:30am an alarm would sound signalling that the bed meeting was starting and the nurse in charge was to attend. The bed meeting occurred three times a day (08:30, 12:30, and 15:30) and was a chance for all senior members of staff from the Medicine for Older Persons wards, to get together and discuss ward occupancy and assess patient flow[10]. The staff discussed both the potential discharges and definite discharges and were expected to have at least one patient in both of these categories.

The field notes from the observations highlight the importance of the bed meeting for the nurse in charge and the demand of the organisation in relation on bed occupancy and moving patients throughout the hospital:

> "During this time the nurse in charge has returned from the bed meeting and is clearly stressed – "it's ok to be shouted at" she says to the ward clerk. "Right better find someone for that bed!" she rubs her eyes "I can't see, if I had a stroke the sisters wouldn't care as long as I found someone for that bed!" Clearly the biggest pressure is getting the patients out. "What time was the transport booked" "we better change it for the afternoon so the package of care will have started" ***FIELD NOTE***
>
> "The nurse in charge has returned from the bed meeting looking agitated "they've just shouted at me again because she's still here, the medication is at the pharmacy, the transport is all booked, let's get her to discharge lounge" ***FIELD NOTE***

Once the bed meeting was over, the nurse in charge would return to the ward ready to attend the board meeting. The board meeting was a chance for all members of the multidisciplinary teams to get together and discuss each patient on the ward individually. The board meeting lasted between thirty minutes to an hour and once finished, the nurse in charge would start on the tasks that had arisen from this, such as contacting nursing homes, relatives or social workers to arrange discharges.

For the nurse in charge, the rest of the day was usually spent liaising with other professionals, both internally and externally, in hope to either increase discharges or move patients along their care trajectory. On top of this, the nurse in charge was often answering queries for nursing staff, as well as ensuring that the patients were receiving the appropriate care from nursing teams. Most of the phone calls to the ward were diverted to the nurse in charge, as well as answering relative's requests when they were visiting. The nurse in charge would often help with assisting

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[10] Patient flow describes the movement of patients throughout the hospital

the patients where possible, either with lunches or personal care when they had the time to do so.

5.7 Ambience of the Ward

From the observations, it was clear that the ambience of the ward differed depending on the time of the day and there was a significant contrast between an early shift and a late shift. On an early shift, the ward environment appeared chaotic. The wards were often full of health care professionals including but not limited to: nursing staff, doctors, matrons, occupational therapists, social workers and physiotherapists who were all visiting different patients at different times. The doctors would begin their rounds and visit each patient at a time with potentially three doctors around the bed space. The health care support workers were completing their washes and were therefore using different pieces of equipment as well as changing all the bedding which caused the wards to feel quite cluttered. The phone rang more often on an early shift with professionals trying to find out about discharges and relatives calling to see how the patients were overnight. Nurses were preoccupied with trying to maintain the schedule for the day, trying to complete their drug round whilst also assisting patients who were waking up for the day.

On the late shift, there was a vast contrast in the atmosphere of the ward. There were fewer members of the multidisciplinary team present as the doctors were more likely to have finished their rounds so would spend less time at the patients' bedsides. The physiotherapists and occupational therapists had finished their assessment and so there were less people in the bays and cubicles. The washes had been completed before lunch and therefore there would be less use of equipment and less need for bed linen to be out, which reduced the cluttered feeling of bays. The nursing staff would not seem as rushed, allowing them more time to complete tasks, which again reduced the chaotic feel which was present in the morning. The patients due to be discharged had usually been transferred to the discharge lounge so the pressure to move patients around had usually subsided. Visitors were also present on the ward which then reduced the pressure of staff to ensure that patients are being constantly observed.

5.8 Patient experiences of care

Before exploring how the work system factors affected nursing staff, this section of the chapter will explain what was observed with regards to people living with dementia experiences of care. Within the previous section that focused on the ward routine, the descriptions were from that of the nursing staff's perspective with the patients being portrayed as passive agents within nursing work. This section will use the evidence from the field notes to describe the experiences for patients with dementia on medicine for older persons ward, particularly focusing on the care they received. Similarly, to the way in which the ward routine was described, this section will focus on both the early and the late shift as separate times. Following on from this, the themes derived from the analysis with regards to patient care will be explained with data from the observations used to evidence the claims made.

5.8.1 Early Shift

When the day staff came onto shift at 07:30, patients were usually asleep and this would remain the same until after handover. Once the night duty staff had left and the day staff had finished handover, the lights would be put on in the wards to signify the beginning of the day and the need to wake up. Depending on who the nursing staff would choose to assist first, the patients would stay in bed (usually asleep) until around 8.30am when breakfast was delivered. For people with dementia, this was the often the case. Due to their needs often being higher, staff felt they did not have time before the end of handover and beginning of breakfast to assist with personal care and therefore, people with dementia would often stay asleep until breakfast was delivered. Prior to the delivery of breakfast, the patients would be assisted to sit up in bed which would involve the back of the bed being raised and a table being placed across the bed ready for the delivery of the tray. The field note below identifies how most shifts started:

> "When I first entered the ward, handover was still happening. I located myself outside of the cubicle of the patient I was observing. The teams were split oddly and out of a row of 5 cubicles, one of the teams was responsible for one of the cubicles out of the 5. Breakfast was being to be delivered and medication round started. Menus were being completed for lunch and dinner. The cleaner was cleaning the corridors. Doctors were just starting to come onto the ward. The Nurse started the day by attending to patients who have diabetes and administering insulin. Deliveries are coming onto ward. Everyone has their own tasks in which they are working on, it seems as though nurses have a clearly defined set of tasks that need to be completed in an order whereas health care support workers seem to have more flexibility and allocate time slots to each patient at the beginning of the day" ***FIELD NOTE***

Food would be delivered one by one around the ward and the patients were then left to eat their food. If the patient required assistance with their food, they would usually wait until the staff had delivered the meals to all the patients in the bays before returning. The greater needs of the people with dementia with eating and drinking, meant they were often sat with their meals in front of them and would be waiting for someone to come and assist. Often, the meals would remain covered, as staff were aware that assistance was needed. Due to staff rushing to deliver the meals to each patient, there was often little explanation as to what the breakfast was which seemed to result in some confusion for people with dementia. On occasion, the patients were seen to be assisting themselves but would put orange juice in their cereal instead of milk or spread porridge on their toast instead of butter. Alternatively, patients who had a diagnosis were observed to be unaware that breakfast had been delivered and would often fall back to or remain asleep.

> "At 08:15 the trays are being delivered for breakfast, the staff deliver the trays one by one to each patient. A health care support worker goes up to the patient "here's your breakfast" "shall I butter your toast?" "Do you want sugar?" She uses these short statements to try and communicate. The patient doesn't respond "I'll butter your toast for you". Again, the patient has not responded but she is assuming what he will want, she needs to go back to deliver more trays so there is a need off the ward here, so she doesn't feel she has the time to divulge further into this conversation. The patient starts to respond, "I don't want it yet" - "yes I'll do it now". She butters his toast and leaves. It appears that the patients have to fit into the time patterns of the hospital, there is no flexbility in this. The patients fit into the tasks allocated time slots. The health care support workers leave the room to deliver the trays to the other patients and the patients in this bay are left to eat their breakfast in silence" ***FIELD NOTE***

> "A healthcare support worker enters the cubicle to deliver breakfast, asks the patient "how did you sleep?" but gains no response. Asks "shall I sit you up?" but again no response, but support workers continue to do so anyway. The support worker then talks to another member of staff "I'll do him and then again in 2 hours". The hospital day seems to be divided into 2-hour slots guided by the repositioning charts and communication fits within this allocated time slot. A health care support worker enters the cubicle to fill out the menu for the patient. Starts interaction "do you like soup?" - no response, so starts to raise voice "do you like soup?" and repeats 5 times. She then moves on to "roast beef or fish pie" and repeats this. After about 5 minutes the health care support worker leaves the bed space and says, "I'll just order him whatever, he can't hear me". I am wondering why she didn't attempt something different – communication aids or writing it down or simplifying it – perhaps these aren't available. Phlebotomists have now entered ward (08.30). At 09:00 the health care support worker explains "right let's begin" ***FIELD NOTE***

Once breakfast was over, the patients were often in bed until it was their "turn" to get out of bed. The patients would usually be asked whether they would like a wash or at times be offered to walk to the shower, however, this was dependent on their ability to walk. During this time, the patients were able to talk to the staff and the nursing staff would often make conversations regarding their personal lives, for example about their families or where they lived. For people living with dementia, who may have been unable verbalise the decision as to whether they would like a wash or shower was often made for them and due to their often poor mobility, it would be suggested that they would have a wash within their bed. Staff would often try to interact with the patients with dementia during this time by asking questions, however, what was witnessed on many occasions was staff talking to one another. As patients with dementia had greater needs, their care would often be provided by two members of staff at a time – this increased the possibility of staff talking to each other, especially when the person with dementia was non-verbal. The activity would usually start with staff trying to communicate with the patient, however, due to the difficulty in holding a conversation, would often end with staff talking to each other.

Once patients were assisted with their personal care, they would sit in the chair or be sat up in bed, again dependent on their ability to mobilise. The patients would then wait here until all the washes had been completed (usually around 12pm) and usually without any interaction. At times, the patients would be asked if the nurses were able to take their vital signs and during this period, they would also be given their morning medication. If the patients had dressings that need changing, the nursing staff may also try to do this before lunch and if the doctor had requested an intervention (bladder scan for example) then this may have also been completed. The field notes below provides examples of when the patients had received assistance with their personal care. As described, patients were often left with little interaction following the completion of the physical tasks:

> "Most of the patients have now been washed and are sat out in their chairs. The lights are off and 2 patients are currently in bed still asleep. It appears that all the "washes" have been completed and the ward looks very tidy. The health care support workers are outside of bay talking to each other." ***FIELD NOTE***
>
> "I am observing in a male bay which has 4 patients in. All four men are sat out in the chair. The lights are off. No staff are currently present. 1 patient is colouring, one is shaving, one has his head down and one is looking around the bay. The board round has ended, and the staff are giving washes in the next bay. I can hear the nurse in charge trying to sort out the discharges and the nurse on this bay is now helping with the washes as she has finished the medication.

> I catch eye with one of the patients, "no-one here is there" I smile – the patients says "same as yesterday". There is awareness that there is no staff present.
>
> There is no interaction until 10.30am and the patients remain in silence and occupying their own time. I see a HCSW leave to go on their break outside of the bay. There is still no communication or staff within this bay – it seems this is because they have all received personal care and there is no care need for an interaction" ***FIELD NOTE***
>
> "Where is everyone" a patient states. Another response "nothing much here is there". – It has now been an hour without the patients receiving any interactions and even to me it feels like a lot more. I can hear the vital pack in the distance and hope to myself that the nurse will come and do the patients vital signs so that they can see a member of staff" ***FIELD NOTE***

At 12pm and when lunch was delivered on the ward, the same routine would be followed as breakfast. The patients would have a tray placed in front of them and any patients that need assistance would wait until all the trays were delivered to the bay. During this time, the patients would have the opportunity to talk to the nurses, however, this was more likely if they were receiving assistance due to the close proximity to staff members. If patients were in a position where they were not sat close to any members of the nursing staff, they would often eat their lunch in silence.

> "At 12:45 the lunch trolley finally arrives, and the team go back to their usual roles in this period. They queue up and wait for the trays to be given to them and delivered. I return to the bay in which I was observing. At 12:55 the trays are starting to be delivered in the bay. Again, the tray is placed in front of the patient "hello, here's your lunch" "shall I turn your table?" "sit up please" and the patients are then left to eat their meals. The four patients within this bay are able to feed themselves and this is then another missed opportunity for interaction, the patients eat their meals in silence. At 13:30 staff return to bay to start collecting trays and filling in rounding sheets. "Finished?" – "yes" and walks out with the tray" ***FIELD NOTE***
>
> "At 12 o clock lunch is delivered on the ward. Again, this is one by one and the interaction is short statements. The patient I am observing is in the cubicle and therefore does not seem to get a lot of interaction. He seems to need help with eating his lunch, however, staff members have not seemed to have noticed and tend to spend their time in the bays. From 12-12.30 the patient it is sitting in his chair asleep as the other staff members are in the bays helping patients who need it. At 12.30 the nurse has started her drug round, she

> enters the cubicle next to the one I am observing with the medication “you alright?” “well they’ve just come in and changed the bed and now I haven’t seen anyone” – the patient is becoming agitated that he has been in the cubicle on his own for a long time” ***FIELD NOTE***

5.8.2 Late Shift

Following on from the end of lunch and the delivery of the medication round, the patients would be repositioned and if needed would be taken to the toilet or have their personal care attended too. The patients would then sit in their chairs or in bed for the rest of the afternoon.

During the period between 2pm and 5pm, the patients were sometimes visited by nursing staff should they have needed a nursing intervention, such as vital signs recorded, wounds that needed dressing or additional medication that needed administering. At times, the nursing staff would complete their documentation in the bay and during these times, the patients may have a conversation with them, again, if they were in close proximity to them. On some occasions, the nursing staff would visit the patients and offer nail care which again would provide an opportunity for patients to talk to them, however, this was a rare occurrence.

During this time period, visitors would often come onto the ward. For patients of whom the visitors would come to see, this would provide an interaction for the afternoon, however, for patients who did not have visitors, the afternoon was often spent asleep or with very little activity.

> “4 patient bay, all female ward. 1 nurse and 2 health care support workers looking after bay. The rounding sheets for the 2-4pm section have been filled in already. The ward seems calm and the staff don’t seem rushed.
>
> The patient starts to say something, and the health care support worker approaches her. The HCSW cannot understand what she is saying but looks to where she is pointing and asks whether she would like a yoghurt, the patient mouths something but again it is hard to tell what she means so the HCSW opens the yoghurt anyway and goes onto to feed her. A nurse enters the room and says that someone needs changing, the 2 health care support workers say they will go now and leave the room. It seems as though the nurse structures the time of the HCSW during this period as they have no set tasks to complete.
>
> At 14:15 3 HCSW enter and start to tidy the bed space, it seems as though they are trying to find tasks to occupy their time. Again, the patient tries to communicate and it is clear that the HCSW cannot understand what she is saying. She then goes onto to agree “yes, yeah” whilst sorting out the desk and then walks away. I wonder why she didn’t use a

> communication aid or try hard to understand what the patient was saying as opposed to agreeing and leaving. They then leave the room.
>
> I see the nurse walking back and forth outside the bay carrying trays with medication in and liaising with the Doctor – it seems they have more set tasks during this time period making it more difficult for them to talk to patients. Nurses have less time as they have a larger number of short tasks to complete, whereas HCSW have more time and ultimately should be providing the most interaction.
>
> During the time period when there is no staff present the patients do seem to become increasingly agitated, 2 of them start to call out names and one repeats "please help me, help me please" however, there is no one to talk back. They then start replying to each other and another starts whimpering. A patient calls out to the HCSW outside of the corridor, but she continues walking, she wants a cup of tea. Again, the patients remain agitated. It is now 14.30 and one of the patients has started crying and another is continuously calling out. Many staff keep walking past the bed space, however, they are not entering. They seem to be cleaning the corridors" ***FIELD NOTE***

At 5pm the ward would become busier again, and the patients would be repositioned ready for dinner. Again, following the same routine as breakfast and lunch, the trays were placed in front of the patients and patients that needed help would be assisted following the delivery of the trays. Once the patients had finished the eating, the trays would be taken, and it would be time for them to have their medication and be repositioned ready for the night shift. The staff would visit the patients one by one and reposition them and assist in getting their pyjamas on should they so wish. Again, during this time the patients would interact with the staff, usually discussing whether they would be on shift tomorrow and if not, what their plans were. During this time there were often be visitors on the ward also. The patients would then be ready for the nightshift to come on at 19:30.

> "For the next ten minutes there are no interactions. I can hear staff in the next bay, completing other rounding tasks. One of the patients has continuously spoken out during this ten minutes but there is no one here to interact with them. At 18:00 a nurse enters the room. This is the first time I have seen a nurse during this observation session the nurse goes to each patient individually and gives medication. The interaction is task focused and minimal. The patient I am observing does not have any medication at this round and therefore receives no interaction from staff. The drug round is over quite quickly – there is not as many drugs at this time as the morning so there is not enough allocated time for communication" ***FIELD NOTE***

5.8.3 Themes in patient care

The above section described the ward culture on Medicine for Older Persons wards from both staff and patients perspective. Throughout both sections there were ongoing consistencies in the themes with regards to the delivery of care for people with dementia. The following sections describe these themes using the observational and interview data as evidence for the claims made.

5.8.4 Patients are expected to fit into the routine

Due to the routinised nature of nursing staff work, patients were expected to "fit in" to the routine of each ward. Patients were expected to allocate certain times to their needs such as needing the toilet and having their personal care attended to in order to fit into the organisation of nursing work. Patients were often dictated to by nursing staff with regards to their care, for example when they were to be repositioned and when they wanted to eat:

> "So, like the routine in hospital is to come in and get everyone washed very quickly and get them up and sat in the chair" ***INTERVIEW (HCA2)***

Nursing staff would appear quite agitated if patients' needs fell outside of the routine, for example if they requested to go to the toilet during a meal time or wanted a cup of tea when they were having their vital signs recorded:

> "The patient requests to go to the toilet, she looks at the clock, sighs and reluctantly goes to get the commode. She comes back with the commode and pulls the curtain around him and leaves" ***FIELD NOTE***

During the observations, it was clear that the care being dictated by a routine was detrimental to patient care and more specifically, for patients with dementia. From the data, it appeared that patients who did not have cognitive impairment were more aware of the routine and would verbalise their needs at times in which they knew were appropriate. For patients with a diagnosis of dementia, this was more difficult, and it was often witnessed during the observations that they were much less able to "fit in". As a consequence, there was often a greater tension between nursing staff and patients with dementia as nursing staff were more agitated with the disruption in their routine, causing them to become frustrated and leading to a reduced capacity to provide relational care.

5.8.5 There is an allocated interaction time

Similarly, and again, as a result of the routine of the ward there was an unspoken rule that there was an "allocated interaction time" in which time for communicating with patients was guided by tasks within the routine of the shift. As witnessed in the observations and as described in the general overview of the ward routine, each patient was provided with an opportunity for interaction during the time in which they received nursing care. Once the care task was over, the nursing staff would move onto the next patient and the opportunity for interaction was over:

> The support worker then talks to another member of staff "I'll do him and then again in 2 hours" ***FIELD NOTE***

> "The nurse goes from one patient to the next administering medication." ***FIELD NOTE***

> "Two nurses enter the bed space, one says to the other "we have done all the 2 hour turns" the other asks whether a patient needs turning, the other HCSW responds "I put her to bed an hour ago, she will be alright for another hour" "oh well you might as well do your online training then". ***FIELD NOTE***

The length of the allocated interaction time was dependent on the expected task duration. Tasks which had a longer duration, such as providing personal care or assisting with meals, naturally had a longer time allocated for interaction. Medication rounds and vital signs usually had a shorter expected duration and consequently the amount of time *allowed* for communicating was vastly reduced.

> "I asked a health care support worker when they think the best time is to talk to a patient, she replied "during meal times or when washing them – you get the longest time to talk"….she allocated certain time for tasks, stating it's about "5 minutes to change a pad" but "20 minutes for a wash". ***FIELD NOTE***

This was often detrimental to relational care as interactions that lasted as long as tasks limited the depth of the conversation that occurred between the nursing staff and patients. There was also a reduced opportunity for interaction that did not have the core focus of the care activity which again reduced the likelihood of relationships being built between nursing staff and patients.

Although, this did affect all patients on the ward, it was even more detrimental to the relational care provided to patients living with dementia. The patients who had dementia had a greater difficulty verbalising their needs within a short time frame. As a consequence, these needs were often missed as staff did not spend the time to explore them once the care task had ended.

