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ORIGINAL ARTICLE

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Recognition and assessment of resident' deterioration in the nursing home setting: A critical ethnography

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Aims and objectives: To explore the recognition and assessment of resident deterioration in the nursing home setting.

Background: There is a dearth of research exploring how nurses and personal-care-assistants manage a deteriorating nursing home resident.

Design: Critical ethnography.

Methods: Observation and semi-structured interviews with 66 participants (general medical practitioners, nurses, personal-care-assistants, residents and family members) in two Australian nursing homes. The study has been reported in accordance with the Consolidated Criteria for Reporting Qualitative Research guidelines.

Results: The value of nursing assessment is poorly recognised in the nursing home setting. A lack of clarity regarding the importance of nursing assessments associated with resident care has contributed to a decreasing presence of registered nurses and an increasing reliance on personal-care-assistants who had inadequate skills and knowledge to recognise signs of deterioration. Registered nurses experienced limited organisational support for autonomous decision-making and were often expected to undertake protocol-driven decisions that contributed to potentially avoidable hospital transfers.

Conclusions: Nurses need to demonstrate the importance of assessment, in association with day-to-day resident care and demand standardised, regulated, educational preparation of an appropriate workforce who are competent in undertaking this role. Workforce structures that enhance familiarity between nursing home staff and residents could result in improved resident outcomes. The value of nursing assessment, in guiding decisions at the point of resident deterioration, warrants further consideration.

KEYWORDS
decision-making, geriatric nursing, hospital transfer, hospitalisation, nurse assistant, nurse roles, nurse staff, nurses, nursing assessment, nursing homes*, nursing roles, nursing workforce, scope of practice

1 | INTRODUCTION

Residents living in nursing homes frequently experience deteriorations due to their advanced age, multiple chronic illnesses and high levels of dependency (Australian Institute of Health and Welfare, 2017). Hospital transfer remains common, despite multiple studies reporting on the deleterious outcomes for nursing home residents (Ong, Sabanathan, Potter, & Myint, 2011; Shanley, Sutherland, Stott, Tumeth, & Whitmore, 2008), concerns regarding the poor use of specialist services (Ouslander et al., 2010; Walker, Teare, Hogan, Lewis, & Maxwell, 2009) and the associated impact on health system resources (Ouslander et al., 2010). It is estimated that 13%–40% of nursing home to hospital transfers are unnecessary (Carter, Skinner, & Robinson, 2009; Codde, Frankel, Arendts, & Babich, 2010; Finn et al., 2006; Saliba et al., 2000). Despite growing pressure to reduce hospital transfers from nursing homes, the events that lead to transfer have been largely ignored (McCloskey & Van Den Hoonaard, 2007). Little attention has been given to the issues preceding hospital transfers from nursing homes, including how a resident's deterioration is managed. Importantly, little is known about nurses and personal-care-assistants' (PCAs) recognition and assessment at the time of deterioration.

What does this paper contribute to the wider global clinical community?

- Poorly clarified roles for nurses and PCAs contribute to inappropriate allocation of tasks, beyond the skill set of PCAs; limited support for nurses to fully participate in the decision-process; and poorer resident monitoring.
- Strategies to improve workforce consistency and familiarity between decision-makers will optimise the recognition and reporting of resident deteriorations and enhance collaborative decision-making.
- Nurses need to be supported at an organisational and professional level to use wider sources of information, including their clinical assessment and familiarity with the resident and family to guide their decision-making process.

2 | BACKGROUND

There are a multitude of factors that impact on the assessment of older people in nursing homes. Major factors include nursing leadership, the organisation of work, staffing numbers and skill mix (Dellefield, Castle, McGilton, & Spilsbury, 2015; McGilton, Bowers, et al., 2016). In numerous studies, the importance of nurse leadership for high-quality nursing assessment has been documented (Jeon, Glasgow, Merlyn, & Sansoni, 2010; Siegel, Young, Mitchell, & Shannon, 2008). In an integrative review, McGilton, Chu, Shaw, Wong, and Ploeg (2016) identified that effective supervision by registered nurses has a statistically significant positive association ($p < .05$, $p < .000$) on the performance of PCAs and resident outcomes. The importance of active leadership in nursing homes including active coordination, clarification of nursing and PCA roles and monitoring of operations has been highlighted by Havig, Skogstad, Kjekshus, and Romoren (2011). Nurse leadership has been associated with increased work satisfaction for PCAs, reduced staffing turnover, enabling more consistency in staffing allocations (Bowers, Esmond, & Jacobson, 2003) and improved resident outcomes (McGilton, Chu, et al., 2016).

