
Theses

2018

The identification of the role and competencies of the graduate nurse in recognising and responding to the deteriorating patient in an acute ward environment: A mixed methods study

Steven Hardman

Follow this and additional works at: <https://researchonline.nd.edu.au/theses>



Part of the [Nursing Commons](#)

COMMONWEALTH OF AUSTRALIA
Copyright Regulations 1969

WARNING

The material in this communication may be subject to copyright under the Act. Any further copying or communication of this material by you may be the subject of copyright protection under the Act.

Do not remove this notice.

Chapter 8

Qualitative Findings

Introduction

The previous chapter presented a discussion of the processes used in recruitment, data collection and analysis for phase three of the study. This chapter provides an explicit description of the focus group findings. The emergent themes and subthemes will be presented along with examples of narrative from the GRNs to support the themes.

Theme 1: Defining the Graduate Registered Nurse Role

The main purpose of the focus group interviews was to gather further information relating to the GRNs role in managing the deteriorating patient. The first main theme that emerged from the data was “Defining the GRN Role”. During the three focus group interviews, it was apparent all of the participants agreed that part of their clinical role involved dealing in some way with the acutely ill deteriorating patient. A participant summed this by stating ”looking after a deteriorating patient is part of our role right now on the wards” (FGP19). This theme was further divided into five sub-themes. These sub-themes will now be discussed.

Theme 1: Sub-theme 1 Defining Deterioration.

During the focus groups interviews, it was apparent that the participants had numerous ways of defining clinical deterioration in the ward patient. One participant stated deterioration was a “change in the patient that causes you concern or kind of makes

you look closer” (FGP05). For many participants, the focus of defining deterioration was placed on changing physiology and abnormality of vital sign observations of the patient. The majority of participants suggested that “altered obs” or vital signs could indicate deterioration in the patient’s condition and were useful in defining deterioration. A number of participants discussed the patients “baseline observations” again referring to physiology. Others suggested deterioration was, “an alteration in the patient’s regular limits” (FGP01) and “was the patients’ health status getting worse, they are below their normal baseline” (FGP20). One participant stated “I think you have got your parameters that you stick to and if they start falling out of those, like they are trending their blood pressure down then they are getting worse” (FGP09).

Some participants focused on the fact that deterioration may be common in people with pre-existing disease processes. A participant stated “they have got a lot of comorbidities anyway so they aren’t necessarily in the best of health to begin with” (FGP13). Other participants were more specific in their definition. One suggested deterioration “occurs when the patient becomes haemodynamically unstable” (FGP07). Many GRN participants specified that deterioration could be defined by abnormal changes in vital sign parameters such as conscious level, altered urine output, high respiratory rate, high pulse rate and dropping blood pressure. An increasing score produced by the track and trigger “early warning score” (EWS) vital sign charts, was identified as a way of defining patient deterioration. One participant stated

You know, looking at it objectively, you’ve got the EWS obs chart out in front of you, you can notice when someone’s deteriorating, there’s a big trend, their respiratory rate might be going up and their BP’s starting to drop and the pulse is up and you’re like, it’s a three now (EWS score) and it got to a five (EWS score)... there’s a problem (FGP15).

Other concepts were also used to define deterioration by the GRN participants. These concepts included specific conditions such as “bleeding” or “low blood sugar”. Some participants equated deterioration with escalating levels of intervention and

dependence of the patient on care provision. One participant stated deteriorating patients are “highly dependent....lots of things going on” (FGP15).

Theme 1: Sub-theme 2 Detecting and Alerting.

The next sub-theme that became apparent was the GRN role in detecting patient deterioration and alerting others. For many of the participants, detecting and alerting others was seen to be the key role of the GRN. A participant stated the GRNs role in deterioration was “strict observation and obviously you let your CN (senior nurse) or your buddy (co-worker) or whoever you need, know what’s going on and if they (the patient) are getting worse or they are getting better” (FGP08).

Other participants also discussed how the GRNs main role was to alert senior nursing staff and medical staff to a deteriorating patient. It was apparent that senior nursing staff and medical staff also expected the participants to raise the alarm if a patient was deteriorating and call for help. The participants talked about being “a voice” (FGP01) or “an advocate” (FGP03) for the patient with an emphasis on “making things happen” (FGP08) by alerting others. Most of the participants felt this was an extremely important role. This sentiment was summed up by FGP09 who stated their role was “to be the voice of your patient, so if they are becoming worse you’re monitoring them very carefully and you are feeding back to the coordinator (senior nurse) and possibly the doctor to help get things done”.

Detection of deterioration was viewed as challenging at times for some participants. There was concern that rapid changes in physiology may be missed or slow decline not recognised. FGP05 commented that it “can be more difficult if the patient can’t tell you...’oh I don’t feel well’ for example”. Another participants stated it can be difficult to detect “if it's a super rapid deterioration, we might not pick it up in time or also if it's not super rapid, if it's just slow and the obs have gotten a little bit altered, but not really too much ” (FGP04). Others mentioned “if you know your patient well enough then you can probably pick up subtle changes. If it’s a brand new patient and you don’t know what normal for them you might miss it.” (FGP11).