5.8.6 Interactions only occurred when tasks occurred

As a result of the ward routine and consequently the allocated interaction time, it appeared that if patients had no foreseeable need then there was rarely the opportunity for relational care to occur. The care provided was often responsive to patient's nursing needs, which resulted in the conversations themselves being mostly care orientated and rarely including any deliberate attempt to learn about the individual's personal history, form a meaningful relationship or involve them in care decisions. The data from the field notes below describes how patients were often left if they have no apparent need:

> "I see the support workers walking outside corridor again, she looks into bay and sees there is nothing that needs doing, she continues walking" ***FIELD NOTE***
>
> "Staff continue to walk outside of the bay and look into ensure that the patients are ok but once they know that they are they leave. There is no interaction if there is no apparent need from patients." ***FIELD NOTE***

Nursing staff only interacting with patients when there was a care need, not only limited the interactions to the theme of the care itself but also left the patients receiving little interaction between each care task. During phase one, patients were observed spending long periods of time without interaction as observed below:

> "It is now 14.20 and the index patient has had no interaction since 13.30. She has spent the time looking out of the window" ***FIELD NOTE***
>
> "From 16:00 - 16:50 there is no interaction, and no one has entered the bay since the tea trolley" ***FIELD NOTE***

Only communicating with patients when they had a nursing need (for example for support with eating or to change position) reduced the likelihood of relationship building and decreased the opportunity for relational care to take place. This had an even greater effect for people living with dementia who were be unable to verbalise their needs as freely and would therefore be left for long periods of time without any interaction. The result of spending long periods of time without interaction was boredom and frustration and this was evident during the observations:

> "A nurse talks comes in to ask what I am doing my research on. I explain. She says "it's weird, patients with normal cognition say I'm bored and you think yeah you must be". She said that patients with dementia get less interaction but because they can't actually say it you don't realise that they must be bored too. She explained that the afternoons are worse as there is less to do – it seems that the staff are aware that the patients must be bored" ***FIELD NOTE***
>
> "One of the patients in the male bay is now drumming on the desk and I see this as a sign of boredom. Another patients sighs again and another patient is fiddling with his clothes. The other is now asleep. These repetitive movements are subtle, but they seem to indicate that the patients are bored. "Where is everyone" a patient states. Another responds "nothing much here is there"" ***FIELD NOTE***

5.8.7 Patients have unmet needs

As discussed in the previous section, nursing staff only seemed to interact with patients when there was a care need and were observed spending little time between this with the patients. For patients with dementia who had communication impairment, it was often difficult to verbalise their needs and therefore only visiting patients when requested meant that a lot of their needs were left unmet. The field notes below describe observations when patients were left with unmet needs:

> **"**The patient who was sighing earlier is now calling out for a nurse but there is no one here. She is quite agitated and is now trying to get out of the bed" ***FIELD NOTE***
>
> "The patient looks quite distressed, he sighs "bloody hell everything seems so heavy!" but no staff respond to this and carry on with their tasks" ***FIELD NOTE***

During the observations, needs were also seen to be unmet when tasks were actually being carried out by nursing staff. Nursing staff were seen to be consumed by the tasks at hand and therefore were unable to identify the small cues that suggested that the patient needs something, again, resulting in an unmet need:

> The nurse has approached a patient to administer medication, she picks up the drug chart "you alright there" she says as the patient catches her eye, "yes" there is a pause "well I say I'm alright". The nurse smiles and returns to her task "back in a sec". ***FIELD NOTE***

> "One of the patients starts whimpering, the HCSW goes over to her bed space "what's the matter". The patient has now stopped whimpering "I don't know" "you don't know". Revalidating what she says. "Well use your buzzer if you need something" and walks away" ***FIELD NOTE***

The failure to act upon these cues resulted in the needs of the patients going unnoticed. Similarly to the other themes, this was detrimental to the care of all patients but even more so for people with dementia. It was even more detrimental for patients who had a diagnosis of dementia and who did not verbalise at all as staff were often so responsive in their work that they would often spend long periods of time without seeing a staff member.

The data suggest a link between a lack of relational care and an increase in agitation. Patients who were left with their needs unmet were more likely to become restless and at times would have increasing levels of agitation:

> "The patient who was whimpering earlier has now become increasingly agitated and is trying to leave the ward" ***FIELD NOTE***

> **"**The patient who was sighing earlier is now calling out for a nurse but there is no one here. She is quite agitated and is now trying to get out of the bed" ***FIELD NOTE***

From the results above it would appear that there was little evidence of relational care happening at all. This is representative of the data collected and throughout the time spent on the wards, a very small number of instances of high-quality relational care was observed.

5.9 Chapter Summary

This chapter provides an in-depth description of Medicine for Older Persons wards and the work of nursing staff. The chapter gives a detailed insight into environment of the wards and illustrates the workings of a typical early and late shift on the ward for the nursing staff, nurse in charge and patients.

The chapter has outlined the patients' experiences of care highlighting that people with dementia are expected to fit into the routine of the ward and within this routine, only have certain allocated time to interact with staff. The findings demonstrate how patients with dementia, only had the opportunity to speak to staff when there was a task being completed and as a result of this, the patients had many unmet needs.

Following on from the discussion in this chapter, the next chapter will explore why the care was delivered in this way and identify the factors of the work system that were impacting on nursing staff capacity for relational care.

Chapter 6 The work system factors of Medicine for Older Persons ward impacting nursing work

6.1 Chapter Introduction

The next three chapters will focus on each objective individually and identify the themes that have derived from the data collected in both phases of the study including the observations (n=100 hours) and interviews (n=23). This chapter will address the first objective and focus on the work system factors that were identified as having the greatest influence on nursing staff capacity to provide relational care for patients with dementia. As mentioned in the methodology chapter, the SEIPS framework was used to assist analysis. This chapter focuses on the first step of the SEIPS model (as shown below) and discusses the following five components of the work system: Person, Organisation, Tools and Technologies, Environment and Tasks.

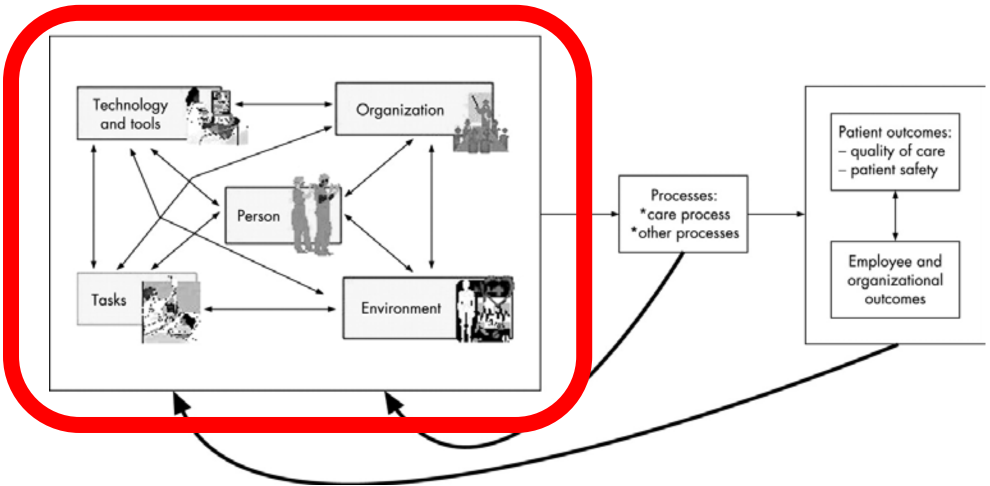

Figure 5 SEIPS Model

6.2 Person

6.2.1 The need to be a team player

One of the influences of the work system that had an effect on nursing staff capacity for relational care was the team-based working that underpinned nursing work. The nursing work observed on the Medicine for Older Persons wards was predominately team based and as mentioned previously, the wards were divided into two teams consisting of one nurse and two-three healthcare support workers (dependent on the number of patients). A clear theme that underpinned nursing work was the need to be a team player and although this may be seen as being beneficial to the quality of care, what was observed was that it was potentially detrimental to the provision of relational care to people with dementia.

Both nurses and health care support workers were observed to be relying on one another to assist with the tasks that needed to be completed whilst on shift. Healthcare support workers, for example, were observed to be very reliant on nurses to finish the medication round within a short time period, in order for the nurses to help the support workers with personal care. Similarly, nurses were observed asking health care support workers to complete vital signs and write aspects of care plans and as a result, health care support workers were also seen to be reducing the time spent on their own tasks in order to assist.

This importance of willingness to help other staff members was very evident in the frustration that nursing staff exhibited when other members of the team were delayed in finishing their own tasks. This was viewed in the observations but also discussed by nursing staff during the interviews with both health care support workers and nurses commenting on team work, how important it was for the team to help each other and again, vocalising their frustrations when this was not the case. In addition, this was highlighted during the interviews in a few instances where nursing staff were commenting on specific colleagues who they did not feel were participating as a member of the team.

> “I’m always updating … who I’m working with, so they know where I’m at and when I’ll be in to help” ***INTERVIEW (RN1)***

> “The nurse comes into the bay and requests help from one of the HCSW, the HCSW looks a bit annoyed and says she will be in soon. The HCSW looks at me and says, “It’s taken her 2 and a half hours to do the medication! And she’s washed 1 patient, we’ve still got 2 rooms” ***FIELD NOTE***

> “The nurse is currently giving out her medication in the bay, she sees a health care support worker “everything ok? – I’ll be in a minute, well when I finish this, I’m not getting anywhere fast today”. ***FIELD NOTE***

The pressure exerted by the nursing team and the conflict observed when members were unable to move swiftly through their work to help each other reflected a shared priority on completion of the scheduled work by the team. This approach, shaped by a culture focused on completion of tasks, resulted in nurses capacity for engaging in relational care with patients being diminished. This pressure to be a team player had a direct effect on the way in which care was delivered and was observed to reduce nursing staff capacity for relational care, particularly for people living with dementia:

> "The nurse has approached a patient to administer medication, she picks up the drug chart "you alright there" she says as the patient catches her eye, "yes" there is a pause "well I say I'm alright". The nurse smiles and returns to her task "back in a sec". She doesn't take the time to listen to what the patient is saying, it seems as though now he has said he's alright she is satisfied and doesn't have the time to listen to more of what he has to say. She returns once she has put the tablets in a pot, "here is your tablets" and pops the pot in front of the patient. She then walks off to the next patient" ***FIELD NOTE***

Patients with dementia often have more complex needs which require more time to be spent on each task. As a result of nursing staff reducing the time spent on their own workload in order to help others, the time spent interacting with patients trying to get to know them or forming meaningful relationships was also reduced. In addition to reducing time spent interacting with patients, staff were also witnessed to be disempowering people with dementia by doing tasks for them in an attempt to reduce time. Many people with dementia on the ward were less able to complete tasks such as feeding themselves, however, with time and encouragement may have been able to do so. As nursing staff were trying to reduce time spent on the tasks, they would often complete the tasks for the person and therefore limit the opportunity for people with dementia to engage in the activity which is a vital part of relational care.

6.2.2 The multiple roles of the nurse

As a result of wanting to be a team player nursing staff and particularly nurses, seemed to have expanded their roles and increased their workload through adopting multiple roles of the multidisciplinary team. During the observations, nurses were often witnessed taking on additional tasks from junior doctors such as performing bladder scans and monitoring heart rhythms. They were also seen to be completing basic clerical work, making pharmacy requests and organising discharges. This adoption of the work of others is illustrated in observation and interview data below:

> "That rarely happens, because you're getting so many people up, and then in between that, you've still got your jobs of observations, doctors' requests" ***INTERVIEW (RN4)***

> "The doctors call upon the nurse who has just started the vital signs. She leaves this and starts talking to the doctor. The doctor is wondering why someone hasn't been discharged – there is obviously been a delay and the nurse isn't sure so she calls upon the discharge

> planner. The nurse is still waiting but she asks to be excused so she can carry on her vital signs” ***FIELD NOTE***
>
> “The doctor interrupts to discuss another patient, the nurse seems annoyed that she has another task added” ***FIELD NOTE***

As nurses were completing tasks that were out of their own role, it meant that healthcare support workers had to compensate for this by performing the tasks of the nurses. Healthcare support workers were often seen to be recording vital signs, taking blood sugars and writing in care plans all of which are seen as registered nursing roles. This change in role was often problematic for both nurses and health care support workers to balance the increasing demand on their workload. The nursing staff were observed trying to decrease the time spent on their own tasks so that they could assist others with theirs and therefore nurses were often seen to be rushing through their workload. Although this could potentially increase efficiency in terms of tasks completed, the consequence of this was less time spent interacting with individual patients.

Similarly to the consequence of needing to be a team player, nursing staff engagement in work outside of their role meant that they were less able to spend time with patient with dementia which then limited the opportunities for relational care. The need to spend time on other tasks was even more complex for nurses as they still had the pressure from healthcare support workers to assist them with tasks such as personal care. Nurses in particular were not only completing their own tasks but were also taking task demands from hospital managers, doctors, other nursing staff and health care support workers so it was unsurprising that they were not able to spend time with patients. Again, this reduced time spent on their own tasks and increased the disempowerment of people with dementia in an attempt to complete tasks quicker, thus reducing the sense of relational care. It is also limited the time available to form relationships with patients and the time to get to know the patient with dementia as an individual.

6.2.3 The internalised rules of nursing staff

The observations provided evidence that the nursing staff worked to internalised rules with regards to their work and the tasks that needed be completed within set time periods. These internalised rules governed the way in which the nursing staff worked and as a consequence regulated the time spent with individual patients.

Throughout the observations the two most resonant internalised rules were that all personal care had to be provided by 12:00 and that the morning medication round had to be completed by 10.30am. The health care support workers seemed to have an unwritten rule that all washes must be completed prior to 12:00, when lunch was delivered and the success of the morning seemed to be based on how many washes were completed in the shortest period of time:

> "At 10:15, the health care support workers on the team have got together on the ward "if I do him, then do him and you do those two and then we will be done" she looks at clock "we've done well today". ***FIELD NOTE***
>
> "A health care support worker comes in as the patients are starting to finish off their breakfast. She goes straight to the paperwork without conversing with the patients. Another healthcare support worker has now left for training and she is worried that it's just her so the washes won't be done. "What about the doubles[11] I've got to do – and we have no floater[12] today either, we won't be finished". She is aware of the rule that the washes must be done by 12" ***FIELD NOTE***

During the observations, it was clear that the team abided by this "internalised rule" that all patient personal care had to be completed by midday. However, when interviewed, no staff member seemed to be able to establish where this rule came from or what would happen if it wasn't followed. Throughout the observations, the washes were always completed within this time period even if the ward was short staffed, with the sacrifice being that each patient received less time with the nursing staff. Despite this internalised necessity from nursing staff themselves that the washes had to be completed within a certain period time, there was no evidence that these rules were required by the hospital organisation and no apparent consequence if it didn't happen. During data collection, there were no notices or policies in place to suggest that these rules must be abided by, nor was it mentioned by managers or reflected in discussions by senior staff members. However, nursing staff remained adamant that it had to be done in this way.

The other internalised rule that was most apparent on the ward was the length of time spent on the medication round. For nurses, particularly in the morning, the time spent administering medication to patients was guided by a rule that it must end before 10:30am.

> "Taking all morning to do the drugs. … … when they could be a lot quicker to -. You know, 'cos patient care is everyone isn't it? It's not just for Healthcare to do a wash." ***INTERVIEW (HCA4)***

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[11] Doubles – People who required two health care professionals to assist them with personal care or mobility

[12] Floater – A member of staff (usually health care support worker) who was not bound to a team but went across the two when help was needed

> "And also, healthcare support workers work really hard, and you need to be seen to be helping them as well. You can't just be doing your meds all day" ***INTERVIEW (RN3)***

Nurses frequently checked the time during the medication rounds. The longer the medication round took, the more frustrated nurses would become:

> "The nurse looks at the clock, it is ten past ten "just finished meds rounds finally – bit of a chaos this morning" she looks relieved that the medication round is over" ***FIELD NOTE***

> "The nurse repeats "your tablet" 3 times to the patient …The nurse looks at clock and shakes her head, she looks at me "look, they won't take their medication". ***FIELD NOTE***

Additional tasks such as needing to locate medication, requests from other professionals and patients trying to get up from their chair were an interruption to the routine of the medication round and again nurses found this frustrating:

> "She puts the tablet on the yoghurt and the patient takes it. The nurse turns to leave and looks at clock "oh my god" and then leaves with the trolley… As the nurse tries to leave, another patient asks to be sat up. The nurse sighs but goes to help, she repositions the patient – "ok?". And leaves" ***FIELD NOTE***

> "The Dr comes onto the ward and requests an ECG from the nurse who is delivering medication, she looks stressed and looks at clock before saying yes" ***FIELD NOTE***

When discussed in the interviews, the nursing staff all contested that they were bound to time rituals. The staff interviewed were aware that these time schedules were there but thought of them as an *ideal* with most saying it didn't need to happen in this way:

> "Cos you want to make sure that all your patients have been washed and checked. Although not necessarily washed, 'cos no one is going to die if they're not washed by 10a.m" ***INTERVIEW (HCA1)***

> "Do this now. Do this now. So, it's very much, you need to keep just specific times, so if you run over on that one, then it stops you being able to give some other form of care or -. So yeah. Although I say 24-hour care, things have their time and their place" ***INTERVIEW (RN1)***

Despite nursing contesting that they abided to time rituals, most then went onto explain that the routine is always followed but couldn't provide an explanation as to why. When asked about policies or guidelines the nurses were unable to identify one that related to this practice. Similarly, they were unable to discuss a time where there was a consequence for not completing the task or following the routines.

> "INTERVIEWER: Has anyone ever actually said to you "why aren't the washes done?" "Why haven't you done your IVs?" "Why haven't your Obs been done?" … RESPONDANT: … No, 'cos I've always done them" ***INTERVIEW (RN1)***

> "INTERVIEWER: Does anyone ever check your work? RESPONDANT: Eeerm. … No. I have never known anyone to do that" ***INTERVIEW (HCA5)***

Whether nursing staff acknowledged that these were mandatory or not, nursing staff were consistently observed to abide to these time schedules. Similarly, to the effect of being a team player and having multiple roles, internalised ruling reduced the time that nursing staff spent with each patient and as result relational care could not be easily provided.

6.3 Organisation

6.3.1 The impact of shift pattern

The way in which nursing staff organised their time appeared to be based on their shift pattern, which was particular to this setting. As described previously, the shift pattern altered between long days, early shifts, late shifts, long early, long late and nights. The nursing staff who worked on a long day often felt they had more flexibility in their work as they had longer to complete each task and therefore should have more time for relational care. Night shifts were also seen as being more flexible than day shifts due to the reduced strain of the additional tasks added by other members of the multidisciplinary team, reduced administration tasks and reduced interaction with family members.

> "But generally, during the day it's busier so therefore you need more people around" ***INTERVIEW (RN1)***

> "So, I would say day – day time is a more … hectic*"* ***INTERVIEW (RN6)***

There were conflicting views on shorter shifts during the interviews. Some interviewees explained that there was less pressure on shorter shifts as you knew that there was another member of staff taking over and if tasks were incomplete it could be picked up by the next team. On the other hand, many of the interviewees felt that there was in fact, an increased pressure on shorter shifts as staff had less time to complete all the tasks.

> "For me, I feel I have someone to hand over to. So, if I have a … margin of time in the afternoon, where I can possibly catch up, because I've got another nurse that I've handed over to. Whereas for people that work long days on this ward, they don't have that"
> ***INTERVIEW (RN6)***

There was also a significant contrast between the early and late shift. There was a general consensus held by all nursing staff that the morning shifts were busier and therefore there was less time to spend interacting with patients. In contrary, the nursing staff stated that the afternoon allowed them to be more flexible in their routine and thus increased the time that could be spent on relational care.

> "Do it now before it all kicks off"- I assume she means at 9am when the other professions come in and board meeting starts. There is general consensus that 9-12 is the busiest period." ***FIELD NOTE***

> "The band 4 explains "yeah, we don't get a lot of learning done, especially not in the morning – no chance". It seems to be common knowledge that the morning is the most hectic" ***FIELD NOTE***

From the interviews, it would seem that due to the different demands of each shift, the capacity for relational care would alter and there would be different times when relational care was more likely to be observed than others. Interestingly, the observations painted a different picture to what the staff described during the interviews. During phase one, the observations revealed that patient received less relational care and spent more time without interaction in the afternoon, despite the nursing staff having less tasks to complete. The staff often used this quieter period start to complete other jobs on the ward such as training on computers or ensuring the ward was clean.

> "A nurse talks comes in to ask what I am doing my research on. I explain. She says "it's weird, patients say I'm bored and you think yeah you must be" …She explained that the afternoons are worse as there is less to do" ***FIELD NOTE***

> “Outside of the cubicle, the ward seems a lot slower paced so it would seem that there is more time to talk to patients, however, none of the staff are interacting with them. The nurse is occupied with medication and the HCSW seems to be more relaxed, spending time on the computers and making drinks” ***FIELD NOTE***

> “It is now 14.20 and the index patient has had no interaction since 13.30. She has spent the time looking out of the window” ***FIELD NOTE***

> “At 14:15, 3 HCSW enter and start to tidy the bed space, it seems as though the staff are trying to find tasks to occupy their time” ***FIELD NOTE***

The similarity between the relational care that occurred during the early and late shift, suggests that actually capacity for relational care is not correlated with work load or lack of time. Despite what nursing staff suggested, the lack of relational care observed at all times of the day suggests there must be other factors influencing how different aspects of nursing work are prioritised.

6.3.2 The organisational priorities

Another influence observed to be affecting nursing work was the priorities of the organisation. During phase two all interviewees were asked to suggest what they believed the hospital prioritised. Most responses included the term “safety” – nursing staff believed that the organisation wanted to keep the patients safe through the reduction of risk. The other key term in the response was “discharge” with most nursing staff concluding that the organisation was very concerned with patients getting out of hospital in a timely manner, even if it wasn’t in the patients’ best interests.

> **“**Moving beds. They don’t see people as people, they see people as beds. So, getting -. So patient flow is a priority” ***INTERVIEW (RN10)***

> **“**Getting patients out of the beds, so that they can have be put through the hospital... We get a lot of pressure on us to try and chase up things that we can’t control, like packages of care. We know there’s a shortage of them out there. We know that as soon as … it’s available, I’d hope Social Care will ring us. They don’t tend to hang around. But we’re still expected to chase them, so it’s additional work, and additional phone calls” ***INTERVIEW (RN8)***

> **“**Priorities are getting patients out as quick as possible; making sure the observations are done on a timely basis, because of the fact that it’s now an acute ward” ***INTERVIEW (RN8)***
>
> “From the hospital’s point of view, moving patients through is obviously …time costed, cost and time effective so that’s a priority” ***INTERVIEW (RN11)***

Following on from the interviews and after reflecting on phase one of the study, it was clear in the observations that these priorities influenced the work of nursing staff both at a ward and individual level. Nursing staff were constantly concerned with patient safety ensuring that vital signs were recorded on time to detect any changes in condition, patients were repositioned in a timely manner to reduce pressure ulcers and any untoward event (such as a fall) was documented to a high standard so that an audit trail was developed. Nursing staff were also always discussing patient discharges and continuously updating discharge systems so that patient movement around the hospital could be maintained.

Throughout the interviews, not one member of staff mentioned relational care being an organisational priority. Neither did they use any other term such as patient centred care or the need to spend time with patients. There was also no mention of the quality of care for people with dementia being a priority which on a specialist older persons wards may have been expected.

