University of Southern Queensland

# THE ROLE OF THE HOSPITAL IN THE HOME REGISTERED NURSE: A PHENOMENOLOGICAL STUDY

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# ABSTRACT

Healthcare and societal expectations change over time, with Hospital in the Home (HITH) registered nurses (RNs) increasing in community profile in Australian nursing domains. The COVID-19 pandemic created pressures on HITH RNs to maintain the health and wellbeing of patients with acute and chronic illness management. A critical understanding of the HITH RN's role is needed because large variations in current position descriptions (PDs) and role functions exist. In this research, I explored the HITH RN role and key functions through a qualitative interpretive phenomenological lens. I also conducted a critical PD evaluation of the duty statements, responsibilities, and accountability to identify the requirements of HITH nurses. In doing so, I revealed HITH RN roles to be complex, encompassing communication, accountability, and responsibilities in autonomous care-delivery settings. Thematic analysis of the data highlighted the challenges and successes of HITH roles. Three key areas emerged: professionalism, knowledge, and responsiveness, but there was a mismatch between scope of practice in the PDs. Overall, in this research I identified challenges in the day-to-day role and function of the HITH RN. The HITH RN undertakes complex roles, working within generic PDs that lack core components of the required autonomous practice, experience, and knowledge. This thesis contains outcomes and strategies that link national and international literature. It also contains recommendations for clarity and improvement in HITH RNs' role, scope, and function. Redefining the principles of the HITH RN role at an advanced level has implications for policy and practice. The advanced care practice rewards achievement and develops role clarity that enables the provision of acute care in the community through a collaborative, timely, efficient, and effective approach.

# CERTIFICATION OF THESIS

I Angela Ellis declare that the PhD Thesis entitled 'The role of the Hospital in the Home Registered Nurse: A phenomenological study' is not more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes. The thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Date: September 9, 2022

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Student and supervisors' signatures of endorsement are held at the University.

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| | |
|---|---|
| AAACN | American Academy of Ambulatory Care Nursing |
| AANA | American Association of Nurse Anaesthetists |
| ACN | Australian College of Nursing |
| AfC | Agenda for change |
| AHFS | Australian Health Framework Systems |
| AHPRA | Australian Health Practitioners Regulation Agency |
| ANA | American Nurse Association |
| ANF | Australian Nursing Federation |
| ANMAC | Australian Nursing and Midwifery Accreditation Council |
| ANMC | Australian Nursing and Midwifery Council |
| AP | Advanced practice |
| APN | Advanced practice nursing |
| CINAHL | Cumulative Index to Nursing and Allied Health |
| CN | Clinical nurse |
| CNC | Clinical nurse consultant |
| CNS | Clinical nurse specialist |
| CPD | Continuing professional development |
| CVAD | Central venous access device |
| DoH | Department of Health |
| ERIC | Education Research Complete and Education Resource Information Centre |
| HaH | Hospital at Home |
| HITH | Hospital in the Home |

| | |
|---|---|
| HITH-IG | HITH Interest Group |
| HREC | Human Research Ethics Committee |
| HWA | Health Workforce Australia |
| ICN | International Council for Nurses |
| IOM | Institute of Medicine |
| NCLEX | National Council Licensure Examination |
| NDIS | National Disability Insurance Scheme |
| NHS | National Health Service |
| NMBA | Nursing and Midwifery Board Australia |
| NMC | Nursing and Midwifery Council |
| NP | Nurse Practitioner |
| NSW | New South Wales |
| PDR | Professional development review |
| RN | Registered Nurse |
| RCN | Royal College of Nursing |
| RCOBGYN | Royal College of Obstetrics and Gynaecology |
| SA | South Australia |
| TL | Team leader |
| UK | United Kingdom |
| USA | United States of America |
| WA | Western Australia |

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# CHAPTER 1: INTRODUCTION

Nurses account for the largest most-significant single healthcare profession in Australia. Current trends, corresponding with global forecasts, suggest that by the year 2030 nine million nurses and midwives will be needed globally, and nationally there will be a shortage of more than 85,000 nurses (Broome, 2020; Pursio et al., 2021). The forecast shortage of nurses as well as the nature of healthcare and societal expectations have changed over the last six decades. A greater focus on acute care at home is seen with strategies and government policy aimed at community ageing, chronic illness management, and oncology care at home to maintain the health and wellbeing of local populations with chronic illness (Drennan & Ross, 2019; Medibank, 2021; Peter McCallum Cancer Centre, 2021). Understanding the role of the registered nurse (RN) who undertakes acute care in the community is now at the fore of health services. The study focuses solely on HITH RNs and no data was collected for other stakeholders, for instance other healthcare professionals, recipients of care or carers.

This chapter outlines the background (section 1.1) and context (section 1.2) of the research, and its purposes (section 1.3). The research question (section 1.4), aim (section 1.5) and methodology (section 1.6) is introduced. Section 1.7 describes the significance and conceptual framework underpinning this research. Finally, section 1.8 includes an outline of the remaining chapters of the thesis.

## 1.1 Background

Since the onset of the worldwide COVID-19 pandemic in 2019, the need for specialised Hospital in the Home (HITH) nursing services is more evident. HITH nursing care has become a more prominent healthcare provider of at-home health care provision for those with COVID-19 (Cavanaugh et al., 2021). Likewise, care needs have increased with fewer hospital beds available for admissions for those with chronic illness, meaning that HITH RNs manage chronic health conditions with acute exacerbations or management requirements at home (Contandriopoulos et al., 2015; Jakimowicz et al, 2017). In this research, I seek to understand the role and function of the HITH RN as the demand increases in scope and practice and the need for more acute care services are required in the home environment. It is known that HITH

nursing care teams provide person-centred care delivering the most appropriate care for individuals in their homes (National Health Service, 2009).

The HITH model aligns with the caring principles of Watson's theory of nursing practice that is inclusive of both "an art and a science" (Watson, 1979). Watson proposed that nursing is characteristic of kindness, sensitivity, and a caring premise. The knowledge and expertise to fulfil the autonomous role of the HITH RN requires an understanding of the science, a decision-making capacity, and an understanding of what the needs of a patient are outside diagnostic areas of hospitals. The knowledge and the caring element collectively make up the "art and science". It is this combination that sets the scene for the role of the HITH RN in providing acute care needs at home. This research is intended to provide more information about the role in practice, that is, at home.

Aligning with Watson's (1979) caring science philosophy and an interpretive phenomenological approach, I seek to share the experience of 12 HITH RNs relating to their perspective of their role and function in caring for acute health needs in the community. In aligning the role and scope in practice, I explored two areas. The first shares the experiences captured through in-depth interviews with HITH RNs. Hearing the experience of the role of the HITH RN is important to understand and grasp the full meaning of the role and scope in practice. The experience would not be complete without including an analysis of each participant's official position description governing their practice. The position descriptions share the scope and definition of key role capabilities in practice and enable full utilisation of nursing resources and defined role duties.

