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Research paper

A qualitative analysis of the role of the Hospital in the Home registered nurse in Australia

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ABSTRACT

Background: Healthcare and societal expectations change over time, with Hospital in the Home (HITH) registered nurses (RNs) increasing in community profile in Australian nursing domains. With increases in service demand and bed pressure creating an increased need for services outside the hospital environment, understanding of the role of the registered nurse working in HITH is needed.
Aim: This research aims to identify the role and function of the RNs' experience in their day-to-day work in the HITH setting. Additionally, the research shares a content analysis of the position descriptions of participating HITH RNs to analyse key performance indicator inclusions and barriers in scope of practice for the registered nurse.
Method: Using an interpretive phenomenological approach and Gadamer's method, 12 HITH RN participants from across Australia were engaged in in-depth interviews. Interviews provided HITH RNs the opportunity to share their experience of the role, and a contributing content analysis of position descriptions followed, providing a synopsis of key areas of commonality and difference.
Findings: Three key areas emerged: professionalism, knowledge, and responsiveness, with an identified mismatch between generalisations in scope of practice in the position descriptions and the shared experience of the HITH RN participants.
Discussion: The research identified shared challenges that exist in the day-to-day role and function of the HITH RN, determining that HITH RNs undertake complex roles, working with generic position descriptions, often absent of core components of autonomous practice, experience, and knowledge. Limitations exist in the scope of practice of the HITH RN resulting in delays in care where advanced practice could be applied.
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Summary of relevance
Problem or Issue
There is limited documented evidence of the experience of HITH RNs understanding of their role. Limited knowledge is available that shares the understanding of HITH RNs practice priorities. HITH RN clinical practice demand is increasing, yet, no first hand experience is documented about the role from RNs employed in the setting.
What is already known
HITH registered nurses provide acute care in community. HITH nursing education pathways and career progression in advanced practice are not formalised. HITH nursing position descriptions are determined by each health service.
What this paper adds
First-hand understanding of the HITH RN experiences of role and scope working in Australia. The HITH RN undertakes a complex role in the absence of an advanced practice model. Highlights the need for consideration of career pathway planning and advanced practice pathways for HITH RNs.

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1. Background

Hospital in the Home (HITH) multidisciplinary teams have rapidly extended patient cohorts and provided timely care for individuals acutely at home (Palesy, Jakimowicz, Saunders, & Lewis, 2018). Simultaneously, the role of the HITH registered nurse (RN) has informally expanded as hospital bed pressure and service demand increase. The progression from traditional hospital-based care to HITH is essential to relieve pressures on the health system. The HITH model provides an appropriate solution that integrates acute health care for patients in their homes (Putera, 2017). RNs work in the setting; however, not one standard position description is evident, with various roles and descriptions available in the Australian context. Understanding the role of the HITH RN is important in progressing the service and in providing career trajectories for nurses.

1.1. Hospital in the Home nursing defined

HITH (in the Australian context) is an alternative to an in-hospital admission where care is provided at home (Varney, Weiland, & Jelinek, 2014; Leong, Lim, & Lai, 2021). The service is subject to regulatory and governance requirements similar to hospital-level care. Services are directed by suitably qualified clinicians for an episode of care, not unlike acute services (24hrs a day, 7 days a week, and 365 days a year), with a service aim of reducing in-hospital bed pressure (Edgar et al., 2024; Varney, Weiland, & Jelinek, 2014; Phillips Fox, 2009). Staff, equipment, and medications are provided alongside specific treatment needs and within recognised safety and quality standards in a person's place of residence or preferred (nonhospital) treatment locations (Queensland Health, 2022; Varney, Weiland, & Jelinek, 2014; Hospital in the Home Definition; Leong, Lim, & Lai, 2021). All care is provided under the explicit orders of a medical practitioner or combined medical practitioner and general practitioner, with some models integrating Nurse Practitioners with medical oversight. The HITH team is responsible for all care components required within that acute episode of care (including but not limited to all medical, nursing, allied health, observation, diagnostics, and treatment).

Patients in HITH services have reported a higher care satisfaction and positive health outcomes, along with a reduction of risks from adverse events from hospital admission and re-presentation to emergency departments (Queensland Health, 2022). The role of the RN in the service is pivotal to service success. Limited research is available on the experience of the HITH RN role in the Australian context. Learning more about the role of staff working in the setting is an important step in ascertaining the experience of the role and function of the HITH RN.