6.3.3 The inevitable issue of staffing

Within the current nursing climate as outlined previously in this thesis, it was inevitable that the issues of nursing shortages would arise during data collection. During phase one, it was observed that each day began with a discussion regarding the day’s staffing levels and was often met with a call from other wards, who were short staffed, requesting members of the team to be moved to their ward. The nurse in charge would begin their day allocating staff to each nursing team. This would more often than not result in a disagreement amongst the shift due to people feeling unsatisfied about working with a number of staff less than expected.

It was not only the observations that highlighted the issue of staffing but during interviews staff also found it difficult to move away from the staffing shortage and how this was impacting their work. When asked about their ideal ward or changes for the improvement of care, most interviewees stated that they would choose to have more staff:

> "Everywhere in the hospital is short staffed so - when they make us short staffed and it's hard to get everything done anyway" ***INTERVIEW (HCA9)***

> "INT: What stops you giving the best care? ….RES: Eeerm, short staff" ***INTERVIEW (HCA4)***

> "INT: Why don't you have enough time? RES: Because we've not got enough staff, and we have too many patients to look after" ***INTERVIEW (RN7)***

> "I just feel that it does boil down to staffing. If you have the staff … we would be able to do the things … that they are expecting of us. But their expectations are getting greater, while our numbers are not" ***INTERVIEW (RN11)***

> "If you have a good staffing day, you've got a lot more time to give…" ***INTERVIEW (RN7)***

> "You know, if a lot more nurses qualified, and then all the wards became really well staffed, then I think most wards would – and I'm sure we definitely would – make that something that we introduced to the wards; time for carers" ***INTERVIEW (RN3)***

From the interviews it was clear that the nursing staff assumed that an increase in staff would lead to an improvement in staff morale, a decrease in workplace stress and most importantly more time to spend with patients.

In contrast to this and as witnessed in the observations; there was little difference in the level of relational care whether the wards were fully staffed or not. There were many sessions of observations when the wards had the correct staffing levels, if not more, and yet, there were no improvements in the amount of time spent interacting with patients:

> "The rounding's for the period of 2-4 seem to have been completed and it is though the nurses and HCSW are having a lull period where there is not a lot to occupy their time, however, there doesn't seem to be a lot of interaction with patients" ***FIELD NOTE***

> "At 11:30 I see the nurse from this bay coming back from break. Most of the patients are now asleep. There are no staff in the bay and I notice that two are in the kitchen having a drink and that there are some staff members in corridor discussing pay slips - it is payday today" ***FIELD NOTE***

> "I decided to walk out of the bay to see what the staff were doing, there are 2 nurses sat on the desk in the next bay looking at the patients but not actually interacting. I see a health care support worker doing this in the room next door also. The nurse in charge is

> filling out the paperwork and seems to be trying to have patients discharged. Again, it seems that they have the time but they aren't using it to talk to patients" ***FIELD NOTE***

Despite nursing staff claiming in the interviews that staffing was the main concern, the observational data indicate that relational care did not improve when the level of staff on the ward increased. Similarly to the thoughts around the lack of time and increasing workload, the observations highlighted that the assumed factors affecting nursing staff capacity are not in fact the only cause. This again suggests that there are other factors that are influencing how nursing staff organise their work which go beyond staffing level and more time.

6.4 Tasks

6.4.1 The measured task

Both the observations and interviews highlighted the task orientated culture of nursing work on Medicine for Older Person wards. Nursing staff were observed carrying out the same set of tasks routinely, at specific time intervals each day with very little room for flexibility. The tasks that dominated nursing staff work included the repositioning of patients, documentation, medication and the recording of vital signs:

> "I see the nurse walk by with the vital pack, she is going to take someone's observations. It seems that this guides nurses' time" ***FIELD NOTE***

> "The band 4 support worker enters the bay to change the bin bag and then fills out the paperwork. She does not engage with the patients. She then takes the obs machine and leaves" ***FIELD NOTE***

> "The patient looks low and in pain, the HCSW is filling out paperwork and addresses the bed space "you alright" but gets no response. She doesn't attempt to follow it up and continues to fill out rounding sheet" ***FIELD NOTE***

From the data, it was evident that tasks that were tangible were regarded as a much higher priority than tasks that were not. It was interesting that the tangible tasks, were often those that were "measured" by the organisation and as such, had to be recorded. The observations suggest that nursing staff did not feel comfortable performing other tasks until the measured tasks were complete. On occasions during the observations, nursing staff were seen to become frustrated if they couldn't complete the measured tasks, even if that meant spending less time with patients.

> "There is a healthcare support worker who has been allocated to an observation bay and needs to stay in there as one of the patients is a high risk of falls. All the patients in the bay are able to feed themselves, but instead of interacting with them, she seems to be finding other things to occupy her time – looking at rounding sheets and tidying. She calls out to the one of the other members of staff "I need to do the paperwork, I can't just stay here" she looks at me "I need to be doing stuff – I like to go round and do the all paperwork first"" ***FIELD NOTE***

This focus on the "measured" tasks, reduced the time spent providing relational care to patients. Interactions, or time spent building relationships with patients with patients were not "measured" by the organisation and therefore nursing staff did not see it as a priority.

6.4.2 The demand of patient flow

From the data collected in both the observations and interviews, the most significant task influencing nursing work was that of ensuring patient flow. The overarching routine that appeared to take priority over most nursing work was the admission and discharge of patients. It was evident in the data that patient flow was one of the main concerns for the hospital and one that was scrutinised regularly. Ensuring that patients were admitted into Accident & Emergency, within the targeted time was dependent on the efficient discharge of patients on wards such as Medicine for Older Persons and this had a significant effect on the staff and patients on these wards.

> "The nurse in charge is now talking to another nurse who I quickly realise is the discharge planner. She comes into the bay, "he looks alright, the transport is booked for 10.30" and leaves. It is clear he is going home today and this is a priority for the ward. There is a pressure at ward level to get patients discharged" ***FIELD NOTES***
>
> "The priorities are getting patients out as quick as possible" ***INTERVIEW (RN10)***

A system that seemed to take priority over all aspects of nursing work was that of Bed View[13] and the attendance to the bed meeting. As highlighted in the previous section, the bed meeting was a gathering of all the senior nurses across the whole of Medicine for Older Persons wards to discuss how many patients were being discharged and how many patients had the potential to be discharged. The bed meeting occurred once in the morning, once at lunch time and again during

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[13] Bedview is an electronic system that allows for patients movement throughout the hospital to be seen. Nursing staff have to update bedview every hour to evidence the occupancy of the ward.

mid-afternoon. All senior staff were required to attend, regardless of what was happening on the ward.

> "At 12.30 there is a call to the ward, the nurse in charge is late for the bed meeting. She has been called to go now. She has to drop what she is doing and go" ***FIELD NOTE***

Additionally, every hour a clock timer would sound signifying that the nurse needed to update Bed view. The timer was based at the reception desk and every hour would make a loud ringing sound that resonated across the ward and could not be turned off until the system had been updated. If these two tasks (bed meeting and bed view system update) were not completed, patients would not be discharged on time or beds were left empty and in a very short period of time, nursing staff on the ward would be notified by hospital managers that the system needed to be updated.

> "If there's no definite discharges, then I have a quick scan through bed view to see if there's any potential discharges for the day, which can then be escalated, which may then be a definite discharge later that afternoon" ***INTERVIEW (RN6)***

This constant additional pressure had a cascading impact across the hierarchy of the hospital, beginning with senior managers and ending with patients which consequently had a significant impact on nursing staff. During the observations, staff were seen to be frustrated and disheartened with regards to hospital managers and the way in which they dealt with patient flow. On a number of occasions nursing staff were seen to have little control over their patients being discharged and the process that coincides with this:

> "During this time the nurse in charge has returned from the bed meeting and is clearly stressed – "it's ok to be shouted at" she says to the ward clerk. "Right better find someone for that bed!" she rubs her eyes "I can't see, if I had a stroke the sisters wouldn't care as long as I found someone for that bed!" ***FIELD NOTE***

> "The nurse in charge has returned from the bed meeting looking agitated "they've just shouted at me again because she's still here, the medication is at the pharmacy, the transport is all booked, let's get her to discharge lounge" **FIELD NOTE**

The pressure of discharge and its impact on nursing staff had a cascading impact on relational care. Nursing staff were pressured to ensure patients were being discharged from hospital and therefore this was always at the highest priority in their work. The tasks involved in ensuring a patient was ready for discharge always took the priority over spending time with patients. This increased pressure reduced the time spent interacting with the patients, again reducing the likelihood of meaningful relationships being formed.

6.4.3 The need to document

Second to the prioritisation of patient flow, the importance of documentation was mentioned by all the nurses in the interviews and was also highlighted in the observations. Nursing staff reported that documentation was always a high priority in their workload and due to the increasing amount they had to complete, it often took up much of their time. The nursing staff reported a lot of their time was spent filling in repositioning charts, writing care plans and documenting incidents, all of which reduced the time they could spend participating in direct patient care:

> "The paperwork. That takes up most …That takes up a lot of time" ***INTERVIEW (RN1)***

> "We sometimes spend too much time on like things that aren't so important... like documentation… and the patient care falls down a bit because we have to get these things done" ***INTERVIEW (HCA9)***

The significance of documentation was also prevalent during phase one of the study. Nursing staff were seen to be so consumed by completing documentation that they would often forget to interact with patients. Similarly, due to the sheer amount that nursing staff had to document, they were seen trying to limit the time spent interacting with patients as a way of ensuring that all documentation was complete before the end of the shift:

> "A health care support worker comes in as the patients are starting to finish off their breakfast. She goes straight to the paperwork without conversing with the patients" ***FIELD NOTE***

> "The band 4 support worker enters the bay to change the bin bag and then fills out the paperwork. She does not engage with the patients" ***FIELD NOTE***

> "You have to ensure everything you have done is written in the care plan before the end of shift ... In their eyes, if you don't write it down, it wasn't done" ***INTERVIEW (RN2)***

The nursing staff in the study were aware that spending this amount of time on documentation was reducing the quality of care they were able to give, however, it appeared that they felt unable to challenge this or make any changes. The data suggests that as a result of an increasing pressure to ensure documentation was completed, the nursing staff were reducing the time with spent with patients knowing that this was wrong but unable to do anything about it.

6.5 Technology and Tools

6.5.1 The domination of technology

The advancement of technology and thus increase of technological features on the ward also had an impact on relational capacity of nursing staff. Perhaps the most significant technological advancement for nursing staff observed in this study was the vital pack. Nurses on the ward were required to ensure that the patient's vital signs were recorded within certain time period to increase the speed of response if any patient deteriorated. Based on the severity of the patient's condition, the vital pack would alert nurses when vital signs should be taken with intervals of 30 minutes, 1 hours, 2 hours, 4 hours, 6 hours and 12 hours.

Although this encouraged nursing staff to spend allocated time with patients, it seemed to have reduced the amount of relational care provided, mostly due to the nature of phone itself. During observations, nursing staff appeared completely focused on entering the data and instead of interacting with patients, would be engaged with on the device itself. The nursing staff were often seen to be holding the phone up towards their face, creating a barrier in their eye line between themselves and the patients.

> "The nurse is very engrossed in the device used to take vital signs and misses the patient waving at the back of the bay – I inform her that he may need something" **FIELD NOTE**

Another consequence of the vital pack was that any interaction that the staff did have with the patients then revolved around the vital signs themselves. Nursing staff were observed to attend to the patient bedside but instead of using this as a chance to create meaningful interactions to form relationships, would focus on the task at hand:

> "A health care support worker enters to take the patients vital signs: "Hello, how are you?" – No response. "I need to check your observations". There was no interaction here, the object of this conversation is the task" **FIELD NOTE**

> "At 11:30 the nurse starts monitoring the vital signs, these generally last 5 minutes for each patient and the interaction revolves around the task at hand "can I take your blood pressure?" "Do you feel sick?" "Are you in any pain?" and then once recorded moves onto the next patient." **FIELD NOTE**

This was supported by the staff in the interviews with nurses reporting that although the vital pack ensured they visited each patient at least once a shift, it was often detrimental to relational care as they were often engrossed in the device. This removed the nursing staff further from the patient and in addition, increased the likelihood of them rushing through interactions to ensure all vital signs were recorded:

> "The vital packs are most important and are time specific, and now that we're Super Acute, I do have to be quite strict on them - if they're due, then I need to make sure they're done" ***INTERVIEW (RN4)***

6.5.2 The location of equipment

Throughout data collection nursing staff reported various factors relating to equipment as an obstacle to relational care including availability, misplacement and readiness to use. The nursing staff reported that they often spent a lot of time locating equipment which consequently took staff away from the patients and reduced time spent on relational care.

> "Down to little things like, you know you go into the clinical room to get things, and they're out, they haven't got anything" ***INTERVIEW (RN9)***

Similarly, the nurses commented on the equipment availability as impeding on the time they could have spent with patients. The nurses reported that they were often spending their shift stocking up medication trolleys or bed linen cupboards, which again reduced the time spent on building relationships with patients and this was evident within the both phases of data collection:

> "Why aren't drugs being checked more? You're running out of antibiotics all the time. So that puts the pressure on the nurse to try and find an antibiotic, and walk round three wards to get it" ***INTERVIEW (RN9)***

The difficulties locating equipment were often met with an undertone of staff expectations of what the staff of the previous shift should have completed. A key example of this throughout the data collection was the stocking of the medication trolley. Staff became frustrated when the previous shift had not replaced medication they had used or had put empty packets back into the trolley:

“I see the nurse start her medication in the bay, she is looking at the clock and seems to be frustrated. She picks up a drug packet which is empty and slams the drug trolley lid, “honestly why don’t people fill the trolley – wastes so much time” and walks into the treatment room” ***FIELD NOTE***

6.6 Environment

6.6.1 Internal Environment

6.6.1.1 The difficulty of observing patients together

Throughout the interviews many nurses discussed how the ward and its physical structuring was a barrier to providing relational care. The location of patients on the wards was seen as a barrier to effective relational care with many nurses commenting on the fact that the beds were spread across the ward. The nursing staff reported that due to the distribution of patients, it was difficult to spend long periods of time in one place which they agreed would allow for more time spent interacting with patients.

> “This morning … I’m in all the cubicles. So I’ve got seven patients… but they’re in seven separate cubicles, spread across the ward… So you’re going all over the place.” ***INTERVIEW (HCA2)***

This factor was highlighted when the nurses discussed how the environment could be improved. Most nurses suggested the idea of being able to observe all the patients together at one time. The nurses believed that having the patients together would reduce the amount of time spent liaising between different bays and therefore increasing the capacity for building relationships with patients.

> “Ideal ward would be to have a small section of patients… in an observable bay.. … You can observe them. You’ve still got curtains, you’ve still got … some privacy for the patient” ***INTERVIEW (HCA6)***

> "So, I would like it as a horse shoe …And at the back of the horse shoe I would like the nurse's station. And then I would like the patient in separate bays, but so you can see into all of them from the nurses station" ***INTEVRVIEW*** **(RN5)**

This component of the work system could be a reason as to why the patients were observed spending a long time without interaction, especially if they were in the cubicles. Nursing staff had to spend time visiting patients across the ward which consequently reduced the time spent with patients which potentially reduces nursing staff capacity for relational care.

> "It is 12:00 and at this point the patient has not received any interaction for 45 minutes" ***FIELD NOTE***
>
> "From 11:00 – 12:00, the patient in cubicle has received no interaction" ***FIELD NOTE***

6.6.1.2 The clinical feel of the hospital

In addition to the layout of the ward, many of the nurses also suggested that the hospital ward felt too clinical and this was deemed as detrimental to getting to know patients as people and providing relational care. When asked what the ideal ward for would be for providing relational care, most nurses discussed the idea of making the wards more homely in an attempt to make patients feel more at ease.

> "So, kind of so … a dining room table, comfy chairs, something to make it look a bit more …homey" ***INTERVIEW (HCA1)***

The idea of making the environment less clinical also coincided with a hope that there would be an atmosphere change, with nurses suggesting that it would be a friendlier environment. There was also a lot of reference to bringing the patients closer in proximity and the idea that they would be able to converse with each other which again was seen as a way to improve care.

> "and bringing just their chairs round, like they don't have to be stuck at – by their beds, and kind of just bringing them into the middle to make it kind of a more friendly environment. Then they've got someone to chat to." ***INTERVIEW (HCA1)***

During the interviews, the nursing staff could easily attribute to the problems with relational care to physical things like the layout of the ward and the clinical feel but found it much more difficult to suggest improvements that could be made to how they could structure their work to overcome these challenges.

6.6.2 External Environment

6.6.2.1 The Impact of Policies

Both the observations and interviews provided evidence that nursing staff prioritise some tasks more so than others. Tasks such as providing personal care and taking regular vital signs of patients were given a greater precedence than spending time interacting with patients and staff were more concerned if they weren't completed. This was evident during the observations:

> "I see that the nurse has now finished her medication and has started using the vital pack, again this is an importance factor on the ward and seems to dictate the nurses time" ***FIELD NOTES***
>
> "The nurse is very engrossed in the device used to take vital signs and misses the patient waving at the back of the bay – I inform her that he may need something. She walks over to him but is still engrossed in the vital pack as she walks "are you alright?" she says as she walks over. He requests to go back to bed, "yes ok, oh wait", she checks the vital pack "I need to take your blood pressure first" and goes to get the machine" ***FIELD NOTES***
>
> "Once she has done this the nurse leaves and walks up to the other patients to fill out their rounding sheets, as she enters the bedspace to fill out the rounding, she smiles at the patient, however, there is no communication" ***FIELD NOTES***

During Phase two of the study, the importance of ensuring patients were repositioned every two hours and vital signs were checked was highlighted by nursing staff in the interviews:

> "Eeerm, priorities are getting patients out as quick as possible; making sure the obs are done on a timely basis, because of the fact that it's now an acute ward" ***INTERVIEW (RN11)***
>
> "You know like on the vital packs where the Obs are, you know, you've got all the red clocks, and you know that you need to check patient's Obs, which is important as well, because you need to check that your patients are safe. So that would worry me." ***INTERVIEW (RN8)***

> “Because you can’t spend all morning with one person. Because you have to make sure that everyone is clean and safe ‘cos you might get pressure ulcer if they’re sat in one position for too long” ***INTERVIEW (HCA3)***

During the interviews when the staff reflected on the way they organised their work, it was clear that they were aware of the detrimental effect that policies were having on the care they delivered, but felt unable to change this due to priority these policies had within the hospital.

> “We sometimes spend too much time on like things that aren’t so important because we have so many policies to follow. We have to do them, and sometimes the patient care falls down a bit because we have to get these things done” ***INTERVIEW (HCA6)***

6.7 Chapter Summary

This chapter has addressed the first objective of the study and has described the different components of the work system: person, organisation, tasks, tool and technologies and environment. In doing so, this chapter provides a description of the work system factors that had the most significant influence on nursing staff capacity for relational care on the wards.

The results illustrate there are multiple factors that influence nursing staff work on these wards. Nursing staff were very concerned with being part of the team and because of this had adopted many roles within their nursing title. Nursing staff gave a higher priority to the tasks that the organisation prioritised, particularly tasks that could be audited such as vital pack recording and documentation. The target driven culture of the ward had led nursing staff to develop internalised rules which impacted the way in which they organised their time. The impact of staffing and shift patterns was also discussed by nursing staff during interviews, however, from the observations it seemed that the care quality remained a constant despite the number of nursing staff on shift or the time of day. This data then suggests that capacity for relational care is therefore not dependent on these factors but that there are other underlying causes which from the data collected are likely to be organisational.

The next chapter addresses the second objective of the study and describes how these work system factors influenced the ways in which the nursing staff worked.

Chapter 7 How work system factors influence nursing work

7.1 Chapter Introduction

Chapter 6 addressed the first objective of the study and outlined the work system factors that influenced nursing capacity for relational care on the Medicine for Older Persons wards. Following on from this, this chapter will now address the second objective of the study and explains how these work system factors impacted on the nursing work or as described in the SEIPS framework, the care processes (as shown in Figure 6). Again, the findings discussed in this chapter were derived from data collected in both the observations (n=100) and interviews (n=23) and evidence from the data will be used to support the themes explained.