The majority of participants felt confident in their assessment and monitoring skills. Issues around their developing knowledge and experience, however, were raised which gave them less confidence when trying to detect subtle changes. One participant stated “I’m ok to assess, to a degree, but I think I still want someone else to maybe assess again” (FGP06).

A lack of confidence seemed to stem from a perception that GRNs might miss an important subtle change, one participant commented “I feel a little less confident in interpreting my assessment, just because you don't want to be the one to miss something else huge” (FGP06). There was acknowledgement amongst the participants that confidence and ability to detect deterioration would improve with experience. One stated;

I think a lot of the time that knowledge comes with time and experience and as a grad you don't necessarily have all that experience but over time you will build on it and you'd learn how to recognise deterioration a lot better and how to act on it and what you need to do to act on it (FGP20).

In the meantime, participants appeared to rely on the support and opinions of the senior nursing staff, and particularly the judgement of the shift coordinator with regards to recognising deterioration in more challenging patients. This was summed up by a participant who stated “I feel like you're second guessing yourself. So you're always asking another senior or someone else you're working alongside if they can just come and check this patient, because I'm concerned” (FGP17).

Theme 1: Sub-theme 3 Knowing the Patient.

A recurrent sub-theme impacting the role of the GRN was “Knowing the Patient”. This sub-theme had a number of threads and was seen as a particularly important factor in relation to detecting deterioration and alerting senior staff. The participants felt it was a significant advantage to “know the patient”, having previously cared for the patient in the ward area. This prior knowledge of the patient gave the participants a better understanding of the patients' disease processes, comorbidities and appeared to aid the participants with overall situational awareness.

One of the other key aspects of “knowing the patient” was linked to recognition of change, as it helped GRNs to recognise subtle changes in the patient’s condition and potentially pick up earlier signs of deterioration. One participant commented;

You might not have had them before, so therefore you don’t get what their baseline was, what they were like yesterday or what they were like this morning versus now, to pick up on the subtle changes (FGP17).

A further participant stated;

If you know the patients well enough you can probably pick up the subtle changes, if you looked after them all day but if they’re brand new to you then you may not be able to pick those changes up (FGP09).

Knowing the patient provided participants with more confidence in their assessment of the patient and made them more willing to seek help and support. Many participants raised concerns about contacting senior nurses and medical staff in particular, FGP15 said “I’m a bit of a wuss, I’m scared of doctors.....if I know I have to call a doctor, I get pretty nervous.....what if he asks me something about the patient and I don’t know the answer”. Some participants commented that “knowing the patient” and having the correct information was important as “you’ve got to know what is going on so you don’t look like an idiot in front of others” (FGP04).

Knowing the patient and having a better understanding of the patient’s condition meant that the GRN felt they were more informed and could then prepare and present a more logical justification to explain their call for help. By “knowing the patient” the participants felt less likely to be dismissed by senior nurses or medical staff. They felt that having knowledge of the patient empowered the participants and that their concerns would be taken more seriously.

Another important aspect of “knowing the patient” was the use of intuition. The participants seemed to use intuition or “gut feeling” when making decisions about the patient’s condition. One participant stated;

I don't know, I just get this gut feeling,...I just have this feeling that it's going to actually become worse. Then I go to my co-ordinator and I say, look, I'm just not happy...even though, say, the observations are fine, I just don't like the look of them (the patient) (FGP04).

Other participants also agreed that they relied on intuition, FGP17 commented that “you’ve got a gut feel that that’s stuff not quite tickety boo, so you get someone else who has a lot more experience to go yay or nay”.

This form of tacit “knowing” was common and was seen as an important aspect of assessment. One of the participants stated;

I feel just like it’s always good to listen to like your spider sense.....because I’ve had things where I’ve just been showering a patient and I’ve been like, I have to take his obs now! No reason but I’m probably like, something’s telling me I’ve got to take his obs (FGP13).

As discussed previously, participants felt that intuition alone was not enough to present a detailed account and convince others there was a problem. Therefore intuition often directed the participants focus and made them gather more subjective data and “know more about the patient”. Generally the participants felt they needed support and validation from changes in objective assessment or from colleagues before they would call for help.

Theme 1: Sub-theme 4 Providing Intervention.

The next sub-theme that emerged from the focus group interviews was “Providing intervention” to the deteriorating patient. Most participants agreed that limited intervention, prior to medical or senior staff review, would be initiated for some

patients. One stated “you’ve got to be putting in an intervention before they get to a point where they die” (FGP13). These interventions included positioning of the patient, administering higher concentrations of oxygen and in some case providing jaw support and suction to manage a patient’s airway. One participant commented that “we do basic stuff but then I run it past the coordinator” (FGP07).