The ageing population and increases in chronicity, newer medications and technologies, and health treatments extend lifespans (AIHW, 2014). The acute care hospital setting is unable to manage an overwhelming demand, and the traditional community setting is unable in its current state to provide for more complex needs (Clarke et al., 2021). The progression from the traditional hospital-based model for providing acute care is essential and the HITH model has been proposed as the most appropriate solution that provides integrated acute health care for patients in their homes (Putera, 2017).

Hospital in the Home services were formalised in Australia in 2006 (Caplan et al., 2011) with a focus to provide acute care at home as a direct alternative to being treated for the same condition in an acute hospital bed. The HITH service reduces

hospital bed days and the overall length of stay of patients (Acumen Research and Consulting, 2019; Caplan & Boxall, 2012; Caplan, Sulaiman, et al., 2012; Deloitte Access Economics, 2011; Department of Health [DoH], Queensland, 2019). Avoidable admissions and readmissions have been prevented, and the patients remain in the comfort and familiarity of their own homes (Deloitte Access Economics, 2011; DoH Queensland, 2019). The staffing model engages enrolled and RNs in care provision while supported by a multidisciplinary healthcare team from the hospital or community general practice primary health setting (Cavanaugh et al., 2021).

A significant catalyst for HITH nursing is fiscal acuity. Australian taxpayers cannot sustain the multibillion-dollar investment in purpose-built hospitals required for an increasingly older population (Montalto, 2020; Nundy & Patel, 2020). Fiscal constraints for hospitalised inpatient care and improved technological advances have tilted the axis from hospitalised inpatient care to providing HITH care (Montalto, 2020; Nundy & Patel, 2020; Slomski, 2021; Wurcel et al., 2019). For instance, several healthcare services moved to outpatient settings (during and post pandemic), outpatient ambulatory therapy, ambulatory care, home health, Hospital at Home (HAH), and HITH services (Martinez & Graystone, 2021). The shift in care setting is necessary to ensure equal access to acute hospital-level care comparable to that delivered in hospital (hospital-level care) to ensure the attainment of quality patient-care outcomes while maintaining costs outside the hospital setting with increased numbers of patients.

Fewer hospital beds are available (Montalto, 2020) because hospitals are preferring to undertake more day cases for surgery, minor injuries, and oncology/chemotherapy, thus moving toward increased hospital-level care in the community. Since the onset of the global pandemic, restrictions on hospital bed numbers have meant that COVID-19-positive patients with milder symptoms are being nursed in the community. The inclusion of HITH services in the residential aged-care area is growing, particularly with the need for additional nursing care with managing the COVID-19 climate to ensure that support and expertise in acute nursing care assistance are provided to staff. An extension or enhancement of the HITH RN role and scope enhances early assessment and has the capacity to include telehealth, thus prioritising care for residents and providing the RN in residential aged-care facilities with support at times of acute illness (Gilbert & Lilley, 2020; Hunt, 2021a; World Health Organization [WHO], 2020d, 2020e). This option decreases the need for

transfer to a hospital for aged residents seeking to remain in their own environment. These options allow residents and the community to receive care at the time and place they prefer, giving greater patient satisfaction (Hunt, 2020) and for the HITH RNs greater satisfaction from having the ability to deliver patient care as requested.

The WHO (2020e) has identified the need to invest in health care education, leadership, and jobs to attract more RNs into nursing. A considered investment strategy will maintain and enhance the evolution of healthcare-provider systems such as HITH services (Clavalle & Prado-Inzerillo, 2018). It is time for individual state and territory health funding levels, plus federal government health policies that apply to all states and territories, to reflect HITH being vital to the current and future healthcare sustainability by supporting services that revolutionise HITH services equating to nursing growth in Australia (Hunt, 2020; Thew, 2019). Learning more about the systems, workforce, practice, and feasibility of HITH services is at the fore. Gaining more information to support and enhance the HITH RN role supports the process of evolution and better access and outcomes for acute care in the community.

## 1.2 Context

My journey in this research is driven by my passion as a nurse and my desire to learn and improve one aspect that I know and enjoy. This is the HITH service that operates from acute facilities to provide care in the home. My journey in Nursing commenced at a very young age in the UK with my desire to bandage my father and I also bandaged my teddy bears including their paws, arms, legs, or head. When I was three, I received a hospital bag with a stethoscope and thermometer that added to my repertoire. During my early school years, I had a fascination for reading about “The Lady with the Lamp”. However, I did not express any wish to be a nurse or carer. It was after I left teacher training college, disillusioned, that I turned to nursing. My background in teaching is still a vital component of nursing. With my teacher training experience behind me, I worked in the Department of Health and Social Security for a short while. I began working in a “Ladies’ Home” that was overseen by nuns. It was there I first realised that I should undertake nurse training. I applied to several hospitals and was accepted by all. The mother superior thought I would be an unruly nurse because I did not always follow instructions but made decisions based on observations. It is noteworthy that Nightingale, in 1859, placed observations as a key nursing skill, as did Chinn (2020) when she stated:

> If a patient is cold, if a patient is feverish, if a patient is faint, if a patient is sick after taking food, if he has a bed-sore, it is generally not the fault of the disease, but of nursing" (p. 32).

Nevertheless, one training hospital offered me a position in their enrolled nurse course. The interviewers asked how I would manage to complete RN training successfully because "you do not have math or human biology". My response was quite firm that I would have to work harder, and I was offered a student RN course, and to this day that is what I have always done. Working hard and looking ahead, looking for opportunities to join groups and associations to increase my networking. Expanding my knowledge and skills ensured that I gave optimal patient care and led teams to deliver succinct and timely care in all my roles from staff nurse to nurse consultant in the UK, to clinical nurse positions in Australia. Each role had increased responsibilities, and differing teaching aspects for students, new nurses, and other nongovernment and government workers. Nonetheless, the imposter syndrome has been rife during my PhD candidacy and was especially reinforced by other healthcare professionals across my career trajectory. However, I have, and always had, time for genuine, caring conversations about sensitive and personal issues. I felt confident that my nursing skills and ability to help my patients and their families to navigate complex situations would lead to improvements in their health and safety.

On migrating to Australia, I asked another RN if I could undertake a certain procedure and I was informed no, so I asked why not and was told nurses aren't allowed to undertake that procedure here. I probed a little further, asking for the rationale behind the decision that nurses could not undertake the procedure if their education, knowledge, and skill level were up-to-date and relevant. The retort was that nurses just don't! Such a negative response piqued my curiosity. I decided to explore the role and role functions of RNs in Australia further. I am only one of approximately 400,000 RNs on the central nursing register in Australia today, but surely, I cannot be the only one to consider my role and role function as an RN in a specialty area. My nursing journey heightened a curiosity within me that is the impetus for this research, especially my nursing experiences since migrating to Australia. Reflecting on these stories that are unique to my journey to becoming an RN has assisted me to gain an understanding of the meaning of the role and role functions of HITH RNs through hearing about and sharing the lived experience of RNs in HITH roles. These

experiences motivated me to enrol in a Doctor of Philosophy Research program to formally evaluate an area of RN practice I am most passionate about.