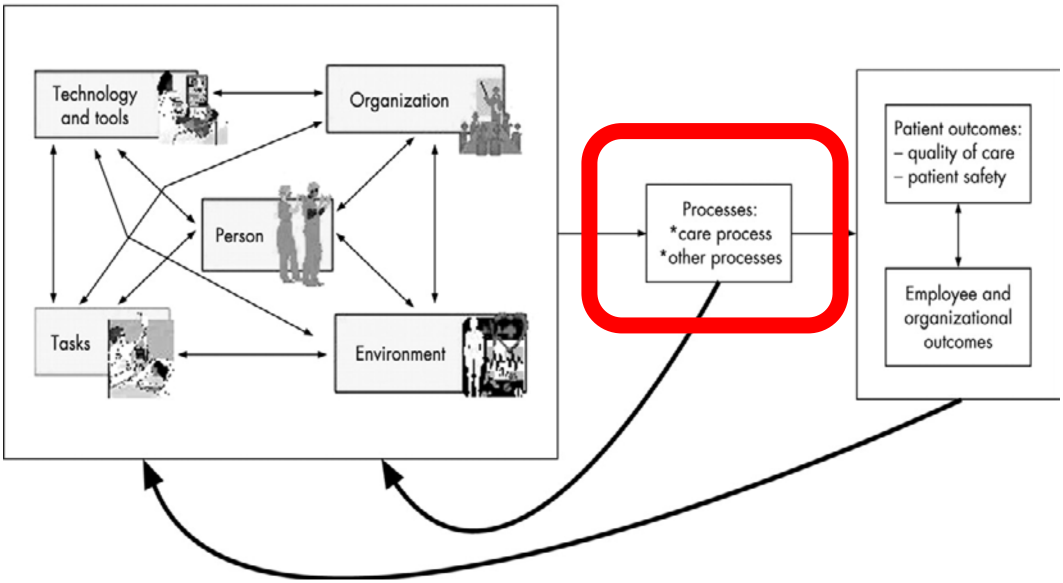

Figure 6 SEIPS Model

7.2 The effect on nursing work

7.2.1 The unwritten temporal structure

As explained in the above two chapters, nursing work revolved around a routine. The routine structured the tasks within the day and, as a result, guided the work of the staff on the ward. As mentioned previously, internalised rules such as nurses ensuring the medication round was complete before 10:30 and the health care support workers having all patients washed and dressed by 12:00 all created an unwritten temporal routine which structured the day and the ways in which the nursing staff organised their work:

> **"**Um, meal times are also set, so mealtimes are dictated when … um the meal trolley comes up" ***INTERVIEW (HCA3)***
>
> "So like the routine in hospital is to come in and get everyone washed very quickly and get them up and sat in the chair. But that obviously doesn't work for everyone" ***INTERVIEW (HCA5)***
>
> **"**Everything fitting into a time. The medications have to be done at this round; washes have to be done" ***INTERVIEW (RN10)***
>
> **"**Another health care support worker enters to deliver the meals, she places the tray on the table next to a patient's bed and starts to sit him up but there is no discussion. The concern at this point seems to be getting the patients meal delivered due to the time constraints of Carillon[14]." ***FIELD NOTE***

The unwritten temporal routine resulted in the staff clockwatching and judging the efficiency of their work on the amount of tasks completed by certain points of the day. There was a clear set of tasks that needed to be completed by lunch time and then again in the afternoon and if this wasn't achieved the nursing staff became frustrated and concerned that they weren't doing a good job:

> "The nurse looks at clock and shakes her head, she looks at me "look, they won't take their medication". There is obviously an expectation of when to finish medication" ***FIELD NOTE***
>
> The nurse is currently giving out her medication in the bay, she sees a health care support worker "everything ok? – I'll be in a minute, well when I finish this, I'm not getting anywhere fast today" ***FIELD NOTE***

This ongoing need to meet the demand of the routine led to nursing staff trying to decrease the time spent on individual tasks so they were able to achieve more within a day. As a result, the nursing staff were spending less time with patients which reduced the opportunity to provide relational care.

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[14] External contractor that supplied catering

7.2.2 The expected task duration

The routine of the ward not only governed the tasks that were completed during certain time periods but also governed the time nursing staff spent on those tasks. Each nursing task appeared to have an expected duration which was known by all staff members and seemed unchangeable. As mentioned previously with regards to the routine, the medication should have lasted no more than two hours, ending at 09:30 and the washes had to be completed by noon are - all examples of where tasks had a set duration.

During the observations, if the task appeared to be taking longer than expected, the nursing staff became increasingly frustrated, which was often reflected in the care they were providing. Nursing staff would often become agitated if the tasks weren't completed by set times of the day due to the feeling that they had let the team down or (as described in the interviews) that it had been a "bad day".

> "Cos you want to make sure that all your patients have been washed, and checked. Although not necessarily washed, 'cos no one is going to die if they're not washed by 10a.m but then if it's not done by 12 you are trying to catch up". ***INTERVIEW (HCA2)***
>
> As the time spent on this patient increases the nurse seems more rushed and there is urgency in her tone: "come on, im trying to help you but you need to help yourself". "Your tablets now, you need to take them". "go on, I need to go now, let's try one more time"… The nurse turns to leave and looks at clock "oh my god" and then leaves with the trolley. It is clear that she thinks this interaction has taken too much time. ***FIELD NOTE***
>
> "One of the nurses comes into the space, she has been looking after a patient in the other bay "this is ridiculous, I haven't even started my drugs yet". – Something has happened that is out of the normal routine which has caused her frustration" ***FIELD NOTE***

The effect of this expected task duration was that nursing staff were often rushing through tasks to ensure they were completed within the designated time and as result, were reducing the time spent with patients. If tasks were to go over the expected duration, nursing staff became increasingly concerned and this was often evident in the way they behaved with patients. As a result, time spent interacting with patients to create meaningful relationships and learn about personal history or involved in decision making were often reduced as the priority was always to finish the task.

7.2.3 The rigidity in routine

The number of tasks that nursing staff had to complete during a shift led to a rigidity in the way they worked and as a result decreased the amount of time they had to spend with patients. The effect of the routine and expected task duration, appeared to have caused nursing staff to be constrained to time schedules and as such they were less flexible in the tasks they completed, and the time spent on those tasks.

> "The patient requests to go to the toilet, she looks at the clock and reluctantly goes to get the commode. She comes back with the commode and pulls the curtain around him and leaves" ***FIELD NOTE***
>
> "I do my drug round but I usually get interrupted…. usually requests for the toilet; - confused patients asking you questions, the same questions over and over again, about wanting to go home" ***INTERVIEW (RN5)***
>
> "The Doctor interrupts to discuss another patient, the nurse seems annoyed that she has another task added" ***FIELD NOTE***
>
> "And then if you're lucky, start a care plan. That rarely happens, because you're getting so many people up, and then in between that, you've still got your jobs of observations, doctors requests" ***INTERVIEW (RN5)***

During the observation period it was clear that this rigidity also caused conflict within the team as nursing staff often became frustrated if other members of the team added tasks to the workload as this was regarded as interrupting the routine. The increasing task demand often left nursing staff feeling concerned that they would not complete all tasks within their shift which then led to feelings of dissatisfaction. To try to reduce the feeling of stress, nursing staff were seen to be rushing through tasks leaving little time spent with patients building relationships.

7.2.4 The impact of being task blind

As a way of meeting the demands of the task duration to maintain the routine and abiding to the rigid structure of each shift, staff were observed to have become "task blind". This term has been created and is used to describe the way in which nursing staff focused solely on the tasks they were completing, as opposed to the patients they were caring for. During observations, when completing tasks, the nursing staff were very much focused on the task at hand as opposed to the needs of the patients behind those tasks:

> "Health care support worker enters to take the patients vital signs "Hello, how are you?" – No response. "I need to check your observations". There was no interaction here, the object of this conversation is the task" ***FIELD NOTE***
>
> "The health care support worker approaches patient "morning", he replies "morning", "for lunch…" and she goes onto explain menu. There is no discussion of how he had slept or whether he had a good night, the menu has to be completed by a certain time" **FIELD NOTE**

Although this may have allowed for an increase in productivity, it reduced the time spent interacting with patients. During the observations, people with dementia were seen to be increasingly anxious when staff carried out nursing tasks without providing reassurance or talking to them as a way of distraction from what was happening:

> "The patient states "I don't know what's going on" but no one responds to it and the nurse continues to assist with the table "you want a spoon?" "Knife and fork please". The nurse leaves. The HCSW spends times with the patient who needs his shoes put on and there was confusion with someone's menu – it seems that if there is a physical or practical need then staff will spend more time. The HCSW spends time walking from one patient to the next assessing whether they need help. "How is the pasta for you" the patient says "I don't know what's going on" but again the staff member ignores it "yes it's soft for you" and leaves the bay. The patient continues to eat his lunch. The patients are sat eating their lunch in silence" ***FIELD NOTE***

This was highlighted in the interviews with nursing staff commenting on the fact they did not feel comfortable spending time talking to patients in isolation of other tasks. The nurses suggested that they wouldn't be seen as being efficient if they were sat talking to patients which suggests that they perceived the organisation itself as placing a low value on relational care:

> "And sometimes I think as a Nurse, people feel that that sort of thing is more important than toileting or ...-. You know, if someone says to me "Why – why were your Obs due, and why haven't you done any of your IVs" and you say "Well this person was really upset, and I spent the morning comforting her", it's not going to go down very well. So, they wonder what you're doing" ***INTERVIEW (RN4)***

7.2.5 The impact of tunnel vision

Not only did staff tend to fixate on the task at hand but the work systems factors seemed to have led to staff developing "tunnel vision" when carrying out tasks. The term "tunnel vision", again has been created and is used to describe how nursing staff were unable to see outside of the work they were undertaking and is related to the concept of being "task blind". The observation data reflected instances in which "tunnel vision" caused staff to miss subtle signals that the patients were distressed. Nursing staff were so consumed by the task at hand that they missed signs such as whimpering and grimacing which could have been indications of distress. Unlike patients who were able to clearly verbalise how they were feeling, for people with dementia these small cues provided nursing staff with an insight into their physical and psychological wellbeing which when missed can lead to further complications at a later time.

> "The nurse in charge has left the room and the other nurse is now washing a patient. The patient is quite distressed and starts crying. The nurse makes empathising sounds however there is little effort to stop task and continues to wash" ***FIELD NOTE***
>
> "The previously distressed patient has started shouting quite loudly again "oh my god, oh my god". The nurse in charge hears this time and re-enters "was that you" "how can I help". There is no response. "what's the matter" again no response – she rearranges the pillows and leaves" ***FIELD NOTE***

Not only did tunnel vision stop the nurses noticing or responding to subtle changes or cues from patients but it seemed to also prevent staff from realising there were other options and resources they could use to improve the care experience for people with dementia. On many occasions, especially during medication round, the nurses were so fixated on the need for patients to take their medication that they became blind to other ways of trying when the patient was refusing:

> "The nurse repeats "your tablet" 3 times to the patient….The nurse looks at clock and shakes her head, she looks at me "look, they won't take their medication"." ***FIELD NOTE***
>
> "As the time spent on this patient increases the nurse seems more rushed and there is urgency in her tone: "come on, I'm trying to help you but you need to help yourself". "Your tablets now, you need to take them". "Go on, I need to go now, let's try one more time". ***FIELD NOTE***
>
> "A health care support workers enters the cubicle to fill out the menu for the patient. Starts interaction "do you like soup" - no response, so starts to raise voice "do you like

> soup?” and repeats 5 times. She then moves on to “roast beef or fish pie” and repeats this. After about 5 minutes the health care support worker leaves the bedspace and says, “I’ll just order him whatever, he can’t hear me”. I am wondering why she didn’t attempt something different – communication aids, or writing it down or simplifying it – perhaps these aren’t available” ***FIELD NOTE***

With regards to relational care, ”tunnel vision” reduced the likelihood of interactions that focused on building relationships and seemed to prevent nursing staff getting to know their patients. The intense focus on the task at hand potentially caused the needs of patients to go unnoticed. Although this may not be a problem for patients were were able to articulate their needs to staff; for patients with dementia who are unable to verbalise, it could was detrimental to their care.

7.3 Chapter Summary

This chapter described how the work system factors identified in Chapter 6 influenced nursing work and in doing so has addressed the second part of the SEIPS model which explored the care process. Analysis of the data using the work systems conceptual framework has shown that nursing work fits within an unwritten temporal routine that both nursing staff and patients are part of. It is clear from these finding that much of the influence on nursing capacity stems from the routine of the ward and the strict time schedules and expectations that nursing place on themselves. Due to the routine of the ward, nursing staff had become “task blind” in which they no longer saw people with dementia as individuals but saw them as sets of tasks. In addition, the nursing staff appeared to have adopted “tunnel vision” in which they were unable identify small cues and to see different ways of working.

Chapter 8, the fourth and final results chapter, will address the third objective of this study and identify how nursing staff are being affected by this lack of capacity and how this is then influencing their work.

Chapter 8 The impact of the work system on nursing staff and their capacity for relational care

8.1 Chapter Introduction

The previous two chapters have addressed the first two objectives of the study identifying the factors of the work system on the Medicine for Older Persons wards and identifying how these are influencing the way in which nursing staff work with regards to relational care. In this chapter, the third objective is addressed and the consequence of the work system for employees (as shown in Figure 8) will be explored. Findings indicate four main effects of the work system on the employees: feelings of guilt, feelings of fear, feelings of lack of control and tensions within the nursing teams.

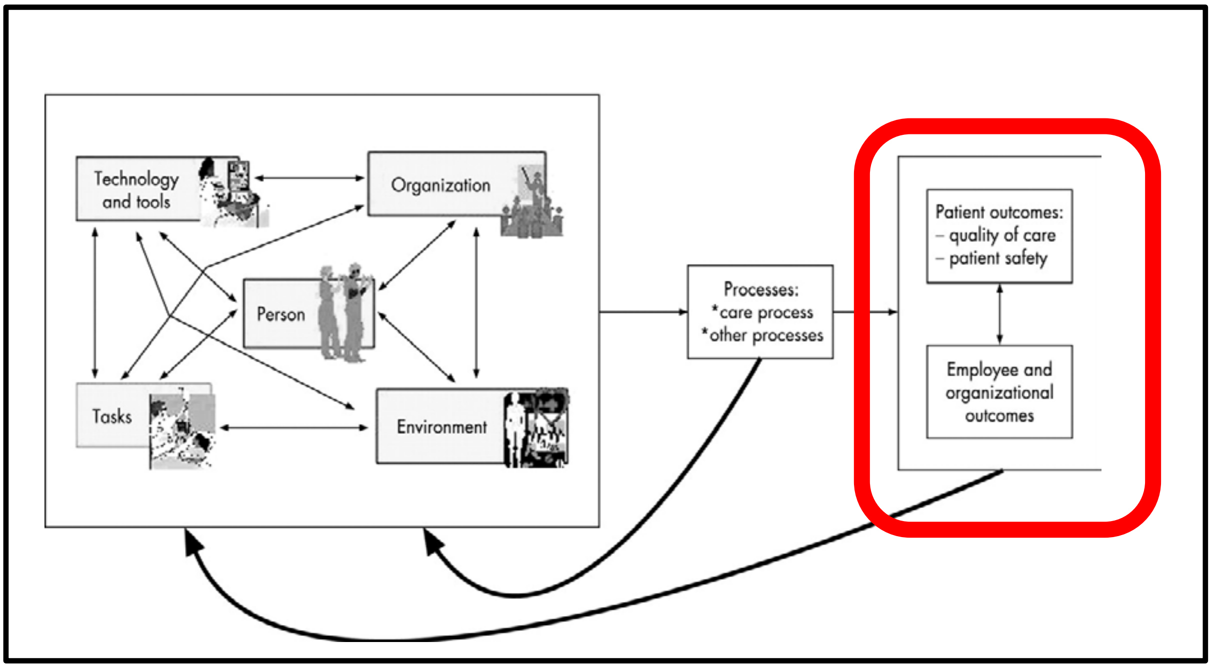

Figure 7 SEIPS Model

8.2 Nursing staff feel guilty

The observational and interview data clearly illustrated that the work system and its effect on care processes negatively impact the nursing staff. Nursing staff knew that the care they were providing was not as high quality as they felt it should be and could identify the reasons for this. However they were at a loss as to how this could be improved. This mismatch between their aspirations for care and the care that was actually delivered led to what appeared to be the most significant emotion fuelled in nurses by their work: guilt.

It was clear in the interviews that the nursing staff felt an overwhelming sense of guilt for not providing patients with a level of care that the staff felt they should receive. Most of the nursing staff commented on the fact that due to the demands of the job they were unable to provide the quality of care they wanted. Many reported that they would often take this this feeling home with them:

> "I think a lot of nurses probably go home feeling quite deflated that they haven't cared as much as possible" ***INTERVIEW (RN4)***
>
> "So I don't think we are failing on it; I just think that we probably wish that we had … we could do more" ***INTERVIEW (HCA6)***

The guilt felt for not providing a high quality of care for the patients was exacerbated by a feeling of guilt for not helping other staff members. This seemed especially significant for the nurses who felt an overwhelming need to help health care support workers. There were discussions about the need to be helping either the team you were with or the team on the next shift:

> "And also, healthcare support workers work really hard, and you need to be seen to be helping them as well. You can't just be doing your meds all the day" ***INTERVIEW (RN3)***

Nursing staff seemed stuck in a cycle of guilt. They would feel guilty if they did not help other members of the team with their work and would therefore decrease the time they spent on their own tasks and consequently decrease the time spent with patients. However, by doing this, nursing staff then felt guilty for not spending time with patients and not providing as high-quality care as they would like. Throughout the data, this cycle failed to be interrupted which left nursing staff feeling dissatisfied with their work:

> "I hate like not being able to give patients enough time. When you're very busy, it really upsets me" ***INTERVIEW (HCA8)***

8.3 Nursing staff feel fearful

The second most significant emotion identified in the data was fear. Although not explicitly identified by the nursing staff, it was clear from the interviews that fear was an influencing factor for the way in which they organised their work. Nursing staff continually reported that if work was missed there would be consequences and this was a reason why they didn't feel they had enough time to spend with patients. Nursing staff were choosing to spend more time on tangible tasks such as documentation or infection control due to a fear of being seen as less efficient to other team members and ultimately, the hospital organisation.

As discussed in the previous chapters, it was observed that certain tasks in the work system took priority and feelings of fear were the driver for this. The fear that nursing staff felt often led to them prioritising tasks that were measured by the organisation and it was clear that these were the tasks that they felt the organisation valued the most. Tasks such as recording vital signs, documentation and discharging patients, were top priority for nursing staff which is perhaps a reflection of the targets they have to meet and because of this nursing staff were more fearful if they were incomplete:

> "And then we had an incident recently, where something happened with a patient, and when he fell and he – he ultimately passed away. And I think the Nurse looking after them that night hadn't documented properly, and it really fell back on her. So that really frightened me" ***INTERVIEW (RN2)***
>
> "You know like on the vitalpacks where the Obs are, you know, you've got all the red clocks, and you know that you need to check patient's Obs, which is important as well, because you need to check that your patients are safe. So that would worry me." ***INTERVIEW (RN8)***

Interestingly, when asked in the interviews what would happen if these tasks were missed, none of the nursing staff were able to give an answer. Staff were either unsure if these tasks were being audited by the hospital organisation or made it clear that because the tasks were never missed, they didn't know what would happen if they weren't done. Similarly, to the rules of the routine, the fear felt by nursing staff appeared to be internalised:

> "**INT:** Does anyone ever check … … your care plans? …**RES:** Eeerm. … No. I have never known anyone to do that… But then if anything was wrong, like say if something went further …if there was a problem, then it would all go … you'd get into trouble" ***INTERVIEW (RN11)***
>
> ***"*****INT:** Has anyone ever actually said to you "Why haven't you done your IVs?" "Why haven't your Obs been done?" … **RES**: No, 'cos I've always done them" ***INTERVIEW (RN7)***

> ***"INT***: Are people checking your documentation? And that you're getting the meds done? … Do you think?, **RES**: I don't know. I don't know how the audits are carried out on this ward but I've never seen anyone" ***INTERVIEW (RN5)***

In addition to this, the nursing staff appeared to possess a very pessimistic outlook on their work which also linked to the emotion of fear. During the interviews, nursing staff often commented on the need to ensure all documentation was updated so if anything went wrong, they would have evidence of the actions they had taken. Similarly, nursing staff repeatedly discussed the need to ensure all patients were repositioned every two hours which again, was motivated by the fear of the patient developing a pressure ulcer.

> "As a Band 6 we have to justify if anything goes wrong. For example, if we develop a pressure sore, it wouldn't stand up in court if we'd said "But they didn't do the rounding because they were spending time talking to patients" ***INTERVIEW (RN3)***

8.4 Nursing staff feel they have no control

Another theme underlying the data was the sense of lack of control and autonomy, particularly for the nurses. Throughout both the observations and interviews it was evident that nursing staff had little control whilst on shift which affected the way in which they viewed their role and consequently, the way in which they provided care.

As highlighted earlier in this thesis, nursing staff were dictated to by the routine of the ward and the rules of the organisation. The pressures of set targets and the need to justify how time was spent, left nursing staff feeling like they had no control over the way in which they organised their work load. A lack of flexibility in nursing work schedules meant that nursing staff did not have control over their own time and did not feel able to spend time with patients building relationships. Instead, their time was spent on tasks dictated by widely understood organisational priorities.

During the interviews, many of the nursing staff stated that they would not feel comfortable explaining to a higher body why they were sat sitting and talking to a patient when there were tasks to be completed and this fear helps explain why relational care was not a priority in this setting.

> "As I say, if there's … constraints on you from a staffing perspective, you can't go and sit with somebody, because that's almost … second in priority to stopping someone from falling, or somebody's incontinent, or … somebody's wandering, and … and the risk of absconding from the ward" ***INTERVIEW (RN7)***

Nurses particularly appeared to have little control over their workload and appeared to have little autonomy with regards to other members of the multidisciplinary team. As described previously in earlier results chapters, nurses were often asked to complete additional tasks by other healthcare professionals, including health care support workers, and although often evident in their reaction that they would have liked to say no, there was no instance during data collection where a nurse was seen to refuse to carry out this additional work. This additional workload increased the demand on nurses' time which added to the feelings of lack of control:

> "there's just more and more being put on the nurse in that particular shift…which is eating into their time that aren't necessarily nursing specific, but … … we are expected to do them now, whereas we weren't" ***INTERVIEW (RN7)***

> "Everything. We're expected to deliver everything … and it's really challenging at times. ***INTERVIEW (RN11)***

Nursing work seemed to be continuously governed by others which exacerbated nursing staff's, and in particular, nurses feelings of a lack of control in their work. During the observations and the interviews, it was clear that nurses were often ruled by those in a position of higher authority, despite the nurses appearing to know what was best for the individual patients.

> "Therefore I think it's a bit unfair at times when we could do with not having one of our colleagues to another ward … And it doesn't make any difference, they will still take that person, and that leaves us quite in a bit of a pickle … But we don't seem to matter; we've just got to get on with it" ***INTERVIEW (RN9)***

A clear example that was discussed was the concept of discharge. The nurses stated that even though they knew that a patient shouldn't be moved to another ward or discharged, they didn't feel they could challenge hospital managers. Patients who were discharged against nurses' own judgement as to their readiness for discharge would often be readmitted. The nurses felt confident about what was best for the patients but didn't feel that they were listened to by managers. This lack of involvement in important decisions about patients they felt responsible for aroused strong feelings of a lack of control over their work and ultimately much frustration.