In general there was a reluctance by participants to provide initial interventions to the deteriorating patient before seeking senior support and permission. A participant stated;

I'm going to go ahead and say no, I wouldn't. I would always just say to my co-ordinator, are you okay for me to do that or what would you like me to do? I would never try and sort of go ahead and do anything (FGP04).

Others agreed with this sentiment, “I wouldn't do it without asking first” (FGP03) and “well, you get authority first” (FGP06)

There was a high level of unease about providing some interventions as participants felt they would “get into trouble” (FGP04) and be working “outside their scope of practice” (FGP08). One participant commented that “scope of practice....it’s hammered into you! You’re petrified that, oh my God, I’m going to lose my registration if I do the wrong thing” (FGP17).

Many participants questioned whether legally they would be supported by the hospital and their professional body if they provided interventions that generally needed some form of “medical approval”. Often the participants commented about seeking permission and the need to have permission granted before providing intervention and support. It was only when “permission” was granted that participants felt enabled and empowered to provide intervention without fear they would “getting into trouble” (FGP04) with senior nurses and medical staff.

The participants also suggested that the provision of initial interventions was limited by the perception of a lack of practice, or not being “skilled” in certain interventions. The participants commented that they may not have had recent training

or updates in some of the skills required and therefore they felt reluctant to provide intervention for fear of “doing it wrong” and again “getting into trouble”. One participant stated;

The one thing that scares me as well is, they teach us about the airway and stuff but I don't think we get enough practice with that, because if I were to walk in and see a patient that's airway was compromised, I probably wouldn't be confident to put like a Guedel (oropharyngeal airway) in (FGP15).

Other participants commented that they needed more consistent practice to develop the required skills. They felt that classroom based teaching was not enough to develop the required level of skill. FGP11 stated “yes teaching, that's all well and good but as long as you do actually get the opportunity to practice it”.

Theme 1: Sub-theme 5 Level of Working.

The final sub-theme from theme 1 was that of the GRNs “level of working” or the complexity of their role in the clinical areas. Again the discussion had several strands to it and emphasised a number of factors influencing the “level of working”.

During the focus groups, the participants discussed the definitions of the levels of working from the “Chain of Response” (DH, 2009). All participants agreed that their role was dynamic and included working at multiple levels from the perspective of the “chain of response”. The majority of participants within the focus groups agreed that the first 3 levels of the “chain of response” reflected their main level of working. FGP13 stated “three...the first three I would say” referring to levels 1-3 of the chain of response. Others suggested the same, FGP06 commented “levels one, two and three..... yes”.

There was agreement during the discussion that at times, the GRN role could include some of the level 4 (Primary Responder) interventions but there was a high level of unease related to providing interventions to the deteriorating patient. Participants felt at times, however, that intervention was needed and they had to “put in an intervention before they get to a point where they die” (FGP13)

The participants' consistent view was that their level of working was tied to their main role in the management of the deteriorating ward patient. The participants felt that their main role was to detect, alert and monitor the deteriorating patient. FGP05 suggested "I would probably deliver as much data as I could and then almost delegate it to the co-ordinator or someone senior to me, like, okay, fair enough, I'm going to ring the doctor. Because usually that's what happens".

The participants also discussed a number of other factors that influenced their "level of working". They commented upon the "attitude of the ward" and the impact of negative emotions on the participants in practice. The need for the participants to seek "permission" from senior staff prior to taking action was highlighted and how this impacted upon their confidence to provide intervention. FGP06 stated;

It depends on the ward, like the ward that I'm on, they want you to run everything past the coordinator. You can't even ring a doctor or you have to run everything past the coordinator and then they'll make the decision of who they call or who they delegate to do what (FGP06).

Other participants indicated that their "level of working" was often influenced by the expectations of the senior nurses and those staff coordinating the shift. One participant commented about the coordinators expectation saying;

I would do basic stuff like giving oxygen, but then I will go out and say, this has happened to this patient, this is what I've done, and they (the nurse coordinator) might then say, okay, well, do this as well. Or they (the nurse coordinator) might say no, they have got to get off that oxygen and I want them to use a hi-flow and so on. So sometimes they'll say no to what you've done and then sometimes yes - and then you'll, sort of learn from that as well (FGP14).

Theme 2: Fear of Getting into Trouble

The second main theme that emerged from the focus group data was the participants' fear of "Getting into trouble". This fear seemed to be a major concern that influenced

the participants' abilities and confidence to manage the deteriorating patient. In particular, the participants commented that the fear of getting into trouble made them less confident in their assessment skills, their knowledge and their ability to interpret information. One participant commented "sometime you just go home and you think, wow, did I make the right call or now I'm going to get in trouble.....you know?" (FGP16). Another stated "there are so many days where I've gone home and not slept, I'm worried! I've called in at 3 a.m. and said, did that patient have to get catheterised, did I miss something?" (FGP08).