1.2. Research question

What is the HITH RNs' experience of their role and function in practice and how does this compare with current position descriptions of HITH RNs in health services in Australia?

1.2.1. Research aim

1. Identify the role and function of the RNs' experience in their day-to-day work in the HITH setting.
2. Conduct a content analysis of the job descriptions of participating HITH RNs to analyse scope of practice and key performance indicators.

2. Research design

2.1. Methodology

An interpretive phenomenological approach guided by Gadamer's philosophical understandings was chosen to explore the experience of the HITH RN role and function in Australia. The research question seeks to understand the HITH RNs' experience of their role and function in the context of their clinical practice with an aim of gaining current lived experience. Interpretive phenomenology guided by Gadamer provided the methodological context to enable the voice of HITH RNs to be heard and thematically analysed for trends, interpretations, and emerging concepts from an interpretative standpoint (Creswell & Creswell, 2018; Gadamer, 2013).

In-depth semistructured interviews using open-ended questions were considered the most appropriate method to produce responses adding more depth and richness to the data gathered. Semistructured questions were used to enhance interview techniques and were essential to building rapport with participants (Brinkmann & Kvale, 2018; Creswell, 2017; Creswell & Creswell, 2018; Liamputtong, 2019). Data analysis was aligned with the hermeneutic cycle, moving back and forth between presuppositions and the parts and whole of the text (Gadamer, 2013; Suddick, Cross, Vuiskoski, Galvin, & Stew, 2020). This process was iterative until meaning was uncovered and themes were identified (Suddick et al., 2020). The lengthy timeframe for data collection added richness to the interview process and enabled depth and integrity from participants, with interviews extended, reviewed, and updated to reflect any changes that had occurred throughout the timeframe.

3. Method

3.1. Participants and inclusion criteria

Participants from each state or territory in Australia were recruited to gain a broader perspective covering metropolitan and regional health services. The inclusion of 10–15 potential participants enabled capacity for participant withdrawal without data quality being compromised. The small cohort of HITH RNs is consistent with phenomenological research and remains true to the methodology (Frechette, Bitzas, Aubry, Kilpatrick, & Lavoie-Tremblay, 2020). The purposive sample better targets the

phenomena through in-depth interviews that gain rich insights into the role and function of the HITH RN (Frechette et al., 2020). Early identification of many differing role titles was apparent as the recruitment process commenced. The researcher sought approval and access to each participant's position description where content analysis occurred as part of the data analysis process. A total of 12 participants were identified, representing regional and metropolitan Australia, with a minimum representative from each State and Territory of at least one participant. No participants withdrew from this study.

Participant recruitment entailed the inclusion of the Australasian HITH Society who emailed all members to inform HITH RNs of the opportunity to participate. Emails were generically sent to all members to ensure that a wide and inclusive approach was used. The HITH members contacted the researcher directly to become involved or for more information. This avoided any third-party involvement that may have resulted in the identification of a particular participant.

Selection criteria were used to ensure that participants aligned with the aim of the research in understanding the experience of RNs' role in a HITH service in Australia. Inclusion criteria encompassed novice to senior HITH RNs currently working in a HITH service in an Australian setting irrespective of role title. The inclusion criteria provided a standardised, methodical process for the inclusion of RNs. An initial discussion with a health service identified services with roles that were inclusive of technical and nursing roles that were not RNs; therefore, the inclusion criteria avoided unnecessary engagement of non-registered staff. Table 1 shares the participant selection and sampling criteria.

3.2. Data collection

Interviews were conducted face to face or via Zoom to align with participant choice and lasted between 45 and 60 minutes. Interview questions and prompts were open-ended and did not challenge or interrogate the participants but, rather, encouraged them to share their experiences (Brinkmann & Kvale, 2018). Audio recordings were converted to written transcripts and member checked by participants. Each participant completed a self and work location–based demographic questionnaire. The study was conducted throughout 2015–2020, with earlier interviews followed up with participants before the finalisation of datasets in 2020 with data saturation achieved. Participant position descriptions were thematically analysed at the conclusion of the interviews to ensure that the experience shared by the RN was not led by the results of the content analysis.

