Chapter 1: Introduction

The aim of this thesis is to report on the research project “The Scope of Nursing Practice Decision Making Framework: A Picture of Practice in Aged Care”. The study was conducted in partnership with nurses from two residential aged care facilities in South East Queensland between November 2008 and May 2009. This chapter outlines the background (Section 1.1), and the context of the study (Section 1.2), the purpose of the study (Section 1.3) and the significance of this research (Section 1.4). A description of the structure of the research project (Section 1.5) follows and the conclusion (Section 1.6) closes the chapter.

1.1 Background
The breadth or scope of a nurse’s practice is determined by their education, competency and authority to perform particular tasks, rather than by a definitive list of tasks or procedures. The Scope of Practice Decision Making Framework (the Framework) provided guidelines to assist nurses and midwives to safely advance or expand their scope of practice and to facilitate nurses and midwives to understand their responsibilities and accountabilities when making decisions relating to delegating to others or when accepting delegation (QNC 2005).

The introduction of the Framework by the Queensland Nursing Council (QNC) in 1998 was cutting-edge reform in confirming the role of the nurse in Queensland. The Framework’s utility and principles were the catalyst for other state nurse regulatory authorities to develop similar models and provided the basis for the development of a national decision making tool (Decision Making Framework) by the Australian Nursing and Midwifery Council (ANMC) in step with the move to national registration of nurses and midwives. Underpinning the Decision Making Framework (DMF) is the goal to maintain client safety by providing guidance to nurses and midwives with decisions to extend their own scope of practice to meet client needs as well as when it is appropriate to delegate some components of care to other health care workers (Fox-Young & Ashley 2010).

While there have been reviews of the Framework in Queensland and information has been distributed to Queensland nurses illustrating how the Framework should guide delegation and practice, anecdotal evidence suggested that in some sectors the
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Framework was not being utilised effectively to achieve the goal of maintaining client safety. There has been conjecture that this may have been a result of changing health care needs, misunderstanding of the intended nature of delegation to enrolled nurses and unregulated care providers or inadequate understanding of the principles underpinning the Framework.

1.2 Context
The focus of this study is the adoption and application of the principles of the Framework by nurses working in residential aged care in Queensland. The Framework was introduced at a time of significant change in aged care services. The evolution of residential aged care since its introduction during the 1960s is well documented. The succession of reforms that culminated in the enactment of the Aged Care Act in October 1997 brought about significant changes to the practice environment of the nurse working in residential aged care (Hunter, McMillan & Conway 2007; Courtney, Abbey & Abbey 2004; Jones, Cheek & Ballantyne 2002). Residential aged care has greater numbers of frail aged with higher levels of dependency and co-morbidities and at the same time, the staff mix has changed with fewer registered nurses and increased numbers of enrolled nurses and unlicensed carers (Martin 2008). In addition, enrolled nurses' scope of practice has evolved significantly to include the administration of medications (Fernandez, Griffiths, Aguilar, Tran & Chester 2008). The current application of the Framework by residential aged care nurses is largely unknown.

1.3 Purpose
The aim of this research project was firstly to explore nurses' descriptions of their application of the Framework in residential aged care through listening to their stories and observing the application of the Framework's principles in their work environment. Secondly, the project sought to generate evidence and explanation of how nurses in this practice environment interpreted and applied the principles of the Framework in Queensland on a day-to-day basis.

1.4 Significance
To enable aged care nurses in Queensland to realise their full potential in relation to their scope of practice and to ensure that clients are offered care that is safe and appropriate, it is essential that nurses understand the philosophy of the Framework and the principles underpinning extension of primary roles and delegation to other health
care workers. Without an understanding of the full potential of the Framework, nurses not only risk limiting their practice and that of their colleagues, but also increasing risk to residents through inappropriate delegation practices.

1.5 Structure
This thesis is presented in five chapters. Chapter two provides a review of the literature that was drawn from Australia and countries with similar practice standards. The literature review describes the evolution of the Framework from its introduction in Queensland to its adoption by the National Nursing and Midwifery Board in 2010 (ANMC 2010). The literature review then explores the impact of the Aged Care Act 1997 on the practice context of residential aged care and how the changes have affected the adoption of the Framework in that context. Descriptions of the change process are presented and the factors that influence the adoption of change are considered. It was illustrated that a management style that achieved a balance between the need for change and the need for clinical staff to feel valued as members of the organisation facilitated the adoption of changes (Jeong & Keatinge 2004).

Chapter three describes the methodology utilised in this study; this was evaluation research using a qualitative approach. While evaluation research is concerned with the gathering of information about a program for the purpose of drawing a conclusion about the program, the introduction of qualitative methods allows the exploration and description of the experiences of participants (Walsh, Duke, Fourer & MacDonald 2007). The recruitment of the participants and how data were collected and analysed is also described.

Chapter four presents the findings of the study and illustrates the emergence of six data-rich concepts that merge into three predominant themes. These themes describe the participants’ interpretation of delegation, supervision and competence and identify that as the role of the nurse evolves within the residential aged care practice environment, role confusion exists. In addition, the findings identify that nurses work outside their scope of practice.

A discussion of the research findings with reference to existing knowledge is presented in chapter five. The conclusions drawn from the study and the implications for practice are included and the chapter closes with the identification of the limitations of the findings.
1.6 Conclusion
This chapter provides the background to this study, its context and its aims. An outline of the structure of the thesis is presented. The following chapter comprises the literature review.
Chapter 2: Literature Review

The utilisation of the Decision Making Framework (DMF) by Queensland nurses in their daily practice in the aged care setting is largely unknown. The question that directs this study therefore seeks to discover how nurses working in residential aged care apply the DMF on a daily basis.

In this chapter the DMF is defined and described and its development for Australian nurses is articulated. The context of practice in residential aged care will then be addressed, with reference to the impact of changes brought about by the introduction of the Aged Care Act 1997 upon the nursing role in this setting. Finally, the link between the context of residential aged care and the principles of the Framework are explored. The conclusion identifies the challenges experienced by nurses in the context of aged care in relation to the adoption and utilisation of the Framework and its applicability to the organisation and supervision of the work of others delivering care.

Literature was drawn from Australia and countries with similar practice standards and was limited to English-speaking sources only. The review of the literature is presented in five sections. The first section (Section 2.1) describes the Framework, how it evolved in Queensland and then provided the basis for the development of a national DMF by the Australian Nursing and Midwifery Council. The impact of the Aged Care Act 1997 and subsequent changes within residential aged care is explored in the second section (Section 2.2). The change process and change management is presented in the next section (Sections 2.3). Section 2.4 considers the Framework within the residential aged care setting. The conclusion of this chapter (Section 2.5) highlights the implications from the literature that directs this study.

2.1 Scope of Practice Decision-making Framework

Tools to support decision making within the scope of nursing and midwifery practice were originally developed in the mid-1990s in Australia and the United Kingdom and have become an integral part of professional self-regulation in a climate of constant change in professional practice (Fox-Young & Ashley 2010).

The International Council of Nurses defines scope of practice as:

... the range of roles, functions, responsibilities and activities, which a registered/licensed professional is educated for, competent in, and
is authorised to perform. It defines the accountability and limits of practice. (ICN 2004: Online)

Further

(S)cope of practice is not limited to specific tasks, functions or responsibilities but includes direct care giving and evaluation of its impact, advocating for patients and for health, supervising and delegating to others, leading, managing … (ICN 2004: Online).

Scope of practice for an individual nurse will therefore be specifically defined according to their own skills, knowledge and competence as well as to the context of their practice (ANMC 2010) and will change over time due to individual development as well as development of the profession (Fox-Young & Ashley 2010).

The Scope of Practice Framework (Framework), now called the Decision Making Framework (DMF), is a decision-making tool designed to assist nurses with decisions about scope of practice, including expanding practice and delegating to others (Fox-Young & Ashley 2010). While Queensland and other states of Australia have had decision-making tools in place prior to the establishment of the National Nursing and Midwifery Board (NMBA) in 2010, the move to a national framework for nursing practice including national registration, gave the Australian Nursing and Midwifery Council the impetus to develop a national decision-making tool that is similar to and consistent with the Framework that was established in Queensland (Fox-Young & Ashley 2010). This has now been officially transferred to the NMBA and forms part of the Professional Practice Guidelines (NMBA 2010).

2.1.1 Introduction of the Scope of Practice Framework in Queensland

In 1992, the Nursing Act in Queensland established the Queensland Nursing Council (QNC) as the regulatory authority for nursing and midwifery. This provided it with the legislative authority to, among other functions:

... determine the scope of nursing practice, including the activities that constitute, or are included in, nursing practice (Nursing Act 1992:13).

The introduction of the Scope of Nursing Practice Decision Making Framework, subsequently called the Scope of Practice Framework (Framework) by the QNC in 1998 was cutting-edge reform in confirming the role of the Australian nurse. It’s utility and principles were the catalyst for other state nurse regulatory authorities to develop similar models. The philosophy underpinning the Framework was that nurses and
midwives would make scope of practice decisions using clear guidelines where the needs of the client are the focus, but also weighing up contextual factors (QNC 2005).

In 1998 a Framework booklet was distributed to every registered and enrolled nurse in Queensland and QNC conducted state-wide education sessions to inform nurses and midwives on the use of the Framework to guide scope of practice decisions. ‘Train the trainer’ type workshops were conducted with nurses from diverse geographical areas who were prepared to act as key informants in their workplaces. In addition a self-directed learning guide was published in 2001 and an interactive CD ROM was produced in 2003 to continue to inform nurses of the Framework. Since 1998, there have been continuing reviews of the Framework in Queensland and as a consequence, a revised Framework and ten Framework Information Sheets (that further discussed the concepts used in the Framework) were developed and were made available through the QNC internet site to support and illustrate to Queensland nurses and midwives how the Framework should guide delegation and practice.

2.1.2 A Decision-making Framework

Decision making in nursing and midwifery practice is a complex process that occurs in a changing health and professional environment and is dependent on many interrelated factors (Fox-Young & Ashley 2010; Fox-Young 2007). Decision making therefore needs to be a considered process that facilitates planning in nursing and midwifery practice in order to meet the needs of clients (Fox-Young 2007).

The Framework is a decision making tool that provides a broad principles-based definition of the parameters or scope of nursing practice rather than a set of tasks or activities that is seen as:

… an empowering model for nursing practice … (and) … a major step in the advancement of nursing potential (McMillan, Conway, Little & Bujack 2001: 7).

It comprises three sets of principles that provide a guide for nursing practice decisions and contribute to safety and quality in nursing practice (Fox-Young 2007).

These three sets of principles in the framework that guide nursing practice are advancement of scope of practice, expansion of practice and delegation (QNC 2005). Nurses practice on a continuum from a beginning to an advanced practitioner therefore
The first set of principles describes how nurses advance their scope (or assist others to advance) through education and the process of delegation, which incorporates assessment of competency and provision of clinically focused supervision (Fox-Young 2007; QNC 2005).

The second set of principles in the Framework is designed to assist nurses to expand their role by integrating activities into their own practice that may be considered to be beyond the accepted scope of nursing practice. This occurs through education and demonstration of competence (Fox-Young 2007; QNC 2005). Queensland has seen the introduction of regulation of nurse practitioners (by the QNC until 2010) with some working in the field of dementia and palliative care. In addition enrolled nurses have also seen their scope of practice expand in recent years to include endorsement to administer medications (McEwan 2008).

Finally, the Framework’s third set of principles outlines the processes involved in delegating nursing activities by registered nurses and midwives to other nurses or non nurses, such as unlicensed carers, after completing a comprehensive health assessment of the client’s needs (Fox-Young 2007; QNC 2005). Delegation occurs using education, assessment of competence and the provision of clinically-focused supervision (Fox-Young 2007; QNC 2005).

Apart from the decision making principles just outlined, the Framework articulates that the scope of practice for each nurse is also influenced by the context in which he/she practices, the clients’ health care needs, the nurse’s own level of competence, education and qualifications and the organisation’s or service provider’s environment (Fox-Young 2007; QNC 2005). The processes of delegation, assessment of competence and provision of supervision (all integral components of the DMF) are each discussed in more detail in the following sections.

2.1.3 Delegation
The ANMC defines delegation as ‘… the conferring of an authority to perform activities of care for a patient/client on an individual’ (ANMC 2010: Online). However, the delegator retains accountability for the decision and outcomes. While this is an important aspect to delegation, the person to whom a task has been delegated is also responsible for that task (QNC 2005). Delegation occurs between registered nurses and midwives, from registered nurses or midwives to enrolled nurses and from
registered nurses or midwives to unlicensed carers. It is the responsibility of the registered nurse or midwife to assess the client prior to delegating care to establish that the context of care is unchanged. Delegation in terms of the Framework refers to the conferring of authority to perform an activity to another person and may be described as ‘new’, for an activity that is not usually part of that person’s role, or ‘established’, when delegation has previously occurred and the context has not changed. The registered nurse or midwife is expected to continue to supervise and provide support to the person undertaking an established delegation (QNC 2005).

2.1.4 Competence, education and qualifications
Apart from the professional ‘entry’ competencies of registered and enrolled nurses, no national benchmarks of developing or ongoing competence exist at this time and such measurement of continuing competence relies on professional judgement and recency of practice (Pearson, Fitzgerald, Walsh & Borbasi 2002). Pearson et al. (2002) suggest that recency of practice has been the only indicator of continuing competence in Australian and states that:

… there is an assumption that nurses who have practiced in the last 5 years will be safer and more competent in their practice (Pearson et al. 2002: 361).

Arbon (2004) asserts that experience is often described as a linear process of development of nursing knowledge and there is little appreciation of the individuality of experience and expertise among nurses. The author suggests that nurses who work in familiar contexts, performing regular or routine tasks, rarely give thought to their actions and are not challenged to reflect on the meaning of their day-to-day experience and the assumption that experience in nursing leads to improved practice and development of expertise in a linear fashion may be flawed (Arbon 2004). With the introduction of national registration in 2010, there is now a requirement for Australian nurses to demonstrate their on-going professional development as well as recency of practice (NMBA 2010).

2.1.5 Supervision
The Framework determines supervision as having three different forms in the practice context. Firstly supervision may be managerial and includes activities such as rostering, team leadership and orientation of new staff. Secondly, supervision may be described as being professional and this may occur when a registered nurse supports
and supervises the practice of an enrolled nurse. Finally supervision that occurs as a part of the process of delegation is described as being clinically-focused. This type of supervision incorporates the provision of education, guidance and support, as well as monitoring and evaluating the outcomes of the delegated activity (Fox-Young 2007; QNC 2005).

The Framework further determines whether supervision should be direct or indirect based on the stability of the client’s health, the educational level of the person accepting delegated tasks and the type of task being delegated (QNC 2005). Direct supervision occurs when the registered nurse personally observes the activity and works with the person being supervised; indirect supervision occurs where the registered nurse is not observing the activity, but works for the same organisation and is reasonably accessible to the person being supervised (Fox-Young 2007; QNC 2005).

Finally the Framework identifies that organisations or service providers have the responsibility to provide an environment that supports the provision of safe and competent care (Fox-Young 2007; QNC 2005).

2.2 The Impact of the Aged Care Act 1997 on Residential Aged Care

The evolution of residential aged care services since their introduction during the 1960s is well documented. During the 1980s and 1990s, there were a series of reviews of aged care services undertaken in response to Australia’s ageing population. These reviews culminated in the development and implementation of a package of reforms that were intended to address the demands of providing care to increasing numbers of aged people into the future, and were underpinned legislatively by the Aged Care Act 1997 and Aged Care Principles that came into effect in October 1997 (Gray 2001).