The participants commented on questioning their own decision making and becoming more cautious, feeling they required senior nurses to check their assessment and interpretation of information before progressing. This was highlighted by FGP12 who said "I feel like you're always second guessing yourself, asking another senior or someone else you're working alongside can you just come and check this patient, because I'm concerned".

The participants' fear of getting into trouble made some worry about their scope of practice and professional consequences when dealing with a deteriorating patients. One participant stated "it's hammered into you, your scope of practice. You're petrified that, oh my God, I'm going to lose my registration if I do the wrong thing" (FGP20).

It was apparent that participants needed permission before providing intervention for fear of stepping outside of their scope of practice. FGP04 said "I would always just say to my co-ordinator, are you okay for me to do that or what would you like me to do? I would never try and sort of go ahead and do anything". One participant commented that "you need to cover your ass and record everything" (FGP03) as a way of mitigating the risk of getting into trouble. This referred to accurate record keeping particularly in relation to interventions that appeared to be on the cusp of their scope of practice.

Theme 2: Sub-theme 1 Seeking Permission.

Throughout the focus group interviews, one of the main topics of discussion that kept emerging related to a sense of seeking and requiring “permission” to act or intervene in the deteriorating patient’s management. This authorisation related to senior nursing staff or medical staff, sanctioning either a call for help or clinical intervention and management for the deteriorating patient. Participant FGP03 stated “In our ward, a lot of the CNs (senior nurses) call a lot of shots and things, and the doctors are all happy with that” (FGP03).

For some participants, it was evident felt they were compelled to gain “permission” from either senior nurses or medical staff, if they wanted to either raise the alarm or provide intervention to the deteriorating patient. It was apparent that the act of seeking permission was often not for support or guidance from senior staff, but to mitigate the risk of getting into trouble. Participants’ comments included “they want you to run everything past the coordinator, you can’t even ring a doctor” (FGP06) or “you need a doctor’s order, we can’t just do it” (FGP01). This requirement created a reluctance by the participants to call for help until they were certain there was an issue and they were not going to get in trouble.

At times participants stated they often knew what needed to be done for the deteriorating patient, but using their initiative, was often frowned upon by senior nurses. This was highlighted by one participant who commented;

“The coordinator was nowhere in sight. I thought, I’m just going to ring the doctor, because this patient is sick now, like vomiting, and I got ripped by the coordinator for using my initiative because I should have contacted her before contacting a doctor” (FGP21).

Seeking permission was also seen by some participants as a risk management strategy, providing protection against “doing the wrong thing” and the potential ramifications of “getting into trouble”. Initially participants discussed a level of uncertainty of what was expected of them in relation to the deteriorating patient and

what they were “permitted” to do. Some participants commented that they “are not legally allowed to undertake some interventions” (FGP22) others felt that “you need to listen to one of the CNs (senior nurses) and get advice as to what you can do” (FGP17).

Other participants provided apposing accounts, suggesting that having authorization from senior nursing and medical staff was empowering, enabling the participants to use their initiative and provide intervention in the knowledge they were doing the right thing for the patient. For many participants, gaining permission or authorization was seen as essential requirement. Permission provided reassurance to some of the participants, validating their concerns with regards to the patient. “I wouldn't do it without asking” (FGP03) and “I'm going to go ahead and say no, I wouldn't. I would always just say to my co-ordinator, are you okay for me to do that or what would you like me to do? I would never try and sort of go ahead and do anything” (FGP04).

This lack of clarification in what the GRN were expected and permitted to do, caused some confusion and anxiety amongst the participants. Professional and legal concerns were raised by the participants. As discussed previously, these related to worries about scope of practice and the potential professional consequences if they had not sought “permission” prior to undertaking clinical interventions. They had scope of practice “hammered into them” at university. The participants commented on feeling “petrified” or suggesting “I'm going to lose my registration” if they provided certain interventions.

Theme 2: Sub-theme 2 Getting it Wrong.

Running alongside the sub-theme of “seeking permission”, the next sub-theme focused on “getting it wrong” or making the wrong decision about the management of the deteriorating patient. Again this had a number of strands that looked at the sub-theme from numerous perspectives. The participants felt that working as a registered nurse was challenging particularly when looking after the deteriorating ward patient. This was summed up well by a participant who said;

Most of the time, can I just say, so it's on record, I feel as a grad you're winging it every day, not really knowing what you're doing. You don't get enough time to spend with the actual patients to do even fluid balance charts. You're running in and out, in and out, and you don't feel like you've got support and you're just winging it. That's how I feel (FGP07).

The participants were concerned about providing the wrong treatment to the patient, particularly if they had not been given "permission" from the senior nurses or the medical staff to provide intervention. FGP18 commented "it's hard at times, you can kill someone if you get it wrong, that's what really scares me". This led to a reluctance of GRNs to provide urgent intervention to the deteriorating patient for fear of making a mistake. FGP04 stated "I think it's kind of because we're worried that we're going to do the wrong thing".