> ***"***And on the patients that aren't definite (discharge), we are then expected to do all the telephoning round and to try and make the discharge definite. And if you haven't updated

> bed view[15], which is what the whole organisation watches … every hour, they want to know what you're doing, and why it hasn't been done" ***INTERVIEW (RN3)***

> "Monday, a patient had just sat down for dinner - had their dinner in front of them, and three senior staff – I think it was one Sister and two Matrons - came and moved three patients while they were just about to eat their dinner. And these are 90-year-old patients with Dementia – and I wouldn't be able to say otherwise" ***INTERVIEW (RN4)***

> "We are expected to attend … operational meetings, which we've never had to do in the past, to justify why our patient hasn't gone down to Discharge Lounge by 9 0'clock" ***INTERVIEW (RN3)***

> "and it's really … frustrating when you know that it would have made a difference, and if someone had listened to your professional expertise, which is why we're in post, then they probably wouldn't have re-presented less than 24 hours later" ***INTERVIEW (RN4)***

8.5 There are underlying tensions within the nursing team

The data suggests that the work system affected the nursing team as a collective. The themes outlined in the above chapters have highlighted that there was some tension between the nurses and the health care support workers. The multiple roles of the nurse and the need for staff to be a "team player" were all observed during data collection and are examples of where there was a need for the staff (registered nurses in particular) to be flexible in their work.

> "And also, healthcare support workers work really hard, and you need to be seen to be helping them as well. You can't just be doing your meds all day" ***INTERVIEW (RN3)***

> "You know, sometimes a Staff Nurse will come up and say "Oh I've finished, who would you like me to wash?" Which is nice but that's rare" ***INTERVIEW (HCA5)***

This flexibility can be attributed to the fact that there are no clear boundaries between the roles of nursing team members. The shared job load meant that roles were not clear. This lack of clarity not only caused tensions within the team but also reduced the care quality for patients:

> "But a lot of the times, that does happen, that health care support workers seem to do -. Not all the time, but seems to me that the Healthcare seem to have the job of the actual

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> care” ***INTERIEW (HCA5)***

> “You know, what we’re going to do; both pull our weight and get on and do the job. That’s what I like” ***INTERVIEW*** **(HCA10)**

> “Now these days, it seemed as if people comes in to work and some of the Healthcare seem to be in charge” ***INTERVIEW (HCA10)***

> “And you know, you haven’t got people sitting on a commode and the next one up the other end is running round like a blue arsed fly, doing all what they’ve got to do. And then as you come out, the people that should be working, are sitting on computer talking and doing what they’ve got to do” ***INTERVIEW (HCA5)***

During the interviews, health care support workers commented on how nurses needed to help them with their tasks - in particular personal care. The health care support workers clearly saw that their work was shared with the nurses, despite the nurses also taking tasks from doctors as well as clerical work:

> “The nurse comes into the bay and requests help from one of the HCSW, the HCSW looks a bit annoyed and says she will be in soon. The HCSW looks at me and says, “It’s taken her 2 and a half hours to do the medication! And she’s washed 1 patient, we’ve still got 2 rooms” ***FIELD NOTE***

> “They won’t – they would just get on and do what they’ve got to do with the tablets. They may have IVs and then they do their Obs. But to me, I can’t see how that can take all morning” ***INTERVIEW (HCA4)***

> “And they’ve done their tablets, they’ve done all their obs, so if they’re -. They’ve finished early. Or not early. They’ve finished on the time they wanted to be doing it in. And then they’ll come and help you, and you’ve had a good day then” ***INTERVIEW (HCA4)***

More subtly in other observations, there was also other underlying tensions starting to show. An example being that nurses were often frustrated when the previous nurse on the shift hadn’t restocked the medication trolley:

> “Why aren’t drugs being checked more? You’re running out of antibiotics all the time.” ***INTERVIEW (RN11)***

Although this was discussed by a nurse in reference to the location of resources on the ward, it is clear that there is an underlying frustration towards staff on the previous shift. Similarly, from the discussions regarding the shift pattern; all nursing staff wanted to ensure that their work was completed before the next shift had started and there was some tensions within the teams if this was not the case:

“Whereas for people that work long days on this ward, they don’t have that and they have to finish everything before the next shift” ***INTERVIEW (RN7)***

These expectations and underlying tensions between the nursing staff highlight how role flexibility is necessary for the team but as the data illustrate, it was at the expense of patient care. Due to internalised rules, expected task durations, and needing to be a team player, nursing staff teams have an undercurrent of tension which has stemmed from a lack of role clarity, all of which negatively impacts patient care.

8.6 Chapter Summary

This chapter presents and explains the impact of the work system on the nursing staff themselves. The findings described in this chapter highlight the emotional toll of the work system on nursing staff. It appears that due to a fear of not being able to complete their work, nursing staff were spending less time with patients in order to complete their tasks. However, they consequently felt guilty if they could not meet the needs of the patients.

This chapter also described how the nursing staff had an overwhelming feeling of no control which appeared to influence how they worked. Nursing staff were not often able to make decisions in their roles and were normally following orders from others. This then led to nursing staff becoming quite rigid and inflexible in their practice resulting in time being spent on tasks rather than spending time with patients, leaving staff with feelings of dissatisfaction with work. As a consequence of these feelings of no control and dissatisfaction in their work, patients with dementia were seen to be receiving no relational care.

The findings in this chapter also highlight the underlying tensions within the nursing teams that seemed to have stemmed from the work system. The multiple roles of nursing work, the expected task durations and the need to be a team player all contributed to an undertone of tension within the nursing team with confusion in role clarity and role flexibility being the cause.

In the following chapter, the results presented in the last four chapters will be discussed. The findings will be compared to the current evidence base and the unique contribution to the body of knowledge will be identified.

Chapter 9 Discussion

9.1 Chapter Introduction

The aim of this study was to explore how work system factors on the Medicine for Older Persons wards affect nursing staff capacity to provide relational care for people with dementia. The objectives of the study were to identify and describe the factors of the work system on Medicine for Older Persons wards, explore the impact of these factors on nursing staff work and highlight the effect this was has on nursing staff and their capacity to provide relational care.

The previous four chapters have discussed, in detail, the data collected during this doctoral study providing evidence from both the observations in phase one and the interviews in phase two. This chapter will now summarise the key findings and core outcomes of this research study, relating these to the current evidence base and placing the findings within the context of the existing body of knowledge.

9.2 Findings and discussion

The findings clearly illustrate that the nursing work system on Medicine for Older Persons wards reduced the capacity of nursing staff for relational dementia care. The findings paint a rich picture of how the work system influences nursing staff and as a consequence, how this influences patient care. They illuminate practice on Medicine for Older Peoples wards, a specialty that might be expected to be attuned and responsive to the complex health needs of older patients but suggests that relational care remains absent in this setting. The findings detail four core features of the work system that exert a significant impact on nursing practice and have a particular influence on the delivery of relational dementia care:

- The routine of the ward and the prioritisation of tasks
- The confusion in role boundaries within nursing teams
- The lack of control that nursing staff have over their work
- The emotional demands of nursing work

These core findings advance our understanding of the challenges faced by nursing staff in the delivery of relational care for people with dementia within the Medicine for Older Persons setting.

9.2.1 Nursing staff have limited capacity for relational care due to it not being an organisational priority

The findings indicate that relational care for people with dementia remains a low priority for nursing staff on Medicine for Older Persons wards, despite the increased focus in the policy context and the expertise that the nursing staff should have to care for this patient group. The data collected in this study describe how nursing staff on the wards spent a limited time providing relational care to people with dementia and that physical care tasks such as documentation, recording vital signs and assisting people with repositioning were much more of a priority. As described in the data, there was a detrimental effect to these tasks being the priority, including staff only interacting with patients when there was physical need and staff focusing solely on the task as opposed to the patient behind that task - all of which reduced the relational care that patient's received.

The data collected in this research echo the findings of the studies explored in the meta-ethnography earlier in this thesis. The seven studies within the review highlighted how organisational priorities shaped the care for hospitalised older adults in a range of settings other than Medicine for Older Persons wards (Cowdell 2010, Parke and Chappell 2010, Moyle, Borbasi et al. 2011, Clissett, Porock et al. 2013, Dahlke and Baumbusch 2015, Dahlke, Phinney et al. 2015, Baumbusch, Leblanc et al. 2016) with patient safety and timely discharges being at the forefront of the care. The results of this thesis have evidenced that these organisaitonal priorities have the same influence on practice on Medicine for Older Persons wards. The influence is in spite of the level of expertise about meeting the health care needs of older people that professionals are expected to have in this particular setting and the well known effect that the nurse-patient relationship has on care quality for this patient group.

This study has identified that organisational priorities are highly significant in determining how nursing staff organised their time. The work structuring and relational care given remained constant across the three wards studied and as observed relational care was not a priority for the nursing staff, mostly because it was not a priority for the organisation. As observed in this study, Medicine for Older Peoples ward had a 'one size fits all' approach to care, which echoes the approach to care reflected in Goffman's institutionalisation theory:

- All aspects of life (sleep, work, play) are carried out in the same place, under the same authority.
- Each aspect of life is carried out alongside others who are all subject to the same conditions.
- Daily life is tightly scheduled by a system of formal rules, which are there to fulfil the objectives of the institution.

Despite the similarities in the institutionalised approach to care, Goffman describes institutionalisation as an intentional attempt to remove people's individuality which was not was what was seen in the data. The findings in this study suggest that the institutionalism occurring on the wards was not an attempt to remove individuality but was an attempt of the nursing staff to manage their workload. These findings correspond to those of Higgs et al. (1992) who suggested that the loss of individuality in the care of the older person in hospital is in fact unintended, however, nether-the-less occurring, due to the people in the institution abiding to the same rules and routines. Nearly 20 years on, one of the findings from this study has identified the same themes with regards to relational care for people with dementia and more specifically on Medicine for Older Persons wards, in which the wards have an expected specialism.

Although relational care is not a priority for nursing staff as a result of it not being a priority for the organisation, the data also suggests that it is a problem that starts outside of the organisation and beginning with national policy. This finding has been seen in similar research in other settings, with increased targets, performance indicators and monitoring stemming from policy drives diverting health care professionals away from the needs of patients (Browen et al, 2011, Calnen et al 2013). In more recent years the concepts of patient safety, patient satisfaction, and patient rights have started a major shift in the overall objectives and expectations of hospital care provision (World Health Organization 2001a). In this doctoral study, the tasks that staff were seen to prioritise on the ward in this setting, correlated to the priorities of the organisation and did relate to recent government initiatives regarding patient safety. The benchmark that pressure ulcers should be eliminated in 95% of NHS patients (Dorey 2001) and the drive to reduce sepsis in hospitals (Department of Health 2015) have successfully infiltrated down to ward level and this was clearly demonstrated through the observations of the nursing work in this study.

The wider societal context as described previously in this thesis demonstrates that the importance of relational or person centred care is alluded to in policy guidance, however, unlike other initiatives this does not seem to have any tangible targets. Perhaps the lack of priority given to relational care by the nursing staff is because there is currently no government benchmark, standardised targets or measurement tool to audit this. Another finding of this study is that nurses tended to focus on the work which was more "visible" and measured by the organisation. A reason that relational care is given less of a priority by nursing staff is that there is currently no way of measuring relational care, meaning it cannot be audited by the organisation and as such it is often neglected.

The lack of national guidance on relational care, together with the ongoing drivers from the organisation to improve other aspects of nursing work, makes it unsurprising that the nursing staff were continually competing between the demands of the hospital and the needs of the patients. Consequently, as demonstrated in the data, the fact that priority was placed on certain tasks by higher authorities within the hospital, guided the ways in which the nurses organised their time and therefore less tangible tasks such as relational care did not have primary significance in their work. This prioritisation of certain tasks resulted in nursing staff creating a routine that enabled the completion of the “visible” tasks in a strategic way. The following section of this chapter will discuss the impact of this routine, particularly with regards to marginalisation of tasks and the impact this is having on relational care.

9.2.2 Nursing staff have limited capacity for relational care due to the routine of the ward

The data from this research identified that nursing staff capacity for relational care was affected by the rigid routine which dominated the wards and nursing staff work. The themes that emerged from the data such as internalised rules, expected task duration and allocated interaction time are all related to the idea that provision of care is ruled by a system of formalities known as the routine.

Routines are defined as *“patterns of behaviour that are followed repeatedly”* (Winter 1965) and they are often embedded in organisations with the function of helping, controlling and coordinating individual actions. Routines allow for specific outcomes to be efficiently achieved and in order for a workplace to work effectively, there must be a secure balance between individual habits and organisational structuring all of which constitute a routine (Winter 1995). In a system as complex as the hospital, the routines are needed to maintain a sense of order and allow for the work to be carried out successfully through synchronisation of the team and tasks.

In this study, multiple routines were found and each one was important for the stability of ward culture. Each member of staff (both nursing and others) knew exactly what tasks needed to be completed and within what time frame, and any flexibility in this was met with some hostility from the team. Although this rigidity in the routine can be justified by the need to remain a sense of stability in the complex environments of Medicine for Older Persons wards, the data collected suggests that this stability was at the expense of patient care. Nursing staff on the study wards organised their work around the routine and patients were expected to fit their needs into this. Any disruption to the routine resulted in nursing staff becoming quite resentful towards certain individuals. These findings echo what was identified in Porock’s study (Porock et al, 2015) who identified that on admission to hospital, a disruption does not just occur to the person with dementia but also disrupts the family, co-patients and staff on the wards, with the ultimate consequence being hospital professionals having a disadvantage in caring for this most vulnerable population. As highlighted in the findings, this was a regular occurrence, particularly for people with dementia which can explain one of the reasons why relational care remained absent.

As described in the previous section, all three wards studied were abiding to the same routine which could be a reason for the lack of relational care provided. Walz, Elam et al. (1993), explored the disadvantages of routines and reported that they are not transferable across a wide range of contexts (Walz, Elam et al. 1993). In his research exploring software design, it was concluded that when routines are moved, productivity declines as the routine is not compatible within varying contexts (Dent 1991). This theory could be used to explain the shortfalls in relational care on these wards. In this study, it was observed that staff on each of the three wards adhered to the same routine, in order to achieve the same general outcomes. This was despite the different contexts in which the work was undertaken and the different patients being cared for which could be a reason for the difficulties in delivering relational care.

The wider healthcare literature suggests that similar routines are occurring across other wards. The findings in Featherstone's (2019) work echo the findings about routines in this study, despite being conducted on trauma and acute medical wards which do not specialise in dementia care. In addition, studies exploring ward routines in other countries have also highlighted similarities between the routine on nursing practice (Rytterström et al 2011), as well as studies of nursing in more varied settings such as mental health units (Isobel 2015). The similarity in findings, despite the different speciality of the wards, suggests that all hospital settings may be working towards one routine and as a result transferring that routines across a number of different wards, all of which have different patients who need different care.

Nursing staff were trying to abide by the hospital routine and because of this, were not achieving the intended outcomes for each patient as they were trying to meet demands of a routine that was not suitable for the Medicine for Older Persons wards. This is a similar finding to that of Tadd et al (2011), in his exploration of dignity for older persons in acute hospital settings. Tadd et al (2011) found that there were conflict of interests between the priorities of the hospital, staff and the patients. The findings in their study outlined that although the majority of staff on the wards were trying to work towards the interests of the patients, their motivations were frequently compromised due to the systemic and organisation factors, predominately the organisational priorities on the basis of measurable performance indicators.

This study has added another facet to this in that it evidences that this is even worse of people with dementia, even on Medicine for Older Persons wards which should have greater expertise. As explained in the previous chapters, people with dementia have very different, and often more complex needs than patients without a diagnosis. The significant difference in needs suggests that a very different set of outcomes and routine is needed to provide high quality care for this patient group. The findings suggest that providing relational care that is tailored to individuals whilst also abiding to one hospital routine is not possible and it is this conflict which is impacting nursing staff capacity to provide relational care for people with dementia.

The data from this study have also provided a contribution to the theory about the disruption of routines. In his study exploring aviation routines, Weick (1990) found that although routines allow for efficient working between individuals, they can be easily be disrupted when individuals within the routine start acting in a more individualised manner as opposed to a collective (Weick 1990). The findings from the study support this claim and provide a greater understanding about the outcomes of a disrupted routine in organisational structuring, particularly in healthcare environments. The data provides evidence that the patients who had dementia would often disrupt the routine as they were unable to fit their needs within specific time schedules and as such the whole routine would seem to break down. Nursing care was seen to break down increasingly when the routine was disrupted, highlighting again that current ward routines and rigidity in nursing practice is not fit for purpose, particularly for people with a diagnosis of dementia.

The importance of the routine was highlighted in the meta-ethnography earlier in this thesis. The habitual way of working that nursing staff have adopted was seen in three other studies that explored the care for people with dementia in hospitals (Cowdell 2010, Parke and Chappell 2010, Moyle, Borbasi et al. 2011). The interview data in this study echoes the findings of Cowdell (2010) who explained that nursing staff often contested that certain tasks needed to be done at certain times. However, what this study adds through the observations of care, is that despite this contesting, the routine is still adhered too. What is intersting is that both this study and Cowdell (2010) were conducted on Medicine for Older Persons wards. The difference between what the nurses said and what they were obseved to do, suggests that there is perhaps a greater awareness of staff on these wards that the care should not be as task centred but due to the demands of the work and priorties of the organisation, this awareness cannot be translated into nursing practice.

The fact that the importance of relational care and the awareness that care should not be so routinised was not translated into practice can be explained through Sheppard’s (1995) theory of marginalisation. The theory states that tasks not envisioned as core within the routine are often omitted, particularly in situations where temporal structures are rigid and strict routines are in place. Sheppard (1995) found that when work is routinised, less tangible elements of professional work are often marginalised, particularly the interpersonal aspects. As highlighted in chapters 1 and 2, relational care remains difficult to objectify, universalise or measure and it is therefore a less tangible element of nursing work. As a result of other tasks being audited and more “visible”, nursing staff were seen to be ignoring these very important interpersonal aspects of care particularly when the shift was busy, and the workload had increased.

Although Sheppard (1995) stated that marginalisation is often an unconscious act, the findings of this study suggest that nursing staff were aware that they were demoting relational aspects of work but were only doing so, in order to make the work more manageable. On many occasions during the research, nursing staff were seen to be distancing themselves from people with dementia, as a way to manage the time spent on certain tasks and to allow for completion of their workload during their shift. The findings challenge the idea that marginalisation is an unconscious consequence of routinisation and suggest that marginalisation is actually a conscious act, with nursing staff making the decision to carry out tasks that they feel are more of a priority than relational care as a way of managing their workload.

The lack of relational care due to the routine of the ward can also be described through Cohen’s theory of standardisation. Cohen (2011) discussed how an increasing need for efficiency across a workplace, particularly in “body work”[16] organisations, often leads to the reorganisation of the order of work and as a consequence, a rationalisation of certain tasks and the dehumanisation of individuals (Cohen 2011). Organisations whereby humans are the objects of labour, often struggle to reorganise their structure due to the unpredictability of people and consequently, aspects of work are standardised in order to make them more manageable. As a result of this standardisation, the recipient of the body work (in this case the patient) is often divided into separate parts rather than being treated as a whole, unitary being. When this standardisation by selection occurs, holistic care is less likely, and dehumanisation occurs (Cohen 2011).

Although Cohen (2011) has suggested that standardisation could be a theory for the way in which certain professionals behave, this theory has not been previously applied to health care work in hospital settings and more specifically within Medicine for Older Persons wards. The findings from this study indicate that that professional standardisation is occurring within this setting. Patients with dementia were not being treated as a unitary whole by the nursing staff despite the heightened focus on holistic care and as a consequence there was a reduction in the relational aspects of care.

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[16] Bodywork: paid work on the body of another (Gimlin 2007)

In contrast, Cohen (2011) suggests that standardisation by selection leads to different parts of the work process being performed by less skilled professionals, for example, nurses are now taking on doctor's work, and healthcare support workers are doing the work of nurses. The data from this study challenges this theory of standardisation, highlighting how this process has not worked for nursing staff and in particular nurses. The research has illustrated that although the nurses continued to take on doctor's work, the expectation remained that they also completed the work that is now predominantly health care support workers and therefore the work is not being performed by less skilled professionals. This data highlights another finding of this research which is that nursing roles are very blurred and there is a lack of clarity in what nursing work entails. The next two sections of this chapter will focus on this, commenting on nursing autonomy in relation to the division of labour, role clarity and tension between nursing teams.

9.2.3 Nursing staff have limited capacity for relational care due to confusion in role boundaries within the nursing team

This study has increased the understanding of the ways in which nursing teams operate on Medicine for Older Persons wards. As explained in the previous section, the standardisation of nursing work means that the workload is divided between the multi-disciplinary team as a way of managing the workload. The concept of multi-disciplinary working has a long-standing recognition in healthcare, particularly in regards to the care for older persons (Atwall & Caldwell 2006, Kilpatrick 2013). The data collected in this study echo the findings of previous research, providing evidence that the division of labour and the workings of the team are at the forefront of care for patients, with different healthcare professionals having set roles and tasks for each patient.

The data collected suggests that there was an underlying theme of confusion in role boundaries within the nursing teams within this setting. Nurses were often juggling their own tasks, the tasks of health care support workers, clerical tasks and even undertaking the jobs of doctors, resulting in them having less time to spend with patients. This increasing task load was mixed with an ongoing need to be an efficient member of the team. In the observations, nursing staff were seen to be rushing through their own tasks in order to help others with theirs and there was a clear expectation that this was their duty. This was then highlighted in the interviews, more significantly from health care support workers who spoke highly of nurses who were more available to help them and showed frustration towards those who were not.