In the nursing home setting, growing demand for aged care services, nursing shortages and increased costs impact on strong nurse leadership with staffing profiles reflecting decreased registered nurse numbers (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014). This has contributed to the provision of care being increasingly delegated to enrolled nurses and PCAs, with limited registered nurse oversight. With a decline in registered nurse numbers in nursing homes (Harrington, Carrillo, & Garfield, 2012), authors challenge the increase in inconsistently regulated and educated PCAs (Duffield et al., 2014; Hewko et al., 2015). In studies to date, there is a lack of attention given to PCAs, and a dearth of knowledge about the role of PCAs in recognising and reporting resident deterioration (Arendts, Quine, & Howard, 2013; Hewko et al., 2015; Laging, Ford, Bauer, & Nay, 2015; O'Neill, Parkinson, Dwyer, & Reid-Searl, 2015).

In the context of changing skill mix, registered nurses are expected to retain overall accountability, yet there is limited guidance, standards or regulations on minimum staffing requirements in nursing homes (Royal College of Nursing, 2016; Zhang, Unruh, & Wan, 2013). Significant confusion regarding nursing home staff roles exists, raising questions about nurse leadership and delegation of tasks (McCloskey, Donovan, Stewart, & Donovan, 2015). Registered nurses are not always comfortable delegating to other care providers (Hasson et al., 2013) and they can experience role confusion in delegation (McCloskey et al., 2015) completing tasks that could be performed by others (Paquay et al., 2007) or assigning PCAs responsibilities that exceed their scope of practice (McCloskey et al., 2015). Uncertainty regarding the scope and role of PCAs in residential aged care (Duffield et al., 2014; Hewko et al., 2015) has contributed to PCAs undertaking an increasing range of tasks previously allocated to nursing staff (Duffield et al., 2014; Webb, 2011), including medication administration (Department of Health and Human Services, Victoria, 2015).

Maintaining adequate staffing levels and skill mix in nursing homes is complex, and there is debate about the adequacy of staffing models. It is estimated that residents in nursing homes in Australia receive care provided by nurses, PCAs, and therapists on average 2.86 hr per resident per day (Willis et al., 2016). These allocations are half the number of hours recommended by Zhang, Unrah, Lui, and Wan (2006), in a literature review of minimum staffing levels for nursing homes. A lack of time to undertake resident care has been previously identified, with reports that residents are

receiving rushed and untimely care, placing staff at risk of unsafe practices and negligence (De Bellis, 2010).

The relationship between registered nurse staffing numbers in nursing homes and quality of care has been debated for several years. It is difficult to draw any clear conclusions as studies in this area are of variable quality, and many lack methodological and theoretical rigour (Backhaus, Verbeek, van Rossum, Capezuti, & Hamers, 2014). In some studies, higher registered nurse staffing presence has resulted in higher levels of quality care (Dellefield et al., 2015) and lower rates of hospital transfer, which authors suggest may be a proxy measure of quality of care (Dwyer, Gabbe, Stoelwinder, & Lowthian, 2014). In other systematic reviews (Backhaus et al., 2014), no consistent evidence of linkages between the registered nurse workforce and quality of care was identified. It has also been identified that improved staffing levels for PCAs are associated with decreased hospitalisations (Backhaus et al., 2014). Such findings suggest that increasing staffing levels or the ratio of registered nurses alone may be insufficient (Havig et al., 2011), and other organisational challenges need to be considered.

Kirsebom, Hedstrom, Poder, and Wadensten, (2017) advocated for increasing the competence of nursing home staff to assist in reducing hospital transfers. However, others have suggested that the internal nursing home culture around care practices may have an influence on how assessment and management of the deteriorating resident are managed (Gruneir et al., 2016). Laging et al. (2015) identified in their systematic review that registered nurses perform few clinical assessments, are fearful of accusations of "failure to act" and experience limited professional support (Laging et al., 2015), contributing to decisions to transfer residents to hospital. Whilst these findings offer insight into some of the workforce challenges associated with limited nursing leadership, low skill mix and high workload that may influence decisions to transfer to hospital, there has been limited critique of wider socio-cultural factors influential in recognition and assessment by nursing staff when a resident deteriorates (Laging et al., 2015; Spilsbury, Hewitt, Stirk, & Bowman, 2011). Given major gaps in knowledge on the recognition and assessment of resident deterioration in the nursing home setting, the purpose of this article was to report on nursing home staffs recognition and assessment of residents' deterioration and to stimulate dialogue about staffing skill mix and organisational workforce structures and protocols to inform policy and practice.

3 | DESIGN

Critical ethnography is used to describe cultures or groups and to uncover "social, political and economic factors, such as oppression, conflict, struggle, power, and praxis" (Schwandt, 1997, p. 22). The method was deemed useful to explore factors impacting on the recognition and assessment of a resident's deterioration, given the changing nature of the nursing home workforce (Harrington et al., 2012; King et al., 2012) and the need to uncover underlying assumptions and expectations regarding nursing home staff roles and responsibilities (Thomas, 1993). To enhance reliability, we followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury, & Craig, 2007), as recommended in the EQUATOR Network Guidelines.