Others commented upon the inconsistency of senior nurses and their expectations, which made the participants confused and reluctant to act, "I've had two different co-ordinators say, why is this person on oxygen? We're not allowed to give it. And the other one say, this person needs oxygen. Do it before you come and see me".

It was evident that many participants were aware of a "hierarchy" in their areas that involved both senior nursing staff and medical staff. Often lines of communication involved an escalation via different staff in the "chain of command" or hierarchy and stepping outside of this was seen as "getting it wrong". One participant commented "well, we're not supposed to, but, then I suppose you wouldn't get in trouble if the doctor was, like, you did the right thing" (FGP04). Others mentioned the need to keep accurate records of discussion and orders from senior staff and in particular medical staff. FGP03 commented that "you need to cover your ass and record everything" as a way of mitigating the risk of getting into trouble.

Theme 2: Sub-theme 3 Organisational Culture.

The final sub-theme that emerged from theme 2 related to "Culture within the Organisation" and how this impacted on the participants. This included the senior staff attitudes as well as the culture of the ward and hospital as a whole. This was

complicated by the fact that in many areas, participants felt the senior nursing staff and medical staff had divergent and inconsistent expectations of the GRN and their role in managing the deteriorating patient.

The participants discussed initially the attitudes of the senior staff and how they influenced their confidence and decision making when caring for the deteriorating patient. In some areas, the participants felt that senior nursing staff were approachable and supportive. FGP05 stated “yes, we do team nursing, so I'd say yes, I'd always have support”. Others commented that “in general the senior staff were supportive of the GRN” (FGP11) and “were generally supportive of the actions you take” (FGP16) with regards to the deteriorating patient.

In other areas, participants felt senior nursing staff and medical staff could be unsupportive and at times belittling, questioning the participants initial decision making. FGP01 commented “sometimes you are scared to ask something because you're like, okay, how many months is it now, should I be asking this dumb question? Will I get grilled?’ The negative emotions often had an adverse impact of the participants and their self-confidence to ask questions and to provide care for the patient. One participant stated “I'm scared to ask at times, I think is this a dumb question and should I be asking this? I pick my people though. Some of them are really approachable, some are not....it's personalities” (FGP 14).

Participants also spoke of the culture of the ward or the hospital. This discussion of ward culture again polarised the participants' opinions. Some felt that their place of work provided a supportive environment where the GRN could work collaboratively in the decision making process. Other participants spoke of a “culture of control”, where using their initiative could get them into trouble with both senior nursing staff and the medical team. Some commented that senior nurses took charge of all decision making, the GRN had no autonomy in making clinical decisions and had to seek permission from the senior nurse in charge. FGP06 spoke of “having to run everything past the coordinator for approval including calling for help”. Others spoke of the expectation that they gather the information and delegate the decision making to

the coordinator, “we need to let the co-ordinators know and they get them to be reviewed by the doctors” (FGP11).

Theme 3: Needs of the GRN

The third main theme that emerged was the “Perceived needs of the GRN” when managing the deteriorating patient. These needs were multifaceted and related to direction and clarification as well as a support structure within the clinical environment and organisation. Once again these perceived needs impacted upon the participants’ confidence and decision making in the clinical environment. From the main theme, three sub-themes were highlighted and will be discussed in detail.

Theme 3: Sub-theme 1 Need for Direction.

The initial sub-theme to emerge was a clear need for direction espoused by the participants. FGP02 stated “I think we still need support with making bigger decisions about patients”. Some of the participants clearly felt out of their depth at times when managing the deteriorating patient. FGP07 summed this up saying “I feel as a grad you’re winging it every day, not really knowing what you’re doing”. FGP02 added that “on the wards you ask someone something and they’ll go, you’re an RN, you should know that, and I’m like, well, I don’t actually really know”.

The participants expressed the need for direction from both senior nurses and medical staff in their decision making and clinical interventions for the deteriorating patient. Many participants felt that senior input gave them clear guidance that they were prioritising and undertaking the correct interventions for the patient. FGP17 stated “I feel like you’re second guessing yourself. So you’re always asking another senior or someone else you’re working alongside if they can just come and check this patient, because I’m concerned”.

Some participants felt unsure what they were required or expected to do before calling for help, “no, I’m probably not 100% clear of what is expected” (FGP09).

FGP07 stated “you just want sometimes just some clarification, do you think I should do this, and then they (senior nurses) turn around and go, you're a RN, you should know that, and you just feel bad”. Accessing senior support and direction allowed the participants to ask questions and clarify what was required of them and what further treatment was necessary for the patient. Seeking direction from senior staff was also a form of validation in regards to their concerns and relieved feelings of being unsure or second guessing their decision to call for help.