Traditionally, residential aged care was arranged into two tiers; nursing homes providing both high and low levels of personal and nursing care, and hostels providing accommodation for the elderly who required social support rather than personal or nursing care. Funding for each type of facility was different. As the demand for residential aged care increased, hostels began accepting people who would traditionally have entered nursing homes and often, as these residents’ care needs increased or changed over time, the residents were forced to undertake a disruptive move to a nursing home (Gray 2001). The Aged Care Act 1997 united hostels and
nursing homes under the one funding system so that hostels would be able to access subsidies for providing higher levels of care, enabling residents to stay in the one location as their care needs changed. Nursing homes and hostels are now both referred to as residential aged care facilities (RACF) (Gray 2001). Until 2007, funding for RACF was based in part on subsidies calculated on the assessed care needs of each resident and care strategies implemented through their care plan, using a specific tool known as the Resident Classification Scale (RCS) (Department of Health & Ageing [DH&A] 2009). In mid-2007, the RCS was replaced by a new tool referred to as the Aged Care Funding Instrument (ACFI) which focuses on core measurable needs that best describe the differences in the cost of care between residents (DH&A 2009). As part of the reform strategy, staff ratios (that used to be part of the nursing home funding arrangements) were removed, allowing greater flexibility of skill mix in RACF (Courtney et al. 2004).

While nursing homes and hostels have always been subject to quality assurance requirements, the Aged Care Act 1997 introduced Residential Care Standards and Accreditation Standards that not only retained the primary focus on care, but also increased the focus on management systems, staff development and continuous quality improvement, and introduced the requirement to comply with specified building standards. RACF that do not achieve the standards of accreditation are not eligible to receive government funding (DH&A 2009; Gray 2001).

The aged care reform strategies of the 1990s have also resulted in an expansion of community or home-based care, and this area of aged care continues to grow. Not only have the number and range of services increased, but the level of care able to be provided in the aged person’s own home has increased (Andrews-Hall, Howe & Robinson 2007; Courtney et al. 2004; Gibson 1998). In their eight year review of residential aged care separations and admissions based on RCS category, Andrews-Hall et al. (2007) demonstrated that as a consequence of the broadening of community services, there were delays in admission to residential aged care and a subsequent increased dependency in those accessing residential aged care services. In addition this report suggested that early discharge from hospital into RACF, with a continuing need for more complex or technical care contributed to the escalation of care needs of residents and pressures on nurses and the practice environment (Andrews-Hall et al. 2007).
2.2.1 Impact of the Aged Care Act 1997 on nurses and their Scope of Practice

The succession of reforms to aged care services has brought about significant change to the practice environment of the nurse in RACF (Hunter et al. 2007; Courtney et al. 2004; Jones et al. 2002). According to Hunter et al. (2007: 6) nursing in RACF prior to the introduction of the Aged Care Act 1997 was ‘... conducted in a manner where specialist aged care knowledge and skills were not widely requested or required’. The authors suggest that prior to 1997, aged care nursing was characterised by inflexible routines that were influenced by the medical paradigm (Hunter et al. 2007). In their inquiry, using a case study approach, the authors sought to explore the processes of change to the scope of practice of registered nurses in RACF since the introduction of the Aged Care Act 1997. They concluded that registered nurses in RACF were

... in the process of moving from a primary role of clinician delivering task focused care to residents … to an amplified primary role which involves clinician, delegation and managerial activities (Hunter et al. 2007:10).

These findings are consistent with those of an earlier work undertaken by Jones et al. (2002). This South Australian study also identified that registered nurses had to adapt to constantly changing roles that were largely derived from the aged care reforms. Registered nurses have accepted increased responsibilities across many areas of clinical practice as well as in relation to the RACF funding through completion of funding applications, and for maintaining the RACF accreditation without which subsidies from the Commonwealth Government could not be received (Venturato, Kellett & Windsor 2007; Jeong & Keatinge 2004; Jones et al. 2002). However Jones et al. (2002) suggested that although it was often said that specialist skills were required by aged care nurses, there was lack of clarity about what those skills were and a tendency to reduce care to numerous tasks to be undertaken.

The implementation of management decisions relating to change over which registered nurses have had no perceived control and the level of support provided are said to leave some with a sense of powerlessness and of being devalued, resulting in a detrimental effect on job satisfaction (Venturato et al. 2007; Jones et al. 2002; Jackson, Mannix & Daly 2003). However other studies show that in those RACF where management adopted consultative processes and policies inclusive of nurses, changes were positively accepted and there was a willingness to implement change (Hunter et al. 2007; Jeong & Keatinge 2004; Jackson et al. 2003).
When the link between funding, staff ratios and skills mix was removed as part of the reform strategies, some consumer groups, staff and other stakeholders were concerned that the aged care workforce would become less skilled (Courtney et al. 2004; Gray 2001). In his review of the Aged Care Act 1997, Gray (2001) did not closely examine the impact on staffing levels or skill mix, but inferred that as the first round of accreditation showed the majority of facilities had achieved the required outcomes, adequate staffing levels were being maintained. Subsequent reviews of the residential aged care workforce in 2004 and 2007 confirm that the number of registered nurses working in residential aged care has diminished as the number of unlicensed carers and enrolled nurses has increased (Martin 2008; Richardson & Martin 2004).

2.2.2 The practice context of residential aged care
According to McMillan et al. (2001: 2) ‘…(E)ach practice context has its own unique set of characteristics’. Long term care of the elderly is often painted in a poor light. This poor image permeates the nursing profession as well as the general population (Robinson, Abbey & Abbey 2007; Price, Alde, Provis, Harris & Stack 2004). This is not improved by the nature of media coverage related to aged care (Robinson et al. 2007; Jackson et al. 2003). Leppa (2004: 27) suggests that the conventional view of aged care is ‘ … that it is easy, uncomplicated, predictable, slow-paced … less intellectually challenging … (and) … less skilled work’. Nurses cite the lack of pay parity as one reason for being viewed as the ‘poor cousins’ of the profession (Stack 2003; Cheek, Ballantyne, Jones, Roder-Allen & Kitto 2003). In their qualitative study into the impact of political reform on the registered nurses’ practice in residential aged care, Venturato et al. (2007) identified that registered nurses experienced tension in their role between the personal satisfaction they derive from their work and the recognition that their practice is not valued by others and tended to internalise the negative beliefs relating to aged care practice.

It is also reported that nurses practising in RACF experience professional isolation and find it difficult to access the benefits of collegial support from other nurses (Robinson et al. 2007; Jackson et al. 2002). Despite this, aged care work is seen by others to be a valuable occupation that ‘… offers the intrinsic satisfaction of making a positive impact on the lives of older people’ (Stack 2003: 12). Leppa (2004: 32) would also argue that although long term care work is different from acute care and often regarded as inferior, it is in fact a ‘… complex, demanding and interesting nursing work environment’.

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With the introduction of Aged Care Structural Reform during the 1980s and 1990s, culminating in the Aged Care Act (October 1997) there has been constant change in the practice context of residential aged care. Nurses report that they have increased responsibility for maintaining funding initially through the RCS and subsequently the ACFI as well as maintaining standards of care and meeting accreditation requirements (Hunter et al. 2007; Courtney et al. 2004; Jones et al. 2002). The processes required to validate RCS claims have driven the development of excessive levels and often repetitious documentation that further restricted the time available for the provision of direct care (Stack 2003) at a time when the health care needs of the elderly in residential care had also been changing (Jones et al. 2002).

2.2.3 Residents' changing health care needs
As has been suggested earlier in this review, the profile of the elderly in residential aged care has changed in recent years, with higher levels of dependency and increased incidence of co-morbidities (Cheek et al. 2003; Jones et al. 2002; McMillan et al. 2001). The growing focus on the provision of community support for the elderly means that those who would otherwise have been eligible for entry to low level residential care are being supported in their own home. It is concluded that when the older person enters residential aged care, they have a higher degree of dependency and frailty, their care needs are increasingly more complex and they are closer to the end of their life span (Cheek et al. 2003). Early discharge from hospital and strategies to reduce admission to hospital from RACF have also contributed to the increasing acuity of residents in residential aged care (Henderson & McMinn 2004; Jones et al. 2002; McMillan et al. 2001). Consequently nurses are caring for residents who have more complex care needs, such as palliative and post-operative care (Jones et al. 2002).

The incidence of dementia increases with advanced age; consequently, as the proportion of the Australian population that is aged 80 years or more increases, so does the number of Australians with a diagnosis of dementia (Cubit, Farrell, Robinson & Myhill 2007). As the baby-boomer generation is now turning 65 years of age, it is predicted that the bulge in the Australian demographic profile will cause a rapid increase in the prevalence of dementia over the next decade (Access Economics 2009). Dementia is a common reason for the elderly to be admitted to residential aged care as it is suggested that at some point, a large proportion of people with dementia will develop what are termed ‘behaviours of concern’ that often precipitate admission.
The Scope of Nursing Practice Decision-making Framework: A Picture of Practice in Aged Care (Cubit et al. 2007). It is estimated that between 60-80% of residents in RACF have a dementing illness (Robinson et al. 2007).

2.3. The Process of Change
Shaw (2007) asserts that today’s health environment is one of constant change and residential aged care is part of that environment. Crookes and Davies (2004: 95) liken change to a ‘… fast flowing river …’ where the focus is keeping one’s head above the water. Shanley (2007) suggests that most health organisations are undergoing rapid change and that most often change is influenced by external factors.

An early and long standing influence on change management and referred to frequently in nursing literature is Lewin’s theory of change (1951) and describes change as occurring in three stages: firstly, ‘unfreezing’ where the need for change is identified, the likelihood of resistance is recognised and planning for implementation of change occurs. Secondly, ‘moving’ describes the stage when participants accept the need for change, and finally, ‘freezing’ or the final stage when the new behaviour is integrated into practice (Shanley 2007; Daly, Chang, Hancock & Crookes 2005; Crookes & Davies 2004). Shanley (2007) in his review of literature on change management in order to provide insights on change that could be utilised by nurse managers, suggests that this approach to change is simplistic and describes a linear process that occurs as a single episode.

An alternative view of the change process is posited by Pettigrew (cited in Shanley 2007) who argues that change is a complex process that occurs over a longer period of time and is referred to as an emergent approach to change management. With this view, managers are required to accept change is complex and to develop plans that are embedded in the context of the organisation and that are constantly reviewed, evaluated and updated based on emergent and often unplanned outcomes over a period of time (Shanley 2007).

As identified in the previous section of this review, it can be asserted that for change to be effective, participants must understand the need and be involved in the planning for change (Watson 2009; Shaw 2007). Organisations that have a hierarchical structure and that mandate change from above, are said to discourage a professional orientation to work (Watson 2009; Crookes & Davies 2004). However, it may be argued that it is necessary for change to be driven from the top down, as senior management usually
has the mandate to set directions and allocate resources for change (Conger cited in Shanley 2006). Shanley (2007) concludes that while change may need to be driven by senior management, it is unlikely to occur unless leadership committed to the change emerges from different levels of the organisation. A similar model of change described by Nankervis, Kenny and Bish (2008) in their research into enhancing the scope of practice of enrolled nurses in rural health services supports the need for ongoing evaluation and refinement of emergent outcomes.

2.4 The Framework and aged care nurses
Nay and Pearson (2001: 38) suggest that many nurses in aged care ‘… just want a ‘job’…’ and are not interested in a professional career’ and therefore (by implication) are not interested in advancing their scope of practice. It is well documented that traditionally the aged care nurse was undervalued and considered to be less skilled and less important than other nurses (Leppa 2004; Jackson et al. 2003; Jones et al. 2002; Horner 2001). It could be summarised that this may be partly because of a lingering ageism, but also because of what is perceived to be the routine nature of the work that is ‘…easy, uncomplicated, predictable (and) slow-paced …’ (Leppa 2004: 27; Jackson et al. 2003). By contrast, some authors argue that the impact of the Aged Care Act 1997 has resulted in registered nurses acquiring a broader range of skills and clinical expertise (Hunter et al. 2007; Leppa 2004; Jeong & Keatinge 2004).

2.4.1: Delegation
Curtis and Nicholl (2004) assert that, while delegation is not a new function in nursing, it is becoming increasingly important as changes occur in the way that health care is provided. The evidence demonstrates that the number of enrolled nurses and unlicensed carers in RACF has increased in recent years (Martin 2008) and registered nurses are increasingly expected to delegate traditional nursing duties to others (Venturato et al. 2007). In their longitudinal qualitative study in the United Kingdom, Maben, Latter & McLeod Clark (2007) predicted that while the responsibility for setting the standards of care remain with the registered nurse, they will increasingly delegate the delivery of direct care to others who they will supervise and manage.

The expectation that registered nurses will be required to organise and supervise the work of enrolled nurses and unlicensed carers requires the ability to delegate effectively. Additionally, as in other health care settings, effective delegation to temporary or supplemental registered and enrolled nurses is sometimes required.
(Aiken, Xue, Clarke & Sloane 2007). However, Curtis and Nicholl (2004) posit that nurses’ abilities to delegate are variable and delegation remains a skill that needs to be developed. It is suggested by other authors that the development of leadership and supervision skills in registered nurses and clear position descriptions of unlicensed carers will assist in enhancing teamwork and appropriate delegation between registered nurses and unlicensed carers (Maben et al. 2007; Baldwin, Roberts, While & Cowan 2003). These authors further contend that registered nurses will require education and support to prepare them for this leadership role. In spite of this, it is asserted that nurses in leadership positions are neither well prepared for nor well supported in their role (Williams, Parker, Milson-Hawke, Cairney & Peek 2009; Paliedelis, Cruickshank & Sheridan 2007).

The Framework (QNC 2005) directs that delegation to enrolled nurses and unlicensed carers requires firstly that the delegation is based on an assessment of the resident’s needs to ensure the context of care remains unchanged and secondly, that the person being delegated to is appropriately educated and has been assessed by the registered nurse as being able to undertake the task. Finally, that the service provider has the responsibility to provide resources to ensure ongoing education and assessment of competency and supervision of unlicensed carers. Just as there is variety in the roles and levels of competence of unlicensed carers, the service providers of RACF are also varied, and while the accreditation standards require the provision of appropriately skilled and qualified staff with the knowledge to perform their roles they do not prescribe how each provider is to achieve this outcome (Aged Care Principles 2004).

2.4.2 Unlicensed carers
Unlicensed carers have been employed in health care settings since the beginning of formalised health care and they perform an important role in RACF, but it is suggested that there is no clear and consistent understanding of their role and of the competencies that they possess (McKenna, Hasson & Keeney 2004; Baldwin et al. 2003). Even though there is no regulatory requirement for the education of unlicensed carers, it is recognised that appropriate training is essential for ensuring quality of care (Brannon & Barry 2004; Aberdeen 2004). There has been an effort in Australia (and other countries) to introduce standardised training which is competency based, without entry requirements, or examinations that can be completed over a period of time (McKenna et al. 2004). Aberdeen (2004) asserts that while there is a nationally accredited course in Australia, the standard of teaching unlicensed carers is variable.
and training is often offered as a work-based traineeship. This, the author suggests, may impair the development of competence in unlicensed carers, as not all workplaces offer a suitable work learning environment and if work practices and attitudes are poor, student unlicensed carers may get confusing messages about their roles and responsibilities (Aberdeen 2004). Aged care service providers are responsible for ensuring that staff in RACF have the qualifications, knowledge and skills to undertake their roles and deliver services that are in accordance with the outcome standards (Aged Care Principles 2004).