3.1 | Sample

Ethical approval was obtained from a university and participating facilities. Directors of nursing approached by BL gave permission for recruitment. A mailed letter was sent out by the nursing home receptionist. Inclusion of residents, who had significant physical and/or cognitive impairment in the observational component of the study, was considered important given the high incidence of dementia and end-stage disease in nursing homes (Australian Institute of Health and Welfare (AIHW), 2017). Resident's capacity to provide informed consent to participate in research is difficult (Cubit, 2010), as many residents lack a "formal" diagnosis of dementia (Eichler et al., 2014), and there are ambiguities and limitations to standardised assessments (Howe, 2012). Consent was sought from a resident's surrogate decision-maker when two registered nurses and/or the resident's general practitioner identified residents who were unable to provide informed consent (Cubit, 2010). Following written, informed consent, 66 participants (three general medical practitioners (GPs), ten registered nurses, ten enrolled nurses, eight PCAs, twenty residents and fifteen family members) took part in the observational component of the study. Fieldwork consisted of 184 hr of observations and conversations, with visits interspersed with periods of analysis. Forty participants completed semi-structured interviews (three GPs; ten registered nurses; nine enrolled nurses; eight PCAs; five residents and five family members). Thirty-eight of these participants were drawn from the observational sample; however, two participants only participated in interviews.

3.2 | Data collection

Data were collected between August 2012–May 2015 in two Australian nursing homes: (nursing home1 [30-bed] and nursing home2 [75-bed]. Staffing arrangements differed significantly between the two sites. In nursing home1, the ratio of registered nurse:residents was 1:30 and supervising care was provided by up to five enrolled nurses, with no PCAs employed. In nursing home2, registered nurses were responsible for higher numbers of residents (1:73) and oversaw care provided by up to two enrolled nurses (sometimes referred to as licensed practical nurses) and 11 PCAs.

The observation stage was unstructured, providing flexibility to explore and evolve as findings emerged (Mulhall, 2003). Handover, medication rounds and interactions between participants in resident's rooms and the living areas were observed. No observational data were collected when residents were assisted with washing and toileting. Conversations during fieldwork were used to engage with participants in a reflexive way to challenge researcher ideas, actions and wider socio-cultural factors that were potentially influencing recognition and assessment of resident deteriorations (Freire, 1972). Brief field-note voice memos were recorded immediately after observation. These

were developed into formal field-notes within a week to ensure an accurate account of the events. Three stages were used involving movement between discreet observer and conversational interviewer: (i) obtaining an overview of the culture under study, including observing interactions between nursing home staff, residents and family; (ii) focusing on particular issues arising in the data and; (iii) reaching saturation and disengaging (Carspecken, 1996).

The semi-structured interviews included a schedule that was developed from observational data and key issues and gaps in the literature. The schedule included questions about the role and experiences of staff when a resident deteriorated including the immediate actions taken; supports for their actions; access to services outside the nursing home setting; and reasons for family requesting transfer. Residents and family were asked about their experiences with deterioration, their involvement in decision-making and factors that improved or worsened the situation. Audio-recorded interviews ranged from 25–67 min and were conducted by BL in a private space at or nearby the nursing home.

3.3 | Analysis

Constant comparative analysis (Glaser & Strauss, 1967) occurred simultaneously with data collection. Field-notes and interview data were transcribed verbatim and entered into NVIVO 7 data management software. Grbich's (2007) "block and file" approach was used. Data were collated into meaningful groupings ensuring chunks of data were left intact to avoid fragmentation of the data and to assist in the identification of commonalities between the data sources, which assisted with triangulation. Similar or related codes were grouped into broader categories and developed into broad themes (Strauss & Corbin, 1998). From a reflective journal, written during data collection and analysis, initial "hunches" were identified that were tested and if necessary, revised, with each successive entry into the field (Hammersley & Atkinson, 1995). This enhanced researcher reflexivity, with data viewed through a critical lens to identify issues relating to ideology, power and control (Thomas, 1993). The purpose was to ensure findings were not "sociologically naïve" (Latimer, 2003, p. 3) by challenging assumptions regarding nursing home staff assessment practices (Sandelowski, 1986).

4 | FINDINGS

Four themes emerged from the data highlighting the influence of staffing on the recognition and assessment of residents at the time of a deterioration: *Delegation and consistency of care*; *Mass care with a task focus*; *Undervaluing nursing assessment*; and *Perceiving nursing home roles*.

4.1 | Delegation and consistency of care

This theme describes the disengagement of registered nurses from residents, and the increasing reliance on enrolled nurses and PCAs to recognise and report when a resident had deteriorated, particularly in the not-for-profit nursing home, where one registered nurse was responsible for overseeing care provided to 73 residents. Findings show that infrequent interactions with residents reduced the likelihood of a deterioration being recognised and decreased the ability for residents to receive care that matched their preferences.