Some found that the perceived hierarchy within the ward environment could be a barrier to seeking direction. In particular the participants found it difficult to communicate directly with senior medical staff. They spoke of feeling uneasy or nervous in case they were asked questions they did not know the answer to. Other participants felt intimidated by senior medical staff and found them unapproachable or dismissive. This made participants reluctant to seek direction or clarify intentions.

Theme 3: Sub-theme 2 Need for Clarity.

The second sub-theme related to the “need for clarity” when dealing with the deteriorating patient. The participants discussed clarity from several perspectives. Initially the need for clarity was raised in relation to the expectations of the GRN in the clinical management of the deteriorating patient. Clarity was also discussed in the need for clear communication from senior nursing and medical staff with the participant.

The issue of poor communication was commented upon in regards to trying to understand the clinical decision making of medical staff, “we need good communication as to why decisions are made, so that we can understand it” (FGP19). This view was echoed in the comment “sometimes you ring up because the patient may have a change, a really big change in their BP or whatever and they (the doctor) are like....Oh, that's fine, that's still fine. You're like, that's not really fine, though, I don't understand”. The need for clarity was particularly important in relation to the goals of care and the undertaking of clinical interventions required by the deteriorating

patient. All participants agreed that good communication improved clarity and team working and facilitated the delivery of timely management to the patient.

The participants also discussed the need for clarity in relation to their role. They were concerned that at times, the expectations of senior nursing and medical staff were inconsistent and unclear. This led to a sense of uncertainty and again influenced their decision making. Also within the policies and procedures of the hospitals, GRNs felt there was a general lack of clarity as to interventions registered nurses were allowed to undertake in an emergency situation and the impact on their “scope of practice”. This again led to uncertainty and fear of getting in trouble, some commenting “We are not legally allowed to undertake some interventions” (FGP22). This seemed to be influencing the participants’ decision making and willingness to clinically intervene.

Theme 3: Sub-theme 3 Need for Consistency.

The final sub-theme that emerged was related to a need for consistency. Again the participants approached this concept from a number of perspectives. Initially the need for consistency was discussed in relation to senior nursing staff within their ward areas. It was apparent from the discussions that participants felt there were a number of areas of inconsistency. They related to the differing attitudes and expectations amongst senior nurses concerning the role of GRN when dealing with the deteriorating patient. This could cause confusion and amongst the participants and influencing their willingness to provide interventions to the deteriorating patient.

The need for consistency also extended to ward policies and procedures in the clinical areas. Many senior staff worked outside of policies and procedures when dealing with the deteriorating patient. This created anxiety and confusion for the participants, and made it difficult for the participants to learn best practice. FGP11 commented “we need to actually use them (policies and procedures) on the ward and have everyone engage with them because everyone has different ways of doing things. The policy stipulates one simple method of doing something, but it’s ignored and everyone’s got their own way”.

Participants also raised the need for consistency in relation to senior medical staff. They commented that each consultant working within the ward area had different and often inconsistent practices when dealing with deteriorating patients. This inconsistency made it difficult to predict what was expected of the participants from multiple admitting consultants. Again the participants felt this made it difficult to grasp developing their role. They commented about inconsistent instructions from medical staff with regards to patient management. FGP13 said “some doctors don’t like us calling the physio or the cardiothoracic physio, for, say, a cough. They don’t believe in the evidence so we have to go through them, but other doctors are more than happy for us too”, communicate with other healthcare professionals.

Theme 4: Improving Performance

The fourth main theme that emerged from the focus group data was “improving performance” in the clinical role of managing the deteriorating patient. Many participants felt improving their performance was vital, and that there was “always room for improvement” (FGP10) or “you’ve got some basic knowledge, and it’s expanding, but we need to gain more and more experience” (FGP15).

There was a clear perception by the participants that they were still novices and working at a basic level. One participant stated;

I think a lot of the time that knowledge comes with time and experience and as a grad you don’t necessarily have all that experience but over time you will build on it and you’d learn how to recognise deterioration a lot better and how to act on it and what you need to do to act on it (FGP20).

Another commented “you know that someone can do a better job than us as new graduates. Someone who’s had more experience, more exposure, more practice is going to do a better job than us” (FGP04). There was agreement from all those in the focus groups that the participants required further support to improve their clinical performance when dealing with the deteriorating patient. FGP01 suggested “we’re not saying we know enough, we’re always... we can always know more”.

Theme 4: Sub-theme 1 Learning & Upskilling

The first sub-theme that became clear from the participants within the focus groups was the need for further learning linked to the complex needs of the deteriorating patient. Some participants commented that they needed to improve their knowledge so they could understand how and why patients deteriorate. Others focused upon improving the knowledge concerning assessment and management of the deteriorating patient.

Almost all of the participants involved, indicated that there was much more to learn in regards to the deteriorating patient. The participants suggested that areas for personal learning included understanding the causes of deterioration, recognising the changes associated with deterioration, and understanding the management required for the deteriorating patient.