3.3. Data analysis

Data analysis commenced with naïve reading, moving forward word by word and line by line to extract collective codes that shared the HITH RN experience (Streubert & Carpenter, 2011). This process was repeated until the whole was understood, and themes became apparent that aided in the interpretation of the experience (AE, MT). Analysis undertaken in this way ensured consistency in terminology and assisted in reducing researcher bias (Frechette et al., 2020). Coding was initially completed by the researcher (AE) and then discussed and reviewed with a second research supervisor (MT). Codification of data occurred until no new themes appeared (AE, MT). Discrepancies were discussed and reviewed, and consensus was gained (AE, MT).

Analysis of the position descriptions was conducted initially by the researcher using the Braun and Clarke (2006) thematic analysis framework. The analysis was undertaken manually and then again using NVIVO© (Lumivero, 1331 17th Street, Suite 404, Denver, CO 80202) as a confirmatory process, individually by the researcher and with a second research supervisor. Initial coding and collation of codes into commonality occurred until themes were generated. The process involved familiarisation with each position description and line-by-line coding to describe and analyse the role and function of the HITH RN based on the position description parameters (Braun & Clarke, 2006). This permitted a comprehensive thematic review of each aspect of the position description content identifying common themes from the text. These themes were compared to the areas arising from the interview process.

3.4. Ethical considerations

Ethics approval was gained from the University of Southern Queensland Human Research Ethics Committee (HREC-H15REA113) before making any contact with potential participants. As part of the HREC approval, support from the HITH Australasian Society Committee and Queensland Health exemption was attained.

4. Results

Demographic data attained from each participant were collated. Eight full-time and four part-time HITH RNs totaling 84.5 years of registered nursing experience and an average 7 years mean experience per participant across the participant group. The specific attributes of each participant are outlined in Table 2. The years of employment within HITH services as an RN ranged from 1 to 15 years. None of the participants had Nurse Practitioner status. The participant attributes aligned with the average age of a nurse in Australia, at 49 years (Australian Health Practitioner Regulation Agency, 2021). Eight participants were older than 46, three of whom were aged 56 to 65. Only one participant was in the 25- to 35-year age group. The participant male-to-female ratio was 92% female and 8% male, which is not unlike Australian data from AHPRA that indicate almost 88% of RNs identify as female, with just under 12% as male (Australian Health Practitioner Regulation Agency, 2021).

The HITH RN role was viewed by participants as a *complex entity* where *greater understanding was required*. Three overarching themes were identified and include professionalism, knowledge, and responsiveness.

Table 1
Participant selection and sampling criteria.

Criteria	Participant selection to meet both sampling criteria	Australian states & territories	Number of participants
Criterion	Australian Health Practitioner Regulation Authority (AHPRA) RN	All Australian states and territories are represented	Ten to 15 participants. Numbers vary between states & territories.
Environment	HITH RNs who work in metropolitan, rural, and regional Australia in a HITH service		
Position titles	All position titles will be included for RNs working specifically in HITH services		
Expertise	RNs employed in HITH services for 1 year or longer		

HITH RN: Hospital in the Home registered nurse.

Table 2
HITH RN participant attributes.

Position title	Age group	Male/Female	State & area	Years in HITH	Qualification	Currently studying	Full /part time
Clinical Nurse	36–45	Female	QLD, Regional	13	BSc. Nursing	Yes	FT
Nurse Manager	56–65	Female	QLD, Metro	8	Hosp trained, BSc. Nursing	No	FT
Nurse Coordinator	25–35	Female	VIC, Metro	2	MSc.	No	FT
Clinical Nurse Consultant	46–55	Female	NSW, Metro	9	BSc. Nursing	No	PT
Clinical Nurse	36–45	Female	SA, Metro	2.5	BSc. Nursing	No	FT
Clinical Nurse	46–55	Female	QLD, Regional	1	BSc. Nursing	No	FT
Nurse Manager	46–55	Female	VIC, Regional	13	MSc.	No	FT
Nurse Manager	46–55	Female	NT, Metro	3	MSc.	Yes	FT
Clinical Nurse	36–45	Female	WA, Metro	2	BSc. Nursing	No	PT
Clinical Nurse/Registered Nurse	56–65	Female	VIC, Regional	15	Dip Nursing Hosp trained RN	No	PT
Clinical Nurse Specialist	56–65	Female	ACT, Regional	10	BSc. Nursing	No	FT
Registered Nurse	46–55	Male	TAS, Metro	6	BSc. Nursing	No	PT

4.1. Professionalism

The theme professionalism shares the explicit need for accountability, responsibility, rules, and regulations. The theme focuses on how participants interpret their role and function in the workplace when initiating, coordinating, and providing care. This professionalism extends to include rapport and communication with members of a multidisciplinary team when referral and consultation are required for a patient and the need to exhibit accountability and responsibility in decision-making.