Unlicensed carers, whose roles include carrying out non-complex care tasks, are not regulated by any professional or vocational body (QNC 2005). Just as the nomenclature to describe the unlicensed carer is varied (e.g. personal care workers, assistant nurses, nurse aides and personal carers), their role and level of competency is also variable and depends on the location and nature of the health care setting in which they are employed (McKenna et al. 2004). Despite this, unlicensed carers play an important role in residential aged care undertaking much of the direct care of residents and for many years have made up a large proportion of the aged care workforce (Jackson et al. 2003). Some authors assert the numbers of unlicensed carers are increasing as it becomes more difficult to attract registered nurses into aged care practice and as the need for cost-effectiveness in health care services increases. Others suggest that the shortage of nurses and cost cutting by aged care providers are contributing factors (Carrigan 2009; McKenna et al. 2004; Baldwin et al. 2003; McMillan et al. 2001; Nay & Pearson 2001).

In their final report on the aged care workforce, Martin (2008) compared the results from 2003 with workforce statistics from 2007. Their report confirms that the numbers of unlicensed care workers have increased over this period while the numbers of nurses has decreased with the ratio of enrolled nurses to registered nurses also increasing (Martin 2008). This report also identifies that approximately 30% of unlicensed carers had no formal aged care qualifications prompting some to call for minimum education requirements and a standardised set of skills (Carrigan 2009; Martin 2008).

2.4.3 Competence, education and qualifications

Anecdotal evidence in acute care (hospitals) suggests that enrolled nurses are practising beyond their educational level and that the difference in the role of the
registered nurse and that of the enrolled nurse is not clear. Yet empirical evidence does not support this view. Gibson and Heartfield’s study (2003) of enrolled nurse practice concluded that although the roles appeared similar, the cognitive and analytical processes used were quite different. This is supported by Chaboyer, Wallis, Duffield, Courtney, Seaton, Holzhauser, Schluter and Bost (2008) who undertook an observational study in order to compare activities undertaken by enrolled nurses and registered nurses in acute care. While some activities appeared similar, the educational preparation for each role was quite different (Chaboyer et al. 2008). In another study in an acute care setting, Milson-Hawke and Higgins (2003) using grounded theory, identified that enrolled nurses in the study determined ‘… their own competency in relation to undertaking new work’ (op cit. 2004: 59). However, as with the previous study, these authors found that although enrolled nurses often reported undertaking the same tasks as registered nurses, they understood their roles were different (Milson-Hawke & Higgins 2003). In their examination of skill extension of the enrolled nurse (in the acute care arena) Blay and Donoghue (2007) found that enrolled nurses seldom performed extended tasks.

By contrast, in their report as part of a larger multi-phased study about enrolled nurses’ scope of practice, Gibson and Heartfield (2005) identified that in some settings, there was a lack of differentiation between the roles of enrolled and registered nurses. While there is a dearth of information about the differentiation between the roles of registered and enrolled nurses in residential aged care, these authors also suggest that it is inevitable that enrolled nurses will assume increasing responsibility for leadership and supervision of unlicensed carers (Gibson & Heartfield 2003). In a report included in the National Review of Nursing Education (McMillan et al. 2001), it was ascerted that enrolled nurses were already leaders of teams in aged care settings.

2.4.4 Supervision
Stack (2003) reports that the required supervision of unlicensed carers restricts the time available for care to be provided by nurses in RACF. However Brannon and Barry (2004) argue that as the reality of provision of direct care by unlicensed carers is increasing; the importance of supervision in long term care organisations (such as RACF) is critical. This view is supported by Maben et al. (2007) who believe that the time has come to acknowledge that the inevitable increase in demand for nursing care with an ageing population requires that nurses will manage the quality of care through clinical decision-making and the supervision of unlicensed carers. They call for better
preparation of nurses for this leadership and supervisory role. Reporting on findings from a training evaluation program, Brannon and Barry (2004) write that work performance improved in those unlicensed carers that were supervised by nurses who had developed supervisory skills, leading the researchers to conclude that effective supervision was crucial to the success of training programmes for unlicensed carers that are designed to improve quality of care.

2.4.5 Service provider’s policies

Policies exist to control nursing practice and are generated at a number of levels from governments and professional bodies as well as the organisation in which a nurse practices (Cheek & Gibson 1997). These authors argue that many nursing policies are regulatory in nature and serve ‘… to regulate activities, behaviour and discretion of individuals’ and may act to constrain practice which contradicts the notion that the professional nurse is autonomous and responsible for their own practice (Cheek & Gibson 1997: 669). The legislative requirements of the Aged Care Act 1997 have had a significant impact on residential aged care. The re-organisation of residential care has resulted in the acceptance of greater accountability in terms of interpreting and implementing the funding tools (formerly RCS and now ACFI), the Standards and accreditation. Jones et al. (2002) report that, despite the increasing complexity of care required by residents in aged care, hours allocated to registered nurses for clinical work have declined in some facilities, and that most allocated hours tended to go directly to activities relating to maintaining funding, such as extensive documentation often designed and determined by management of organisations in response to what they perceive is required to meet external demands.

Service providers have the responsibility of providing a policy framework and resources to ensure the ongoing education, competency assessment and supervision of unlicensed carers and the evaluation of the outcomes of delegation (QNC 2005). Unlicensed carers have always made up a significant proportion of the aged care workforce. However the proportion of unlicensed carers in aged care is rising in an unplanned way and some suggest that they are replacing unfilled nursing positions (Nay & Pearson, 2001). In a climate of concern for the continuing sustainability of residential aged care services, it may be argued that there could always be a temptation by employers to continue to expand the role of unlicensed carers as they are more plentiful and less expensive (McMillan et al. 2001).
2.5 Implications and Conclusion

It is evident from the literature that the context of residential aged care provides nurses with particular challenges as the Australian population ages and the numbers and acuity of residents in institutional care increases. As nurses are increasingly expected to organise and supervise the work of unlicensed carers, the understanding of the importance of delegation and the ability to work through others is essential. The Framework provides the structure for nurses to achieve this understanding, however there is no evidence to suggest that nurses in residential aged care have adopted the Framework or utilise it to support clinical decision-making.

This study sought to identify how aged care nurses incorporate the DMF into their daily practice. This chapter reviews the origins of the Framework and the principles that guide decision making. The introduction of the Aged Care Act 1997 and subsequent changes relating to residential aged care and their impact on the practice environment of nurses working in this field have been explored. Chapter 3 will present the methods used to formulate and tackle the question – how do Queensland nurses working in residential aged care apply the Framework in their daily practice?
Chapter 3: Research Design

This study was designed to evaluate the utility of the Decision Making Framework and to elucidate the level of adoption of the Framework into the daily practice of nurses working in residential aged care in Queensland. It is positioned in terms of aged care nurses' conceptualisation of the Framework and their perspectives in relation to its usefulness on a day to day basis. Section 3.1 describes the methodology used to guide this project which was evaluation research using a qualitative approach. Evaluation research is well established in social science (Babbie & Earle 1998) and may be described as a disciplined inquiry that looks to assess the actions of a group by determining what has been accomplished by a particular program or how a program is operating (Utley 2011; Hall 2004; Clarke 2001). Research methods of participant selection and sampling, focus groups, semi-structured interviews, observations and document review are outlined in Sections 3.2. Data collection and description of the management of data forms Section 3.3; data analysis that led to the conclusions drawn from the study and issues relating to the trustworthiness of the findings will be made more explicit in Section 3.4. Finally, the chapter concludes with the identification of the ethical considerations relating to this research (Section 3.5).

3.1 Research Methodology

This is a qualitative evaluation research study. Evaluation research is the gathering of information about a program for the purpose of making some sort of conclusion about the program and it may inform future decision-making (Bennett 2003; Roberts, Priest & Bromage 2001; Clarke 2001). Traditionally, evaluation research was based on precise measurements of outcome using an experimental model where research participants were selected randomly and rigorous attention was applied to exclude variables (Hall, 2004; Bonner 2003). Evaluation research may be described as being either summative or formative. Where the study seeks to gather information about the effectiveness or outcome of a project at its completion, the approach is referred to as summative evaluation. A formative approach to evaluation occurs when the processes of a particular program are the object of the research while the program is still in progress (Utley 2011; Hall 2004; Bennett 2003).

Qualitative research is concerned with gaining insight into individual experience (Nieswiadomy 2008) and is described by Miles and Huberman (1994: 6) as an attempt ‘… to capture data on the perceptions of local actors “from the inside”’ through
processes of attentiveness and understanding, at the same time suspending or putting aside the researcher’s pre-conceptions about the topic. The researcher looks for patterns or themes in data that are directly gathered from participants or through the researcher’s observations in order to gain an understanding of meaning from the participant’s point of view (Houser 2008).

It is argued that the traditional approach to evaluation ignores the situational nature of a social program, and does not acknowledge participants’ understandings, or provide interpretations of a particular situation or explanations regarding the process of implementation of a program (Walsh et al. 2007; Hall 2004; Bennett 2003; Bonner 2003). The introduction of qualitative methods in evaluation research allows the development of greater knowledge and understanding of how a program is working and is concerned with exploration and description of the experiences of participants (Walsh et al. 2007; Clemow 2007; Kelly 2004; Hall 2004). Sometimes evaluation of both the outcomes of a program as well as illumination of the processes of the program needs to be undertaken and it is said this is best achieved by the application of both quantitative and qualitative (or mixed) methods in evaluation (Giddings & Grant 2009; Clark 2001). Qualitative evaluation research is relevant to this study as the measure of usefulness of the Framework depends on the perceptions of those who are applying it on a daily basis.

Qualitative evaluation methods were originally developed for mainstream education. Nurse researchers have applied these methods to nurse education, with special consideration of the clinical practice arena as in Ellis’ (2003) exploration of the context of continuing education and the factors that may influence changes to practice after participation in such education or in Durgahee’s (1997) exploration of the process that makes reflection a learning exercise for nursing students. Wood (2006) asserts that increasingly, nurses will be required to provide evidence of best practice and evaluation research will assist in achieving this goal.

In order to answer the questions being asked in this project, a formative evaluation approach was adopted using qualitative data collection methods. The theoretical underpinning of the use of this qualitative approach is based on the reality of the individual’s understanding and application of the Framework on a day to day basis and was appropriate as the researcher was attempting to be informed by what people said about their experience. A systematic examination of issues and effects of The Scope of
Practice Framework in day to day practice was undertaken through the interpretations and applications of the participants. Open ended data collection consistent with the formative approach occurred through direct observation, the conduct of focus groups and semi-structured interviews. As the researcher is a registered nurse who currently works in the aged care sector, it was imperative to acknowledge pre-conceptions about the application of the Framework in residential aged care practice context and to set them aside while listening to participants. Analysis of a limited number of documents used by participating RACF that related to the Framework and its application in residential aged care contributed to the study (Clemow 2007).

3.2 Research Methods

The methods used in this research project are consistent with qualitative evaluation research. Data were collected using different methods, namely focus groups and semi-structured interviews, direct observation and document review. This use of multiple methods of data collection is referred to as triangulation which facilitates the cross checking of the data and can improve the validity of and add rigour to findings in qualitative research (Giddings & Grant 2009; Houser 2008; Miller & Alvarado 2005).

3.2.1 Sampling and Research Participants

Selection of participants for this study was made by convenience sampling. Convenience sampling is described as recruiting participants who are readily accessible to the researcher. The advantage of this type of sampling is that it is easier for the recruitment of participants in terms of logistics and costs (Houser 2008). However the disadvantage of convenience sampling is that bias may be introduced as data is only gained from those who have volunteered to participate (LoBiondo-Wood & Haber 1998). The potential for bias would further increase if the researcher is involved in participant selection (Houser 2008). In this study the researcher played no part in the selection of participants and, due to its context (residential aged care) the risk of bias was further mitigated as each group of nurses at both sites represented the greater proportion of the total population at the respective site. To illustrate, the nurse manager focus groups comprised 100% of nurse managers at the respective sites.

The initial approach was made by telephone call to key personnel from different Aged Care Services located in different regions of South East Queensland. At this point, a general overview of the project was provided and an interest in participating in the project was expressed at two sites. Written information was provided to the
organisations electronically (Appendix A) and formal consent to undertake the research at each site was provided. A key person at each site was the point of contact for disseminating information that was provided by the researcher to nurses in their organisation. The researcher also liaised with this person to make arrangements regarding time and dates of focus groups, interviews and observations. In order that a complete understanding of how the Framework was understood and applied, nurses who (a) make delegation decisions and (b) accept delegated assignments were included. Selection of participants for the observation activities was undertaken at the time the focus group discussions and interviews were held and further consent to embrace the observation activity was obtained.

3.2.2 Focus Groups
The goal of using focus groups is to ensure collection of abundant, relevant and high quality data (Morrison-Beedy, Cote-Arsenault & Feinstein 2001). A focus group is a form of group interview that relies on interactional discussion between the participants to generate data that provides insight into participants’ perceptions, attitudes, experiences and reasoning (Curtis & Redmond 2007).

Any group discussion may be called a focus group as long as the researcher is actively encouraging of, and attentive to, the group interaction. (Kitzinger and Barbour in Barbour 2007: 2)

Focus groups may be seen to be superior to individual interviews, as the data elicited is richer because of the group interaction that provides a powerful dynamic and enhances individual experiences and perspectives that are missing from individual interviews (Houser 2008; Morrison-Beedy et al. 2001).

Stokes and Bergin (2006) assert that focus groups are synonymous with qualitative research but there are strengths and weaknesses in using this method for data collection. Some researchers argue that using focus groups for data collection will be quicker and more cost effective (Barbour 2007; Stokes & Bergin 2006). However, this assertion is not generally supported as considerable resources in terms of cost and time are expended in preparation for data collection, transcription and analysis of the data as well as just getting the group together (Houser 2008; Barbour 2007; Stokes & Bergin 2006; Freeman 2006; Jamieson & Mosel Williams 2003).
The main advantage of focus groups is the utilisation of group dynamics to assist participants to explore and clarify their views about the topic under discussion, encouraging all participants to have a say (Barbour 2007; Freeman 2006; Stokes & Bergin 2006). Homogeneity of groups allows free flowing discussion and enhances group dynamics (Curtis & Redmond 2007; Barbour 2007; Macnaghten & Myers 2004). This open communication between participants helps with clarification of differences and similarities in expressed opinions and experiences (Freeman 2006). While interactions between the group participants can yield valuable insight into their experiences, opinions and behaviour, group interactions can also lead to conformity with participants and an unwillingness of some participants to disclose their opinions (Curtis & Redmond 2007; Stokes & Bergin 2006; Jamieson & Mosel Williams 2003). Thought must be given to the composition of focus groups, as an imbalance of power between group members from formal or informal hierarchies, may inhibit a free flow of ideas and prevent individuals from expressing themselves (Barbour 2007; Freeman 2006). The establishment of sub-groups within a homogenous population may not only remove this imbalance of power, but also allow the analysis of differences between groups (Freeman 2006).

Group discussion is guided by the researcher’s focus which ensures data collection that is relevant to the project; however, the impact of the researcher on the data needs to be taken into consideration when data is analysed (Curtis & Redmond 2007; Barbour 2007). The utilisation of a question guide that is designed to facilitate the use of open ended questions by the researcher will ensure that participants respond freely (Jamieson & Mosel Williams 2003). The researcher, when moderating the group, seeks to keep the group on the topic and encourages discussion between all participants (Macnaghten & Myers 2004).