The discussions of the Nurse-Doctor relationship long been observed in research (Wicks, 1998), particularly with regards to the now shared roles (Weller et al 2011, Tang et al 2013, Burford et al 2013 Wilson et al 2016) and it is therefore no surprise that there were aspects of nurses performing medical work within the findings. Since the 1990s and the concerns regarding excessive hours worked by junior doctors (Hughes 2002), there is now a wealth of studies that have argued that the traditional model of the Doctor-Nurse power struggle is dissolving, possibly due to nurses crossing professional duty boundaries due to work pressures (Allen 1997, Allen 2002, Stein-Parbury & Liaschenko 2007) or due to nurses increased access to higher education and specialist courses (Snelgrove and Hughes 2000, Hughes 2002). The findings of this study support this theory with nursing staff observed as taking on requests from the medical team, however, with little animosity observed. The division of labour appeared mutual between doctors and nurses with both professions being aware of the separate tasks they were to complete.

The findings of this study suggest that there is now tension within the nursing team themselves. The findings highlight the confusion in role boundaries and role clarity resonating between health care support workers and nurses. Throughout the interview data, there was an underlying theme of tension between nurses and health care support workers regarding role clarity and role flexibility. Previously, nursing staff and health care support workers had very separate roles, however, now that responsibilities in roles are increasing, these role boundaries are much more blurred. There is no longer a clear divide between the work of nurses and health care support workers and often within the findings, many members of the nursing teams were undertaking the same tasks. Not only did this cause tensions in the dynamics of the team but it was also having a detrimental impact on patient care. As explained in the findings, nurses were seen to be reducing the time spent on their own tasks, in order to help health care support workers with their tasks and the consequence of this was that the patients received less interaction which reduced the opportunity for relational care.

The data collected in this study provides an interesting perspective to the way in which nursing staff roles are defined. Governing bodies and regulatory authorities are pushing for greater role clarity level and there is an emphasis on tightening role regulations, particularly with the introduction of Band 4, Nurse practitioners, however, at a ward level, flexibility is desired (Wright, & Bretthauer, 2010). The concept of role clarity and role flexibility has been explored within healthcare literature, for example, in her study exploring the introduction of inter-professional care co-ordinators within healthcare, Bridges (2004) illustrated that there is a fundamental tension between role flexibility and role clarity and that the two are incompatible, stating that it is in fact impossible to fully specify competencies when boundaries of a role are viewed as flexible.

The data from this study echoes these statements, suggesting that complete role clarity and role flexibility are contradicting, however, the findings add further depth to the statements made by Bridges (2004) in that they present how this contradiction is affecting patient care. Bridges (2004) findings highlighted the difficulty this tension caused for nursing staff and what this study contributes to this knowledge is that that the effect of this does not stop at a staff level but is actually detrimental to patient care. This study has gone one step further to previous work and has not only identified the tensions between the nursing team but demonstrated what effect this is having on the way nursing work and consequently the effect on patient care. As illustrated in the findings, as a result of the confusion in role clarity, nurses were attempting to reduce the time spent on tasks seen as their own, in order to help the health care support workers with further tasks that were viewed as nursing work. As a consequence of this confusion in role clarity, the nurses were spending less time with patients and therefore the opportunity to provide relational care was decreased.

Tension between the roles of healthcare support workers and nurses is cited within the literature, however, not in any sufficient detail. In their work exploring divisions of labour across nursing teams, Allen and Hughes (2002) suggest that the tension within the nursing-health care support worker interface exist in relation to the delegation of registered nursing tasks to health care support workers. Allen and Hughes (2002) suggest that registered nurses do not feel comfortable delegating to healthcare care support workers and feel that if nursing work was to expand then more registered nursing staff would be needed. In contrast, the findings from this research have challenged the views of Allen and Hughes (2002) suggesting that the tension between the nurse-healthcare support worker interface actually stems from the healthcare support workers expecting nursing staff to help with the personal care as well as complete their own tasks.

Not only do these findings add more knowledge to what we know about the flexibility of roles in healthcare, they also challenge previous beliefs regarding power within the hospital environment. As mentioned previously, other research has highlighted how the medical hierarchy within health care seems to be dissolving. This study has provided evidence that there may be developing tensions within the nursing team themselves. Another finding of this study is that hierarchy on medicine for older persons ward are not top down but bottom-up and on some occasion, sideways in. As illustrated in figure 8**,** dominance over work is now stemming from the organisation, hospital managers, doctors, others registered nurses and healthcare support works. This new hierarchy model suggests that although other healthcare professions autonomy may be increasing, this is not the case for nurses and if anything, the control over their work is in decline. As nurses are often the frontline of the hospital organisation, this lack of control over the way they organise their work is detrimental to the care for the patients. The impact of low autonomy is explained in the next section of this chapter.

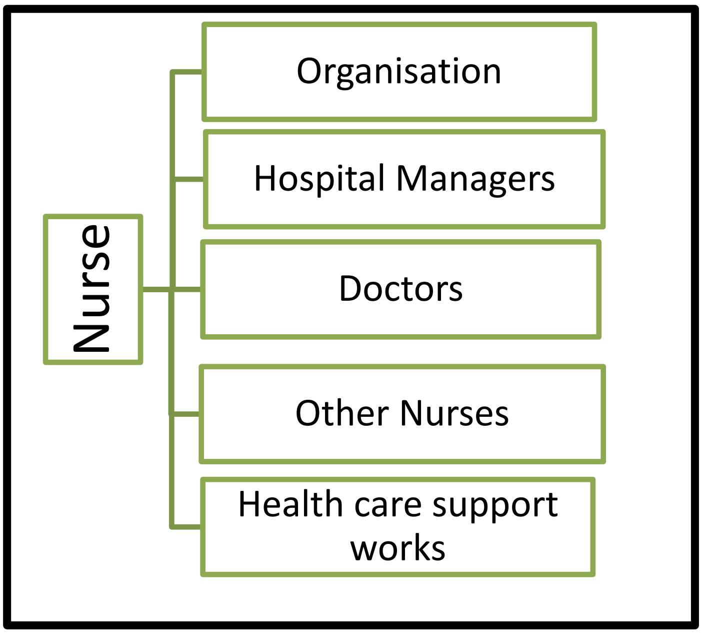


Figure 8: Professional influence on nursing work

9.2.4 Nursing staff have limited capacity for relational care due to lack of control over their work

This section of the chapter will discuss how the nursing staff on the Medicine for Older Persons wards faced a higher demand of work which was being met with a low control over this work. The lack of control that nursing staff face in relation to the content and context of their practice is well citied within the literature. Research undertaken in the early nineties highlighted the same findings as those identified here (Goddard 1993, Whyte 1995, Lashinger & Havens 1996) and more recent studies have suggested that hospital environments that allow for greater autonomy have increased performance and improved patient outcomes (Institute of Medicine, 2004, Aiken et al. 2008). Despite this recognition of the need to allow nursing staff to be more autonomous, the findings of this study suggest that over 25 years on, we are continuing to see the same practices.

As evidenced in the data, nursing staff continue to be governed by both national and organisational priorities and not the needs of patients. As highlighted in previous chapters, nursing staff felt unable to justify spending time with patients as they felt they should be doing other tasks. The staff also felt that they had to complete certain tasks by certain times as explained in the sections on expected task duration and the unwritten rules experienced. What is interesting about these findings and different to what has been discussed in previous studies, is that it seems to be the nursing teams themselves that are reducing the level of control over their work as opposed to senior members of the organisation. The data suggests that the nursing staff on these wards had internalised rules that were controlling the way they worked and as evidence in the data, these were not implemented by the hospital organisation. The findings of this study suggest that although the reasons for nursing staff to practice in this ways stems from the organisation, it is actually the nursing teams that are having the greatest impact on their autonomy and are placing this pressure on their work which has not been identified before.

Whether it is the hospital bureaucracy or the nursing staff themselves, the data has suggested that the environment of Medicine for Older Persons wards is one of high demand and low control. The outcomes of environments with varying levels of demand and control is well explored in empirical studies. Studies focusing on human organisations have concluded that staff who work in settings with a high demand, require high levels of felt control over their work to support their wellbeing. The job demand-control model (JD-C) model (Karasek 1990) suggests that job stress and employee wellbeing is situated between two basic characteristics: psychological job demand and job decision latitude (De Jonge, Mulder et al. 1999). The term “psychological job demand” is defined by Karasek (1990) as the psychological stressors present in the work environment such as time pressures or heavy workload. The concept of “job decision latitude” is a term used to describe the workers ability to control one’s own work activities and skill usage (Karasek 1990). As the model illustrates *(figure 9),* jobs with a low job decision latitude and a high job demand are usually the positions where there is a high strain and the risk of psychological/physical illness is greater. In contrast, jobs with a higher decision latitude and a low job demands present less strain and vice versa.

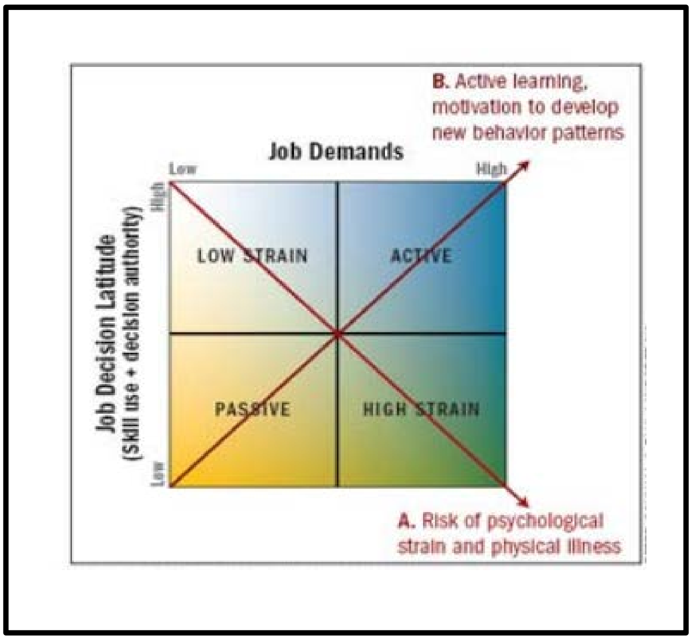


Figure 9 Job-Demand Control Model

The theory is well citied within healthcare literature, with regards to staff outcomes such as occupational stress (Beehr, Glaser et al. 2001), burnout or sickness (De Rijk, Blanc et al. 1998) and staff turnover (Chiu, Chung et al. 2009). The findings of this study echo the findings of other studies underpinned by this model and from the data collected it is evident that the staff often felt guilty or deflated when leaving a shift which had the potential to affect their wellbeing. Previous studies that have explored staff wellbeing in relation to job demand-control have focused on health care professionals in general (De Jonge et al, Laschinger et al 2001, 1999, Elovainio et al 2005) and there is little research that explores this model with nursing staff in particular. This study has added to the knowledge base and provided a more succinct study that has focused on nursing staff in particular and has highlighted the effect of this environment on this staffing group.

Although this theory has been discussed with regards to staff outcomes, there is a scarcity of literature that has explored the effect of high job demand and low control environments on patient outcomes and more importantly patient care. In their study exploring links between staff experience of work and acutely ill older peoples' experience of hospital care, Maben, Adams et al. (2012) did comment on the job-demand control environment of the hospital suggesting that this was one of the key contextual factors impacting on older persons care. Interestingly, the staff within Maben's et al (2012) study stated that they felt a high control over their work which is different from the findings in this doctoral study as the observations and interviews outlined the opposite, suggesting nursing staff felt dictated to as opposed to being able to make decisions about their work.

Although Maben, Adams et al. (2012) commented on the lack of autonomy in the hospital environment, this was more focused on factors that were really out of the nursing staffs control, such as staff shortages, the movement of staff across wards and the inadequacy of training. Maben et al (2012) did not explore the extent of staff control over aspects of their own practice. In contrast, this study found that nursing staff not only lack control over external factors such as staffing but also have limited control over aspects of their own practice such as the duration and timing of tasks and even more importantly, the time spent interacting with patients, all of which contribute to the ongoing failures in the provision of relational care.

9.2.5 Nursing staff have limited capacity for relational care due to the emotional demand of nursing work

The findings indicate that on top of the tangible work tasks that nurses had to complete during their shift, there was also another form of work that they were carrying out simultaneously – emotion management. Throughout the data collection, there were underlying themes of guilt, fear and lack of control. From the undertones of these emotions in the way nursing staff worked, it became evident that another reason that nursing staff lack capacity for relational care is due to the emotional demand of their jobs, or, as it more commonly known: emotional labour (Hochschild, Irwin et al. 1983).

The recognition of the emotional work carried out by nursing staff and its effect on nursing work has been present in the literature since Goffman explored one's presentation of self in the mid 1950's (Goffman 1956). Goffman's identified that workers often present an appearance of expected emotions, whilst their real emotions are hidden. The concept of Impression management was then developed in 1983, when the term emotional labour was first defined by Hochschild, Irwin et al. (1983). In their study of flight attendants, Hochschild, Irwin et al. (1983) defined emotional labour as the effort of workers to manage feelings in order to create a publicly acceptable facial or body display (Huynh, Alderson et al. 2008). Hochschild, Irwin et al. (1983) state that the primary purpose of emotional work is to promote, in others, a feeling of being cared for and it is therefore no surprise about its relevance in nursing.

The term caring itself, is in fact a complex concept; Fealy (1995) explains that there are two different types of caring: caring *for* someone and caring *about* someone. Caring *for* someone is about the physical tasks that one undertakes, whereas caring *about* someone is more constructed by the relationship that individuals have and is usually at a much deeper emotional level. For one to provide relational care, the concept of caring needs to go beyond physical tasks and therefore nursing staff should be "caring about" the patients as opposed to "caring for" them. Recognising the emotional effort of "caring about" someone and the and human fallibility (Archer 2007), the term emotional labour can be used to describe the persona that nursing staff adapt during encounters when providing care to patients. From previous research we know that emotional labour is often greater when caring for people with dementia (Bailey et al, 2013) and this viewpoint is supported by the findings from this study.

Nursing staff on the study wards were seen to be spending limited time interacting with people with dementia and were often distancing themselves from this patient group through failing to explore their needs further. It is unclear whether this was a purposeful act, however, other studies have suggested that this distancing technique is a coping mechanism for nursing staff to sustain their person as a way to manage their emotional labour (Norberg et al, 2002, Kokkonen, et al 2014). Although the data provided from this study cannot explain why the nursing staff distanced themselves from patients with dementia, the understanding of the wider structuring of nursing work provided from the findings suggests that it is was actually a way for nursing staff to manage their workload. A recent study by Allwood et al, (2017) could provide a further understanding to this. The study explored communication techniques between staff and patients with dementia and found that closing conversations was particularly problematic for professionals when talking to people with dementia. This finding could perhaps explain what was seen in this data with staff not attempting to start conversations with this patient group due to concerns that they would not be able to end and the concern that they would have a reduced amount of time to complete their workload. Unlike previous research that suggests that distancing is a way to ensure the caring persona is maintained, this study suggests that the distancing is a way for nursing staff to ensure that they are able to complete all aspects of their work.

Despite the lack of understanding about why this distance is occurring, this study has highlighted that the distance created by nursing staff had a negative effect on patient care, with a lack of further exploration into patients' needs causing an increased likelihood of expressions of negative emotions. This finding is supported by Kitwood (1997) who found that distance can cause a feeling of insecurity amongst people with dementia. This study has also found that this method of distancing also had a negative effect on the nursing staff, with nursing staff disclosing ongoing feelings of guilt for not providing a high level of care. These findings echo the findings of Griffiths et al, (2013) who found that staff caring for older confused patients often have a lower psychological wellbeing with feelings of hopelessness, anxiety and frustration, all of which were displayed by nursing staff within the data.

The fact that nursing staff are distancing themselves from patients with dementia to manage their workload, presents another complexity in regards to nursing work on Medicine for Older Persons wards. From the data presented in the previous chapters it is evident that nursing staff felt guilty for not providing a high level of care for the patients but this guilt was being juxtaposed with feelings of fear regarding the consequences of not managing their workload. The concept of fear in nursing with regards to the care they provide has not been well explored within the evidence base. Studies have focused on the fear felt by student nurses (Sharif and Masoumi 2005, Moscaritolo, 2009) and with regards to violence from patients (Lanza 1983, Jansen et al 2005), however, fear related to inefficiency and managing workload remains a gap in the literature. Although the concept of fear may be underlying in research of stress and burnout, the findings of this study have highlighted that nursing staff on Medicine for Older Persons wards do in fact feel fearful with regards to the management of the work and relational care for patients is suffering as a result of this.

The data suggests that it is not only patient outcomes that have been affected but nursing staff outcomes are also impacted. Dealing with these strong emotions of guilt and fear is increasing the overall amount of emotional labour that nursing staff are undertaking. The concern with jobs that require a high level of emotional labour, is that there is an increased possibility of burnout (Leiter and Maslach 1988). Burnout is described as a syndrome of emotional exhaustion with an increased sense of personal exhaustion and consequently a sense of depersonalisation from others (Maslach, Jackson et al. 1986). These consequences of burnout as described above are highlighted within these findings. The literature surrounding burnout highlights that it is usually a product of both personal and environment factors, however, much of the research has focused on environmental factors alone (Maslach, Jackson et al. 1986). The data collected in this study supports the evidence base with regards to the environmental influence, with nursing staff highlighting the impact of high workload and low staffing and its effect on patient care, however, the findings also provide evidence of more personal factors that could contribute to this. The ongoing themes of team support and team dynamics suggest another source that is contributing to nursing staff burnout and could provide an explanation as to why relational care remains elusive, regardless of level of staffing and workload on each shift.

The importance of social support in the workplace and its positive effect on burnout is citied in the literature (Langford, Bowsher et al. 1997) with research into nursing satisfaction claiming that system centred approaches to health care above personalised care is a reason for nursing staff leaving the profession (Kitson 2018). However, this has not been explored thoroughly within the context of Medicine for Older Persons wards. The evidence from this study suggests that the Medicine for Older Persons wards are characterised by high level of system led work resulting in increasing feelings of guilt by the nursing staff who work within them which is another key finding from this study. Other studies that have previously analysed work settings, external to healthcare, have found that these characteristics often lead to an increased level of burnout (Schwab and Iwanicki 1982) suggesting that it is these factors that need addressing to prevent further decline in the older persons nursing workforce.

9.3 Strengths and limitations of the study

This section will discuss the strengths and limitations of this study. Although these have been commented on throughout the thesis (particularly in chapter 4), this section will highlight the key strengths and weaknesses in light of the findings that have emerged and will allow readers to assess the weight that can be attributed to the claims made in the remainder of the chapter.

A number of strengths in the design of the study lend weight to the findings and conclusion drawn. Firstly, an ethnographic approach enabled an in-depth exploration into the culture of the wards studied and a real insight into the ways in which nursing staff work on Medicine for Older Persons wards. The ethnographic methodology meant that a participatory approach was adopted, allowing for access into data that would have been unavailable through formal data collection techniques alone. The intensity and duration of time spent on the wards, mixed with the deeper relationships formed with the participants (Lincoln 2001) has allowed for a greater understanding into the lives of the nursing staff (Buch and Staller 2014) and the challenges they faced in the provision of relational care.

The study was conducted over a short time period (2017-2018) due to the constraints of the clinical academic doctorate. Although through ongoing supervision it was agreed that data collection had reached saturation, this study could have been improved by being conducted over a longer time period to add weight to the findings made. Another limitation of this study lies within the lack of generalisability of the findings as data were collected from only three wards within one NHS Hospital. This therefore limits the findings to one geographical area and therefore this may well have limited the diversity of the population studied.

Despite the arguably limited time spent in the field and potential lack of generalisability, the wide range of methods used for the inquiry enabled nursing staff work to be examined from a number of different angles. The incorporation of both observations, interviews and informal conversations lends weight to the findings drawn and has allowed for an added richness to the account given. The rich contextual description as provided in the earlier results chapters enables the reader to judge the “fittingness” (Lincoln & Guba 2000) between the study context and their experience of healthcare, allowing them to draw conclusions regarding the relevance of this account to their own practice. In addition to this, the theories tested through the process of data collection and analysis are also more widely applicable and can be used to enhance the understanding of the current health care system

9.4 Contribution to the body of knowledge

This thesis has made a unique contribution to the body of knowledge as it has provided a rich, in-depth, exploration into the work system of a Medicine for Older Persons ward and identified the effect this has on nursing staff's capacity to provide relational care for people living with dementia.

Chapters 2 and 3 of this thesis highlighted that there is limited knowledge about the about the care for people with dementia on specialist older persons wards as most studies that explore the quality of care for people with dementia focus on acute, general medical wards. The studies that have explored care on these wards suggest that care quality should be higher on wards such as medicines for older persons (Featherstone, Northcott et al. 2019) however, this has not been explored this in any detail.

The findings of this doctoral study highlight the implications of the work system on nursing staff capacity to provide relational care and suggest that even on specialist older Persons wards, relational care remains absent. The findings show that the origins of nursing staff’s capacity for relational care are largely situated within the organisational context as opposed to nursing staff themselves.

This next section of this chapter will identify the contributions this study has made to the body of knowledge, both empirically and theoretically.

9.4.1 Empirical Contributions

Findings from this study have illustrated that providing relational care for people with dementia on Medicine for Older Persons wards can still be a challenge for nursing staff, despite the expertise that staff have in caring for this client group. The findings have highlighted that the same factors that impact on other wards can still do so on these speciality wards and therefore indicate that capacity for care does not sit with the individual nursing staff but sits within the organisation.