I am passionate in believing that "home is best" for care provision and that it is a privilege to be invited into a patient's home to deliver the healthcare required. As an RN, I wanted to explore the role and role function of HITH RNs in Australia to share the experiences and identify areas where professional growth and clarity can be gained.

### 1.3 Purposes

In this research, I have sought clarity about the role and function of the HITH RN. I explore and describe the experiences of RNs employed within Australian HITH health care services in relation to their role and role function from their perspective. I seek to understand the role and function outlined in position descriptions relating to the HITH RN through an analysis of key performance indicator inclusions.

### 1.4 Research Question

The specific research question in this research is:
What is the HITH RNs' experience of their role and function in practice?

### 1.5 Research Aims

My aims in the research are to:

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 key performance indicator inclusions and barriers.

The research design permits consideration of all aspects of the function of the role, the clinical governance structure of the setting, the role descriptions, and the requirements in care coordination and practice within a multidisciplinary health care team from documenting the RNs' experience, and through a content analysis of the associated position descriptions.

## 1.6 Methodology

I used an interpretive phenomenological approach to share the experience of the HITH RN role and function. In doing so, I used purposive sampling to engage HITH RNs from any Australian health service. This approach was chosen to enable the voice of HITH RNs to be gathered to provide insightful firsthand knowledge of their role and function in practice. Purposeful sampling enabled HITH RNs from each state and both metropolitan and regional areas to be represented. This provided the research with a broad and yet inclusive approach to understanding the role and function in the Australian health service context. HITH RNs from across all states and territories in Australia participated voluntarily. I used a content analysis to critically analyse the role and function of the HITH RN position description documents.

I gathered qualitative data from participants using semi-structured, in-depth audio-recorded interviews. The interview questions were open-ended, and I did not challenge or interrogate the participants but, rather, encouraged them to share their stories (see Brinkmann & Kvale, 2018).

Data collection was aimed at:

1. gathering important accounts of the participants' experience and
2. capturing these experiences in a manner that allowed me to interpret and report my findings.

Recorded interviews were transcribed into a textual format to enable thematic analysis. I used constant thematic analysis with NVIVO© (Version 12) data management software on a Mac platform to ensure effective and efficient data management and analysis (see Jackson & Bazeley, 2019). I organised data into one system through a process of continual coding, comparing, and cross-referencing. Using NVIVO© added a further confirmatory phase in which I checked initial and subsequent themes against specific quotes from the interview scripts. Further linkages of emerging themes were compared with the literature to highlight gaps and new knowledge. In the thematic analysis, I used a process of codification to identify meaningful themes. During the study, emerging themes and subthemes resulted in the formation of a concept map illustrating defined relationships. Data analysis concluded with the emergence of relevant themes from the data.

Content analysis of the participants' position descriptions highlighted the key areas of commonality and discrepancy in role function, skill, and knowledge. In the

content analysis, I used NVIVO© data management software to analyse the position descriptions by commonality, difference, skill, and knowledge. I determined concept maps and key emerging themes through a process of iterative thematic analysis.

This thesis gives an account of the participants' journey, the background, the supporting literature, the research design and the process, and the results of both in-depth interviews and the content analysis of the associated position descriptions.

## 1.7 Significance, and Conceptual Framework

Nursing is the largest profession in the healthcare workforce in Australia. There are over 800,000 registered health practitioners plus a further 35,000 health practitioners on the temporary pandemic sub-register (AHPRA, 2020). Almost 445,000 nurses are registered with AHPRA across the three levels of accredited registration, including the enrolled nurse (EN), RN, and Nurse Practitioner (NP). Only 2,069 nurses registered with AHPRA are NPs, and 1,237 of these are registered to prescribe medications (AHPRA, 2020).

HITH teams have rapidly extended patient cohorts. Palesy et al. (2018) undertook an integrative review analysing over 2,700 pieces of literature to gain a better understanding of clients and their needs, funding, and regulation as well as care-worker skills, tasks, demographics, employment conditions, and training needs. The global acute care-at-home sector (HITH, HaH, H@H, Home Care, At Home Care) comprises one of the fastest-growing workforces, and none captures the landscape of Australian acute-care nursing at home from the perspective of role and function. Due to the multiple choices of "at home care" across the world, it makes it difficult to make an overall statement regarding role perspectives and functions. Especially, as each geographical area, or service may have higher health priorities and different patient cohorts. A few captures service changes around the early-warning score for deterioration of the patient (Gray et al., 2018a, 2018b) or changes in treatment plans (Ibrahim, Babl, et al., 2016; Ibrahim, Hopper, et al., 2019).

This research ensures that an understanding of the role and scope of practice of the HITH RN is shared. This will assist policy and governance standards in defining and refining specialised roles in the profession of nursing that align with the Nursing and Midwifery Board Australia (NMBA) national regulatory standards and the Health Practitioner Regulation National Law Act (2009) (National Law Act 2009; NMBA, 2018). The research offers opportunities to gain needed insight into the role and

function of the HITH RN to provide capacity for that nurse to develop a scope of practice suitable to community needs in a time of the global coronavirus pandemic or to avoid hospital admission and/or readmission in an ever-stretched health care environment. The research outcomes and recommendations described in this thesis will assist in providing a definitive outline of the position and role in which HITH RNs function.

The role and role function of HITH RNs was discussed in the print and broadcast media during the COVID-19 pandemic resulting in an independent review of Newmarch House in New South Wales (Gilbert & Lilly, 2020). The review questioned how staff provided direct patient care in relation to catering, activities, and social isolation during the pandemic. At a crucial moment in a national crisis, HITH RNs were allocated to Newmarch House to support a limited aged-care workforce in residential care during the time of a serious illness outbreak. The report revealed unavailability of qualified nursing staff in the setting, acute resident demand, and the need to manage older persons at home rather than in hospital. The outcomes of the review indicated that different and improved health service models are needed to support the ageing population in Australian residential and community aged-care settings. To effectively contribute to this topic, questions are raised in residential care by HITH RNs to define the RN role with greater scope and clarity.

Watson's (1979) philosophy and science of caring framework aligns with a contemporary theory about how HITH RNs conduct their role function and scope in practice. The theoretical framework acts as a guide to understanding the data and results with the aim of portraying the results that share the experience of staff. This provides a strong sense of what the nursing roles and scope in practice in contemporary nursing portrays for a HITH RN. Watson's philosophy outlined a strong emphasis on caring achieved through a lifelong process of education and learning, linked with experiential practice, and knowing and understanding the core principles of the role of the RN.