The number and size of focus groups held is determined by the research project. Barbour (2007) asserts that more groups is not necessarily better and, although traditionally focus groups comprised ten to twelve participants, a maximum of eight can be challenging in terms of moderating groups and analysing transcripts. Barbour (2007) also contends that it is possible to have focus groups comprising 3 or 4 participants and still effectively explore in depth, the participants’ experiences and ways in which their perspectives are constructed.
When planning focus groups for this project, consideration was given to the size and structure of the group. To ensure that there was no imbalance of power within any group, managers and non-managers participated in separate groups (Curtis & Redmond 2007; Barbour 2007). This was achieved by arranging focus groups to comprise only nurse managers, only registered nurses or only enrolled nurses. A question guide that contained a few brief open-ended questions and several stimulus topics that were used to initiate discussion was developed (Appendix B). The guide was not used to dominate discussion, but to initiate discussion and to prompt and redirect participants to the topic or to elicit clarification (Curtis & Redmond 2007; Barbour 2007; Jamieson & Mosel Williams 2003). Scheduling focus groups at a time to suit participants who worked different shifts was another consideration.

In this research project, semi structured interviews were conducted where it was not possible to form focus groups of a suitable number, for example the limited number of managers at a specific site as a result of the context of the study – residential aged care, and the impracticality of recruiting a suitable number from multiple sites. This would risk the formation of a disparate group, with less opportunity to facilitate group process in the time available.

3.2.3 Semi-structured interviews

Interviews allow the collection of rich information about personal perspectives and beliefs on a one to one basis and add understanding to the evaluation process (Houser 2008; Roberts et al. 2001). Interviews may be described as being focused at one end of the scale or totally unstructured at the other end, with variations between these extremes and are often used with other methods of data collection such as focus groups (Roberts et al. 2001). The semi-structured interview sits somewhere in the middle and allows the researcher flexibility to probe unclear or ambiguous meanings of words and phrases, clarification of inconsistencies and maximises the potential for interactive communication which is beneficial for the establishment and maintenance of rapport (Nieswiadomy 2008; Barribal & While 1994). These authors assert that probing can be invaluable in ensuring reliability of data. While interviews can be versatile and flexible, there are limitations to this type of data collection.

Firstly, the personal skills of the researcher may influence the quality of the data; the provision of more structure to an interview may assist a novice researcher to gather data more consistently and to probe for more detail (Roberts et al. 2001). Barribal and
While (1994) assert that the friendliness, approach and manner of the researcher contribute to securing reliability and validity of data. After the introductions, it is important to put participants at ease. These authors also contend that the researcher should have some knowledge of the topic of interest to ensure that important data is not missed. However, it may be argued that a researcher who is familiar with the field may introduce bias and should therefore be aware of this potential and attempt to minimise their impact on the data collected by remaining as neutral as possible (Houser 2008; Whiting 2008; Roberts et al. 2001).

Secondly, while it may be assumed that self-reporting is accurate and therefore valid, participants may provide information that they believe is more correct, rather than providing an honest account (Roberts et al. 2001). Maintaining a neutral stance and using probing questions through the interview reduces this risk (Houser 2008; Barribal & While 1994).

Finally, interviews can be time consuming and even a large number of interviews may not collect as much data as would be collected using focus groups (Houser 2008). The benefit of group dynamics that generate rich data when utilising focus groups, will also be missed (Stokes & Bergin 2006; Roberts et al. 2001).

A question guide with open ended questions the same as that used in the focus group discussions was used in this project to maintain focus on the research topic (Appendix B). In preparation of the guide, consideration was given to the wording of questions and topics to ensure any ambiguity of meaning was avoided and the questions were as neutral as possible in order to encourage an environment that facilitated truthfulness in the participants (Houser 2008; Barribal & While 1994).

3.2.4 Observations
Qualitative observations occur in the natural context and draw the observer into the complexity of the phenomenon (Adler & Adler 1998). The observer gains insight into the participants’ perspective without participating in the activity by remaining as unobtrusive as possible, recording the observed events and subsequently analysing them. Observations may be described as being direct or indirect. When direct observations are made the participants have agreed to be part of the research. Conversely, when indirect observation is conducted, subjects may be unaware of the observations (Houser 2008). Observation may also be described as non-participant –
where the researcher is the complete observer or participant observation when the researcher observes behaviour while they work or live with the participants (Watson & Whyte 2006).

Data from direct observations are likely to produce insights that are accurate for the participants' understanding, but may not be extended to the wider population. One of the strengths of direct observation is that there is little potential for the observer to influence the events being observed. ‘The naturalness of the observer role coupled with its non-direction makes (observation) the least noticeably intrusive of all research techniques’ (Adler & Adler 1998: 89). However, the raised awareness of the topic under investigation by participants being observed may produce changes to their behaviour; this is known as the Hawthorne effect (Groenkjaer 2002; LoBiondo-Wood & Haber 1998). Another strength of observation as a research method is that it allows the researcher to actually see what a participant does in a particular situation without being dependent on what participants say they do as in focus groups or interviews (Roberts & Taylor 2002).

Validity of observation as a research method is susceptible to the researcher’s bias or subjectivity when interpreting data. This may be reduced by the researcher putting aside their own values and beliefs (Watson & Whyte 2006; Roberts & Taylor 2002). Reliability of the data can also be improved by repeated observations at different times and in different places (Adler & Adler 1998). Observation has increased rigour when combined with other data collection methods and is rarely used as the sole source of data (Adler & Adler 1998).

Selecting what to observe and how to sample the events was very important. For the purpose of this project, how nurses applied the principles of the Framework was the event that was the focus of the observer. As the application of the Framework in practice could not be described as a single event to be observed in its entirety, time sampling was conducted. Time sampling describes observing behaviour during specific periods of time (Nieswiadomy 2008). Therefore, the timing of the observations was based on the timing of the handover between nurses at the change of shifts when delegation decisions are made and also two other periods between the beginning and end of the eight hour shift where supervision and support were likely to be undertaken in relation to delegation. Two observation activities were arranged, one of a registered nurse and the other of an enrolled nurse. Data collection was unstructured, but field
notes were taken of those events of interest. The field notes were not just for recording observations, but also for the observer’s personal and professional reflections (Groenkjaer 2002).

3.2.5 Document review

Documentation ‘... forms a cornerstone of modern life ...’ (Prior 2004: 375) and is far more than a ‘... neutral conveyor of information (Cheek & Gibson 1997: 671) and can take on many forms that may be either ‘receptacles of context’ or ‘functioning agents’ and may be researched from either angle (Prior 2004). Despite this, documents are not commonly incorporated into research (Miller & Alvarado 2005; Prior 2004). Miller and Alvarado (2005: 348) assert that qualitative researchers ‘... seek to understand the world from a participant’s point of view, by listening to or observing a person in a natural environment’ and to use documents as a source of data is to put themselves at some distance from real people. Documents can be important sources of data that can contribute to triangulation and the consequent increased validity of a study (Clemow 2007; Miller & Alvarado 2005).

In this study, the content of a limited number of documents relating to the application of the Framework and utilised at the participating sites were analysed in order to gain an understanding of the underlying values and assumptions that they contain, with consideration of the situational context as well as the institutional structure (Miles & Huberman 1994).

3.3 Data collection

The focus group discussions and the semi-structured interviews were audio-recorded using a digital recorder that was small and unobtrusive. The recordings were able to be downloaded onto the computer in preparation for transcription. The verbatim transcripts were developed into word documents from the recordings and names that were embedded in the interviews were removed in order to maintain confidentiality of participants when managing data (Lindgran 2010). While developing and analysing a verbatim transcript is time-consuming, it is rigorous and allows the researcher to be immersed in the data and to return to the original data (Curtis & Redmond 2007; Barbour 2007; Jamieson & Mosel Williams 2003). The participant observation data were also developed into word documents.
Notes were taken during and immediately after focus group discussions to record the researcher’s observations of the salient features of the group dynamics such as group interactions and non-verbal behaviours. These notes contributed to the analysis (Jamieson & Mosel Williams 2003; Morrison-Beedy et al. 2001) and were included as part of the initial analysis after each focus group session (Morrison-Beedy et al. 2001). Similarly, field notes were recorded by the researcher immediately after the interviews and observations and contributed to the data to be analysed.

In total data was collected from two focus groups, five semi-structured interviews and two periods of observation that took place at two different sites with 15 nurses participating. As mentioned earlier in this chapter, the size and number of focus groups reflects the context of residential aged care where unlicensed carers form the greater proportion of the workforce. The following table displays the composition and number of each of the data collection activities.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Focus Group 1</th>
<th>Focus Group 2</th>
<th>Interviews</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled nurses</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

3.4 Analysis of data

‘Data analysis is the heart of qualitative research’ (Rehm 2010: 149). Thorne (2000) asserts that data analysis is the most complex phase of a qualitative research project where inductive reasoning processes are utilised to interpret and structure meanings derived from the data. Reflexive and iterative reflections were important aspects of data analysis. Reflexivity or the acknowledgement of the researcher’s own bias or expectations was achieved by reflecting on their own background and experience in residential aged care and identifying where bias may prevent the researcher ‘hearing’ the participants’ voices. Iterative processes begin as soon as data collection begins and refers to the unfolding of meaning in repetitive waves of analysis (Rehm 2010).

Thematic analysis occurs when there is elucidation of themes as expressed in the transcripts that provide insight into the participants’ thoughts, beliefs and attitudes and was the approach utilised to analyse the verbatim transcripts of focus groups and semi-structured interviews and observation data in this project (Butcher, Holkup, Park &
Content analysis was applied to documents contributing to data. ‘Qualitative content analysis is a dynamic form of analysis of … data that is oriented toward summarizing the informational contents of that data’ (Sandelowski 2000: 338). Data were managed and analysed with the assistance of NVivo 8 program (Bazeley 2007).

The first step taken in the analysis was one of becoming familiar with and organising the data. The researcher read and re-read the transcripts in order to gain a greater understanding and insight into the statements made by participants and to support the rigour of analytical process. Organisation of the data is integral to the process of analysis and was conducted in a methodical manner (Tuckett 2005a; Attride-Stirling 2001; Miles & Huberman 1994). Data was organised initially to identify the method of collection and the source of data, for example, the characteristics of the focus group (Tuckett 2005a). Data was then coded with the use of the NVivo nodal system. Phrases, sentences or paragraphs containing patterns that related to each other were categorised, coded, grouped and re-grouped looking for themes that were reviewed and dissected meaningfully (Gabrielle, Jackson & Mannix 2008; Tuckett 2005a; Miles & Huberman 1994). Codes or nodes were re-coded and merged at several points to streamline the number of codes and to avoid repetition.

The researcher then began the process of recursive consideration of the words and actions of the participants in collaboration with the study supervisors. The thoughts of the researcher were recorded in informal notes and shared with supervisors; this enabled deeper exploration of ideas and the development of links between participants and common themes in the data (Rehm 2010). Codes and data were scrutinised carefully until themes emerged encompassing several sub-themes. In order to maintain the richness of data, the words of participants were used and titles of themes were derived from the participants’ words (Houser 2008; Boyd 2002). Robustness of the analysis was enhanced through recording and disclosing the details of the systematic analytic process (Tuckett 2005b; Attride-Stirling 2001).

3.5 Ethics

In qualitative research as in other research paradigms, potential ethical issues such as research methods, informed consent, confidentiality, and anonymity are anticipated and considered (Vivar, McQueen, Whyte & Armayor 2007; Orb, Eisenhauer & Wynaden 2001). The primary means for ensuring the rights of participants is through informed consent. Informed consent is the ethical principle that governs an individual's
participation in research. Rather than a mere signing of a consent form, informed consent is a process of information exchange that includes verbal dialogue and written materials that are sufficient for a person to decide whether to participate in the research or not (Palmer, Cassidy, Dunn, Spira & Sheikh 2008; Houser 2008). Participants need to be assured they have the right to withdraw at any time (Houser 2008; Orb et al. 2001). In this research project personal discussion and written information about the project was provided to participants before consent was confirmed by a signed, plain language consent form (Nieswiadomy 2008; Vivar et al. 2007; NHMRC 2007) (Appendix C). This written consent was obtained prior to the commencement of the focus groups, interviews and observations and participants were reminded they could withdraw at any time.

‘The research process creates tension between the aims of the research … and the rights of the participants to maintain privacy.’ (Orb et al. 2001: 93). An undertaking must be made to maintain the confidentiality and anonymity of participants. Anonymity occurs when the data cannot be linked to the participant, even by the researcher. Maintaining confidentiality is described as the protection of participants by ensuring that information provided by them is not linked to any individual and those participants’ identities are not divulged (Nieswiadomy 2008; Whiting 2008; NHMRC 2007; RCNRS 2003; Orb et al. 2001). In this study, the data was linked to the participants as the researcher conducted the focus groups, interviews and observations. The researcher was therefore required to maintain confidentiality and this was achieved by removing any reference to individuals or organisations in the transcripts, by storing data in a secure way without identifying labels and ensuring access to data was limited. Assurance was provided by informing potential participants that published reports would not identify individuals and that this would be achieved by describing participants and their settings in general terms (Nieswiadomy 2008; Vivar et al. 2007; RCNRS 2003). In using focus groups for data collection, however, the researcher is unable to guarantee absolute confidentiality, as they have no control of the participants when the focus group discussion has ended (Jamieson & Mosel Williams 2003). At the commencement of the group discussion, the participants were asked to respect the confidentiality of the group.

Most universities and many health organisations have research ethic committees that seek to prevent harm to participants in research. This is achieved by reviewing research proposals that involve human participation (Holzemer 2010). In keeping with
the University of the Sunshine Coast requirements, approval for this project was sought from the Human Research Ethics Committee. In addition, approval was obtained from the organisations that provided the opportunity to recruit participants for this study and permission to look at documents that may be relevant to the study was also obtained (Appendix D).

This chapter has described the methodology applied in this project, how participants were selected, the data collection methods utilised and the process of data analysis. Ethical considerations and how these were addressed have been outlined. The findings from the analysis of the data are presented in the following chapter.
Chapter 4: Findings

This chapter presents the findings from the analysis of data from the interviews and focus groups, the observation studies and documents obtained from the participating sites. Section 4.1 provides the setting for the study. From the data emerged six concepts: ‘work allocation viewed as delegation’, ‘permanence as a measure of competence’, ‘you don’t really supervise’, ‘unrecognised potential for expansion’, ‘evolving roles and role confusion’ and ‘working outside of scope of practice’. Section 4.2 examines each of these concepts in turn. The three themes that arise from these concepts are identified at the conclusion of the chapter (Section 4.3).

4.1 The setting
As identified in the previous chapter, the difficulty in recruiting sufficient numbers of each category of nurse to conduct only focus groups in the context of aged care was realised and as a result two focus groups and five semi-structured interviews took place at two different sites with 15 nurses in total participating. While one site (Site A) was ‘for profit’ and the other ‘not for profit’ (Site B), they were similar in size and had a similar mix of high and low care residents. The layout of the sites was different. Site A was divided into three sections or ‘wings’; one section was for residents generally requiring a lower level of care and the other two sections were for those residents needing a high level of care; each section was quite separate from the others and each had its own office/desk space. Site B was similarly divided into three sections with the same distribution of residents, however, the two high care sections were adjacent to each other and staff in these sections shared an office. The distribution of nurse participants from the two sites is displayed in table 2.