Seven of the 12 participants acknowledge limitations in their role due to the need for role expansion or more advanced practice authority. These participant narratives highlight what care provision was needed and their capability to provide care. Six participants expressed concerns that RNs '*must not be coerced into undertaking duties outside their role*' as prescribed by their scope of practice and role description; however, on the contrary, this resulted in '*extended waiting times for orders*' to be approved by the relevant medical practitioner. Three participants raised the moral obligations to the patient. Further questions arose about the capacity of the RN in care provision at a higher level, particularly when broad statements were apparent in the overarching position descriptions.

All participants mentioned needing to contact the treating team or General Practitioner (GP) and the difficulties that arose in relation to '*waiting*', '*call back*', and '*follow-through*'. Each participant was aware of the need to request advice and medical approval before care changes; however, many RNs identified what clinical care was needed but lacked the ability to authorise this care, claiming that restrictions by professional boundaries prevailed. In each of these cases, once the order was received, care was provided by the HITH RN. Participant 1 shared "*The pressure is on when it is you that needs to respond. Timing is everything and waiting often means a decision in care does not happen quickly. We often know what is needed but there's a gap in waiting for the order to be able to do what's needed*". This raises a question about the validity of extended or advanced scope of practice for commonly arising requests that are not complex or needing medical intervention. Professionalism in communications and in role function as care coordinator and collaborator was expressed as an everyday issue with a need for regular communications with general practitioners for ongoing care orders.

Balance of power and dominance were identified as barriers to HITH RNs' role and function, and this negatively affected the professional status of the role. Participant 3 expressed frustration with "*Doctors command what a nurse can and cannot do, and yet this sometimes entails long waits for treatment that is in the long run completed by the RN*". The legal parameters of requiring a medical order dominated conversations, and participants referred to this when assessing patients and deciding whether to transfer patients to HITH services and, secondly, when a patient's condition altered at home.

The participants' insights to autonomy and clinical decision-making are incorporated within an RN's scope of practice. Participant 5 noted that *"RNs today are taught to question if they lack understanding of a request or prescription, and make the most appropriate clinical decision, you know, in the best interest of the patient"*. All participants highlighted the essence of professional approaches to clinical decisions inherent to the everyday function of the HITH RN. Despite the ability of the nurse, participants spoke of working in a medicalised HITH care model, where Participant 5 described *"nursing roles and role functions are controlled by the level of accountability and responsibility allowed through medical orders and reviews"*.

Seven of the participants indicated challenges to the HITH RN role to extend practice by constantly engaging in critical thinking, reflexivity, and autonomy when delivering care. These professional aspects of the role were identified as decision-making, care coordination, and delivery. Participant 1 aptly identified safety as a priority: *"I put safety first, and question what I do and whether it is right and if it is safe for the patient, my colleagues and myself"*. Participant 2 highlighted her understanding of safe patient care and her scope of practice:

> "We must be careful and considered in our judgement. The importance of knowing when to act, when to ask, and when to refer, comes with knowledge, experience, and confidence in our clinical status, level of education, and capability. This is important to me and my practice".

4.2. Knowledge

Knowledge identifies with being an expert, as people who are very knowledgeable about and have extraordinary skills in their area of work have the capacity and capability for autonomous practice and innovation in role conduct and function. Participants were unanimous in their quest to continue gaining more knowledge as each year of practice progressed. However, participants were clear that, even with an increase in knowledge and capacity, the HITH RN scope of practice remained static.