There was also a general consensus that university preparation covered some of the required knowledge. One participants commented;

We've had a lot of the theory, because I've learned all this stuff at uni and before. Then when you come onto the ward and you see it in action you're having a look at your roles, you're able to link it all together. You're actually able to formulate what's going on so that gives you a clearer picture on how to help that patient as well. So I think the theory is still really, really important (FGP05).

Some participants, however, commented that often much of this is forgotten, "you get so much stuff at uni and you come here and you're like, I don't really remember" (FGP12) and "it was really good but, still, you move on from that semester and...you don't forget it, but you don't remember it until you come to it in practice" (FGP07). Others felt that university provided too much theory based information. FGP03 said "that was a huge issue with undergrad, I reckon. I think so much of it is so theory-based and you're just regurgitating facts and it's like what's the use, it's in one ear and out the other and you forget it once the exam's over".

The participants also focused upon their competence. They felt competence related to the GRN working independently, “to me, it's the ability to do something by myself and do it correctly” (FGP08) and “do it correctly without needing extra support” (FGP10). There was a clear focus upon the practical application to managing the deteriorating patient, “I feel like competence is well reinforced set of skills” (FGP07).

The participants commented on the potential issue of not acting in a safe and competent manner. FGP09 stated “I can do it, but I just need someone to reassure me that I'm doing it competently and that because of the ramifications of what might happen if you haven't done it properly”. Others commented about their concerns of not being fully competent in that “you can kill somebody, that what really scares me” (FGP18).

Participants talked of improving their knowledge and skills within the clinical setting. They felt it was extremely important that new knowledge and skills could be consolidated within their areas of practice. Educational clinical support was seen by many participants as essential to improving their performance with the deteriorating patient. There was universal agreement within the focus groups that the current model of formal educational support offered to participants was in parts inadequate. This support relied heavily upon pre-arranged study days over a period of 12 months and *ad hoc* meetings with the ward based Staff Development Nurse (SDN).

The participants felt that alongside classroom based education, there was a need for more education sessions that were grounded in the clinical setting. GRN comments included “we definitely need hands on learning, scenarios and questions” (FGP21) and “I feel like 90% of what I've learnt in my nursing has been in practice” (FGP11). Some commented the study sessions didn't need to always be formalised “even if it was just like ten minutes during each shift, if the SDN or whoever said, come on, we're doing a practice of the MET (emergency response to clinical deterioration)” (FGP02). Others supported the idea of informal practical education sessions, “just impromptu, out of the blue, so you've got that kind of oh, snap, this is happening now” (FGP06).

Some discussed the need to restructure the graduate learning programs to focus more on skills particularly at the beginning of the graduate year. Participants commented that the education that was provided on the deteriorating patient was useful in the graduate program, “it’s helped me hugely” (FGP09). However, some participants felt it was being provided late on in the program “it needs to be earlier, it’s too late at the end” (FGP16) and “having those days earlier in our programme would be better” (FGP08).

Theme 4: Sub-theme 2 Formal Structured Mentorship.

The majority of participants highlighted the need for a system of formal mentorship within all the clinical areas. This would involve participants being assigned a senior nurse mentor within the clinical area. They commented “yes mentorship would be really good for us” (FGP04) and “I don’t know but I think sometimes just working with a really experienced nurse, that actually would work, one-on-one with you” (FGP08). The participants felt having formal mentors would allow them time to ask questions whilst in clinical practice and provide a role model to learn from.

Some commented that their ward area had informal mentorship programs that were often *ad hoc* and ineffective. FGP06 stated “well, yes, we do have informal mentors but we never see them because they are always rostered differently”. Another participant commented “we have a mentor on our ward but I’ve only worked with her twice in the whole time I’ve been there” (FGP11). One participant stated;

“I find that the students are buddied up with someone on our ward, they are buddied up and do the same roster. We (the GRNs) are with a different person every day and none of them really know where you are in your learning, so you can’t necessarily develop your learning because they don’t know where you’re at! So they end up taking over some of the things that you should really be learning” (FGP17).

This meant that often the process of mentorship was abandoned due to the lack of time for the participants to meet with their mentor or a lack of consistency not being assigned to work with mentors. The participants discussed the need for consistent

mentorship, someone who knows them and where they are up to in their clinical development.

The participants felt they needed periods of regular protected time similar to that offered to junior doctors. This would provide time to work alongside their mentors and gain valuable feedback and clinical guidance to improve their clinical knowledge and competence when dealing with patient deterioration.

Theme 4: Sub-theme 3 Clinical Support.