## 1.8 Thesis Outline

The thesis is structured into eight chapters. Chapter 1 contains an overview of the context, purpose, and significance of the research. This is followed by a discussion of the historical underpinnings of HITH services in Australia and the known role of the RN. The background to the research question and aims are presented. The

justification and significance of the research are also discussed, and information about the research design, methodology, and setting are introduced. Chapter 2 contains an overview of the literature surrounding the context of HITH services, the legislative and historical underpinnings of HITH, and the scope of practice and governing standards relating to the role of the RN. An introduction and a more comprehensive discussion of the role and function of the RN working in the HITH context are outlined, and the functions experienced in the role are outlined from the perspective of the literature. The findings from the literature are also discussed in relation to the roles of the RN working in the HITH environment in Australia, including models of care with or without a multidisciplinary focus and economic drivers. The literature review indicates a lack of HITH RN-specific information because the role is often defined by general RN roles. I also describe the series of questions that were generated to contribute to the reflexivity and transparency as I addressed the research question. Chapter 3 contains a description and justification of the methodology that I used in this research. Linking directly with the methodology, in Chapter 4 I provide information about the research design, selection of participants, the research setting, data collection strategies, ethical considerations, and data analysis processes. In Chapter 5, I present the findings of the research in both descriptive and interpretative forms, including descriptive comments from staff specifically outlining the role and function of the RN and the thematic analysis. Then, in Chapter 6, I provide information about the interpretative analysis of the position descriptions of RNs working in a HITH service**.** Chapter 6 also contains an articulation of the interconnectedness of the position descriptions and the experiences gained from the RNs via the interviews. Linkages, commonalities, and disconnections between the two areas of analysis are explored. In Chapter 7, I discuss the findings presented in Chapters 5 and 6. In Chapter 8, I offer recommendations for future practice to align HITH nursing with NMBA standards of practice and professional practice. I also present recommendations for the HITH Society Australasia board and suggest opportunities for future research that meet an objective of their current strategic plan, while noting the research limitations. And finally, I provide a summary of the conclusions in relation to the theoretical context of the literature and the results of the current research.

# CHAPTER 2: LITERATURE REVIEW

This chapter is a narrative review of the literature about the Hospital in the Home (HITH) program, its legislative and historical underpinnings, scope of practice, and governing standards. The findings from the review are discussed in relation to the roles of the RN working in the HITH environment in Australia and to the models of care with or without a multidisciplinary focus. The economic drivers and fiscal constraints in establishing and maintaining nursing teams are considerations in health-service planning with specific relevance to the HITH RN. This chapter commences with the context that established the role of the HITH RN in Australia.

This chapter outlines the context (section 2.1) with literature review search strategy and search terms in section 2.2 and section 2.3. The historical lens of HITH nursing from inception until now is presented in section 2.4. The evolution of nursing roles (sections 2.5 and section 2.6) and inclusion of nursing regulations (section 2.7) Nursing scope of practice (section 2.10) form the premise of defining the HITH RN in practice. Various aspects of the advanced practice role (section 2.13) in HITH RN roles internationally is shared that further develops the construct of the HITH RN role from professional competence (section 2.14), leadership (section 2.15), knowledge requirements (section 2.16) and education (section 2.17). The caring caritas philosophy of Watson (section 2.19) underpins the research and is explored through the conceptual framework and its linkage to exploring HITH RN roles in contemporary nursing in Australia. The literature review commences with the context of the Hospital in the Home service.

## 2.1 Context

Hospital in the Home is a direct substitution for acute hospital in-patient care. The service delivers care in the patient's residence of choice, allowing patients to participate in their care to achieve optimal clinical outcomes (Queensland Health, 2017, last updated 18/01/2022). The COVID-19 pandemic has stretched acute care resources within an already over-burdened healthcare system. The inclusion of "virtual wards" during COVID-19 has enabled greater interface with telehealth mechanisms that have now become part of everyday practice (Begun & Jiang, 2020; Hunt, 2021a, 2021b; Monaghesh & Hazizadeh, 2020; Wijesooriya et al., 2020). Staff burnout,

service demand, and the need to isolate have further impacted the HITH service as it expanded care-at-home services during the pandemic. Simultaneously, the role of the RN has informally expanded to include the increased need for acute assessment, referral, and management of patients at home from a HITH RN. It is currently timely to explore HITH RNs' experience of their role and function in practice as health care demand and pressure on acute health services expand and medical shortages in primary care prevail. Understanding more about the role of the HITH RN and its function in the health care setting better enables integration of services to assist with current drivers of demand. The role of the RN encompasses all activities physically, psychologically, or socially and the decision-making process that relates to the nursing care of a patient for a particular condition in the home environment (NMBA, 2020a, 2020b, 2020c, 2020d, 2020f). The professional standards of practice and the competency standards of the RN underpin the core work components of the RN in a HITH service. Standards such as RN standards of practice (NMBA, 2020a), codes of conduct (NMBA, 2018), ethical decision-making behaviours (ICN, 2021), decision-making frameworks (NMBA, 2020b), NP standards (NMBA, 2021), and professional codes for advanced practice (NMBA, 2020c) are explored alongside the literature (Stewart, 2020).

The literature search includes peer-reviewed journal articles; systematic and integrative reviews; editorials; reports; codes, standards, and governing documents surrounding nursing or the practice of HITH nursing; and discursive, qualitative, quantitative, and mixed methodologies surrounding the HITH RN. All papers were required to be in English. Reviewing different types of papers gave valuable insights across all methodologies and writings that aim to outline the specific aspects defined in the context of the review relating to the role and function of the HITH RN.

The specific literature review question asks:
What are the HITH RNs' experiences of their role and function in Australia from inception to now?

## 2.2 Search Strategy

Completion of a narrative literature review involved searching a variety of databases including PUBMED, Medline, The Nursing Reference Centre, and EBSCOhost. Relevant journal articles, government reports, and reference books that

are subscribed to either electronically or in hardcopy were located. EBSCOhost MegaFile Complete was selected as the primary source because it permitted simultaneous searching of more than one database. EBSCO-published databases were then used to sort citations by relevance and dates. The following multidisciplinary databases were also included: Allied Health, Health, Law, Biomedicine, and Women's Health. These databases were selected because of their relevance to the topic: Academic Search Complete and Academic Search Ultimate. The Cumulative Index to Nursing and Allied Health (CINAHL) and ClinicalKey was also included because they have the most comprehensive full-text collection of nursing and allied health journals that date from 1981. The initial search strategy provided a comprehensive review of the relevant scholarly literature.

## 2.3 Search Terms

Search terms included "Registered Nurse" OR "Nurse Practitioner" OR "Advanced Nurse". These search terms were then combined with the Boolean Operators "AND" and "OR" "Australia" OR "Global" OR "Hospital in the Home" OR "Ambulatory Care" OR "Outpatient Ambulatory Therapy." "role*", "function*", "scope", "practice" and "work". Other terms were used to capture specific methodology relevant to the study. These included "Phenomenology" OR "Hermeneutics" OR "Methodology" AND "Thematic Analysis". The following limits were added to the search: English language, journal articles, research articles, reports and nursing policy and procedure, and expected nursing standards. The results of the literature review are presented below. Additional to this search, historical perspectives about HITH in Australia are reviewed and presented.