<table>
<thead>
<tr>
<th>Participants</th>
<th>N</th>
<th>Site A</th>
<th>Site B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled nurses</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

In addition, one registered nurse and one enrolled nurse were observed at intervals across eight hours of their working shift. Each was observed at the beginning and end of the shift when change of staff was occurring and at a time of greater communication...
and delegation of care. Two other periods were also observed between the beginning and end of the eight hour shift. Brief notes were taken during the observation activities, and each set of notes was recorded in more detail soon after the observation had finished.

Data from the focus groups and interviews were audio-taped and transcribed verbatim. A thematic analysis of the transcripts provides the basis of the conclusions drawn about the application of the Framework by nurses on a daily basis in the aged care context. To enrich the analysis, the findings of the observation studies and documents have been combined with the findings from the interviews and focus groups. Excerpts drawn from the research transcripts have been included in this paper and although it is important that isolated statements are understood in the broader context of the interview, these exemplars will help illuminate the findings of the study.

4.2 Concepts that emerged from the data

The systematic analytical process described in the previous chapter led to the emergence of a series of sub-concepts that merged into six prevailing concepts. Each of these concepts is described with its sub-concepts in turn.

4.2.1 Concept 1: Work allocation viewed as delegation

This data-saturated concept indicated that issues related to the perception of what delegation is were noteworthy. Delegation in terms of the Framework refers to the conferring of authority to perform an activity to another person. Delegation in the context of aged care occurs between registered nurses, between registered nurses and enrolled nurses and between registered nurses and unlicensed carers. It is the responsibility of the registered nurse to assess the resident to establish that the context of care is unchanged, prior to delegating care. Two sub-concepts contributed to this concept, ‘powerlessness’ and ‘perceptions of fairness in allocation of work’.

For enrolled nurses in this sample, the understanding of delegation was often confused with what may be described as allocation or distribution of work. At both sites nurses were assigned residents in a particular area of the facility through a pre-prepared roster by nurse managers who were not usually providing direct care for residents. One of the intents of the Framework is to support nurses with decisions about delegation and accepting delegation; however the ability to make decisions in this way was not evident. The following comment from an enrolled nurse at Site A illustrates this:
Oh well, I work in the nursing home end so I am delegated all the people who are in the nursing home. EN1

There is no resemblance between this form of ‘delegation’ and that which is explicit within the Framework. However at Site B, two nurses (who may be two enrolled nurses or one enrolled nurse and one registered nurse) are allocated (through the pre-prepared roster) to the one area of the facility and they decide between themselves how the residents in that area are assigned. The enrolled nurse participants at this site reported that decisions about how work is arranged are based on perceived workload and preference. If one half of the area is seen to be more demanding, the enrolled nurses will reallocate to evenly distribute the workload; otherwise they select according to personal preference. The following comments from an enrolled nurse describe these processes:

*We decide between ourselves, we may have preferences; one side may be heavier [sic] than the other side so you may have a change around to give each other a break; or if they are equal it’s your preference really …* EN3

*You divide it between yourselves.* EN3

and when an enrolled nurse was working with a registered nurse:

*Again, the RN has a preference for one side so the EEN generally takes the other side.* EN4

Again, the processes of ‘delegation’ of resident care bears no resemblance to the processes of the Framework and do not include contemporaneous assessment of residents’ needs. One enrolled nurse participant described delegation as being hierarchical, where enrolled nurses accept delegation from the registered nurses and they, in turn, delegate to unlicensed carers:

*Well you start at the top, you’ve got your manager, it’s like a tree, you’ve got your framework of the staffing. Below her comes the CNC, and then you’ve got your RNs, then you’ve got your ENs, then AINs and care workers. Depends*
whereabouts you are on that tree who you actually delegate to. Anybody above us – RNs, CNC could delegate to us and we can delegate to the carers and the AINs  EN3

While the clearly flawed interpretation of delegation by enrolled nurses was of concern, the understanding expressed by registered nurses was similarly incorrect. Even though one registered nurse described delegating activities to the enrolled nurse who had been assessed as being competent in those activities, delegation, as described by the Framework, was not well understood. Assignment of residents through the roster, or distribution of work, was seen by the registered nurse cohort as a form of delegation, similar to that understood by the enrolled nurse group:

*Just you are delegated to a particular area that’s all … the facility is divided into areas*  RN1

To further demonstrate this lack of understanding, one registered nurse described internal policies as preventing delegation; another demonstrated their lack of understanding of delegation with the following comment:

*Well, at the moment, our hierarchy, it’s just not allowing us to delegate because we’ve got EENs here predominantly. And they’re not allowed to do a whole lot of the work that they’re supposed to be employed to do, and we’re supposed to be doing it now. So what’s the point of even trying to delegate?*  RN6

Not only does this excerpt show a lack of understanding about delegation, it also suggests a sense of powerlessness in the registered nurse, whereas the intent of the Framework is to enable and support professional decision-making. The data also identifies that some registered nurses understand that delegation only occurs between registered nurses and enrolled nurses yet delegation to unlicensed carers was rarely described despite unlicensed carers comprising the largest proportion of the aged care workforce.

Although nurse managers see the registered nurse as the team leader and therefore responsible for delegation, the nurse manager participants were unable to articulate
delegation processes that reflected the Framework. One manager described it in the following manner:

*Are you talking about RN responsibility? Because we are delegating everything, everything out there aren’t we? So it’s about knowing if our staff are competent and being aware that you are delegating because you are accountable.* NM2

Nurse manager participants from Site B reported they had policies that clearly delineated delegation roles and nurse managers at both sites confirmed that resident care is allocated based on geographical criteria through pre-prepared rosters. This would suggest that decisions regarding delegation are directed by policy or geography rather than by professional guidelines. Although it can be reliably accepted that most enrolled nurses work under established delegation, the data indicates that it is the enrolled nurse who determines the context of the delegation and refers only to the registered nurse when they self-assess that a situation is beyond their scope of practice. The following excerpt from a nurse manager illustrates this:

*I think in aged care, particularly with trained nurses, you really only have one on. So delegation comes – say we’re the managers as the registered nurse, we might only have an EEN under us. So they work under our delegation, and they work on the floor and do their work, only if they need to step up and ask, they come and ask us, or whoever the RN happens to be. That’s how we run it in aged care.* NM4

This example illustrates that the manager’s comments reflect those of the registered nurse cohort that delegation occurs only between the registered and enrolled nurses. The data also strongly suggests that there is an expectation that enrolled nurses will delegate to unlicensed carers, although one manager clearly understood the scope of practice of the enrolled nurse in relation to delegation ‘*… which is really only RNs to ENs because they can’t delegate.*’ NM3

Observational data from two sites both contradict and confirm these findings. At one site, the observed enrolled nurse was working with a registered nurse. Even though the care tasks were largely distributed based on geographical criteria, a team approach to
care was adopted. Some tasks were shared, some were delegated to the enrolled nurse in both areas of responsibility, and others were undertaken by the registered nurse. Collaboration was evident throughout the day and was evidence that there was fairness in the distribution of workload. At the second site, the observed registered nurse was rostered to an area with a team of unlicensed carers. Care activities were delegated to the carers both verbally by the registered nurse and through written directives developed and recorded by the registered nurse in individual resident care plans. The registered nurse was seen to evaluate care outcomes for residents throughout the day.

The interpretation of delegation by nurses at all levels in this study does not reflect the meaning of delegation as described by the Framework. Instead of collaboration between nurses with residents’ needs at the core of decision-making, delegation was described as being hierarchical where the allocation of work was undertaken by nurse managers, separate from residents and the context of care. This process clearly removes the capacity to delegate from registered nurses who are better positioned to assess residents’ needs and evaluate outcomes of care. Where registered and enrolled nurses were in a position to be involved in the allocation of work, decisions were made based on perceived fair distribution of workload rather than a contemporaneous assessment of residents and their care needs. The following diagram demonstrates the link between the sub-concepts and the first concept ‘work allocation seen as delegation’:

**Diagram 1: Sub-concepts that contribute to Concept 1**

```
Powerlessness                    Perceptions of fairness
                                    
Work allocation seen as delegation
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**4.2.2 Concept 2: Permanence as a measure of competence**

This concept evolves from three sub-concepts, ‘established working relationships’, ‘competence measured by the ability to do a task’ and ‘expanded scope in one area indicates competence in other areas’. Competence is described in the Framework as
the combination of skills and knowledge, as well as attitudes and values, that enables a nurse to practise to an acceptable standard. Competence is integral to delegation, as an enrolled nurse and an unlicensed carer must be assessed as competent before being delegated or accepting a delegated activity. Competence may be determined through structured education and assessment or by observing practice and assessing the knowledge base in those activities.

All of the enrolled nurse participants believed that registered nurses largely relied on their self-assessment of competence. Competence however, is measured by their ability to complete an activity or task as all enrolled nurses reported they would not undertake an activity that was unfamiliar to them. The following excerpts illustrate this:

… they rely on you to go to them and if you’ve got something that you feel you know you can’t handle you need help with. EN1

I think they know that, particularly us, if we’re uncomfortable with something, or not confident with something, we will ask … they know that. EN4

Some enrolled nurse participants believed that the registered nurses’ confidence in their self-assessment of competence was a result of established working relationships:

I do most of my mornings with a particular RN with whom I have a great working relationship …EN2

And coming from years and years of experience and you know um the establishment you work for, oh yes, ‘we deem you to be competent to do this and competent to do that …’ EN2

In established working relationships when the enrolled nurse cohort worked with unlicensed carers and no registered nurse, knowledge of the skills of team members gained through working the same shifts in the same areas over a period of time was reported to make the allocation of work easier. Generally, as the team leader, the enrolled nurse described allocating new or temporary unlicensed carers to work alongside an experienced carer who was familiar with residents and the tasks to be done. The following data illustrates this:
Again, because we try to have one more experienced carer on each side, they can generally take the lead in seeing newer cases. EN4

You like to put a fairly new person with a more experienced (person) so they can learn from them. EN3

The data suggests that it is the experienced and known unlicensed carer who is demonstrating care, observing and assessing the competence of new unlicensed carers, rather than a registered nurse. This is measured against achieved standards of care accepted as competence through permanence in the workplace.

Competence with one expanded area of practice was assumed to assure competence in other areas of practice. This is clearly demonstrated by one enrolled nurse participant who expressed concern that, because some enrolled nurses had gained medication endorsement through formalised education and assessment, the registered nurses and nurse managers assumed that enrolled nurses were now competent in other areas of practice that were normally the registered nurses’ domain:

… ‘oh you’ve got your med [sic] endorsement, right you can do this and this’ and everything they try to lay on you everything that does belong to the area of the registered nurse you know? EN1

The data from the nurse manager cohort supported this assumption. One manager said when talking about a nurse who had been enrolled for a long time but had recently achieved medication endorsement:

… and she worked as an assistant nurse, she wasn’t given any roles outside … but as an EEN she’s brilliant … she’d actually been doing most of the care planning … NM4

In relation to competence, the registered nurse cohort was largely concerned with new or temporary staff who were assigned to their team. As with the enrolled nurses, registered nurses often equated competence to experience, particularly in relation to the competence of unlicensed carers. Whether competence was assessed was not evident in the data, as less experienced staff of all levels, were teamed with more
experienced staff who had been determined as being able to set a good example and are capable of ‘taking the lead’. The following comment by a registered nurse illustrates this:

*You try to work, the teams work in pairs which, so you try and work with someone who will lead, not follow, who will set a fine example.*

RN3

The fact that often unlicensed workers and registered nurses work the same shifts over long periods of time was also recognised as validating this determination. However one registered nurse reported that the scope of education of unlicensed carers was not always known to them which suggests some uncertainty by the registered staff regarding the competence of unlicensed carers they were working with.

Assessment of the competence of the enrolled nurse by the registered nurse only emerged from the data in the interviews in relation to temporary (agency) enrolled nurses. The approach to assessing competence that was used with agency or temporary enrolled nurses was not clear. One registered nurse participant suggested that assessment of competence was instinctive. However the ability of the enrolled nurse to manage time and undertake specific tasks determined the assessment of competence. This is demonstrated by the following excerpts from the data:

*We try to find out what their experience is, get to know them; you know who you can get to do something.* RN3

*... usually giving medications that they do is probably as much as they'll achieve in a day; and you say 'well you can just do that one'* RN4

A nurse manager participant also expressed concern regarding the competence of temporary staff recruited from a nursing agency and requested a profile that outlined the education and experience of each contracted person. The data indicated that like the other nurse groups, nurse managers saw permanence and established working relationships as optimal when assessing the competence of staff. Another nurse manager said:
I think one of the benefits of a place like this too is they tend to work the same place, the same shifts … and they just all sort of slot in. NM3

Although assessing the competence of enrolled nurses by registered nurses was raised infrequently through interview, observation of the enrolled nurse illustrated that assessment of competence did occur. In one observed incident, a resident required a wound drain to be removed, a procedure infrequently undertaken in an aged care facility. This activity was delegated to the enrolled nurse by the registered nurse who first of all asked if she had performed this activity before, and then ‘talked through’ the procedure with the enrolled nurse to ascertain the enrolled nurses’ knowledge, skill level and willingness to complete this task. As indicated previously, both nurses had worked together frequently for some years and indicated that knowing each other so well professionally made interactions between them almost seamless. In addition, during the change-over to the oncoming staff for the afternoon shift, the same registered nurse was observed to talk (prior to commencement of ‘handover’) with the oncoming registered nurse, who was temporary (agency) staff, to establish their experience and recency of practice at this particular site.

The data suggests that for this cohort of nurses, competence relates more to new or unfamiliar staff and the reported approach to assessing competence bears no resemblance to that described in the Framework, but rather focused on the ability of staff to complete tasks. Where staff had worked in the same area with the same colleagues for a period of time, nurses had more confidence with decisions about competence. Data emerged to indicate that the recent expansion of the scope of practice of enrolled nurses through medication endorsement has led to the assumption of competence in other expanded areas. The following diagram demonstrates the link between the sub-concepts and concept two ‘permanence as a measure of competence’:
4.2.3. Concept 3: ‘You don’t really supervise …’
Analysis of the data indicates that the activities associated with supervision are not well understood or consistently applied. Supervision is integral to delegation and refers to the clinically focused supervision that occurs between registered nurses and enrolled nurses or unlicensed carers. Supervision is described in the Framework as being direct, when the registered nurse is observing the activity of another or indirect when the registered nurse is accessible to staff undertaking the activity. The sub-concepts of ‘support versus supervision’ and ‘call me if you need me’ have formed this concept.

The enrolled nurses in this study did not report being directly supervised. However they all described feeling well supported by the registered nurses working with them and only had to ask for assistance from the registered nurse for it to be provided. Only one participant indicated that the registered nurse initiated contact through the shift. The data indicates that the indirect supervision provided generated feelings of being valued, as one enrolled nurse commented:

They’re not hanging over your shoulders, they give you a level of autonomy but if you need the help you’ve only got to ask; they’re all pretty good. EN3

Paradoxically the data also suggests that indirect supervision creates tension for the enrolled nurse. For example, one enrolled nurse participant expressed feelings of discomfort about approaching a registered nurse with concerns, as they saw the registered nurse as being very busy and themselves as intruding:
… you feel like you are a nuisance, yeah. Sometimes it’s probably because they are flat out themselves, but they are supposed to be here to support us. EN2

As with the enrolled nurses, registered nurses do not express or demonstrate an understanding of the link between delegation and supervision as set out in the Framework. While some registered nurse participants reported they communicate with the enrolled nurse through the shift, often at the meal break, there is an expectation that contact will be initiated by the enrolled nurse who determines when they need support from the registered nurse. The following data demonstrates this:

They are very good at coming to you to tell you things they notice through the shift. You don’t really supervise, but you are there all the time and know what is happening. RN1

We check with them through the shift; at the break or something. They will ask if they need assistance; we know them very well. But they look after their area. RN1

The expectation that new or agency enrolled nurses will initiate contact with the registered nurse is the same, except when that enrolled nurse is allocated to work in the same area as the registered nurse. One registered nurse commented:

That doesn’t happen very often; I suppose it’s the same, you expect them to ask for assistance if they need it. RN1

However, another registered nurse saw their role as being a supportive one when mentoring new enrolled nurses until they had the confidence to make their own decisions, rather than providing supervision. The supervision of unlicensed carers only received one small remark by this cohort of registered nurses and it is unclear whether direct or indirect supervision is provided to this group of workers:

We supervise a variety of quality of carers that come in. RN3

Nurse managers also have a mixed understanding of supervision as described in the Framework. The data suggests the concept of direct and indirect supervision is well
understood. However the requirement that clinical supervision is an activity that involves a registered nurse is misconstrued. This is demonstrated by concerns expressed by some managers from this cohort. Firstly, they were concerned about the type of supervision provided to enrolled nurses, especially when registered nurses were making resident care decisions remotely, as the following examples from the data show:

*It is a little bit of a concern when it becomes indirect with such a high level of high care residents.* NM4

*I pick up the errors, and go in and try and fix it, and put something in place straight away so that that doesn’t happen again.* NM5

Secondly, nurse managers described enrolled nurses as struggling to provide supervision to unlicensed carers. Supervision in this instance refers to the enrolled nurse’s role as team leader. This comment by a nurse manager demonstrates this:

*Supervise, our ENs? I think they still struggle, even in a supervisory role, even, I don’t know, and unfortunately I don’t think the care staff have the respect for an EEN that they have for an RN.* NM5

There is no evidence in the data to suggest that nurse managers provide clinically-focused supervision to registered nurses or enrolled nurses rather their supervision is managerial in terms of development of rosters and management of staffing mix. However nurse managers are accessible to nurses if they are required.

Data from observation of both the enrolled and registered nurse confirm that supervision of both the enrolled nurse and unlicensed care workers was largely indirect or absent. At both sites, the enrolled and registered nurses were observed to collaborate regarding resident care at regular intervals throughout the period of work. At Site A where the registered and enrolled nurses worked in separate areas this was observed to be the provision of collegial support rather than clinical supervision. However at Site B, where the registered and enrolled nurses worked as a team, it was seen to be indirect supervision. Direct supervision was only observed at each site when ‘as required’ narcotic analgesia was being administered to residents and the registered and enrolled nurse in both instances were involved in this activity.
When observing the registered nurse, it was noted that communication with unlicensed carers did occur from time to time throughout the period of work, but was mostly concentrated at the end of their work. Similarly, when observing the enrolled nurse, unlicensed carers were seen to communicate periodically throughout the day and mostly at the end of their shift. Their communication was with the registered nurse that was working in the same area on that day. No episode of direct supervision of unlicensed carers was observed.

The data from this cohort of nurses indicate that direct clinical supervision does not occur, but as registered nurses are readily available on site, indirect supervision is reported to occur. The data implies that enrolled nurses see their role as being autonomous and that support rather than supervision is provided when they identify the need. This is confirmed by both the registered nurses and nurse managers who expect the enrolled nurse to recognise when they need support and to ask for it when this occurs. The following diagram demonstrates the link between the two sub-concepts ‘support versus supervision’ and ‘call me if you need me’ and the third concept ‘You don’t really supervise’:

Diagram 3: Sub-concepts that contribute to Concept 3

4.2.4. Concept 4: Unrecognised potential for expansion to practice

The Framework provides principles which guide the advancement or expansion of the registered nurse scope of practice and advancement of the enrolled nurse scope of practice. Analysis of the data demonstrates that the understanding of these principles is not clear and that they are not frequently utilised. The sub-concepts that contributed to this concept are ‘perceived restrictions’, ‘real restrictions’ and ‘ageism within aged care’.
While all the enrolled nurse participants said they are happy to advance their scope of practice if provided with the appropriate education to do so, they believe that there are not many opportunities to receive the necessary education within aged care, and look to return to acute care or seek opportunities provided by acute care, suggesting a negative view of aged care nursing. The following example from the data demonstrates this:

*I just found … I was learning a lot more, a lot more wider [sic], there was more variety. In the hospital system you’ve got the wound care nurse that you can get more training from … but you don’t have that in the nursing home system.* EN4

Another enrolled nurse expressed the concern that educational opportunities are not made available to all staff, and topics offered tended to meet organisational needs rather than the needs (or wishes) of the enrolled nurses, restricting their potential to advance their scope of practice.

Some enrolled nurses in this cohort acknowledged that many nursing activities were outside their scope of practice and although uncertain, held the perception that the parameters of their scope were created by organisational policies and procedures rather than understanding the differences between their role and that of the registered nurse and the principles underpinning advancing practice. One enrolled nurse when talking about a particular procedure explained:

*I think that comes up in the policies and procedures of the organisation doesn’t it? I don’t know.* EN2

The data demonstrated that registered nurses are also unclear about the principles that guide advancement and expansion of scope of practice, both in relation to enrolled nurses and their own role. Registered nurses in this cohort, while not seeking to advance or expand their practice, agreed they would be supported by their colleagues and the organisation if faced with a new or unfamiliar situation or procedure: ‘…*they wouldn’t just plonk it down in your lap and say “this is new, deal with it.”*’ (MHR2), and ‘we’ve got really good educators here … we’ve got all sorts of education’ (MHR2). The reasons mentioned for not seeking to expand their scope of practice included being satisfied with their current practice, being unable to expand any more due to time constraints and not wishing to expand their practice as they were looking to retire. The
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following are examples of the comments made: ‘No, I’m quite happy with what I’m – I haven’t got time’ (RN1), ‘I can’t take on any more’ (RN6) and ‘Retirement is what we want’ (RN4)

Assisting enrolled nurses to advance their scope of practice was not seen by some registered nurses in this study as being part of their role. Rather, they saw this responsibility belonging to the organisation:

_We’ve got a workplace education officer … we can just pass them on to that one._ RN4

By contrast, another registered nurse expressed concern as they saw management not providing the same support and education to enrolled nurses as was provided to unlicensed carers:

_I feel really sorry for the ENs; they don’t get the training or recognition for their experience that the care workers do._ RN1

Yet another registered nurse expressed the view that enrolled nurses should expand their role by becoming registered nurses:

_You would encourage her to do her registration, become an RN. And that would be what I would do._ RN4

Organisational policies, regulations and the Framework were seen by registered nurses as real restrictions to their scope of practice as well as to that of the enrolled nurse. For example, at one site, registered nurses bemoaned the fact that they are no longer allowed to initiate ‘over the counter’ analgesia preparations for residents, due to changes to organisational policies. In other examples registered nurses believed enrolled nurses were restricted by legislation and organisational policies when they were unable to give an ‘as required’ medication without the required clinical assessment of the resident by a registered nurse, or to write a wound care plan without registered nurse oversight. The following excerpts demonstrate this:
And the hierarchy here have [sic] said they can’t give a PRN medication. Like … they’re not allowed to give it without an RN. RN6

But the policies here … won’t allow them to write a care plan for a skin tear. A skin tear. You can’t write a care plan for a skin tear without an RN doing it. RN6

Registered nurses expressed frustration at what they perceived to be restrictions to the enrolled nurse scope of practice. The following comments illustrate this:

And it takes away from the enrolled nurses …. There’s so much that they can’t do. I understand that there’s got to be rules and there’s got to be guidelines but there’s [sic] not RNs to work … RN3

And they’re not allowed to do a whole lot of the work that they’re supposed to be employed to do, and we’re supposed to be doing it now. RN6

And now the policy is, the EENs can’t read a care plan and review it. I have to do it. RN6

Just as the enrolled and registered nurses have a misunderstanding of the Framework’s principles relating to advancement and expansion of practice, the data demonstrate that nurse managers also misunderstand the principles. Paradoxically, while nurse managers expressed the belief that the role of the registered nurse is growing, they all agreed (and concurred with the registered nurses) that registered nurses were generally not interested in expanding their scope of practice. They asserted that some registered nurses move to aged care to complement their lifestyle by getting the type and frequency of work they want, while others practice in aged care to wind down before retiring. The data provides the following examples:

Especially when the great majority I don’t know, a great many RNs because it’s their pocket money – they are not working full time, they come to work and they do just want to do their time and then go home again NM2
I find personally the very few registered nurses that we’ve got onsite want to expand anything, they want to wind down. NM5

Yeah and retiring, going into aged care. NM4

These nurse managers also believed if registered nurses did wish to expand their scope of practice, they would not remain in aged care, demonstrating a negative view of the profession in aged care. This is demonstrated by these excerpts:

I think too with our aged care particularly that anybody who wants to extend their practice, or up skill, or get anywhere tends to leave aged care and go back into the acute. NM5

And I think a lot of those people who look to up skill, and extend their scope, and get further into it tend to go to those sorts of places rather than stay in aged care. That’s just the way it is. NM4

That the Framework, QNC and legislation have all served to restrict the scope of practice of the enrolled nurse, preventing them from stepping into the registered nurse role was expressed by nurse managers at one site. The following example illustrates this:

I feel they are disempowered by the QNC for not looking at expanding their scope of practice. I think it is something that desperately needs doing. Because an advanced practice EN, particularly in aged care, is practising the same as a registered nurse in a lot of places and, um, I think it is not recognised. Aged care is going that way, you know, in the world of aged care more enrolled nurses in the field rather than registered nurses and I just think they are behind the times and that they need to look at what these people are capable of doing and look at their experience knowledge and skills. NM1

… legislation hasn’t caught up with reality. NM2
By contrast, the managers at another site who had recently attended workshops that included information regarding the Framework, did not see restrictions to scope of practice for either the registered or enrolled nurse and believed that their organisation’s policies reflected the guidelines provided by the QNC and the requirements of the Aged Care Act.

It is evident from the data that there is unrecognised potential for expansion for all levels of nursing within residential aged care. Nurses in this cohort believe that their practice is restricted by legislation, and organisational policies, but do not recognise that delegation, supervision and the development of competence are within the realms of their practice and will provide opportunities for advancement of scope of practice. Instead, nurses in this cohort see that the avenues for advancement or expansion to their scope of practice are within the acute care sector. Diagram 4 illustrates how the sub-concepts of ‘perceived restrictions’, ‘real restrictions’ and ‘ageism within aged care’ are linked to the concept ‘unrecognised potential for expansion to practice’:

Diagram 4: Sub-concepts that contribute to Concept 4

4.2.5. Concept 5: Evolving roles and role confusion
The role of the registered nurse is different from that of the enrolled nurse and the unlicensed carer and the differences are defined by scope of practice, legal parameters and, to some extent, organisational policies. In recent years the context of aged care has changed, with increasing numbers of residents with greater acuity and more complex care needs. In addition, with decreasing numbers of registered nurses in the workforce, the roles of nurses have been changing as well. The expansion of the enrolled nurse role to include medication endorsement was designed to assist with the
declining registered nurse workforce and has significantly changed the role of both the registered and enrolled nurse. With this concept, three sub-concepts ‘tensions within roles’, ‘doing the same work’ and ‘completing the paperwork’ emerged from the data.

The data indicates there is an increased misunderstanding of each nurse’s role, which in turn, leads to tensions within the workplace. In a semi-structured interview at Site A, enrolled nurses stated they were doing the same work as the registered nurse; this was a catalyst for resentment as they said they were seen as a cheaper alternative to registered nurses, as the following excerpts illustrate:

… as far as aged care goes, we do, in my eyes, we do everything the RNs do now anyway. EN2

… for the amount of money they pay you they’re really getting good value. EN1

Why should we be doing exactly the same work and all we are getting is ‘Oh well, thank you very much’? EN1

Additionally, these enrolled nurses reported that some registered nurses believed their positions were at risk because enrolled nurses were assuming their role. The following statement from the data illustrates this:

… a lot of RNs feel their positions are in jeopardy because they think the ENs are gonna [sic] come in and take over their entire role. EN1

The enrolled nurses from Site A also claimed that some registered nurses displayed animosity towards them because resident assessment, care plan development and care plan review were not within the scope of the enrolled nurse. While these enrolled nurse participants acknowledged that registered nurses were required to write and review care plans, as well as complete assessments that they contributed to, these activities were seen to be documentation for funding rather than an essential part of the registered nurses’ role. As one enrolled nurse participant explained:
… but that’s not the main part of nursing, the thing it’s the main part of documentation … but um we are quite capable on the floor … of looking after the whole area. EN1

Despite understanding that the enrolled nurse role was different from their own, registered nurses believed that enrolled nurses have been employed to replace a diminishing registered nurse workforce and were therefore expected to undertake the same role. Prior to the expansion of the enrolled nurse’s scope to include medication endorsement, enrolled nurses frequently undertook the same tasks as unskilled workers and were often perceived to be equivalent to unlicensed carers. One registered nurse from Site B claimed:

Yes, but they’re doing the RNs’ jobs. They’re doing medications. They don’t work on the floor as AINs. They’re actually employed as RNs. RN3

However the registered nurses from Site B did recognise that enrolled nurses did not have the educational preparation to undertake the role of the registered nurse and acknowledged that their organisational policies required enrolled nurses to refer to the registered nurse in some circumstances:

If somebody falls over, if need be, she’ll call the RN … to assess if she thinks they need to go off to hospital. RN6

In another example from the data, the registered nurse described a wound care pathway that was written by an enrolled nurse that the registered nurses were not following because they knew that the directions provided in the pathway, were not appropriate for the resident:

They’re not allowed to do it, the paperwork. It was one that slipped through the cracks and it just shows the reasons why it shouldn’t. RN4

Some registered nurses struggled with their changing role, frequently referring to assessments as ‘paperwork’ without appreciating the cognitive aspect of their role inherent in undertaking assessments. In addition the registered nurses saw their
traditional tasks, such as medication administration, being taken over by enrolled nurses.

The nurse managers at one site believed that neither the enrolled nurse scope of practice nor the role of the registered nurse was well understood by the organisation. Just as the enrolled and registered nurses did, nurse managers believed enrolled nurses were employed to take the place and fulfil the role of registered nurses who were less available. Despite this, the nurse managers acknowledged that the educational preparation of enrolled nurses was not sufficient for them to step into the registered nurse role fully. They also believed that preparation for the role of the registered nurse in aged care has not focused on what they see as the managerial or team leader responsibilities of the registered nurse.

The role of the registered nurse, according to one nurse manager participant, had been poorly understood; tasks such as administering medications have been seen as activities that can be undertaken by others. However the cognitive functions associated with tasks such as medication administration and undertaken at the same time, such as assessing residents and supervising and observing staff, had not been recognised. The following extract from the nurse manager data illustrates this:

I see what they do, you know, a drug round is giving pills, and anyone can do it effectively at the end of the day, it's what they do while they're doing it that I think is – people often don't understand. And I think it is that assessment that they're doing, and they're overseeing … and they're assessing lots of things around them.

NM4

The role of the registered nurse is now frequently seen as ‘completing the paperwork’. One nurse manager described the aged care sector as utilising enrolled nurses as providers of care to residents and registered nurses for documentation and assessment:

… it's more and more using EENs out on the floor, and registered for supposed – probably can't say that – documentation and assessment. NM4
Frustration was expressed by one manager who believed that the focus on documentation requirements by registered nurses had a negative impact on clients and that assessment and care plan development was undertaken without the client being central to the process. This example from the data demonstrates this:

*I guess I find from my perspective that the scope of practice and the documentation requirements, fairly often doesn’t reflect what’s really going on, that’s the frustration for me that you have this wonderful care plan that’s been described by no one who’s actually on the floor and seeing all the little flummoxes [sic] that are occurring, looks good and whatever, but in actual fact that’s not what’s happening. So we’re not getting to the care of the patients. That’s the really frustrating part. You’re making things look good and comply, and not actually giving people care.* NM3

Nurse managers have seen their own role change and saw themselves doing less work in the clinical area and spending more time ensuring the income of the facility was maintained, as the following comment illustrates:

*… we’re number crunchers, we’re sort of budget managers, that sort of thing. The actual nursing side of our job as managers is really small.* NM4

Nurse managers, registered and enrolled nurses in this cohort, while acknowledging the roles (and scope of practice) of registered and enrolled nurses are different, express the belief that enrolled nurses are doing the same work as the registered nurse. However, the point of difference is identified by most participants as being the requirement of registered nurses to undertake assessments and care plan that are frequently referred to as ‘paperwork’ and are viewed as being separate from resident care. Additionally, nurse managers acknowledged that their roles as well as those of the registered and enrolled nurses had changed in recent years, yet there has been little preparation for the changing responsibilities. Diagram 5 demonstrates the link between the sub-concepts and the fifth concept ‘evolving roles and role confusion:'
4.2.6. Concept 6: Working outside of the scope of practice

No sub-concepts contributed to this final concept. That nurses, in particular enrolled nurses, might have been working outside their scope of practice was not recognised by registered nurses and some nurse managers, even though they saw enrolled nurses being employed as substitute registered nurses. At one site, the enrolled nurses, not the nurse managers, recognised that they worked outside their scope of practice at times and looked to management to address this issue. One enrolled nurse commented:

Yeah it probably opened our eyes to the things that we do work beyond our scope of practice – so I hope management sort of takes that on board. EN2

The nurse managers at another site recognised that enrolled nurses often work outside of their scope of practice and acknowledged that it is a problem. They reported that enrolled nurses work outside their scope of practice because it is seen to be quicker and easier for the enrolled nurse to make decisions, especially when the registered nurse is not at hand or on site. It is also recognised that enrolled nurses who are identified as being competent, will often work outside of their scope. However one participant saw the potential for the enrolled nurse who is not competent to also work outside of their scope of practice and the concern this would create, as the following excerpt identifies:

… they step outside their scope if they’re competent, and if they’re not competent they step outside of their scope because
The data from this cohort identifies that enrolled nurses are working outside their scope of practice and this is recognised by the enrolled nurses and nurse managers. While some nurse manager participants were concerned, it is evident that working outside of their scope is expected of enrolled nurses.

4.3 Conclusion:
The six concepts identified in this chapter have merged into three prevailing themes that are common to all groups of nurses in this study. The themes are ‘That’s not the main part of nursing’, ‘You don’t really supervise’ and ‘That is the reality’ and diagram 6 (page 60) illustrates the links between sub-concepts, concepts and themes. Discussion around these themes will occur in chapter 5.
Chapter 5: Discussion and Conclusions

The Framework clearly articulates the processes of assessment of competence, delegation and supervision by the registered nurse to the enrolled nurse and unlicensed carers and ensures that the resident is central to decision making. The evidence from this study demonstrates that the Framework is not clearly understood and is not applied to practice in the daily work of the nurse in residential aged care.

The previous chapter concluded by presenting six data-rich concepts that emerged from the analysis of data from focus groups, interviews, observations and documents. Three prevailing themes were formed from these concepts. In this chapter discussion of these three themes will be presented with reference to existing knowledge (Sections 5.1, 5.2, and 5.3). This will be followed by conclusions drawn from the study (Section 5.4) and finally, the limitations of the findings will be identified in section 5.5.

The three themes are:

1. ‘That’s how we run it in aged care’
2. ‘That’s not the main part of nursing’
3. That is the reality

5.1 Theme 1: ‘That’s how we run it in aged care’
Contributing concepts were:

- Work allocation viewed as delegation
- ‘You don’t really supervise’

Delegation and supervision are inextricably linked by the Framework.

Diagram 6: Concepts merging to form Theme 1

The Scope of Nursing Practice Decision-making Framework: A Picture of Practice in Aged Care
5.1.1 Work allocation viewed as delegation

Delegation occurs when a registered nurse (or midwife) confers the authority to perform an activity of care for a client to another person (ANMC 2010). Delegation has been identified in the literature as being a function that will become increasingly important in residential aged care as registered nurses will be more frequently required to supervise and manage others who will provide direct care to residents (Maben et al. 2007; Curtis & Nichol 2004).

Analysis of the data from this study indicated the prevailing perception of delegation by the participants was the management of workload through task allocation. The pre-prepared work roster was seen as the delegation of work, with both enrolled and registered nurses being allocated geographically to an area, sometimes working as a team, but more often in separate locations. Unlicensed carers were allocated work within geographically identified teams. The activities inherent in the allocation were not always articulated; allocated activities were assumed as being part of ‘established routine’ rather than established delegation.

While registered nurses in aged care are responsible for assessing and planning the care of residents, it may be argued that enrolled nurses in aged care always work under established delegation because of the perceived unchanging nature of resident needs in aged care. However, the literature provides evidence that, since the introduction of the Aged Care Act in 1997, the profile of the residential aged care client has changed to one whose needs are increasingly more complex, with shorter lengths of stay suggesting a changing context of care (Henderson & McMinn 2004; Cheek et al. 2003). Therefore, the understanding of delegation as expressed by the respondents is flawed as contemporaneous assessment of residents’ needs is not included as part of the process to establish that the context of care remains unchanged.

The data from this project clearly demonstrates that enrolled nurses are free to interpret the context of the delegation and will only refer to the registered nurse when they self-assess the need. Enrolled nurses in this cohort had to clarify their position in relation to scope of practice and refused to complete activities they believed were outside their scope, while the registered nurses expected enrolled nurses to initiate clarification rather than taking responsibility for the delegation process themselves. While this approach to care is accepted by registered nurses and is seen by nurse managers to be a norm within residential aged care it can create tensions in the...
workplace. On the one hand, enrolled nurses feel concern that they may be adding to the registered nurse’s already busy workload; on the other hand, registered nurses feel disempowered and unable to delegate to enrolled nurses as they see enrolled nurses usurping their role. This view would support the postulation by Fernandez et al. (2008) in their investigation into the views of registered nurses and nurse unit managers relating to the expanded role of the medication endorsed enrolled nurse, that some registered nurses believed their role would be eroded by enrolled nurses.

Another misunderstanding indicated by the data was that delegation is seen as being hierarchical, registered nurses to enrolled nurses, enrolled nurses to unlicensed carers whereas the Framework clearly places the responsibility for delegation with the registered nurse. This belief of the inevitability of enrolled nurses being team leaders who delegated to and supervised unlicensed carers was also expressed by participants in the report into the role and function of the enrolled nurse in Australia by Gibson and Heartfield (2003). Jones and Cheek (2003) also suggested that enrolled nurses were frequently placed in a leadership role that involved delegation to unlicensed carers. This perception remains almost a decade after these studies. However this study found that although enrolled nurses were rostered as team leaders and as such were required to allocate activities to unlicensed carers, they were seen by nurse managers to struggle with that leadership role. This may be because unlicensed carers have not accepted the changed role of the enrolled nurse who traditionally worked alongside them, undertaking similar tasks. With the expansion of the enrolled nurse scope of practice to include medication endorsement, the role of the enrolled nurse has changed from being the same as theirs to one of team leader, without the preparedness and support for this new responsibility. Despite the large proportion of unlicensed carers employed in residential aged care (Martin 2008; Jackson et al. 2003) the data from this study implied that delegation was often seen as an activity that only occurred between registered and enrolled nurses yet the Framework clearly states that delegation emanates from the registered nurse to enrolled nurses and unlicensed carers.

5.1.2 ‘You don’t really supervise’
The links between delegation and supervision were not well understood by all levels of nurse in this study. Supervision of both enrolled nurses and unlicensed carers was indirect and ad hoc. Registered nurses rarely initiated contact with the enrolled nurses unless they were working as a team and relied on the enrolled nurse to seek assistance if they identified a need. This was particularly evident if there was an
established professional relationship. This reflects earlier findings of Gibson and Heartfield (2003) that registered nurses applied differing interpretations of supervision in practice based on their familiarity with the enrolled nurse. Both registered and enrolled nurses allocated new unlicensed carers to work with more experienced unlicensed carers who had been identified by them as being ‘able to lead’ or being ‘able to set a good example’. This suggests that in this scenario, the responsibility of registered nurses to provide supervision has been abrogated.

The nurse managers in this cohort, although adopting the same approach to supervision as the registered nurses, had concerns that the level of supervision was insufficient for the increasing level of acuity of residents. However, rather than being instrumental in initiating change to the model of care, nurse managers sought to identify and correct issues as they arose rather than being more proactive. This reactive approach to management evident in this study supports the view that nurse managers are often poorly prepared and supported in their expanded and complex role (Paliadelis et al. 2009). Williams et al. (2009) assert that nurse leaders are required to make a paradigm shift from a focus on tasks and systems of control to a focus on building organisational culture that produces positive outcomes that are congruent with practice development.

5.2 Theme 2: ‘That’s not the main part of nursing’

Contributing concepts were:
- Evolving roles/role confusion
- Unrecognised potential for expansion

The Framework clearly positions the client as central to the registered nurse role with decision-making and the scope of practice utilises broad principles as the determinant of scope rather than a list of tasks (Fox-Young 2007; QNC 2005; ICN 2004).
5.2.1 Evolving roles/role confusion

While the overall number of nurses has decreased in recent years, the ratio of enrolled nurses to registered nurses has increased (Martin 2008). At the same time, the roles of both enrolled and registered nurses in aged care have been changing. While registered nurses have seen their role move from a primary, largely task focused position, into an amplified role that encompasses clinician, managerial and delegation activities, enrolled nurses have been able to expand their scope of practice to include medication administration (McEwan 2008).

Earlier studies by Gibson and Heartfield (2005) and Milson-Hawke and Higgins (2003) found that there was a lack of differentiation between the roles of registered and enrolled nurses with confusion on the part of some registered and enrolled nurses about the scope of practice of the enrolled nurse. The findings from this study resonate with the literature in that considerable confusion continues to exist among this sample regarding the scope of practice of the enrolled nurse and the perception that registered and enrolled nurses are doing the same work.

Traditionally, enrolled nurses provided assistance with daily living activities to residents, similar to the role of unlicensed carers (Gibson & Heartfield 2005). With the achievement of medication endorsement, enrolled nurses are seen to be increasingly allocated care of residents where previously registered nurses were rostered. While the enrolled nurses are said to be under the indirect supervision of a registered nurse who may be working in a different area of the RACF or accessible by telephone, this practice has led to the perception that enrolled nurses are doing the same work as registered nurses. The prediction by Courtney et al. (2004) that service providers or senior management might see enrolled nurses as cheap replacements for registered
nurses is reality in the eyes of some enrolled nurse participants who on the one hand claim that they are doing the ‘same work’ as registered nurses and are resentful this is not recognised by management. On the other hand, they acknowledge that their roles are different.

5.2.2 Unrecognised potential for expansion

Significantly, some enrolled nurses in this cohort saw the function of the registered nurse as ‘doing the paperwork’, giving rise to the belief by some enrolled nurses that their role of providing direct care to residents was more important than that of the registered nurse. The registered nurse role was seen to be administrative and somehow disassociated from the resident. Registered nurses in this study also refer to their responsibilities of assessment of residents and development of plans of care as ‘paperwork’. Like the enrolled nurses, they recognised the scopes of practice of both roles were different, but expressed frustration that although enrolled nurses have replaced them on the work roster, they are unable to complete all of the activities of the registered nurse. Consequently, registered nurses felt that when they were allocated to a shift, they had to complete their own tasks, as well as those beyond the scope of the enrolled nurse but inherent in the enrolled nurses’ work allocation and commonly referred to as ‘the paperwork’. This clearly demonstrates that registered nurses are not only confused about the difference between their role and that of the enrolled nurse; they are also unclear about their own changing scope of practice.

The view that enrolled nurses provide care to residents while registered nurses complete the ‘paperwork’ and that assessment and care plan development are disconnected from the resident was also held by some nurse managers. This reflects the strong link that was forged between funding and documentation of resident care needs that was introduced as part of the Aged Care Act 1997 and was in place until 2008. Registered nurses were responsible for completing (in many cases excessive) documentation that was determined by management as being necessary to maintain funding (Jones et al. 2002). While the new funding instrument (ACFI) has been introduced in part to reduce the excessive documentation, the disassociation between ‘paperwork’ and residents continues.

Even though nurse managers at the different sites had different perspectives about the roles of enrolled and registered nurses, they continued to prepare work rosters that did not reflect the differences between the roles of the two levels of nurses. Some nurse
managers realised and were concerned that the role of the registered nurse was not clearly understood and that when a registered nurse was undertaking a visible task such as medication administration, they were also carrying out other intellectual activities such as assessing residents and supervising staff. However there was no evidence that this understanding had influenced a changed approach to staffing models that embraced the differences between the nurses’ roles and a consequent improvement in care delivery. By contrast, other nurse managers did not differentiate between the roles of enrolled and registered nurses at all and saw legislation and the Framework as being restrictive.