In both nursing homes, registered nurses were expected to delegate most resident care to enrolled nurses or PCAs, which contributed to registered nurses' lack of familiarity of residents. Registered nurses working at nursing home1, which was smaller with a higher RN-to-resident ratio, demonstrated greater familiarity with residents, compared with registered nurses working at the larger nursing home2. When registered nurses were more familiar with residents, they had greater knowledge of the residents' clinical conditions, medications and idiosyncrasies, enabling them to expedite decisions more efficiently:

> *Two registered nurses discuss which residents would benefit from an optometrist review. No paperwork is in front of them. "[Resident A] has cataracts, she should be reviewed, [Resident B] has just bought a new pair of glasses". . .. Both registered nurses know every resident.*
>
> *(Observation Nursing Home1)*

In Nursing Home2, observational data indicated registered nurses were often disengaged from residents with limited knowledge of their medications, co-morbidities and overall health status:

> *Registered nurse1 speaks to enrolled nurse 2 to get some assistance completing a depression score for a resident. Registered nurse 1 relies heavily on enrolled nurse 2 to tell her about the resident and asks: "Any signs of pacing?" Enrolled nurse 2 responds: "She can't walk".*
>
> *(Observation, Nursing Home2)*

Registered nurses were heavily reliant on enrolled nurses and PCAs to recognise and report deterioration:

> *They [Personal-Care-Assistants] maintain that contact more than the registered nurse . . . they get them up, they dress them up. They're talking to them during the shower. They're in a better position to determine that this resident today is not well.*
>
> *(Registered Nurse1, Nursing Home2)*

> *They are my eyes and ears. If they don't tell me that something is wrong I wouldn't know.*
>
> *(Registered Nurse2, Nursing Home2)*

Registered nurses suggested that PCAs recognition of a deterioration is reliant on the knowledge of the resident that they acquire through frequently caring for the same residents, rather than clinical acumen or any attempt at a more detailed assessment:

Most of them [PCAs] will pass general comments like "Room number 53 is not eating anymore" or "Room number 53, oh she looks pale" and they may just mention it in passing without realizing it could be something that's happening or maybe the resident in room 53 is deteriorating. (Registered Nurse4, Nursing Home2)

Enrolled nurses and PCAs highlighted the value of caring for the same residents on a regular basis to assist in recognising changes in a resident's health status:

They're just declining. . ..You can tell especially when you're looking after them for so long and you can see . . .. you notice the changes. They don't want to get up. They just want to stay in bed. They don't eat. Just like that. (Enrolled Nurse1, Nursing Home2)

However, familiarity with residents was hindered by organisational management processes that reduced PCAs' ability to frequently care for the same residents:

. . .when they go up the other end [work in another part of the nursing home], they might as well have gone interstate. (Resident 6, Nursing Home2)

Familiarity was also hindered by the high turnover of staff in Nursing Home2 resulting in time being taken away from resident care to orientate new staff:

I'm constantly training staff just to have them leave. (Enrolled Nurse1, Nursing Home2)

Residents reported a preference to be cared for by nurses and PCAs who had acquired knowledge of the needs and preferences:

She just knows how I like things done. (Resident4, Nursing Home1)

A general practitioner argued that "good" nursing home staff who were familiar with the residents, the residents' family and the resources available in the nursing home were central to better resident outcomes and more efficient resource use:

The staff here are the cornerstone of management of aged care. Good staff will probably save the government millions in a year . . . they know the patients [residents]. Good staff have got the clinical acumen to know when and when not to call doctors, when things are manageable at a nursing level and don't have to be escalated to a medical level. Good staff are able to interact with relatives. They're able to negate any potential problems far better than we are. . .and that's because they know the staff, they know the residents, they get to know the family. If you've got people who are chopping and changing, they don't know, so they are more likely to, as I said, hand more off to someone else. (General Practitioner1 Nursing Home2)

Drawing on observational data, it was clear that registered nurses who had knowledge of the resident's preferences were able to advocate more effectively. These nurses demonstrated greater knowledge of the resources available in the nursing home and as seen in the example below, obviated the need for resident transfer to hospital:

I know [resident name] and he would definitely tell me if he had pain and he has none. . ..If I have a resident who I know would want to go to hospital, then of course I will send them but knowing [resident name], he will be very anxious and I don't think it's fair to do it to him. . . I know his GP and I know he is one that will come and see him today. If he has to go in based on the X-ray, fine. If they decide that it all looks okay and he can stay here. Brilliant. (Registered Nurse1, Nursing Home1)

4.2 | Mass care with a task focus

This theme depicts the inadequate focus on the individual needs of residents, contributing to resident health deteriorations not being recognised, and residents experiencing a decreased ability to report concerns about their health.