## 2.4 Historical Background

Australia is a vast continent with a growing population that requires a variety of acute and community healthcare services. Rural and remote areas alongside more regional and densely populated metropolitan areas make health service delivery in such complex areas. The HITH service has been informally used in Australia for over 120 years, led by the Silver Chain Group in South Australia (Silver Chain Group, 2017). This was closely followed by services in Western Australia. Silver Chain have expanded their service model to deliver services in Victoria, New South Wales, and

Queensland (Silver Chain Group, 2017) as the complexity and acuity of patient care have increased.

The introduction of HITH services in Australia was based on the premise of providing care and assistance to patients in their homes initially through Commonwealth funds and now funded by state or territory government public healthcare funding, or private consortiums and not-for-profit organisations (Hostetter & Klein, 2020; Silver Chain Group, 2021). These services began in Western Australia in 1894 when care was provided to the sick and the poor in their own homes (Silver Chain Group, 2021). Around the same time in South Australia, the District Nursing Association was formed. By 1885, Victoria had formed the service, Melbourne District Nursing, and in 1910 Queensland formed the Mother's Union District Nursing Association (Silver Chain Group, 2021). These informal and not-for-profit services have continued, changed, and morphed as the decades evolved, some with health funding, others funded by consumers privately (Silver Chain Group, 2021).

In 1994, the concept of HITH nursing in Victoria and New South Wales emerged, with other states and territories following (Australasian HITH Society, 2007). By 2003, Victoria had introduced a formal case-mix funding strategy for transfer to home from hospital for continuing acute care (Duckett, 1998). In the same year, Silver Chain (WA) developed and introduced "Comcare" with a smartphone for their field nurses. Silver Chain continued to expand services and now has centres in Queensland and additional services in South Australia.

A group of healthcare professionals in NSW began the Hospital in the Home Australasia Society in 2006, holding the first Hospital in the Home Scientific Conference in 2007 (HITH Australasian Society, 2007). The formal approach to HITH services had begun (Australasian HITH Society, 2007). In 2006, Victorian HITH services were developed to meet local needs, resulting in greater access to healthcare services in the local health district. The New South Wales government engaged Deloitte Access Economics (2011) to review the economics of HITH services providing high-level evidence to influence the government's health department decision making about HITH services (Myers & Twigg, 2017). By 2012, Caplan and Boxall (2012) had provided a meta-analysis of evidence on why home is best even for acute-care management of some illnesses. The evidence suggested greater satisfaction with care that was provided at a lower cost and was also associated with lower mortality rates 6 months after discharge, in fact 38 percent lower for those cared for at

home (Caplan & Boxall, 2012). Improvements were also noted with better functional outcomes for older patients having less chance of ending up in institutional care (Caplan & Boxall, 2012). Expansion of HITH services in both public and private sectors continue with increased prevalence as the progression of the COVID-19 pandemic weighs heavily on acute-care hospital resourcing (Broome, 2020; Kaye et al., 2021). This more formalised public health system approach is now the dominant service and is currently governed by the Australian public health system under the jurisdiction of state and territory governments.

In 2021, every state and territory in Australia identified the need for a fully functional supported HITH service. Montalto et al. (2020) reported that care delivery in HITH services has expanded across Australia and has benefited patients and healthcare providers by reducing readmissions and mortalities. Montalto et al. (2020) aimed to increase admissions to HITH services over a 7-year period. Their analysis revealed that HITH admission numbers grew at almost twice the rate of non-HITH admissions and that HITH plays an important and growing role in the care of patients with a range of conditions and often with multiple co-morbidities. The authors argued the "challenge for health systems is to expand clinical roles further to determine specific clinical areas in which HITH may prove to be useful but not currently used" (Montalto et al., 2020). The World Health Organization (WHO, 2020e) reported on the status of the COVID-19 pandemic and has encouraged healthcare systems to be flexible in care delivery, including the use of HITH expertise in times of crisis (WHO, 2020a, 2020b, 2020c). Irrespective of the historical underpinnings of the HITH service throughout the 20$^{th}$ century, the service remains an evolving concept, not one of expanded roles that encompasses areas of advanced practice (Gilbert & Lilly, 2020; Keeling, 2015).

Prevailing ill health and an identified residential aged-care crisis in relation to the COVID-19 situation in 2021 resulted in the need for nursing care and management strategies by HITH RNs more broadly in the community and in residential aged-care settings. Gilbert and Lilly (2020) questioned the clinical roles and positions of staff in the residential-care setting and an urgent deployment of HITH RNs was sent to assist in the coordination and care management of residents. It was the HITH RNs who became responsible for the introduction of hospital-level personal protective equipment and nursing interventions and plans in several residential aged care settings (Gilbert & Lilly, 2020). Hospital in the Home services and HITH nurses gained media

notoriety during the COVID-19 pandemic in New South Wales following an independent review of Newmarch House Aged Care Facility as resident deaths, care concerns, and an uncontrollable spread of COVID-19 occurred in that facility (Gilbert and Lilly, 2020).

The review highlighted that "healthcare was prepared for a storm not a cyclone". Hospital in the Home clinical nurses regularly managed acutely ill residents in the nursing-home environment. However, significant during this situation was the lack of nursing home staff to provide care for non-infected residents (Kennett, 2020). The significance of the breakdown in leadership as well as deficiencies in communication between staff and outside agencies led to life-threatening situations and resident deaths (Gilbert & Lilly, 2020). This was coupled with depletion of staff due to quarantine orders at short notice and the spread of COVID-19 in the facility. Issues were compounded by incorrect personal protective equipment use and a lack of infection prevention and control processes in the residential aged care settings. The issue of communication with families was highlighted as significant. There was a lack of minimal personal care for the residents in isolation. The patients were malnourished as staff left meals outside the rooms of infected residents, and family were not able to deliver freshly prepared hot meals. Additionally, not being able to hug family members increased patient anxiety and affected residents' well-being (Gilbert & Lilly, 2020). HITH RNs visited residents and provided assessments and appropriate care and management plans for staff. It is a model not regularly used by HITH services, but one that worked well in the emergent situation and has continued.

## 2.5 Current Health Climate

The increasing prevalence of the HITH service and the need to consider viable alternatives in patient care in the community has highlighted the role and function of the HITH RN with a more contemporary lens. Cai et al. (2021) indicated that readmission rates from HITH-based services led by RNs were lower than readmission rates from acute facility discharges and accounted for an almost 50% reduction in emergency presentations leading to a cost saving of 48% (Cossette et al., 2015; Soril et al., 2015; Tsai et al., 2018; Wadhera et al., 2019). Australian economists have estimated savings of $3 billion due to the effective implementation of HITH services. Therefore, HITH remains an economically driven healthcare improvement strategy

that delivers both positive patient outcomes and economic benefits for services (Cai et al., 2021).