Registered nurses were unclear about the principles that guide advancement and expansion of the scope of practice and there was little desire for them to expand their own scope or to assist the enrolled nurse to advance theirs. Both enrolled nurses and nurse managers believed that expansion of the enrolled and registered nurses’ scope of practice was not possible in residential aged care, despite some authors asserting that registered nurses in residential aged care had acquired a broader range of skills and clinical expertise (Hunter et al. 2007; Leppa 2004; Jeong & Keatinge 2004). This negative belief about aged care nursing practice reflects the findings reported by Venturato et al. (2007). In their qualitative exploration of the impact of the political reform in residential aged care, the authors assert that registered nurses working in this sector have recognised that their practice is not highly valued by others and as a result some have internalised these negative professional beliefs. Working without collegial support and in relative professional isolation as reported by Robinson et al. (2007) and Jackson et al. (2003) may also contribute to this negative perception.

All levels of nurse in this study believed that organisational policies restricted the scope of practice of registered and enrolled nurses. However the data indicated that the lack of understanding of the role of the enrolled nurse by registered nurses and nurse managers in this sample resulted in the perception that the enrolled nurse scope of practice was particularly restricted in that they were unable to fulfil roles of the registered nurse.

5.3 Theme 3: That is the reality

Contribution concepts were:

- Permanence as a measure of competence
- Working outside the scope of practice
Competence is described as the combination of knowledge, skills, attitudes, values and abilities that underpin performance and is one of the factors that influence an individual's scope of practice (Fox-Young 2007).

**Diagram 8: Concepts merging to form Theme 3**

Permanence as a measure of competence

Working outside the scope of practice

That is the reality

5.3.1 Permanence as a measure of competence

The process of assessment of competence of both enrolled nurses and unlicensed carers in this study was vague and largely measured by the ability to complete certain tasks within a given timeframe rather than ascertaining the skill and knowledge inherent in the performance of tasks. Registered nurses relied on the organisation to assess the competence of unlicensed carers and some were unaware of the level of education provided or the standard of competence achieved. This reliance on the organisation may be misplaced given that in a review of the residential aged care workforce it was identified that 30% of unlicensed carers have no formal aged care qualifications (Martin 2008). Nurses at all levels in this study expected enrolled nurses to assess their own competence in any situation and to report this to the registered nurse; established working relationships added confidence to this process.

While assessment of competence (as an integral step in delegation) was infrequently reported, great value was placed on familiarity and the fact that many staff at all levels had worked together for a number of years. Years of service were interpreted as experience and experience was equated to competence. Pearson et al. (2002) would argue that years of experience are only one indicator of competence and Arbon (2004) asserts that using a linear approach to describe experience, may result in the individuality of experience not being appreciated. Arbon (2004) also asserts that working in a familiar context and performing regular tasks, may not result in the development of expertise. The reported practice by all levels of nurse of ‘pairing’ new
staff with experienced staff has the potential to perpetuate practices that do not reflect the changing context of residential aged care.

Enrolled nurses in recent years have seen their scope expand to include medication administration; this has been achieved through formalised education programs and their competence with this activity was formally assessed. However, this achievement has led to the assumption that enrolled nurses are now competent in other areas of practice particularly as a team leader and are often placed in this position without educational preparation. Jones and Cheek (2003) found that, even though enrolled nurses were leading teams of unlicensed carers in the residential aged care setting, both enrolled and registered nurses identified the need to develop leadership skills, suggesting lack of preparation for the leadership role. In addition, if registered nurses are not supported to expand their role with the changing context of aged care, role confusion between registered and enrolled nurses will prevail, and the registered nurse role will remain static and irrelevant.

Nurse managers and registered nurses associated assessment of competence more frequently with temporary or agency staff. This may be related to the commonly held perception that temporary staff are less skilful than permanent staff (Aiken et al. 2007). While at one site a profile outlining staff education and experience was requested from the host agency, this was not reported from the second site where the ability to undertake a set number of activities within a given time frame within a shift was one measure of competence, otherwise it was expected that the temporary staff self-report their competence. Aiken et al. (2007) refutes the view that temporary staff are less skilled and suggests that greater emphasis should be placed on providing a comprehensive orientation to the service.

5.3.2. Working outside the scope of practice
Analysis of the data indicates that registered nurses in this study and nurse managers from one site, did not recognise that enrolled nurses frequently worked outside their scope of practice, despite believing that enrolled nurses are being used to replace registered nurses. However, knowingly or otherwise, all enrolled nurses were expected to work outside their scope, particularly when the registered nurse was elsewhere in the facility or off site and only available by telephone. Those who were judged to be ‘competent’ were encouraged to make their own decisions and those who were not
identified in this way were not discouraged, as enrolled nurses making their own decisions was seen to be expedient.

This expectation that enrolled nurses will accept responsibility that may be beyond their scope of practice reflects the findings of Gibson and Heartfield (2005) in their exploration of the development of the role and educational preparation of enrolled nurses. In this study enrolled nurses reported being given too much responsibility and that in the aged care setting, management expected too much of the enrolled nurse (Gibson & Heartfield 2005). Blay and Donoghue (2007) reported in their exploration of skill extension of enrolled nurses that enrolled nurses not only worked outside their scope of practice, but were willing to undertake these activities. Enrolled nurses in this study, while acknowledging that they believed they worked beyond their scope of practice, also accepted this position.

5.4 Conclusions and recommendations
The literature identifies that change in today’s health environment is constant, rapid and most often influenced by external factors (Shaw 2007; Shanley 2007). Residential aged care, as part of the health care environment, is no exception and changes in this sector have been constant and significant since the commencement of the Aged Care Reforms in the mid-1980s. Simultaneously, the nursing profession has also been changing.

For change to be effective, even though driven downwards from senior management, requires leaders to emerge from all levels of the organisation to embrace and commit to the change management process (Shanley 2007). Registered nurses in the aged care sector who perceive that change has been imposed upon them without their involvement in the change process may not be committed to change and may try to maintain the status quo with the risk that their role will remain static and ultimately become redundant within the sector. There is clear evidence in this study that their role has changed little for over a decade, despite the significant changes politically and in client acuity, suggesting that there has been little leadership internally in this time. One recommendation from this study is that aged care providers should value the role of the nurse in aged care and should look for opportunities to provide education and support for the development of leadership skills for both existing and future nurses in this practice area.
The Framework exists to assist the nurse in decision-making about scope of practice while keeping the needs of clients as the central focus, to differentiate between the roles of health care workers and to promote collaboration and teamwork (Fox-Young 2010; QNC 2005). In this study, a significant finding was that there was a lack of understanding of the Framework and as a consequence, an inability to apply its principles in the workplace. Indeed, correspondents were either unable to articulate their understanding of the Framework and how they applied it to their daily practice or described it as a set of guidelines or a list of activities (particularly for enrolled nurses) that defined their scope of practice.

Aged care providers need to recognise that the nurse’s role is pivotal to the provision of a quality service and organisational improvement outcomes. Organisations should therefore provide education and support for nurses to enable them to expand and embrace their changing roles and to explore and implement new models of care that reflect the changed context of residential care and the changing aged care workforce. Nurses may then feel empowered to play a more active role in determining their scope of practice and related decision-making processes, thereby transforming finite resources into value and quality for all stakeholders.

Consideration also needs to be given by organisations to establish means to ensure that information about the differing scopes of practice is provided to all levels of health care worker, to improve the limited understanding that currently exists. This may encourage professional decision-making that has the client as the focus, rather than the organisation’s operational goals. Finally, this paper may serve to inform a future review of the national Decision-making Framework (DMF), particularly as it is applied in the aged care sector.

5.5 Limitations
This study involved 15 nurses at two RACF in south east Queensland. While the size of the sample may not allow the findings to be generalisable for the greater population of nurses working in the aged care sector, it reflects the application of the Framework for these participants. However a larger study may provide further insight into the adoption of the Framework into the daily practice of nurses working in residential aged care.

A larger study may also seek to identify differences in the application of the Framework by nurses in the aged care sector based on size of RACF, their
geographical locations (rural or urban) or the organisational focus (‘for profit’ or ‘not for profit’). Future research may also explore clinical governance and the application of the Framework in the community sector, as the numbers of programs to provide more complex levels of care for the frail aged in their own homes are implemented.
The Scope of Nursing Practice Decision-making Framework: A Picture of Practice in Aged Care

Reference List


Appendix A

Research Project Information Sheet

We are inviting you as a Registered Nurse, Nurse Manager, Midwife or Enrolled Nurse to participate in a research project aimed to evaluate the relevance of the Scope of Nursing Practice Decision Making Framework to daily nursing practice.

Your participation is voluntary and a decision to assist or not participate will not have any adverse effects, penalty or loss of entitled benefits. If you do consent to participate, you may discontinue participation at any time, again without any penalty. No explanation or reason for withdrawal is necessary.

Participation

There are two levels of possible participation. You may want to participate in one aspect or both, but you should not feel obligated to participate in both aspects.

Focus Groups

You are invited to join in a group interview with your colleagues (there will be separate groups for RNs, ENs, NM and midwives). The focus group aims to gather a wide variety of opinions and experiences in relation to the Framework, so diversity of opinion is welcome.

Before the interview starts, you will be asked to sign a consent form to participate, but you may change your mind at any time. Any opinion expressed during the interview is confidential to the group present.

The focus group will be tape-recorded but your names and place of employment will not be used in the analysis of the discussions. We invite you to read the analysis of your focus group if you wish and you may withdraw any statements that may not represent you fairly.

Each focus group should take no longer than 60 minutes in duration.

Because all names and identifying information will be removed from the transcripts of the focus groups, it is unlikely that any information used can be directly attributed to any individual.

Observation Study

We are also seeking the assistance of one Registered Nurse/Enrolled Nurse to participate in an observation study for one shift. The researcher (a registered nurse) will accompany the volunteer during 4 periods of a working day. However they will not interfere with any aspect of client care or distract the volunteer through conversations during the shift. The purpose of this activity is to observe how the Scope of Nursing Practice Decision Making Framework informs practice during a typical working day.

The volunteer will be observed/ accompanied for the following periods of one working day:

- The first 60 minutes of a shift
- At hour 3 of the shift for 30 minutes
• At hour 5.30 of the shift for 30 minutes
• The last hour for 60 minutes

**Potential adverse effects to participants**
There are no anticipated adverse effects to any participant and all opinions and actions will be treated with respect by the researchers. During the observation study, the research assistant will endeavour to be as discreet as possible at all times to reduce any feeling of discomfort to the person being observed.

Although your employer has agreed to allow us to recruit staff from your facility to participate, they will not have access to specific data that provided by their staff. However they will be offered a final report of the study with data from multiple sites.

**Potential benefits of participating**
While participants will gain no direct benefit from their participation, the project as a whole is aimed at ensuring that the Scope of Nursing Practice Decision Making Framework assists you to be able to practice to the full potential of your license.

**Confidentiality**
All data that may identify individuals will be removed from transcripts and codes will be applied to represent participants. Your signed consent forms will be stored separately from the research data and any record of contact details of those who have asked to read draft analyses will be secured in a locked filing cabinet accessible only to the principle investigator.

Within focus groups, issues that are discussed within the group are confidential to that group.

**Use of data**
All information and data collected during this research study will only be used for this project. Should there be any request for the data to be used for any other purpose, your written permission will first be sought and if not given, the data will not be released.

Should any participant withdraw their consent during the conduct of the study, all of their data will be removed from the project.

The data from this project will be developed into an article for publication in the *Forum*, distributed to you by the Queensland Nursing Council. Other forums will also be sought, such as international and national journals and conferences.

**Getting personal feedback**
As we mentioned earlier, you may read the draft analysis of your focus group to ensure that your opinions have been fairly represented. In addition, we are happy to provide you with a synopsis of the findings at the completion of the study.
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Both Dr Mosel Williams and Dr Barnes are experienced with the nature and processes of this project through their own research and supervising research of higher degree students.

Should you have any concern about this project, please feel free to contact Dr Mosel Williams by email or on the number provided above.

You should take time to consider whether you wish to participate in this study. If after having time to think about it you decide you would like to participate, please contact the Chief Investigator at the telephone number/e-mail address given above. Your response by (insert date) would be appreciated as it is planned to commence the study shortly.

Sponsors
This project is funded by the Queensland Nursing Council but is conducted independently by the researchers listed above.

Appreciation
Thank you for considering this request. The researchers and the University of the Sunshine Coast appreciate that you have considered contributing to this project.
Appendix B

SONP Decision Making Framework: Potential cues for Focus Groups

SONP impact
- Understanding of the intent of the document
- Availability of information
- Perceptions of utility of the DMC
- Use of supporting explanatory documents on www
- Workplace support to use it

Using it to guide delegation to others (RN, NM)
- Individual understanding of delegation
  - Delegation versus Allocation/Assignment
- Examples of delegation in daily practice
  - Who does it
  - Based on what information
  - To whom
- Models of care (primary versus team) and delegation practices
- Responsibilities associated with delegation
- Workplace champions/resource persons

Using it to inform individual scope of practice (All)

RN, NM
- How the DMF influences individual practice
- Inexperienced staff or pool/casual staff use of DMF
- Being delegated new/different activities
- Support from more experienced staff with new/challenging activities

NM
- How the DMF influences individual practice
- Inexperienced staff or pool/casual staff use of DMF
- Being delegated new/different activities as NM
- Support from more experienced staff with new/challenging activities
- Impact of models of care on use of DMF
- Impact of skill mix on SONP, DMF & delegation

EN
- How the DMF influences individual practice
- Inexperienced EN or pool/casual EN use of DMF
- Being delegated new/different activities
- Not being delegated/allocated activities
- Support and supervision from RNs
- Workplace champions/resource persons related to SONP & DMF

**Using it to expand your practice (All)**

- Areas of your practice that you may wish to extend or expand
- Relationship of this to the SONP DMF
- Conditions that influence you adopting new activities and practices
- Conditions that influence you encouraging another RN, EN or midwife to adopt new skills or activities
- Workplace champion/resource person encouraging staff to extend practices for:
  - benefit of patients
  - relieve workplace pressure
  - professional advancement of the nurse
Appendix C

Consent to Participate in Research

The Scope of Practice Decision Making Framework: A picture of practice
The purpose of this study is to evaluate the relevance of the Scope of Practice Decision Making Framework to daily nursing practice.

Consent
I ……………………………………………………… have read and understood the Research Project Information Sheet for the study The Scope of Practice Decision Making Framework: A picture of practice. I agree to be a participant in the research study in the following capacity (delete which aspect you do not agree to participate in) and give my consent freely to:

- Focus group interview

I understand that:

- My participation in this research project is entirely voluntary and if I choose not to participate I will incur no penalty or loss of benefits that I might otherwise be entitled to
- I may withdraw from participation at any time without explanation
- I may request a copy of my research data
- All personal information given by me will be kept in strict confidence
- Any information or opinions that can identify me as an individual will be de-identified and no data included in any report, presentation or publication related to this study will be attributable to me.

I understand the contents of the Research Project Information Sheet for the research study The Scope of Practice Decision Making Framework: A picture of practice and this Consent to Participate in Research form.
I agree to participate in The Scope of Practice Decision Making Framework: A picture of practice research project and give my consent freely.
I understand that the study will be carried out as described on the Research Project Information Sheet, a copy of which I have kept. I realise that whether or not I decide to participate is my decision and will not affect me in any way. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. Any questions I had about this research project and my participation in it have been answered to my satisfaction.
The Scope of Practice Decision Making Framework: A picture of practice

I request that a copy of the draft analysis of the focus group in which I participated be sent to me prior to final analysis.

Yes No

Please send me a synopsis of the findings of the study upon its completion.

Yes No

Contact name: ________________________________
Email: ________________________________
Or
Mailing address: ________________________________
_________________________________________________________________
_________________________________________________________________
Appendix D

Consent to Participate in Research

The Scope of Practice Decision Making Framework: A picture of practice
This purpose of this study is to evaluate the relevance of the Scope of Practice
Decision Making Framework to daily nursing practice.

Consent
I …………………………… on behalf of ……………………………. Hospital/Organisation
have read and understood the Research Project Information Sheet for the study The
Scope of Practice Decision Making Framework: A picture of practice. We agree to
participate in the research study through provision of access to organisational
documents related to the Scope of Practice and give consent freely.

I understand that:

- Participation in this research project is entirely voluntary and if we choose not to
  participate we will incur no penalty or loss of benefits that might otherwise be
  entitled
- I may withdraw from participation at any time without explanation
- I may request a copy of my research data
- All corporate information given will be kept in strict confidence
- Any information or opinions that can identify the corporation or organisation will
  be de-identified and no data included in any report, presentation or publication
  related to this study will be attributable to our organisation.

I understand the contents of the Research Project Information Sheet for the research
study The Scope of Practice Decision Making Framework: A picture of practice
and this Consent to Participate in Research form.

I agree to participate in The Scope of Practice Decision Making Framework: A
picture of practice research project and give my consent freely. I understand that the
study will be carried out as described on the Research Project Information Sheet, a
copy of which I have kept. I realise that whether or not we decide to participate is my
decision and will not affect the organisation in any way. I also realise that we can
withdraw from the study at any time and do not have to give any reason for
withdrawing. Any questions I/we had about this research project and my participation in it have been answered to our satisfaction.

Signatures

__________________________________ __________________
Organisation representative Date

_________________________________________ ___________________
Investigator/Researcher/s Date