A depersonalised, "mass care approach" was identified, and nurses and PCAs were forced to follow institutionalised regimes rather than the individual needs of residents. Residents and family were expected to have an awareness of the institutional demands that limited the capacity for staff to provide personalised care:

Some residents just think it's just them. They don't realize that there are 89 other residents that we have to care for. (Personal-Care-Assistant8, Nursing Home2)

Inadequate organisational assessment of the time needed to provide for some aspects of resident care contributed to inadequate staffing and resulted in resident deterioration. Many family members raised concerns that there was inadequate time for staff to assist residents with meals, contributing to residents losing weight:

I'm not going to let her starve to death until I have to. Maybe eventually she would. But not while I'm here. Not while she's able to eat. I'll feed her. I don't care if it takes me two hours. They can't spend that time, I understand that, but I'm not prepared to sacrifice her for their problems. (Family Member1, Nursing Home2)

Residents reported that a task-focused "rushed" approach limited their ability to raise concerns about their health and request care that matched their individual needs:

> *They [the PCAs and nurses] don't have time to listen to you. They just come in to get the job done. . . .It's not much good if it's a one-way conversation.*
>
> *(Resident2, Nursing Home2)*

Such findings were supported by PCAs who reported that they were under pressure to focus on the tasks at hand, rather than taking time to "check in" with each resident:

> *You're not looking, you're just rushing. Cause you're doing this one but you're thinking of the other one, the other 20 you've got to do.*
>
> *(Personal-Care-Assistant5, Nursing Home2)*

Expectations amongst PCAs to keep on top of their workload resulted in a reluctance to report to the nurse when a deterioration was detected as it was considered to result in delays:

> *No-one wants to work with someone who is going to slow them down or get them behind. . . if we report it to the registered nurse, then we have to wait for them to come and then we're just stuck there waiting. . .it's easier just to keep going.*
>
> *(Personal-Care-Assistant5, Nursing Home2)*

4.3 | Undervaluing nursing assessment

Undervaluing nursing assessment reflects findings related to an erosion of the role of registered nurses in assessment and an undermining of clinical expertise. Nurses argued that policies and organisational protocols engendered a task-focused approach with responsibilities devolved to PCAs who were inadequately prepared for their role:

> *The PCAs are told "You need to check that there are ten medications listed on the chart. Are there ten medications in the blister pack? Do the names on the blister pack match the names on the medication chart? If yes, give it. If no then get the RN". That is it.*
>
> *(Enrolled Nurse2, Nursing Home2)*

Poorer resident outcomes were associated with inadequacies in PCAs' clinical knowledge, assessment skills and focus on task completion. An example was a PCA caring for a resident with congestive cardiac failure with increasing pitting peripheral oedema. The personal-care assistant focused on assisting the resident to get dressed and did not recognise the swelling as a sign of deterioration:

> *Personal-care-assistant recognition of a deterioration: "Her feet won't fit in her shoes because they're all swollen." Personal-care-assistant response to deterioration: "I'll put her in these slippers instead."*
>
> *(Observation Personal-Care-Assistant4, Nursing Home2)*

Observations of PCAs confirmed concerns raised by nurses that PCAs did not always recognise signs of a deterioration:

> *A resident with significant pitting oedema is administered Frusemide. The PCA does not notice the oedema and does not question the dose of Frusemide. The PCA actually can't differentiate between medications as she hands them over.* *(Observation, Nursing Home2)*

In comparison, registered nurses expressed a greater capacity to undertake a clinical assessment prior to, and following administration:

> *We have to actually assess the resident. We have to know what the medications are for.*
>
> *(Enrolled Nurse2, Nursing Home2)*

A lack of clarity regarding the role of PCAs in resident assessment was evident in the variable attitudes towards assessment amongst PCAs. Some PCAs adopted a "nurse-like" identity and were frustrated that their role in recognising resident deterioration was undervalued and not formally acknowledged:

> *I am so much more than a carer. . . I am a sort of nurse. I know so much more, and carer, just doesn't do justice to all that I do and all the skills that I have. . . . I can recognize when a resident is going to die. The legs go dark, the breathing, I know these things. Then I see on the TV carers are the lowest paid. I think you wouldn't do this for the money.*
>
> *(Personal-Care-Assistant5, Nursing Home2)*

Other PCAs did not consider assessment to be part of their role or responsibilities contributing to further deterioration and increased suffering:

> *Yesterday, I go into this resident's room, I see this dressing full of blood you know and smelling. I said to the other PCA. . . "Didn't you see this?" and the other PCA said, "Yes, but what am I supposed to do about it? That's the nurse's job, not mine".*
>
> *(Personal-Care-Assistant1, Nursing Home2)*

Resident's reported that registered nurses were infrequently involved in their care contributing to concerns that their healthcare issues were not being monitored:

I don't ever see the RN. I don't even know who the RN is most days. I just don't feel like anyone here really knows what I am about. *(Resident6, Nursing Home2)*