Nundy and Patel (2020) and Slomski (2021) urged hospitals to explore the possibility of HITH services as an alternative to a hospitalised stay. Hospital in the Home RNs are now used to a greater extent than previously in Australia's history. The studies by Nundy and Patel (2020) and Slomski (2021) are like that of Wurcel (2019). The outcomes were that HITH services decreased hospital expenses for home care by approximately $30,000 per patient in 2019. Nundy and Patel, along with Slomski's outcomes highlighted decreased emergency room visits at $300 per person, resulting in more convenience and less expense for patients and their families (Levine, 2020). The number of older persons is projected to double to 1.5 billion by 2050 worldwide (WHO, 2021a). The significant increase in ageing populations, means Australia is not immune to the demands of more patient-centric healthcare services, which in turn increases the demand for home healthcare (Australian Institute of Health and Welfare [AIHW], 2021; Market Analysis Report, 2020). Slomski (2021) suggested that healthcare costs would increase as the global economy continued in a quest to manage COVID-19 and a growing ageing population (Slomski, 2021). Such an increase in ageing populations without the increase in the general population will require more health care clinics to be Nurse-led (NP co-ordinated) in the face of generalised medical shortages both nationally and internationally. The use of new technologies, treatments, and vaccines continues to stretch the over-stretched healthcare budget.

Services that reduce admission and keep individuals at home are emerging as popular choices. The WHO (2021a) reported that the estimated growth of the ageing population will substantially increase patient volume and will topple the supply and demand in healthcare. By 2025 worldwide, it is estimated that there will be a shortage of 29,000 NPs (Haddad et al., 2022; Wellay et al., 2018). Models of care that distribute care and focus on individuals at home are preferred.

With an ageing population and a desire to age at home, changes to healthcare practice that provides support and more acute care at home are needed. Sweden has implemented some very low-cost but high-impact approaches to care at home (The Borgen Project, 2018). These approaches include a law to keep couples together and finding the right level of care for individuals as they age. Physical activity is prescribed, sometimes in combination with medications with continued monitoring by a doctor while residing at home and being supported through required nursing care.

The Borgen Project has, as Australia has, a home helper service to install shower rails and curtain poles, for instance, to prevent injuries such as hip fractures from falls.
The lack of consideration since 2003 from the Australian government reveals a gap in the literature about HITH. The only mention of HITH services is noted in the document *Improving care for older people: A policy for health services (2003)* and this information is now almost two decades out of date (Cho, 2018). Beard et al. (2015) commented that, with population growth, new cost-effective approaches are needed for elder and long-term care that meet the needs of the growing ageing population while containing costs. These reports do not consider HITH as an alternative. However, Beard (2015) suggested low-level community living would include age-friendly cities or the adaptation of traditional services and products to meet the demands of specific populations, again with no specific mention of HITH services. Furthermore, no current information is available about how HITH services, and more importantly how HITH RNs, will cope with the influx of ageing Australians while managing a pandemic situation that requires acute-level care at home. Access for the community, and for those ageing at home requiring healthcare, highlights the importance of HITH services. To assess HITH outcomes, Levine et al. (2018) undertook a trial across a broad selection of patient cohorts to discover whether any differences could be found between cost effectiveness and quality care of acutely ill patients. They concluded that transferring acutely ill patients to a home-substitution program such as HITH initially resulted in an increased cost for the use of the service, but then significantly improved physical activity of patients at home compared with hospitalised patients. The outcomes did not identify any significant differences in quality, safety, and patient experience; however, the researchers did note that a larger trial was required to gain more definitive results. Levine, Ouchi et al. (2020) undertook a larger trial that indicated there were substantial reductions in HITH costs, with increased healthcare use and fewer readmissions, and there were added benefits of increased mobility of patients and increased well-being while in their home environment (Levine, Ouchi et al., 2020).

The HITH service provides individuals more choices in their healthcare by offering better access to services with the improvement of efficiencies of in-home service delivery (Acumen Research and Consulting, 2019; Caplan & Boxall, 2012; Caplan, Sulaiman, et al., 2012; Deloitte Access Economics, 2011; Department of Health, Queensland, 2019). The benefits to the healthcare system and the patient

remain clear on the clinical effectiveness of at-home care with a 30-day transitional period post-acute care (Federman et al., 2018). These results suggest that it is an opportune time to revolutionise HITH-RN acute care in the community, particularly at a time when rising costs, a spiralling healthcare demand and continual healthcare needs are seen.

Canadian Healthcare experienced rising demands and rising costs of healthcare like Australia, the US, and the UK (Hartmann & Hayes, 2017; Morris, 2017; Palesy et al., 2018). This situation arose because of higher age groups in the population, higher acuity, and a higher incidence of acute conditions with underlying chronic diseases. In contrast to the Australian public health system, according to Barua et al. (2107), Canadian Healthcare is underachieving despite previous substantial monetary input, with underachievement due to several issues. Kaasalainen et al. (2014) argued that one issue is a lack of role clarity between what nurses do and a lack of understanding from management about how nursing roles impact patient care (Gannon et al., 2010; Kaasalainen et al., 2014). In contrast to ensure there was role clarity, the US Senate passed the Senate Bill 296/H.R. 2150, the Home Health Care Planning, and Improvement Act, in March 2020 as part of the CARES Act. The Act (2020) allows advanced practice RNs to order, certify, and recertify home health and terminal illness for hospice services. If a similar Act were passed in Canada, maybe the health care at home budget would decrease. Furthermore, if a similar Act was passed in Australia, it would increase access to NP-led patient acute care at home services (ACN, 2020a, 2020b). The shift adds a potential cost saving for Medicare of more than $80 million over 5 years from the rising healthcare costs associated with home-based primary care and complex chronic disease management (Macleod et al., 2004; Stajduhar et al., 2011; Wolff-Baker & Ordona, 2019).

HITH services can be scaled up at times of crisis, resulting in less economic impact and greater community-care outcomes. Pericàs et al. (2020a) concluded that HITH is a safe and efficacious provider of acute COVID-19 patient care at home. They suggested that aligning the different stakeholders could avoid unnecessary deaths and complications related to strains of COVID-19. A COVID-19 management plan for care delivery at home in Barcelona indicated that, despite limitations due to low numbers, patient safety and satisfaction were good, with readmissions due to drug-related side effects rather than worsening symptoms (Hartley & Perencevich, 2020; Pericàs et al., 2020b). The study about a COVID-19 management plan by Pericàs et

al. (2020b) revealed a reduction in the economic burden of the pandemic for the health service when nursing care is delivered at home. Hartley and Perencevich (2020) and Pericàs et al., (2020a, 2020b) point out that HITH can cope with the increases in patient numbers when the healthcare system reaches breaking point. Pericàs et al. (2020b) suggested that a short hospital admission before transfer to HITH resulted in a shorter total care admission time and HITH RN time at home. The pandemic has offered a suitable alternative health model that is more inclusive of HITH perspectives. The American government has given hospitals complete freedom to implement home-based acute services to meet the growing needs of the vulnerable and ageing population (American Hospital Association, 2020). Such commitment to home-based care allows for specialised care led by HITH RNs in a close collaborative model with other health service disciplines (Pericas et al., 2020b).