The participants gathered knowledge through preceptorship, mentorship, and a curiosity about the world. However, there was little evidence about whether there was consistency concerning the 'what and how' of how formalised professional development was acquired. However, it was generally thought that knowledge increased with postgraduate education, online certificated courses, reading, and mandatory training. There was a discussion about enhancing knowledge, professional identity, and purpose through undertaking reflective practice. Suitable mentorship from the perspective of the participants was deemed highly important. However, in all participant transcripts, the notion of mentorship was based on and expressed well by Participant 8 as an "*informal process*

led by an individual RN, rather than through a consolidated, co-ordinated formal mentorship program".

Participants believed that learning was necessary to improve knowledge and skill development on an ongoing basis to remain current in practice. Eight of twelve participants identified problematic access to education and lack of HITH-related postgraduate education opportunities. Financial support, staff availability, and time were identified by seven participants as reasons for not attending or completing education. Nevertheless, Participant 11 said that during home visits, "*HITH* RNs *work in isolation, making us semi-autonomous in our decision-making capacity*", and therefore require ongoing upskilling and knowledge development. Reasons for regular skills updates are the "*reduced capacity to liaise with a team directly at point of care*" (Participant 6) and the "*busy*" team approach in health services. Participant 8 expressed an analogy raised by many that, when employed to work as an RN on a hospital ward, RNs "*can liaise with colleagues at point-of-care and a broader interprofessional team faster*" with support processes readily available in the face-to-face context.

Participant 10 identified that HITH RNs must be "*able to communicate and advocate for their patients*". A further participant shared "*autonomy in scope of practice*" to senior nursing positions and, "*In many other professions professional knowledge is obtained through planned career steps by successful examination or completion of postgraduate courses. This appears to be voluntary in nursing and not part of any structured career planning process. For a HITH nurse this is risky as clinical decision making must occur at an advanced level as we are the only one in the home with the patient*" (Participant 4).

Participant 7, said: "*Nursing autonomy increases the level of patient care benefits.*" This increases healthcare equity. "*Autonomy increases with knowledge and skills gained through education collected over years of working*" (Participant 7). Evidence-based practice changes the type of nursing care that is safely delivered within the bounds of the RN's scope of practice. In agreement with previous participants, this participant commented on the "*functions of RNs involve clinical decision making*" (Participant 1). Thus, according to Participant 12, RNs:

> "… should question [whether] a potential treatment change is the right thing, that it is safe. Do they have appropriate knowledge and skills for the task, will it harm the patient, the family or even the RN, individually or professionally?"

Commentary that linked questioning practice and achieving best practice provides a suggestion that research or the use of best practice derived from research guides clinical decision-making and ultimately practice-based decisions. HITH RNs are essential in providing observation, communication, and coordination that reduces adverse patient outcomes. The results indicated the need for an ongoing education and advanced clinical decision-making capacity that is aligned with scope of practice, as well as with the flexibility to make and act on decisions in practice.

4. .3. Responsiveness

Responsiveness is part of the RN's professional responsibility. Responsiveness highlights the need for reflective care decisions by the HITH RN. Responsiveness was significant as the HITH RN works in a diverse environment where acute care decision-making is needed in a person's home environment. Responsiveness was deemed important by participants because they were seen as the provider of care, the coordinator of services, and the known contact person for patients in the HITH program. Being responsive was regarded as a critical trait of the HITH RNs because it was the HITH RN who reassured and assessed patients in their care and provided the link between care and the interprofessional healthcare team. The participants each identified responsiveness and having autonomy and authority in care and decision-making as key to the success of the role.

A need for responsiveness in the manner of the HITH RN became clear from the interviews. All the participants referred to advanced practice in various areas of discussion. Moreover, two participants said, "*RNs ensure delivery of the most optimal appropriate care for the best outcome for patients, keeping in mind quality and safe care*" (Participant 11) and a further participant expressed "*Hospital in the Home provides a clear framework for RNs to deliver care to those with more complex needs in the community setting. Our role is to provide the right care at the right time at home*" (Participant 9). These statements emphasised the need for appropriate and responsive care. The care described often requires an extension to the base role of the HITH RN to be more responsive in areas of required clinical care. Two participants shared:

> "Postgraduate courses targeted at HITH RNs are needed. It would be the biggest advantage of increasing scope of practice for HITH RNs to continue with your education, learning more, and gaining greater skill and knowledge specific to the role (Participant 7). Some days are so challenging and there I've not been able to find a course to help me with the additional skills I need" (Participant 1).