Registered nurses also demonstrated variable expectations regarding their role in recognising and assessing residents at the time of a deterioration. Observation revealed that some nurses performed a comprehensive assessment of a resident prior to advocating a direction of care:

I've done the assessment and I back myself… if anything changes, I can always call the doctor then, but for now, I am happy that the resident is comfortable and not in any need for immediate review.
(Registered Nurse1, Nursing Home1)

Registered nurse assessment had a direct influence on resident management as general practitioners were often not present at the nursing home and relied on accurate and comprehensive assessment to guide decisions:

I think I have a good portion of influence because the doctor relies on my observation and assessment..the doctor finally will have to decide what's happening but he [sic] depends on the nurse's assessment to do that.
(Registered Nurse1, Nursing Home2)

However, many registered nurses highlighted the isolation that they experienced at the time of a deterioration and problems associated with not being able to collaborate with a doctor to determine the best approach to managing the resident. One nurse described a resident who he thought was "on the way out," but explained that he felt obliged to follow the advance care plan, rather than his assessment:

If the advance care plan says for transfer and I can't get through to the doctor, then the first thing I would do is call 000 [number for the ambulance].
(Registered Nurse3, Nursing Home2)

Many nurses reported a lack of support for their clinical assessment and an expectation on them to follow protocols thereby limiting their autonomy:

I think with protocols, for some nurses, it just becomes a process of "don't think, just do".
(Registered Nurse6, Nursing Home2)

Observational data revealed that at the time of a deterioration, many nurses placed limited emphasis on the importance of their clinical assessment to assist in determining a direction of care. These nurses performed minimal physical examination beyond a set of vital signs before contacting the resident's general practitioner. These registered nurses demonstrated less confidence in their clinical assessment; were more likely to cite fear of litigation if the resident deteriorated further; and experienced a greater obligation to follow rigid nursing home protocols that did little to support nursing autonomy:

Instead of sort of trying to gather some information whether they need to see the doctor.., they immediately pass it on. ….Because a very small percentage can go pear-shaped and people [registered nurses] are now taught make sure you refer on… and not using their clinical acumen to the same degree. And I often say, "Well what are you letting me know?" "Oh, it's our policy, we have to notify you….. *(General Practitioner1, Nursing Home2)*

4.4 | Perceiving nursing home roles

This theme encompasses consideration of the philosophy of care in nursing homes and how this influences the approach of nursing home staff to assessment when a resident deteriorates. Some resident deteriorations were ignored or dismissed due to concerns that reporting abnormal assessment findings to the resident's doctor may trigger a cascade of investigations and interventions, without any improvement to the resident's quality of life:

We have to train them [nurses who come from the hospital setting] to settle down and not jump on every change…. We just don't do bells and whistles and some of them just don't get that. *(Registered nurse4, Nursing Home1)*

Nurses emphasised the importance of considering the resident deterioration within the context of the resident's stage of disease progression:

We're just on another merry-go-round of more intervention, more futility. I guess that's the important thing … that there's no point in doing an investigation if you're not going to act upon it.
(Registered Nurse 6, Nursing Home2)

There was debate amongst participants regarding whether further investigation of deterioration would improve or hinder a person's quality of life. Some nurses and doctors were more likely to investigate deterioration than others. In fieldwork observations, an ECG machine located in the corridor was seen:

… it's there because we had a registered nurse who identified that poor old Jan had an irregular heartbeat. The next thing she's on the phone organizing a review and then this thing [ECG machine] turns up. It'll just sit there, I mean we don't use them, what are they going to do for the resident, put a pacemaker in? I certainly hope not. *(Enrolled Nurse 3, Nursing Home1)*

However, it was also apparent that at times that attitudes towards a resident deterioration contributed to inadequate assessment resulting in further suffering:

> *They [nurse at a previous nursing home] were very reluctant to send you to hospital …. But the nurse wouldn't give me the oxygen one morning and I went in and I was starting to go blue… Fortunately the day staff come on about an hour later and I went straight in there [to hospital]. So they kept me in there for about three weeks. I went back [to the hostel] and she said "Don't you want to talk to me?" I said "well you were in charge". She didn't say anything… I could have died.*
> *(Resident3, Nursing Home1)*

Assessments undertaken in the nursing home were sometimes considered to be inadequate by residents and family. A lack of access to diagnostic tools in the nursing home limited prognostic certainty that a conservative approach was the most appropriate course of action. It was also emphasised that nurses and GPs in the nursing home setting could advocate against but not refuse hospital transfer if requested by a resident or family:

> *I mean hospitals are always going to have more facilities and more you know, blood tests and 'CT scanners', ultrasound machines and everything like that and if they're there, people want to use them. You can't say 'oh you can't use it'. You can say that, but you have to really think about; I mean it's very difficult for people to come on board sometimes. If they're worried about their mum or worried about their dad and there's the intensive care unit or a big hospital just down the road and you say 'no you can't go there'.* *(GP1, Nursing Home1)*