Hospital-standard acute care at home has proliferated around the world for the same pandemic-induced reasons. Even before the pandemic, Australia had seen an increase in specialised care being delivered at home (see Appendix A), with specialities such as neonates, paediatrics, spinal, use of ventilators at home, oncology, and palliative care (Colville, 2022). Hospital in the Home healthcare delivery is less disruptive because it encompasses the patient's individual lifestyle regarding social, economic, cultural, and environmental factors (Buchan et al., 2018). The benefits of role and service changes, and a shift to a care-at-home approach for some patients, requires more consideration in relation to the role and role function of the RN, therefore, understanding the context of HITH RN roles requires exploration.

## 2.6 Evolution of Nursing Roles

The historical background of nursing registration is relevant to the evolution of the HITH nursing role in Australia. Several key historical events have assisted in the development and evolution of the general nursing role today and in the emergence of specialisations including that of the HITH RN. The most notable reforms to Nursing occurred during and following wartime.

Between World War II and the Vietnam War, the 1950s saw significant changes in the nursing profession with an increased focus on education, improvements in basic training, and the emergence of tertiary education institutions and higher education qualifications for nurses (Queensland State Archives, 2016).

Nurse education transformed the nursing profession from the historical perspective of nurses being a doctor's handmaiden as a subservient or vocational role up to the 1970s and '80s to one of educated practitioners able to lead services and care in acute and community settings (Bessant, 1999; Chiarella, 2021; Lowe, 2020). In 1984 in Australia, legislation was passed to move nurse education into universities. This enabled the emergence of a Nursing a professional status that previously lacked. As tertiary prepared graduates, a nurse was aligned with other health professionals in educational status. By 1993, the only pathway to become an RN was through a university nursing degree. These changes altered the landscape of Australian nursing for RNs. Aspects of critical thinking, assessment and coordinating teams became an inherent component of the role. RNs as stakeholders contributed to the optimisation of education standards and practice capabilities (Casey et al., 2017; Department of Health, Queensland 2013a, 2013b; Mannix, Wilkes, & Daly, 2013; Nursing and Midwifery Council [NMC], 2021a). Professional nursing standards, education standards, and the change from certificate to bachelor's qualification occurred. The educational change enabled a pedagogical approach (the delivery of content to nurse education and the incorporation of an "art and science" in learning) and a professional context for clinical decision making and more autonomous practice (Biggs, 2011; Damopolii et al., 2020). This art and science approach provided the avenue where skill and care adapted to modern health knowledge. Nursing was no longer a vocation, but rather an evolving profession. It is this premise that developed today's practice, education, and regulation, linking with Watson's caring philosophy and an advanced nursing practice framework (Franjić, 2020; Watson, 1996).

## 2.7 Nursing Regulations

In Australia, regulations about nursing occurred in eight forms of legislation until 2010 (Australian Nursing Federation [ANF], 2013; International Council for Nurses [ICN], 2010) as each state and territory developed its own legislative training and registration standards. The Australian legislative framework variations were like those of the United States of America and Canada, where state, territory, and provincial registrations contain variations in regulations and standards of practice (ICN, 2013).

The nursing regulatory pathways relevant to nursing have guided the development and strengthened HITH nursing services. HITH RNs, like all RNs regardless of speciality, are registered with the Australian Health Practitioner

Regulation Agency (AHPRA). There is a train of thought that general community nurses are the same as HITH RNs, but they are not. The main factor is that HITH RNs care for acutely ill patients at home, general community nurses do not, that require close monitoring. HITH RNs make critical decisions that can have serious consequences on the patient's condition. In some instances, these may be life-threatening. Implementation of Queensland HITH guidelines occurred recently (Queensland, 2021). These guidelines have been developed through the Office of Clinical Excellence with input from the Queensland HITH services managers and leaders and are informed by the NMBA regulations and standards (NMBA 2018). The guidelines offer a clinical governance strategy for patient assessment, management, and evaluation for acute care provided outside of tertiary facilities and rather in an individual's home (Department of Health Queensland, 2019). However, such guidelines are not consistent across Australia.

There are four models of clinical governance used in HITH services where these services are predominantly managed by RNs. These comprise:

1. The inpatient admitting team, senior doctor, or NP, who retains responsibility and accountability of care for the patient throughout the episode of care. The HITH team communicate and consult with the admitting team regarding the clinical management plan after discharge.
2. The HITH authorised practitioner model where care is transferred from the inpatient admitting team to an authorised and approved HITH practitioner. The HITH team assume care requirements and legal responsibility for providing treatment.
3. A combination model in which a mix of the first two clinical governance models enables greater flexibility of the service with clear clinical governance and reporting lines.
4. A mix of private and public healthcare partnerships in which the HITH or inpatient team shares governance with the patient's general practitioner.

Creation of guidelines for the models of care provide a starting point for further defining the workforce and, specific to this research, the role and function of the HITH RN.

## 2.8 Defining the role of the HITH RN

The HITH RN provides acute nursing care for individuals in their own residences that aims to be person centred and evidence based (Arendts et al., 2011; Barnard et al., 2016; Frohmader et al., 2018). This care is aligned with both a medical and social care service model, providing integrated care from traditional acute hospital facilities by RNs semi-autonomously in the individual's home. The service most often operates within a multi-disciplinary team, often with ongoing communication with the patient's general practitioner or, in some instances, a medical specialist. Some teams are led by RNs, others by allied health professionals, and rarely by medical practitioners (Queensland Health, 2020). Information about the patient's medical and social history guides the proposed plan of care within a multidisciplinary approach to medical treatment through RN care delivery for individuals in the community (Queensland Health, 2020).

Although the principles of practice have been defined, the roles within the services remain unclear. A multitude of nursing titles have emerged, leading to role confusion and lack of clarity for the HITH RN. Each nursing service within the same or different hospital and health districts may have nurses employed at the same level but with each speciality having different expectations, role titles, and functions (Jacob et al., 2017). The lack of clarity regarding role and function, and to what extent advanced practice can or should occur, causes many issues particularly with role accountability and responsibility (Chief Nursing and Midwifery Officer Australia, 2017). Without a concise definition for the role and function, and without clarity of advanced practice or minimum education standards, difficulties occur in optimising the HITH service and its potential outcomes.

Some organisations underutilise HITH RNs due to a lack of understanding of the expanding duties and capabilities of these RNs, in addition to fiscal and nursing resources that limit care activities (ACN, 2019). Research has clearly demonstrated the positive impact of HITH RNs on patient satisfaction, quality of patient outcomes, and patient safety, along with reduced adverse events and inappropriate hospital admissions (Clinical Excellence Queensland, 2020; Federman et al., 2018; Giap & Park, 2021; Levine et al., 2018; Levine, Ouchi, et al., 2020). With improved technological advances, there has been an increased transfer level to HITH services (O'Connor et al., 2016; Orlando et al., 2019). In turn, this means the budget for

inpatient hospitalised care decreases or stays stable. However, public-hospital bed numbers have increased on average by 1.5% per year between 2013 and 2016, and according to the Queensland Office of Clinical Excellence, they remain unchanged in 2021. The increased need for inpatient hospital beds means that the corresponding transfer rate of hospitalised inpatients to HITH services should reach 5.5% of the total hospital inpatient admissions in coming years.