The participants showed that HITH RNs undertake acute patient care within the patient's home. It is "*important to provide safe patient care and to exercise the right level of authority and autonomy to avoid disciplinary action and litigation. It is about the patient and the care they need*" (Participant 10). Participants shared a variety of sources that their professional knowledge and skills come from including a combination of mandatory competencies and postgraduate education, mandatory updates, journal reading, research, and years of experience. Nursing is a dynamic and diverse profession that is, according to Participant 9, a "*balance of service requirements, years of experience and educational qualifications*". Participant statements indicate that, "*without guidance from all professional sources, the quality of patient care delivered by HITH RNs would decline sharply*" (Participant 6).

The participants had mixed views about HITH RNs' awareness concerning their role and role function within the workplace. One participant echoed the sentiments of four further participants and argued that "*changing roles are challenging from one healthcare area to another, or according to the position they hold in the workplace*" (Participant 3). Two participants discussed the lack of recognition of HITH RN knowledge and skill levels through other healthcare professionals' misunderstanding of the role of HITH RNs. These participants argued that HITH RNs are seen as a *"generalist who provide care based on the medical or allied health orders"*. Seven participants believed that there was little respect for skill and ability; however, it was established that they were the first line of communication linking patients with the right healthcare provider. The need to continually wait for an order when skill, ability, and the capacity to appropriately respond or refer suggested that without such recognition, the scope of practice for HITH RNs is not sustainable and leads to fragmentation in care and care decision-making. One participant stated:

> "HITH RN scope of practice is sometimes undefined … as autonomous practitioners need a more clearly defined job description specifically for HITH…as some work as HITH nurses under a broad umbrella of community which is not necessarily acute care … and with a clear delineation between post-acute services and acute services is needed" (Participant 1).

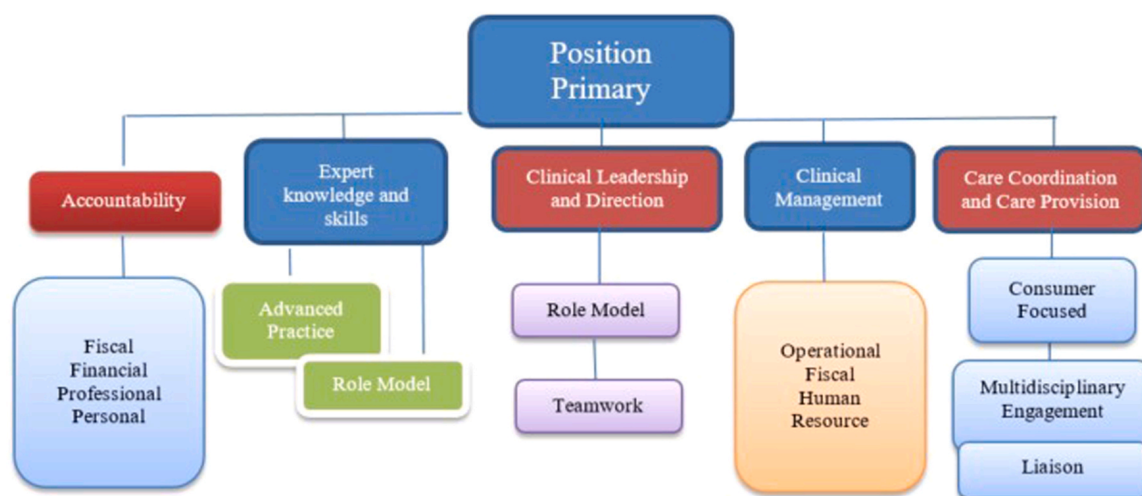

Fig. 1. Results of the analysis of the key responsibilities in the position descriptions.

4.4. Position description analysis

Extending the themes emerging from the interviews with HITH RNs, five areas arose from the analysis of the duty statement of the HITH RN. These included the statement of duty, key responsibilities, organisational role, workplace behaviours, and professional responsibility. The results and their subcategories are presented in Fig. 1 and align in many instances with the themes arising in the participant interviews.