Nursing home staff and GPs also emphasised that residents and family are sometimes more likely to accept the opinions of hospital doctors and nurses regarding whether or not further investigations and interventions were warranted:

> *You'll get the families who want … that sort of you know, acute hospital opinion. And that's what counts…. It's all good and well, we can say whatever we like here but no, we need the professionals. The 'real nurses' and the 'real doctors' at the hospital to tell us.*
> *(Registered Nurse4, Nursing Home2)*

5 | DISCUSSION

The inclusion of both nurses and PCAs in this study provides vital insight into how a resident deterioration is recognised and assessed within the context of this workforce profile. Nurses and PCAs are socialised into their assessment roles and behaviours through the "internalization of interpreted reality" created through communication, exchanges and relationships with individuals, groups and society (Messersmith, 2008). An ethnographic approach enabled insight into how the shared understanding of assessment practices were created and used by nurses and PCAs in their day-to-day practice. Although nurses and PCAs demonstrated varying approaches to assessment, there was an identifiable shared culture within each group. Critical analysis was used to consider how the culture of assessment was directly influenced by nurses and PCAs perceptions, interpretation, expression and response to the social realities of the nursing home setting (Lederach, 1995).

Findings from this study illustrate that perceptions of the value of assessment in older people deeply influenced the culture of assessment in the nursing home setting. Underpinning this discussion is the devaluation of clinical assessment in the nursing home setting. A more clearly defined philosophy of care is needed to ensure assessments by nurses are relevant and focused on best outcomes for nursing home residents. The findings indicate that the devaluation of assessment by nurses has had a twofold effect: firstly, disaggregating assessment from tasks associated with resident care, contributing to pressure on nurses to delegate tasks to PCAs who were inadequately prepared for this role, and secondly, contributing to a reliance on referrals and transfers at the time of a deterioration.

5.1 | Value of workforce consistency

Opportunities to optimise the recognition of a resident deterioration by supporting workforce consistency were identified in the findings of this study. These findings are important given the dearth of evidence identified in a systematic review exploring the value of consistent resident assignment and the need for clearly defined measurement outcomes (Roberts, Nolet, & Bowers, 2015). Personal-care-assistants demonstrated a unique culture of assessment, relying on their familiarity with residents, rather than clinical signs, to recognise deterioration and report that "something was different" (Phillips et al., 2006; p. 416). Such findings highlight the value of familiarity between PCAs and residents to optimise the likelihood of a deterioration being recognised. Yet, workforce structures did little to foster familiarity between PCAs and residents as depicted in the inconsistent allocation of PCAs to the same residents; and low workforce retention. Findings from this study highlight that poor retention of staff, constantly orientating new staff and being inconsistently allocated to residents not only contributed to the destabilisation of familiarity between residents and staff, but also created a shift in focus from holistic to "basic care," ultimately reducing the likelihood of a resident deterioration being recognised. These findings build upon the work of Bowers et al. (2003) who asserted the value of a consistent workforce, claiming that "good care-giving, is based on the establishment and maintenance of good relationships with residents … and any disruption to these relationships was detrimental to the quality of the care provided and the quality of residents' lives" (p.36).

5.2 | Delegating to PCAs

Poor articulation of the influence of assessments by nurses on resident outcomes has likely contributed to the loss of nurses in the nursing home setting. Widespread disagreement and confusion regarding the roles and responsibilities of different levels of staffing in the nursing home setting have been previously identified (Jervis, 2002; McCloskey & Van Den Hoonaard, 2007). Some argue that only tentative links can be made between nurse staffing levels and quality of nursing home care (Spilsbury, Hewitt, Stirk, & Bowman, 2011). However, findings from this study revealed that despite PCA's low status in the healthcare hierarchy (Anderson, Srivastava, Beer, Spataro, & Chatman, 2006), they do have a significant influence on decision-making, including recognising and reporting resident's health deterioration, albeit that this may not be underpinned by an adequate knowledge base.

Personal-care-assistants are frequently defined as workers who assist with basic daily routines for individuals with chronic illness or disability. Clinical assessment is poorly acknowledged as an important aspect of the PCA role, yet findings highlight that registered nurses relied upon PCAs to report when a resident had deteriorated. Such expectations have become embedded into nursing home staff culture, yet the educational preparation and supervision requirements for PCAs are not mandated placing residents at clinical risk.

Delegating resident care activities, such as medication administration and personal care, has been mooted as an opportunity for nursing homes to maximise the use of RNs in dedicating more time to the higher-level skills of critical thinking, supervising and coordinating (Culver, 2007; McCloskey et al., 2015). Such assertions demonstrate limited acknowledgement of the importance of assessments undertaken at the time of care delivery. Analysis of the findings from this study asserts that assessment needs to be more securely fastened to tasks associated with resident care to avoid assessment being considered an optional component that is left to the discretion and variable knowledge of the individual involved. There may be an opportunity to enhance the role of the PCA in assessment, but more research needs to be performed in this area.