There is limited research that looks at the work system as a whole to gain an understanding of how the different factors impact on each other and how this affects the way the work is organised. What is unique about this study’s contribution to the body of knowledge is that there has been a detailed exploration of the work system of Medicine for Older Persons wards as a whole and how this can impact on the relational capacity of nursing staff, specifically for people with dementia.

Most studies within the current evidence base have a focus on care outcomes (Bridges, Nicholson et al. 2013, Featherstone, Northcott et al. 2019) and fail to address the concept of employee experiences or outcomes. This study has helped to address this gap in the literature as the focus of the study was on the nursing staff.

The findings have demonstrated how organisational priorities still affect nursing staff on these speciality wards and that the priorities remain the same throughout the hospital, despite the differences in patient needs. The study also highlights how the routine of the ward can have a significant impact on nursing staff and the way in which they deliver care.

The findings have highlighted the complexity that nursing staff can face in relation to staff hierarchy and more importantly the complex dynamics within the nursing team themselves on Medicine for Older Persons wards. These findings have also illustrated the potential disparity between role clarification and role flexibility, particularly on Medicine for Older Persons wards where the work is shared between the nursing teams and the role boundaries are increasingly blurred.

Finally, the findings have thrown light on the effect of work systems factors on nursing staff themselves and how this influences the care they provide. The findings have demonstrated that nursing staff on Medicine for Older Persons wards feel significant emotions of guilt and fear in their work combined with a feeling of no control, all of which impact their capacity to deliver relational care.

9.4.2 Theoretical Contributions

This section of the chapter will summarise where the findings add to, challenge or support existing theory. The study findings support the theory of marginalisation from Sheppard (1995) who states that the less tangible elements of work are often marginalised when strict routines are present. The findings have supported this claim and evidenced that nurses were prioritising tasks that were tangible and as a result relational care became less of a priority. However, in contrast to Sheppards (1995) suggestion that marginalistion of tasks often happens unconsciously, the findings in this study demonstrate that nursing staff were in fact choosing to demote less tangible tasks as a way of managing their workload.

The theory suggested by Cohen (2011) in which the standardisation of tasks leads to the dehumanisation of individuals has also been supported by these findings. Nursing staff were seen to be dehumanising patients into separate tasks rather than one unitary being, again, as a way of managing their workload. However, in contradiction of what Cohen (2011) suggests in relation to standardisation causing work being completed by less skilled professionals; the findings provide evidence that the work is actually being shared amongst all professionals and that standardisation on Medicine for Older Persons wards has led to anyone carrying out the work as a way to ensure it *was* completed.

This study has made an important contribution to theories regarding multi-disciplinary proffesional working within hospital organisations. The findings support the idea that the previous nurse-doctor heirachy seems to have subsided, however, the findings suggest that the complexities in team work has now shifted to withn the nursing team themselves. This is a timely finding, particularly with the introduction of Band 4, nursing practitioners in the UK NHS which may add to this complexity.

The findings have also added to the theory regarding environments consisting of high demands and low control. The findings support that environments of this type, such as Medicine for Older Persons wards, result in decreased staff well-being. The findings also add another facet to this theory and suggests that these environments also have an effect on patient outcomes and reduce the quality of care. The findings have highlighted that environments with high demand and low control not only affect nursing staff wellbeing but also have a significant impact on the care in which they provide, which consequently has a detrimental effect on the patients.

9.5 Chapter Summary

This chapter has discussed the findings of this research in relation to the evidence base and explored them further using theoretical underpinnings. Several important findings have emerged from this study that have implications for the improvement of relational care for people with dementia on Medicine for Older Persons wards. The findings illustrate how nursing staff capacity for care is not down to individuals but is multifaceted and mostly sits within the hospital organisation itself. Several factors emerged from the interpretation of empirical data using the work systems theoretical framework to guide analysis, such as the difficulty in team dynamics, the routine of the hospital and the priorities of the organisation, all of which reduced nursing staff control and consequently reduced their capacity for relational care. Nursing staff are continuously juggling the demands of the organisation and the needs of the patients and unfortunately, it seems that the demands of the organisation are always the priority.

The next and final chapter of this thesis focuses on the recommendations for both practice and future research which have arisen from this work.

Chapter 10 Closing comments and recommendations

10.1 Chapter Introduction

The previous chapter discussed the findings of this study in relation to the broader health and social care context and current evidence base. This chapter will progress the discussion of the findings and present the implications that they have on nursing practice. The chapter will then go onto suggest the recommendations derived from this study and conclude with a summary of the research.

10.2 Implications for nursing practice in hospital

The aim of this study was to provide an in-depth description of Medicine for Older Persons wards, identifying how work system factors influence nursing staff capacity to provide relational care for people living with dementia. The study has highlighted five core findings that identify the reasons why the nursing staff lack capacity in this setting: relational care was not an organisation priority; nursing work is based upon a routine; there is confusion of roles within the nursing workforce; there is a high emotional demand from the job and nursing staff have little control over their work. Not only has this study has made a contribution to the evidence base, the findings have also led to the development of implications for nursing practice. The findings form this research indicate that the following areas need to be the focus of interventions in order to make improvements to relational care for people with dementia on Medicine for Older Persons wards:

- Relational care needs to be an organisational priority
- Nurses need to have increased autonomy in their role
- Nurses need emotional support on the acute care ward
- Increased focus on role clarity, role flexibility and team work
- Relational care needs measurable standards

These areas for practice will be discussed in the next section of this chapter:

10.2.1 Relational care needs to be an organisational priority

An ongoing theme throughout both data collection and analysis was that the priorities of the organisation were having a significant influence on the way in which nursing staff worked. Nursing staff were prioritising the tasks that were prioritised by the organisation as opposed to the priorities of the patients. For relational care to be viewed as a priority for nursing staff and be at the forefront of their work, there needs to be a drive for relational care at a higher organisational level. A system wide push for relational care to be improved that is led by the organisation would hopefully cascade down to ward level, influencing nursing practice and improving relational care for people with dementia.

10.2.2 Nursing staff need more control over their work

The data collected in this study illustrated the difficulties that nursing staff and particularly nurses, face in terms of control and autonomy in their role within this setting. One of the findings is that nursing staff capacity for relational care is reduced as nursing staff have no control about which aspects of their work to prioritise due to both the hierarchy in the hospital but also due to the pressure they place on themselves. To increase the likelihood of nursing staff developing new behaviour patterns and making improvements to the delivery of relational care, nursing staff should have a greater autonomy within their roles and be able to make greater decisions about how their work is organised.

10.2.3 Nursing teams need additional emotional support

It is evident from the findings of this study that as well as providing nursing care, nursing staff are also managing emotional burden when on shift, whether that be from the patients themselves or a result of organisational pressures. This cycle that nursing staff seem to have adopted, in which they feel fearful of not getting tasks completed so distance themselves from patients but then feel guilty for not proving a high relational care, can only be broken if nursing staff are offered support to help them manage these emotions. The concept of fear and guilt and the constant pull between the two needs to be intercepted to allow for an increased capacity for relational care. This interception will occur through an amalgamation of increasing nursing control and supporting their emotional needs. If this is successful, nursing staff should have a greater capacity to provide relational care for patients with dementia, despite external influences such as staffing and increasing workload.

10.2.4 Nursing teams need more clarity in their job roles

The concept of team work was ongoing throughout the data, with the dynamics of team working being highly relevant to determining the work that nurses were expected to complete. The findings from this study highlight that there is an underlying tension within the nursing team that is based on the confusion between role clarity and role flexibility. These expectations were seen to be increasing the pressure on the nursing team and more specifically nurses, which was causing them to rush through their own tasks and consequently spend less time providing relational care to patients.

Many studies have been conducted that explore the team work and skill mix and its effect on care, however, there does not seem to be any recommendations or interventions available to manage this. There is now a wealth of studies that have explored the difficulties presented by staff skill mix and nursing teams and the next step is to work on how this can be improved.

10.2.5 National benchmarks and standards for relational care

As indicated earlier in this thesis and evidenced through the data, relational care was not a priority for nursing staff and this is potentially because it was not a tangible task that was audited by the hospital organisation. The tasks that were given the highest priority by nursing staff at a ward level were the tasks that were mandated and measured by the organisation such as documentation and pressure ulcers

Further work is needed to make relational care is a more integral component of nursing, identifying exactly what it is and what needs to be done to achieve it. To increase the likelihood of this happening, relational care needs to be made a “measurable task”. A development in national policy that sets tangible standards for relational care would also increase its priority on the acute care ward, reducing the risk of it being marginalised by nursing staff. Both an external (national policy) and internal (hospital organisation) push to improve relational care could significantly impact its priority at a both a ward and individual level.

10.3 Recommendations for Future Studies

Following the completion of the study and the review of the current evidence base, further areas of research have been identified that need to be addressed in the future. This research study has provided a starting point for improving nursing capacity for relational care with dementia on Medicine for Older Persons wards through describing the work system factors that nursing staff are currently facing. It is now essential to explore the ways in which these challenges can be overcome, to not only assist in the development of the body knowledge but to also change practice. Potential areas of research are described in Table 9 below:

Table 9 Areas Identified for future research

Topic	Rational
i) Research into various interventions improving team work, in particular between nursing teams.	Research that builds on the team work between nursing staff teams would be beneficial to improving the care for patients with dementia in the acute care setting. Interventions that focus on communication amongst members, leadership and team coordination could all improve the delivery of care.
ii) Studies that explore nursing autonomy	The evident lack of control and autonomy that nurses feel is clearly impacting the way in which they work. Research that explores this further and identifies interventions that regain this would consequently improve the care for patients.
iii) Studies which explore the experience of nursing staff on the acute ward in different socioeconomic and cultural groups.	The current study families were mostly from the same socioeconomic (middle class) and cultural group (white British) and so further studies could explore whether gender, socioeconomic and cultural group differences influence nursing capacity for care on the acute care ward.
iv) Research into improving relational care at a societal and organisational level	Most studies focus on relational care at a ward level, however, it is evident from the findings that the challenges tend to stem from a higher organisational/policy level. Research that explores how we can change relational care at this level would likely improve the care on the wards.
v) Research that explores the emotional needs of nurses	Nursing is without a doubt emotional work and within the current context this is only becoming more challenging for nursing staff. Research is needed to find interventions that allow nurses to manage this could increase their capacity for relational care.
vi) Development of a measurement for relational care	As highlighted above, relational care is currently not measured within hospital organisations. The creation of a measure that can be adopted by organisation would increase the likelihood of relational care occurring on hospital wards.

10.4 Closing Comments

This thesis has provided a detailed exploration into the work system of a Medicine for Older Persons wards and has identified the factors that influence nursing staff capacity for relational care for people with dementia within this setting. The study aimed to address three main objectives as detailed below:

1. To identify and describe the factors of the work system within medicine for older persons ward that influence nursing work
2. To explore how work systems factors, influence nursing work
3. To explore what effect this influence is having on nursing staff and their individual capacity to provide relational care

The findings from this study outline the factors that are affecting nursing capacity for relational care on the Medicine for Older Persons wards for people living with dementia. This thesis has provided evidence that nursing staff on Medicine for Older Persons wards face the same challenges in providing relational care for people with dementia as other hospital wards, despite the speciality that they are thought to uphold. This finding then suggests that the capacity for relational care is not just based on individual members of the nursing team but with the hospital organisational context and until the need for relational care is addressed at an organisational level, relational care is unlikely to improve.

The findings highlight the impact that organisational priorities have on what happens at a ward level and the way in which nursing staff work. It is evident from these findings the impact that policies can have, particularly when they are promoted through organisations. Therefore, it is argued that the responsibility for providing relational care does not only lie with the nursing staff but that actually the responsibility sits at a higher organisational and even more so, societal level. A much more measurable and defined policy needs to be created and organisations need to promote and audit this through the hospital. If national policy and organisations do not prioritise relational care, despite the evidence base suggesting its impact, how can nursing staff be expected to.

This study has provided further understanding of the work of nursing teams on hospital wards. The findings echo what is already within the evidence base about the dissolving of the doctor-nurse divide. The findings suggest that due to confusions in role clarity and the need for role flexibility, these tensions are now within the nursing teams. The expectation of nursing teams to help one another and the confusion is role allocation is having a detrimental effect to relational care, with staff reducing time spent on tasks in order to support each other.

At present, nursing staff are currently managing the demands of the patients, their own emotions, organisational priorities, dynamics within the team and routines of the wards. As described in this thesis, nursing staff rarely make decisions in their role and are normally governed by the routine of the ward or the orders of others. The combination of having a role with very high workload with little control is detrimental to staff morale, staff motivation and efficiency in work. From the wider evidence base, we know it is unlikely that nursing staff work load is going to decrease, however, if their job decision latitude is increased it is more likely that they will have an increased capacity to provide effective relational care.

The study has provided recommendations for further studies, however, most importantly the results provide evidence that any further research looking to improve relational care should start with the organisation. Nursing staff are aware of how to provide relational care, however, due to the organisational context in which their work is completed, they have no capacity to provide it. Relational care needs to be given the same priority as physical care, especially for patients with dementia and unless this is addressed at an organisational level, it is unlikely that nursing staff capacity for relational care for people with dementia will improve.

Appendix A Patient Information Sheet for observations

Version: 2 Date: 23/11/16

Name of Researcher: Emily Oliver

Study Number: 211448

You are being invited to part in a research study which is being conducted on your ward areas. Before you decide whether to take part, the researcher would like you to understand why the research is being conducted and what your participation will involve. Please take the time to read the following information and to discuss with others if you wish. If there is anything that is not clear or you would like further information, there are contact details and the end of this sheet.

What is the purpose of this study?

This study aims to evaluate how nursing staff approach and engage with patients with dementia on acute hospital wards. Communication between staff and patients constitutes an important part of the quality of nursing care, influencing both patient and staff satisfaction. From previous research it is evident that communication between nursing staff and patients with dementia can often be difficult and even more so when on an acute care environment.

The study aims to identify how time affects communication between patients and staff and what are effective strategies that nursing staff use to overcome these. The data collected in this study will be used to create a framework that focuses on time and communication on acute care ward and this can be used to influence education and training given to staff in the acute care ward and ultimately improve communication between staff and patients with dementia.

How long will the study go on for?

The first phase of the study which is the observations will last for six weeks. The total number of observations for this study will be 54. There will be three observation sessions a day that will last 2 hours, three days a week but these will happen at different times and on different wards. Your ward will be sent a rota explaining when the observations are happening.

Who is organising and funding the research?

The study is being organised by a PhD Student at the University of Southampton in partnership with staff from your trust. The research study is being funded by The National Institute for Health Research.

Who has reviewed the study?

All research conducted within the NHS is looked at by an independent group of people called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by NHS ethics.

Why have I been asked to take part?

You have been invited to take part in this study as you are a patient on one of the wards in which this study is taking place.

Do I have to take part?

Whether you want to take part in this study is completely your own decision. If you agree to take part, you must sign a consent form; however, you are free to withdraw from the study at any time, without having to give a reason. Should you decide to withdraw, or not take part, there will be effect on you, your care or any future role in this study.

What will happen if I take part?

The researcher will be observing your care and does not expect you to do anything differently. For periods of two hours at a time, an observer will find a discrete location where they can see and hear interactions between you and members of the nursing staff. The researcher will record information about the interaction when you talk to or otherwise interact with the nursing team. The researcher will be observing all interactions, including those behind closed curtains. The researcher will not come behind the curtains but will be listening from outside. The researcher may want to talk to you during observations, to gain an understanding of your experience when communicating with the nursing team.

What will the researcher be observing?

The researcher will be looking at how time affects the conversations you have with the nursing team. The researcher will be observing how long the interactions are, whether they are social interactions or about your care. The researcher will be looking at whether the nursing team are governed by time and different tasks and whether this affects how they talk to you. The researcher will also note how the interactions made you and the nursing team feel and may ask questions after the interactions has occurred to get a better understanding of this. The researcher will not be observing or recording any details about your care, personal or medical details.

Will the researcher be providing care?

The researcher will not be providing care to any patients on the ward. The researcher will only intervene if there is an emergency situation and he or she will ensure that the Nurse is made aware if there is any potential harm.

What are the possible benefits of taking part?

The findings from this study will be used to create a framework which will be used in training for communicating with patients with dementia in hospital. The information you provide could potentially be used to increase effective communication between staff and patients with dementia on an acute hospital ward.

What are the possible disadvantages of taking part?

The observations will not allow you to be individually identified and no personal details will be recorded. Data collected during this research will remain strictly confidential and information, with no names, will be stored in a locked storage space. The only limitation to this confidentiality is in the unlikely event that the researcher observes events which may constitute incompetence, misconduct or unsafe practice. If this happens, the researcher will inform the nursing team that they are reporting them to the ward manager.

What if there is a problem?

If you are concerned with any aspect of this study, you can contact the researcher via the details at the bottom of this sheet. If you remain unhappy and wish to complain formally, you can do this through the Trust complaints produce and details of this can be obtained from the trust.

Will the data be confidential?

Yes. Your personal and medical details, any names of people or places mentioned will remain confidential and will not be written or verbally reported. As mentioned above, the only exception to this is in the unlikely event of incompetence, misconduct or unsafe practice, which would be reported to the ward manager.

Will the information be safe?

All participants will receive a study number and therefore all personal information such as names will be destroyed as soon as possible. The data will be collected in the form of field notes and then transcribed onto an electronic document. The document will be in a password protected file in a password protected computer and will be kept in a locked room. All bits of paper that have been used in the study, such as consent forms will be stored in a locked cupboard in the locked room and only the researcher and research nurse will have access. As part of the University of Southampton’s policy, once the study is finished and all the data has been analysed, the information (both paper and electronic) will be stored in secure storage at the University for ten years and then destroyed.

What will happen if I don’t want to carry on with the study?

You are free to withdraw from the study at any time, without a given reason. If you choose to withdraw, we will completely respect your decision and this will not affect you, your care or any other role you have in this study. If you choose to withdraw during the observation, the information already collected will be used for this study but as mentioned before it will not be identifiable and no further data will be collected.

What will happen to the results of the research study?

The data from this study will be used to develop an evidence based framework which will potentially be used on the wards as a training tool to aid communication between staff and patients with dementia. The results will be published in journals and potentially presented at conferences and on websites so that what we have learnt can be shared with others who provide care in older persons in the UK. If you are interested, a summary of the findings can be sent to you.

What to do now?

If you would like to be involved in this study then you need to sign a consent form given by the researcher who will then tell you when the observations will start. If you do not want to be involved in this study then thank you for your time.

Further information and contact details

If you require further or more specific information about this study and advice about whether you should participate please do not hesitate to contact the researcher on: 07526754431 or speak to the manager or nurse on your ward.

If you have concerns or complaints about the research please contact:

Research Governance Manager, Room 4079, Highfield Campus, University of Southampton, SO17 1BJ.*Tel*. 023 8059 5058 *Email:* Rgoinfo@soton.ac.uk

Many thanks for your time and consideration.

Appendix B Full recruitment strategy for participants lacking capacity

Material in this appendix is drawn from learning materials and resources in on-line GCP training module "Informed Consent Involving Adults Lacking Capacity".

One of the main purposes of this study is to include patients with dementia as research participants. Many studies tend to exclude those are unable to consent and therefore little is known about the experience of acute care from the perspective of patients with cognitive impairment. Patients with a diagnosis of dementia or cognitive impairment are potentially more vulnerable to lower standards of care and therefore the researcher of this study feels strongly about including their views and experiences in hope to improve their hospital experience.

This study will adhere to the five key principles of the Mental Capacity Act:

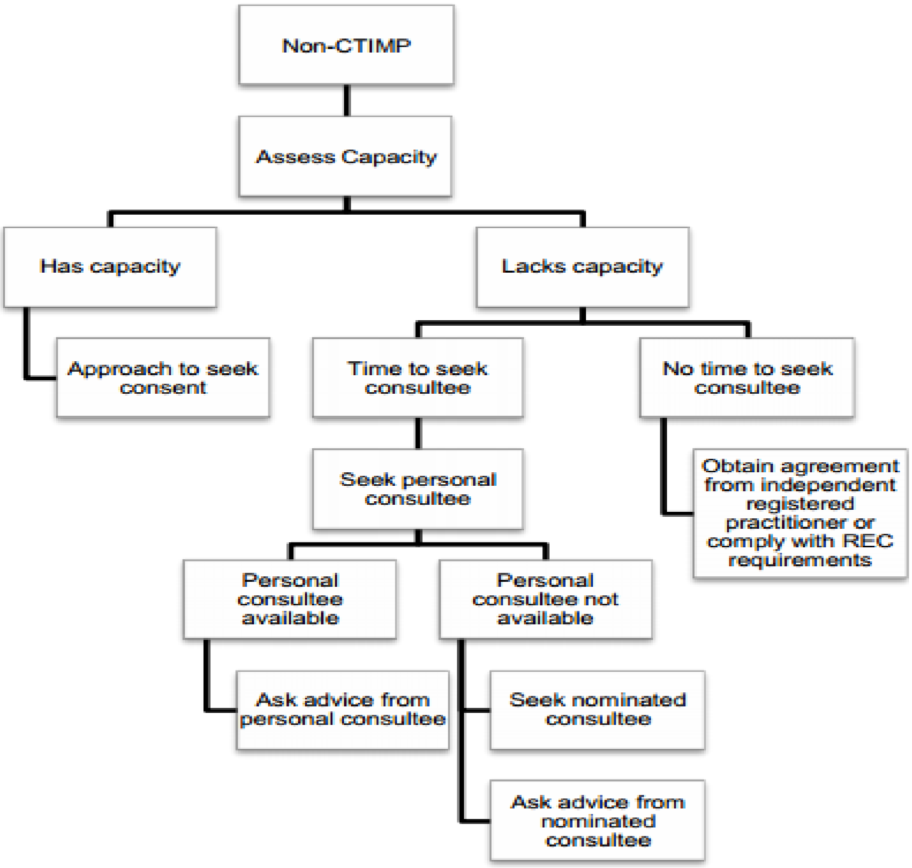
- Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
- A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms

Those recruiting patients who have cognitive impairment or a diagnosis of dementia will be trained in assessing capacity and will follow the NRES decision tree as shown in *figure 1*. A capacity assessment will be performed by meeting with and talking to the patient, reviewing medical notes and if necessary, discussing with those who know the patient, e.g. members of the clinical team or next of kin. The questions that the recruitment team will consider are as follows:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?

- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

Figure 1:



If the recruitment team conclude that the patient does not have the capacity to make a decision regarding participation, they will identify an appropriate person to consult who can make a decision regarding their participation. At first, a personal consultee will be sought after, that being someone who cares for the patient and is interested in their welfare, i.e. next of kin. If a personal consultee is not available, then a professional who knows the patient and is not involved in the research will be consulted. Once identified, the consultee (either personal or professional) will be informed of all aspects of the study which is relevant to their decision and will then be given the opportunity to ask questions. The recruitment team will then be looking for advice from the consultee about whether the patient should participate in the research and what they believe the patient's wishes would be, if they had the capacity to make a decision. The consultee will be given as much time as they need to come to a conclusion and the information they provide will be documented in the participant's patient's notes.

If the decision is that the patient would not want to be included in the study, then no data will be collected and randomisation of patients would occur again. If the consultee agrees for the patient to be included in the study, then data collection will commence, however should the participant indicate (verbally or non-verbally) that they would not like to take part, despite reassurance from the research team, then data collection will be halted. The data collected up to this point will be retained and used but no further data will be collected from this participant. The research team are aware that capacity can fluctuate and therefore "process consent" will be used throughout.

Appendix C Patient Consent Form Observations

Version: 1 **Date:** 04/10/16

Study Number: 211448

Please initial in the boxes provided and provide your name and signature at the bottom. ☐

I can confirm that I have read and understood the study information sheet, version: 2, dated: 23/11/16 for the above study. ☐

I have been given the opportunity to asked questions about the study and understand that my participation is voluntary. ☐

I understand that taking part in the study will include being observed. ☐

I have been given adequate time to consider my decision and agree to take part in the study. ☐

I understand that my personal details such as name will not be revealed to people outside of the project. ☐

I understand that I can withdraw from the study at any time and I will not be asked any questions about why I no longer want to take part. I am also aware that my care will not be affected in any way should I choose to withdraw. ☐

I understand that if I do withdraw, any information I have given up to the point of withdrawal can be used in the study. ☐

I understand and agree that the information I share will not be shared to anybody outside of the study, unless, there is a risk to myself or others. ☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study. ☐

Data Protection: I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of Participant: ____ Date:

Signature of Participant: ____ Date:

Researcher signature: ____ Date:

Appendix D Participant Recording Sheet

Appendix D: Participant recording sheet

Version: 1 **Date:** 04/10/16 **Name of Researcher:** Emily Oliver **Study Number:** 211448

Date	Participant Name	D.O.B	Location	Capacity	Consent (C)/Decline (D)	Professional/personal consultee contacted	Professional/personal consultee Consent (C)/Decline(D)	Reason for not being included

Appendix E Rota for Observations

Wk	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9			1 G3 08:00 – 10:00 11:00 – 13:00 14:00 – 16:00	2	3	4	5
10	6	7 G2 10:00 – 12:00 14:00 – 16:00 17:00 – 19:00	8	9 G4 08:00 – 10:00 11:00 – 13:00 13:00 – 15:00	10	11	12
11	13 G3 12:00 – 14:00 16:00 – 18:00 18:00 – 20:00	14 G2 13:00 – 15:00 15:00 – 17:00 18:00 – 20:00	15	16	17	18	19
12	20	21	22 G2 09:00 – 11:00 13:00 – 15:00 17:00 – 19:00	23	24 G4 09:00 – 11:00 12:00 – 14:00 15:00 – 17:00	25	26
13	27	28 G2 12:00 – 14:00 13:00 – 15:00 18:00 – 20:00	29	30	31 G3 08:00 – 10:00 11:00 – 13:00 14:00 – 16:00		

Appendix F Detailed Observation Procedure

1. Display “ward information poster” in locations throughout the ward that are visible to patients and visitors.
2. Once the index patient has been randomly selected and nurse-in-charge agrees with their inclusion the relevant patient will be approached.
3. Study explained and information sheet given.
4. Capacity Assessed – If the patient has capacity they will be asked to consent. If the patient does not have capacity then guidance for patients who lack capacity to make decisions will be followed and consultee approached.
5. If patient/consultee declines then return to stage 2 and start recruitment process again. If patient/consultee consent then observation will take place.
6. Before observation begins, remind staff allocated to that area that observation will be taking place and answer any questions - If a member of staff objects, continue observation but do not record data about that staff member’s part in observations.
7. Prior to the beginning of the observation also, verbally explain about the study to each patient and any visitor’s present, providing copies of “Patient and Information sheet” where necessary.
8. Display “Ward information poster on observations” in clinical area where observation is planned.
9. The observer will find a discreet location that is out of the way of clinical work. The observer will observe for 2 hours, making field notes of what they see. During this time, the observer will also interact with staff and patients.
10. Once the two hour observation session was over, the researcher would verbally thank patients and visitors involved, and record in patient’s medical notes, and in researcher log about patients and visitors who agreed to take part or refused to take part.
11. At close of observation, verbally thank staff involved and record in researcher log about staff agreeing or refusing to take part.

Appendix G Interview Information Sheets

Version: 1 **Date:** 04/10/16

Name of Researcher: Emily Oliver

Study Number: 211448

I would like to invite you to take part in a research study which is being conducted on your ward areas. Before you decide whether to take part, I would like you to understand why the research is being conducted and what your participation will involve. Please take the time to read the following information and to discuss with others if you wish. If there is anything that is not clear or you would like further information, there are contact details and the end of this sheet so please do not hesitate to contact me.

What is the purpose of this study?

This study aims to evaluate how nursing staff approach and engage with patients with dementia on acute hospital wards. Communication between staff and patients constitutes an important part of the quality of nursing care, influencing both patient and staff satisfaction. From previous research it is evident that communication between nursing staff and patients with dementia can often be difficult and even more so when on an acute care environment.

The study aims to identify how time affects communication between patients and staff and what are effective strategies that nursing staff use to overcome these. The data collected in this study will be used to create a framework that focuses on time and communication on acute care ward and this can be used to influence education and training given to staff in the acute care ward and ultimately improve communication between staff and patients with dementia.

Who is organising and funding the research?

The study is being organised by a PhD Student at the University of Southampton in partnership with staff from your trust. The research study is being funded by The National Institute for Health Research.

Who has reviewed the study?

All research conducted within the NHS is looked at by an independent group of people called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by NHS ethics.

Why have I been asked to take part?

You have been invited to take part in this study as you work in the nursing team on one of the wards in which this study is taking place.

Do I have to take part?

Whether you want to take part in this study is completely your own decision. If you agree to take part, you must sign a consent form; however, you are free to withdraw from the study at any time, without having to give a reason. Should you decide to withdraw, or not take part, there will be no effect on you, your role in the trust, or any other role you have in this study.

What will happen if I take part?

This part of the study involves interviewing nursing staff to gain an understanding of their experience of communication with patients with dementia. If you agree to take part, you will be interviewed in a one-to-one, audio recorded interview. The interviewer will be a researcher from the University of Southampton and they will arrange to meet with you at a time or place of your choosing. The interview will be semi-structured meaning that the researcher will have questions and topics they would like to cover but there is also scope for you to raise other issues relevant to the study objectives. The interview should last approximately one hour.

During the interview, the researcher will ask you about your experiences of communicating with patients with dementia, how the acute care environment impacts effective communication with patients with dementia, what strategies you use when communicating, whether these are effective and where these have developed from.

What are the possible benefits of taking part?

The findings from this study will be used to create a framework which will be used in training for communicating with patients with dementia. The information you provide could potentially be used to increase effective communication between staff and patients with dementia on an acute hospital ward.

What are the possible disadvantages of taking part?

The interviews are expected to be straight forward as they are related to your job role. In the unlikely event that something is heard that suggests unacceptable behaviour or unsafe practice, the interview will be required to report this matter following Trust policy, however, this will be discussed and explained.

What if there is a problem?

If you are concerned with any aspect of this study, you can contact the individual listed at the bottom of this sheet. If you remain unhappy and wish to complain formally, you can do this through the Trust complaints produce and details of this can be obtained from the trust.

Will my taking part in this study be kept confidential?

During the interview there will be an audio-tape recorder so that the interviewer can listen without the need to take notes and to ensure that nothing you say is missed. Following the interview, text will then be transcribed from the recording. During transcription, any names or other identifying details of people or places will be replaced by code. Following transcription, the tapes will be destroyed. Your personal details, any names of people or places will remain confidential and will not be included in written or verbal reports from the study. The data may include direct quotes from your interview, however, we will contact you to discuss whether you are happy with this and if you disagree or we cannot contact you then the quote will not be used.

What will happen if I don’t want to carry on with the study?

You are free to withdraw from the study at any time, without a given reason. If you choose to withdraw, we will completely respect your decision and this will not affect you, your role in the Trust or any other role you have in this study. If you choose to withdraw during the interview, the information already collected will be used for this study but as mentioned before it will not be identifiable and no further data will be collected.

What will happen to the results of the research study?

The data from this study will be used to develop an evidence based framework which will potentially be used on the wards as a training tool to aid communication between staff and patients with dementia. The results will be published in journals and potentially presented at conferences and on websites so that what we have learnt can be shared with others who provide are in older persons in the UK. If you are interested, a summary of the findings can be sent to you.

What to do now?

If you are not willing to be involved in this study, then thank you for your time. If you would like to be involved, please fill in the consent form attached in the envelope and place the envelope in the post box located on your ward. The consent form will request your email and then I will respond to you. You will not receive any other emails except those trying to arrange a time to interview.

Further information and contact details

If you require further or more specific information about this study and advice about whether you should participate please email me.

If you have concerns or complaints about the research please contact:

Research Governance Manager, Room 4079, Highfield Campus, University of Southampton, SO17 1BJ.*Tel*. 023 8059 5058 *Email:* Rgoinfo@soton.ac.uk

Many thanks for your time and consideration.

Appendix H Invitation to Interview

Dear Sir/Madam,

I am a Clinical Academic PhD Student, funded by the National Institute of Health Research and working as a staff nurse within Queen Alexandra. I am very interested in compassionate care for patients with dementia in the acute hospital environment and am inviting you to participate in a study exploring the effect of temporality on communication with patients with dementia. The study aims to find out how time affects the communication between nursing staff and patients with dementia. I hope to use the findings in this study to develop effective ways of talking to patients with dementia in a fast pace, ward environment such as the acute care setting.

As part of this study I am asking members of the nursing team (nurses and health care support workers) to be interviewed. As a member of the nursing team, you are in an ideal position to provide valuable, first-hand information from your own perspective. If you take part in this study, I would like to have an informal interview with you, within the hospital that will last approximately 30 minutes. I have attached a detailed information sheet which will provide you with more information on the study and what I am asking of you.

There is no compensation for participating in this study, however, your participation will be a valuable addition to our research and findings could lead to developments in better care for patients with dementia in the hospital.

This invitation has been sent to you through your ward manager so I currently do not have access to your personal email address. If you are willing to participate please complete the consent form attached, providing your email address and place it in the letter box that has been provided. I will then email you asking you to suggest a day and time that suits you and I'll do my best to be available.

If you have any questions please do not hesitate to contact me through the details provided below.

Thank you for your time,
Emily Oliver

Email: eo2g11@soton.ac.uk

Appendix I Interview Consent Forms

I can confirm that I have read and understood the study information sheet, version: 1 , dated: 04/10/16 for the above study. ☐

I have been given the opportunity to asked questions about the study and understand that my participation is voluntary. ☐

I understand that taking part in the study will include being interviewed and audio recorded. ☐

I have been given adequate time to consider my decision and agree to take part in the study. ☐

I understand that my personal details such as name and employer address will not be revealed to people outside of the project. ☐

I understand that my words may be quoted in publications, reports, web pages and other research outputs but no names will be used. ☐

I understand that I can withdraw from the study at any time and I will not be asked any questions about why I no longer want to take part. ☐

I understand that if I do withdraw, any information I have given up to the point of withdrawal can be used in the study. ☐

I understand and agree that the information I share will not be shared to anybody outside of the study, unless, there is a risk to myself or others. ☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study. ☐

Data Protection: I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous. ☐

Name of Participant: ____ Date:

Signature of Participant: ____ Date:

Researcher signature: ____ Date:

Participants email address: ____

Appendix J Semi-Structured Interview Guide

Start by telling me the structure of your day from when you come onto shift to when you leave?

On the ward where you work now, how is the nursing work organised on a shift to make sure all the work gets done on time?

What impact does this have on PWD's experiences of communication with staff (or on your communication with patients with dementia)?

Do you feel you have enough time to get the work done?

How is the work prioritised and who sets the priorities?

Can you explain why things are prioritised in this way?

How is communication affected by this? And specifically patients with dementia experience of communication? - Can you recall a time when you were able to communicate well with a patient with dementia on your ward? If yes, tell me about it – what happened?

Why would you say it went well?

What was it about that situation that meant you were able to do what was needed?

What about a time when you didn't think you were able to communicate well with a patient with dementia? Why did it go well?

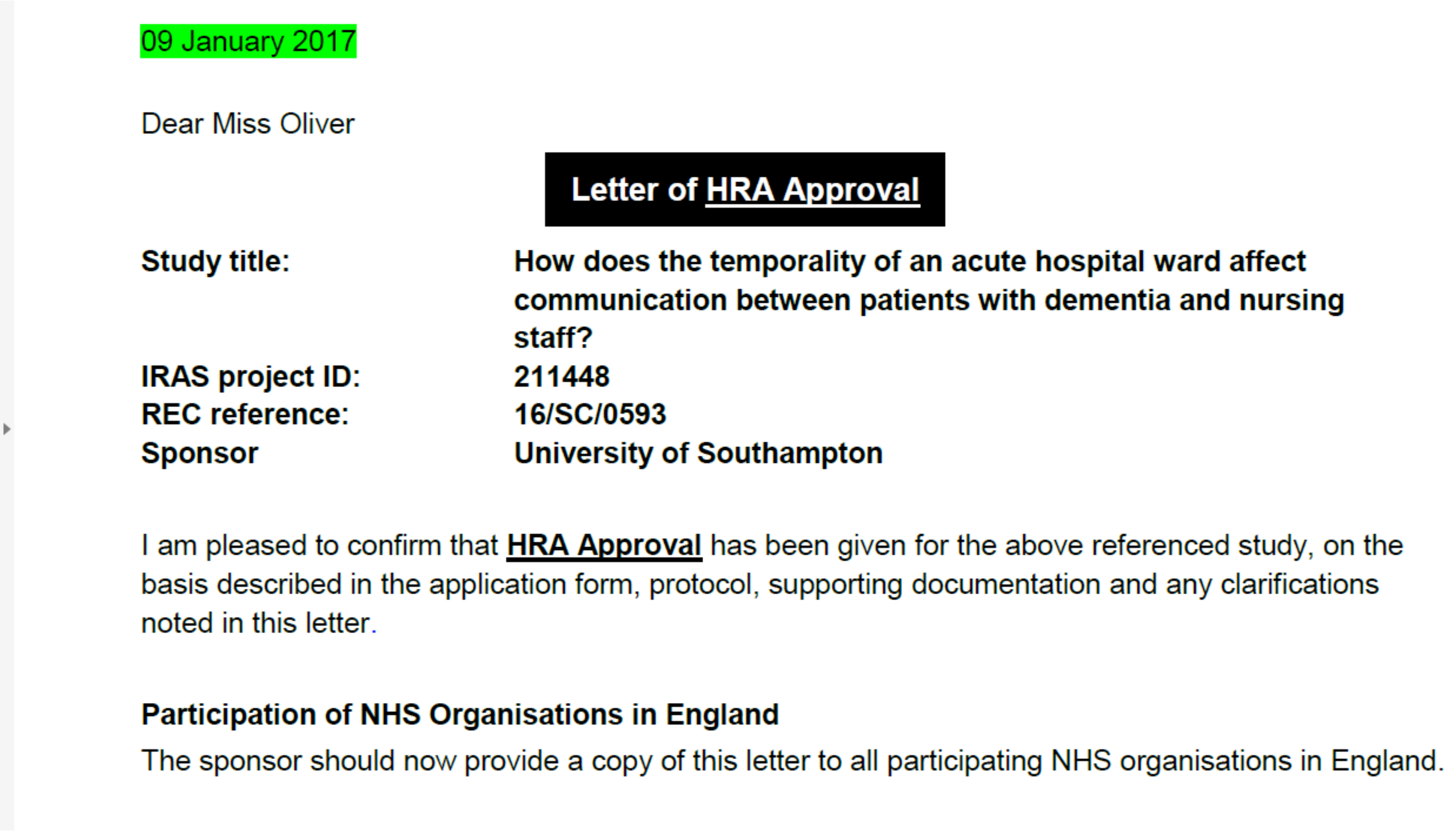
What got in the way?

What strategies have you identified which helps with communication with PWD? How does it make it better? Do you get to use these strategies? How does impact on patient care?

Appendix K Example coding log

Code	Description
Temporal Feature	Any task/activity/duty that affects nursing staff. I.e. vital signs, medication, meal times, rounding.
Technological Temporal Feature	Any temporal task (as above) that is electronic. I.e. vital pack, bed meeting timer, falls alarm.
Interrupted routine	A task that is not in the normal temporal routine of the ward and the staff's reaction to this.
Outsourcing	Care is given to the patients from a professional not based on the ward, I.e. Dementia Care Team or Older Persons Mental Health Team or Enhanced Care Team.
Ignored	Communication Strategy: Nursing staff who purposely/accidently ignore patients who verbally or non-verbally communicate a need.
Temporal routine outside of ward	Temporal aspects that are outside of the ward routine but still have an impact at ward level. I.e. admissions and discharges, Carillion, bed meeting, social workers, community teams.
Validation	Communication Strategy: Staff enter reality of patient with dementia
Repetition	Communication Strategy: Nurse repeat back what the patient has said to them.
Task Fixation	Staff are focused on the task as opposed to the patient
Patient Discussion	Any comments made to researcher by patients.
Staff Discussion	Any comments made to researcher by staff.
Short Statements	Communication Strategy: Nursing staff communicate with patients using short statements: usually one sentence at a time.
Environment	Any description of environment that could have an effect on nursing staff and patient interaction.
Time available but not talking to patients	Where there seems to be no tasks to complete but staff spend this time doing other things as opposed to interacting with patients.
Measured Task	Any task that could be audited by the hospital organisation.
Unmeasured Task	Any task that cannot be audited by the hospital organisation.

Appendix L Approval Letter



09 January 2017

Dear Miss Oliver

Letter of HRA Approval

Study title:	**How does the temporality of an acute hospital ward affect communication between patients with dementia and nursing staff?**
IRAS project ID:	**211448**
REC reference:	**16/SC/0593**
Sponsor	**University of Southampton**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix M Nurse Staff Banding

Staff Member	Role
Band 2 – Health care support workers	Non-registered staff who are responsible for assisting with activities of daily living (personal hygiene, eating and drinking, mobilising, repositioning). They may also help with nursing duties such as taking bloods, inserting catheters or doing dressings.
Band 3 - Health care support worker	The same as Band 2 health care support workers but often have a work placed qualification such as a National Vocational Qualification (NVQ) and have worked in the role for longer.
Band 4 – Nursing Associate	Nursing associates are non-registered members of the team who also have an NVQ but at a higher level that health care support workers. Nursing associates have the same duties as nurses, including administering medication but do not have a registration with the nursing and midwifery council, the UK's national body for the registration of professional nurses.
Band 5 – Staff Nurse	Qualified members of the team who have a registration with the nursing and midwifery council. Band 5 Nurses will have a degree or a diploma in nursing and are responsible for a set group of patients (e.g. administering medications, assessing, venepuncture, wound care and other clinical duties).
Band 6 - Sister	These nurses carry out many of the same tasks as band 5's, but are more senior and more experienced than the staff nurses and more likely to be in charge of the shift. They may also carry specific responsibilities for the overall running of the ward (e.g. rostering) in accordance with the wishes of the ward manager.
Band 7 – Manager	Band 7's responsible for running a ward or unit, and usually have budgetary control. They will employ staff, and be responsible for all the local management (e.g. rostering, approving pay claims, purchasing equipment, delegation duties or tasks).
Band 8 – Matron	The matrons are responsible for overall departments and collections of wards. The matrons take a more administrative role overseeing budgets, monitoring staffing levels and maintain patient flow. They also have budgetary control over ward spending and domestics.

Appendix N Lay information sheet for people with dementia with visual/audial loss

Version: 2 Date: 23/11/16
Name of Researcher: Emily Oliver
Study Number: 211448

Hello my name is Emily Oliver. I am a Clinical Academic PhD Student working at the University of Southampton. I am undertaking a research project exploring how time affects communication between nursing staff and patients with dementia. The results of the study will be used to develop effective ways to communicate with patients with dementia in the hope to provide them with a better standard of care.

The first phase of this study involves observations of the ward environment and the interaction between nursing staff and patients. The observations would last for 2 hours and will occur three times throughout the day. The results of the study will not include any names and I will not have access to any of your personal or medical records.

I was wondering if you would like to be involved in this study. If so, I have an information sheet to provide you with more details and then I would need you to fill out a consent form.

If you do not wish to take part then that is no problem, I would just like to say thank you for your time.

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