The next sub-theme that became evident focused on improving the performance of the GRN through the provision of clinical support. There were a number of different perspectives on the levels of support provided by different staff within the participants' areas of work. The participants discussed the need for a more supportive clinical environment where all staff are approachable and have time to help. Participants discussed the issue of senior staff being overstretched, "no one's got the time or everyone's too busy and then someone will go, I'll do it because it will be quicker". FGP07 stated "everyone is too busy to help". This influences the participants' development as senior staff have no time to teach and take over. "Because everyone's busy you're out of time, you just get somebody who can do it quicker and faster and know what they're doing so then you're not actually learning it anyway" (FGP06)

Participants also pointed to issues such as "being scared to ask" (FGP01) and finding "it is very daunting talking to doctors" (FGP19). One of the solutions put forward by the participants was to have more clarity and consistency from senior nurses and medical staff in relation to the expectations of the GRN (discussed previously). A solution put forward by the participants was more inclusive multidisciplinary team working, including debriefing sessions with all members of staff in attendance. Some of the participants felt this would help to highlight good practice and as well as gaining points for improvement. Using this initiative would provide lessons from the whole team perspective.

There was recognition that the SDNs were a valuable resource for the participants learning and development. Many felt the SDN's were extremely busy, overstretched and time poor. This led to a sense of frustration and a feeling of being forgotten and left on their own. "SDNs are good, but at the time, they've got about six people to look after, like mine for example, she's got ENs now as well".

The participants expressed difficulty meeting with the SDN, "I know we all have SDNs but sometimes you don't get to see them much. You know, if you have a burning question or like even just time for reflection. We just go home sometimes and it's like, well, that happened today and I had no one to talk to" (FGP07). FGP06 stated "SDN yes they are good, it's just you can never grab them when you need them".

One solution put forward by the participants was to have more SDNs working clinically to offer support when dealing with acutely ill patients. They felt this would provide an additional level of clinical support and also provide valuable teaching and upskilling for the participants within the clinical environment.

Theme 4: Sub-theme 4 Competency Based Assessment.

The participants expressed a need to improve their clinical expertise when assessing and managing the deteriorating patient. The participants felt this could be achieved by focusing on competency-based education relating to the assessment and management of patient deterioration. The participants discussed the need for a clearly defined set of clinically based competencies which outlined the expected level of practice of a GRN. FGP19 commented "you need a clear set of goals and a clear set of standards and as long as know what we need to do, and know how we have to do it and what we have to do to get there, it's all good"

Most of the participants felt that competencies focusing on how to assess and manage the deterioration would provide them with confidence "having pre-defined clinical competencies with almost a checklist of this is what you do in this situation or that, yes that would be really useful" (FGP12). FGP18 suggested "it would give you a

framework, a basic list of things and then the next step. You know, these are the things you can do before you need to really get somebody else to”.

The participants felt it was necessary for robust clinically based assessment of competencies. FGP09 commented “yes having a clinical assessment of competence, it would be scary but it would be useful”. Others supported this “yes it’s got to be clinical assessment” (FGP11) and “hands on assessment, it’s got to be hands on. It would maybe make us more confident and then you’d be... in thinking like, I actually know about this, I can do this, even though we do anyway” (FGP15).

These would be assessed by senior RNs or the SDN within the clinical area to ensure that the participant was performing to the correct standards required. One stated;

I would like, for me, whoever’s signing it off, to be a consistent person. So potentially, if you had say four SDNs, you know, either running the show or on the ward and you’re six months’ up, you like to have some consistency with that, the same SDN so that their expectations still remain the same. Do you know what I mean? (FGP18).

Theme 4: Sub-theme 5 Specialised Training.

To facilitate improved performance, the participants pointed to a need for training and education that focused specifically on the management of acutely unwell and deteriorating patient. Although participants agreed that some of this content was covered in undergraduate and graduate program education, they felt that there needed to be significantly more in the graduate program.

In particular, the participants discussed the need for clinically focused and practical training on managing deterioration. They agreed that it needed to be “hands on” practical training focusing on both knowledge and skills required to manage the deteriorating patient. “Yes, we need scenario based, where we’re actually working with the masks and things like that and going through practical examples, it’s hands on” (FGP11). Other participants agreed, “yes, we need hands on, practical learning”

(FGP17) and “we need hands on sessions that really challenge us, throwing questions at us” (FGP 19).

This was summed up by FGP19 who stated;

We need scenario based learning like, where you’ve got some case studies and scenarios, things like that, hands on. Because otherwise it’s just like you’re trying to read a paper and apply theory that’s completely separate to what you’ve learnt, to what you’re doing on the ward (FGP19).

Participants felt they needed more focused training on using the EWS vital sign scoring chart systems and knowledge of the interpretation of their assessment. They felt this could be delivered in both classroom and ward based education sessions. Participants also felt that regular practical scenario based training involving all members of the multidisciplinary team would be useful in developing skills and understanding but also defining roles and expectations within the clinical team. This they felt was key to improving performance.

Summary

This chapter has presented the findings from the focus group interviews. The emergent themes and subthemes from the data analysis have been discussed along with extracts from the participant statements as evidence of the themes and subthemes.