Problems associated with a poorly defined, disempowered nursing home workforce are identified and support a previous ethnographic study (Jervis, 2002) reporting on the limited autonomy of PCAs to assert limitations on their roles and responsibilities. Likewise, nurses have been unable to assert the importance of their role in resident assessment contributing to their decline in the nursing home setting. Such findings highlight the importance of articulating linkages between tasks associated with resident care and corresponding assessments required at a policy and organisational level. This is supported by PCAs' reports of the limited recognition of the "real" time needed to engage in resident care. Such findings highlight the need for residents' care needs to be explicitly known, including accurate accounts of time, skills and knowledge required for specific tasks. This sets a challenge to address a dearth of research supporting assessment by nurses and its influence on resident outcomes. Nurses face significant barriers to increasing their presence in nursing homes, due to projected nursing workforce shortages (Harrington & Jolly, 2016; Medical Executive Council, 2016) and a reluctance amongst nursing home organisations to increase registered nurse numbers because of economic cost (Everhart, Neff, Al-Amin, Nogle, & Weech-Maldonado, 2013). It is imperative that nurses demonstrate their value in improving resident outcomes as well as demonstrating cost-efficiency.

5.3 | Valuing assessment in nursing home

Previous studies have identified that the use of clinical pathways, encouraging nurses to undertake advanced assessments and commence treatment prior to medical review have resulted in reduced hospital transfers (Carusone, Loeb, & Lohfeld, 2006). However, in a study exploring how protocol-based care effects clinical decision-making, it was highlighted that "while the logic of protocol-based care is algorithmic, in the reality of clinical practice, other sources of information supported nurses' decision-making process" (Rycroft-Malone, Fontenla, Seers, & Bick, 2009, p. 1490). This highlights the importance of nurses' agency at the time of a deterioration.

Consideration of nurses' autonomy, defined as "having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base", ... has both a personal and a professional dimension (Skar, 2009, p. 2226) and is critical in the nursing home sector where on-site access to doctors is limited. However, nurses can experience vulnerability and isolation advocating a direction of care on the basis of their assessment findings, with limited access to doctors (Laging et al., 2015). The findings in this current study highlight the internalised historical image of nurses, encompassing that of "the doctor's assistant" (Fealy, 2004), in both nursing home policies and nurses' attitudes towards assessment. Inflexible nursing home protocols that essentially mandate medical review when residents deteriorate reinforce the reliance on medical assessment, limiting nurses' perceptions of agency in decision-making and infiltrating nurses' perceptions regarding the organisational support to act "autonomously."

It is evident that opportunities exist to elevate nurses' assessment practice and recognition of its importance in the nursing home context. Nurses, as human agents, are both partly formed by their sociality, but also have the capacity to transform their society (Archer, 2015). The emergence of enhanced assessment behaviours by nurses (Penprase & Norris, 2005) relies on nurses' courage (Gallagher, 2011) to agitate ambivalent societal and professional perceptions of nurses' roles in decision-making. Nurse leaders who model comprehensive assessment skills and autonomy will encourage others to do the same (Gallagher, 2011). However, micro, day-to-day practices of nurses, cannot be changed without clear lines of communication with the macro (organisational, professional, political and educational arenas) (Fulton, Lyon, & Goudreau, 2014).

6 | LIMITATIONS

The Hawthorne effect is frequently cited as a limitation of observational research (Polit & Beck, 2010), whereby participants adapt their

practices to display behaviour they believe the researcher wants to see (Parsons, 1974). However, the credibility of the findings was enhanced through prolonged engagement, triangulation of different research methods and collaborative analysis using collaborative conversations and member checking.

Some further limitations include that participation in the study was restricted to participants who were competent in speaking English, and interviews were only conducted with residents who were considered to be competent to consent. Further research is needed to support greater participation of residents with dementia or cognitive impairment in studies.

7 | CONCLUSION

Nursing home staff have a profound influence on the recognition and assessment of a resident at the time of a deterioration. As workforce structures continue to evolve, it is paramount that careful consideration is given not only to workforce consistency, but also to the delegation of resident care to appropriately educated staff. Fostering familiarity between residents, nurses and PCAs increases staffing knowledge of the resident's baseline health status and enhances an individualised approach to care, enabling earlier recognition of a resident deterioration. Clear articulation of the assessment needs associated with resident care is essential when debating the value of registered nurses' presence and the possibilities for an enhanced PCA role. Furthermore, greater trust in the registered nurses' ability to make a decision not to instigate a medical referral on the basis of their assessment findings needs to be considered and integrated into nursing home policies and protocols.

CONTRIBUTIONS

Study design: BL, RN, MB; data collection and analysis: BL, RN, MB and manuscript preparation: BL, AK, MB, RN.

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