A degree of generalisation in the role and function of the HITH RN was ascertained, and there was no specific reference about what differentiates a HITH RN from other RNs, Clinical Nurses, or Clinical Nurse Consultants. A vagueness in clarity of wording regarding role title and function exists, where clarity in the role was experienced by the HITH RN in the interviews or from differences in scope of practice or role delineation. Table 3 shares the key areas with consistent references to leadership, care coordination, accountability, extended care, responsiveness, skill, and communication. There is minimal reference to innovation, career pathways, or self-development; however, there are clear statements about leading the professional development of other staff.

The Position Descriptions offered a consensus of the accountable and responsible role of the HITH RN, having key responsibilities in communication, professional accountability, leadership, and coordination in areas of care and as a change agent. These areas aligned with the interview theme of professionalism with a focus on accountability and responsibility. Autonomy and leadership were described by the HITH RN in the interviews, and this was further outlined in the position description with nine of twelve position descriptions outlining the need for a "*professional accountability*".

Care is an overarching principle and the most relevant area in the position descriptions. Care coordination and the management of human and fiscal resources were elements in the fundamental practice of the HITH RN. Staff development was noted in all the position descriptions, seeing the HITH RN role as the connection between care and evidence-based practice. Staff education excluded HITH RN self-education and did not focus on the HITH RNs as the providers of education, the mentors, and the leaders for staff who answered questions arising from all other levels of staff.

A generalisation in the Position Descriptions was noted that included clinical, management, quality, and care parameters. A vagueness in wording regarding role title and function existed, and there was no specific reference to what differentiates a HITH RN from other RNs or, for that matter, a Clinical Nurse, a Clinical Nurse Consultant, and in one Position Description, an RN. Alignment was skewed in the specific areas of role function as the HITH RN was articulate with descriptions and anecdotes of what this function entailed. There was no reference to specific roles for HITH RNs, and the Position Descriptions were very broad; however, there are consistent references to leadership, care coordination, accountability, extended care, and communication. These areas are shared in the interview themes and discussed by HITH RNs as an area of confusion in the scope of practice based on the written position descriptions provided and the generalisability noted. There was minimal reference to innovation, career pathways, or self-development; however, in the interview themes, education was prioritised by participants to endure skill, knowledge, and practice required for autonomy and advanced clinical decision-making capacity. It is these differences and similarities that offer greater insight into the collective role of the HITH RN in practice.

5. Discussion

The HITH RN role is multifaceted and complex. The role encompasses tiers of communication, accountability, and decision-making. Nonetheless, the participants' lived experience is discussed, and areas of role ambiguity with respect to role titles, advanced practice, specialisation, skill, and knowledge are identified. The

Table 3
Key areas arising from the position description data analysis.

Key areas arising in the data	Key codes
Statement of duty	Expert; Leader; Leading Professional Development; Care; Staff Management
Key responsibilities	Accountable; Change Agent; Communicator; Coordinator; Leader; Responsible; Professionally accountable; Decision Maker
Organisational role	Position status; Reporting obligations; Qualifications; Reporting responsibilities; Role Purpose; Unit Description
Workplace behaviours	Advanced level clinical skills: Analyse and interpret data; Develops self and others; Honesty, integrity, and respect; Informs decision-making; Leads and manages teams; Sets expectations for staff; Decision Maker
Professional responsibility	Professional; Accountable; Responsible; Caring; Knowledgeable; Practical; Problem solver; lifelong learning; Innovative/creative; Timely and responsive

literature has commonalities with delegation, accountability, and responsibility as key roles in many specialised areas of nursing practice, making the HITH RN align with aspects of more advanced nursing care (Asakura, Satoh, & Watanabe, 2016; De Braganca & Nirmala, 2017; Donmez & Ozsoy, 2016; Ghadirian, Salsali, & Cheraghi, 2014; Ibrahim & Qalawa, 2016; Nouri, Jouybari, & Sanagoo, 2017; Ó Lúanaigh, 2015). More work is needed to understand the terms of primary healthcare and hospital healthcare, particularly in relation to HITH services and the RN in acute care provision in the community. Such understanding is important to HITH RNs in nursing teams because a distinction between similar titles may have consequences for the patient and nurse. The results indicate a mismatch between the scope of practice, role function, and the emerging themes in the position descriptions derived both from the HITH RN interviews and the content analysis of position descriptions. The outcomes suggest a dissonance between the scope of practice in position descriptions and the emerging themes from the experience of HITH RN participants.

HITH RN position descriptions are inconsistent, simplified, and broad in detail to the true scope and function of the HITH RN. HITH RNs with the same position title in different HITH locations can have different trajectories, ideologies, and educational status. The generalisation in position descriptions adds a barrier to professional advancement and to more advanced roles for the HITH RN. The experience of the HITH RN in their role and function was clear from the interviews, where skills, knowledge, and the ability to advocate and care for a patient in a timely manner were noted. The need to wait for updated orders and the dependence of the nurse on a medicalised model of care were noted to have added to delays in care and frustration felt by HITH RNs. Clarity in the interviews identified that HITH RNs practice at advanced levels of specialisation, utilising acute care knowledge and skills in a non-hospital-based environment. More work is needed to understand the terms of primary healthcare and hospital healthcare, particularly in relation to HITH services and the RN.

The interviews revealed a divergence in career pathways to becoming a HITH RN as well as a need for education pathways from novice to expert in the HITH RN role. Governance structures determine the elements of the role and function of the HITH RN and show a difference in scope from the medically driven healthcare culture of acute care in hospital. An increasing number of HITH services have a nurse-led model of care where the importance is in knowing the role and role functions of HITH RNs to enable effective at-home patient care. This model aligns with the professional and responsive approach discussed by participants. The scope of practice in nursing has distinct demarcations from that of medical practitioners. Each profession performs roles according to the defined boundaries outlined by relevant regulatory bodies that are defined by professional competency standards of practice (Niezen & Mathijssen, 2014; MacNaughton, Chreim, & Bourgeault, 2013; Nursing and Midwifery Board Australia, 2016). However, in the nursing profession, the need to expand the scope of practice is real. Consideration of the inclusion of ongoing education provides a career pathway to ensure a process of understanding, competence, and certification of an advanced scope of practice, and this requires consideration in the role of the HITH RN (Birks, Davis, Smithson, & Cant, 2016; Birks, Smithson, Lindsay, & Davis, 2018; White paper Optimising Advanced Practice Nursing).

6. Conclusion

The ongoing need for acute care in the community is clear. The HITH RN is strategically and clinically positioned to provide care, leadership, and linkage between patient and health practitioner. The findings provide greater clarity and understanding of the HITH RN role and their professional responsibility in practice. It is essential for HITH RNs to be provided with opportunities to practice to their full capability. HITH RNs must also explore opportunities to broaden their knowledge, skills, and overall potential in care provision and management. As a professional group, HITH RNs need to take some control of their education and practice through formal professional development pathways, mentorship, and clinical supervision. This self-determined pathway requires greater clarity and confirmation through more formalised education and career pathway structure that supports the professional nurse in practice. Governance structures and professional peak bodies are called to attention to learn from the experiences of the HITH RN. These experiences may assist with solutions that enable innovative models of care inclusive of better integration of HITH acute care models in community. Enhancing an existing service through the attention and development of HITH RNs to their full capacity is one strategy in strengthening the Australian healthcare system for the future.

Authorship contribution statement

Angela Ellis, Melissa Taylor: Conceptualization, methodology, and ethical project management. **Angela Ellis:** Data curation, writing – original draft preparation. **Melissa Taylor, Angela Ellis:** Data analysis and verification. **Angela Ellis:** Visualization, investigation, and analysis. **Melissa Taylor:** Supervision, edit, feedback, constructive review and writing; **Angela Ellis, Melissa Taylor**: Reviewing, editing, and finalisation of paper.

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Ethical statement

The University of Southern Queensland Human Research Ethics Committee approval (H15REA113) (low risk) was approved on June 5th, 2015. No biological/chemical human or animal research was undertaken. As part of the HREC approval, support was gained from the HITH Australasian Society Committee and Queensland Health exemption. The ethics approval processes included providing information about the purpose of the study, recruitment of participants, participant consent, data collection details, confidentiality, and storage and destruction of data. When sending potential participants information regarding the study, a participant information sheet, consent, and withdrawal form were included in the information pack, as this is part of my risk management strategy.

Conflict of interest

The authors Angela Mary Ellis and Melissa Taylor certify that they have no affiliations with or involvement in any organisation or entity with any interest (such as educational grants; membership, employment, consultancies, or other interests; and expert testimony or patent-licensing arrangements) unless otherwise stated, or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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