New nursing roles that provide acute care in the community have evolved with the changing face of nursing as a profession. For instance, there has been a slow growth in Australian NP positions. NP roles are fraught with many roadblocks as discussed by Gardner (2004), and Elsom and Happel (2009). The barriers include protocol and system requirements for nurse prescribing, Medicare influences including a limited scope of item numbers for practicing NPs and ongoing medical gatekeepers inclusive of roles and responsibilities working with the medical profession (Elsom, & Happel, 2009; Gardner, 2004). As early as 1999, in the UK Nurse Consultant roles and Modern matrons were introduced. The new roles were required to have a Masters' degree to ensure some of the barriers and objections to developing these autonomous nursing roles were eliminated. NP education in Australia has been slow to evolve with education only available in some jurisdictions once a medical sponsored position is available. This has restricted the growth of NP numbers and restricted clinical availability particularly in rural and remote areas. New roles in geographical locations where non-traditional care providers deliver complex care that includes medical care and nurse-led implementation, and evaluation of care were discussed (Hutchinson, Simpson, Pace, Campbell, White, S & Lennon, 2011; Hutchinson, East, Stasa, & Jackson, 2014; Vianello et al., 2013). Nurses in specialised roles require training to accurately care for the needs of consumers with diseases and to be competent, confident, and able to undertake care of the patients with higher acuity who would normally be hospitalised (Morilla-Herrera et al., 2016; Vianello, 2013). Further work on HITH RN roles remains outstanding in education and specialisations.

The role and integration of the HITH RN requires consideration in future models of healthcare service around the required skill and knowledge level. It has been established that nurse-led services increase the flexibility and availability of valuable clinical skills, allowing for greater access to healthcare for the wider population (ACN, 2019). An unexpected benefit of nurse-led clinics besides increased availability of

healthcare professionals, is that they release some of the less complex medical issues and disease processes from the medical profession directly to nursing care (Howe, 2016a, 2016b). Recently developed emergency department models, according to Plath et al. (2018), use nurses specialised in a specific area can provide expert, safe patient care provided the RNs have the required evidence-based education, knowledge, and skill.

Research undertaken by Kucera et al. (2010), revealed with increased knowledge, skills, and functions, rural nurses can confidently and comprehensively apply a broad range of skills to undertake patient-focussed care and treatment plans without medical involvement (Rural and Isolated Practice Health, 2020). This shift from a purist caring perspective that is a more patient-focussed approach offers an efficient and timely assessment and management of patients in the community (Aroke, 2018; Kucera et al., 2010; Kuipers et al., 2019). The alignment of both the art and science of caring, and clinical assessment and intervention, provides the ideal platform for the HITH RN.

According to Aroke (2014), the shift in nursing dynamics is empowering for RNs, particularly for recognition of skill, knowledge, and experience in advancement. Aroke (2014) observed that, when RNs had direct patient contact in primary-care locations and undertook examination, assessment, and follow-up care, there was an increase in their nursing skills, clinical decision making, and communication. Cornick et al. (2018) and Mona (2016) found similar outcomes in their studies. Aroke's (2014) observations aligned with the findings of Karaca and Zehra (2019) and Molina-Mula and Gallo-Estrada (2020) in highlighting that, when sufficient information is given, patient satisfaction increases because of nursing care (Institute of Medicine [IOM], 2011). Such a move results in the utilisation of higher-level skills evident in RNs who have skill, knowledge, and experience of the clinical situation that enables critical decision making and collaboration with other healthcare team members (Nibbelink & Brewer, 2018). This opens discussion about the purpose and function of more nurse-led services aligning with HITH programs and changes to historically driven medical models of service coordination.

## 2.9 Nurse Led Services

In Australia, nurse-led services have grown over the last two decades, particularly in relation to community and outpatient services (Douglas et al., 2017; Fedele, 2020; Howe, 2016a, 2016b). Global concern over the increased cost of providing nursing care to a growing and ageing population with increased comorbidities is one of the primary triggers for the development of nurse-led services. Nurse-led services aim to meet the increasing demand for quality patient-centred care with better and easier access to quality services (Delamarie & Lafortune, 2010; Jacob et al., 2013; Newhouse et al., 2011; Royal College of Nursing [RCN], 2018a; RCN, 2018b). Benton and Ferguson (2017) suggested in the United Nations report on health that there are many opportunities for growth. New developments and changes in the way treatments are delivered are two key considerations. For instance, advances in treatments such as chemotherapy, intravenous antimicrobials, and specialised wound-care products have enabled patients to be safely treated in their homes for acute conditions that would otherwise have required hospitalisation. Many service areas can now be delivered in community settings. These service areas include cystoscopy clinics, cardiac clinics, sexual health clinics, and HITH services that include intravenous therapy, antimicrobial therapy, complex wound management, chemotherapy, and hyperemesis management—with a number of these nurse led (Quallich et al., 2019; Royal College of Obstetrics and Gynaecology [RCOG], 2020). There have been investigations into solutions to the shortfall of medical professionals that see the emergence of nurse-led clinics, particularly in rural areas and in women's health (Delamarie & Lafortune, 2010; Duckett, 2005; Duckett et al., 2014; Quallich, 2019; Queensland Health, 2017). Pringle (2009) and Koch (2014) suggested that nurse-led clinics provide a holistic point of care approach with shorter waiting times in comparison with general practitioner clinics.

Specialised services within HITH are emerging, one of which is gerontological nursing. This service has eased the challenges imposed by the growth of an ageing population and the current COVID-19 disease management processes at home (Queensland Health, 2020; Wolf-Baker & Ordona, 2019). Considering this, Price (2017) argued that the scope of practice for RNs should be reviewed in line with current standards to discover the reasons for inclusion or exclusion of these service areas in a nurse's scope of practice. Roles are supported by some HITH nurse-led

services. However, more depth in governance detail is needed to ensure transferability, education, and confidence in services on a larger scale.

The UK and other countries have many different specialised nurse-led clinics, with high levels of autonomy, especially in oncology and haematology (Berglund et al., 2015; Browall et al., 2017; Knox, 2020). These clinics are reported to be acceptable to patients, carers, and staff, and they have been deemed appropriate in several medical specialties, because they are cost-effective (Berglund et al., 2017; Browall et al., 2017; Knox, 2020). New Zealand has several Maori community-based nurse-led services, particularly in areas of high deprivation. Nurse-led healthy lifestyle clinics (NLHLCs) have a positive impact on improving healthcare, patient empowerment, and nurse empowerment (Marshall et al., 2011).

A study by Marshall et al. (2011) outlined obstacles to the success of nurse-led clinics, including funding, problematic IT systems, some patients not attending appointments, and other patients excluded due to timing of the clinics. Challenges to alleviate waiting lists and outpatient reviews encourage alternative models of health service. The HITH service incorporated through a nurse-led approach has emerged during the COVID-19 pandemic, particularly in rural areas to assist where medical practitioners are not visible. To assist in the staffing and service shortfalls, and to encourage and care in the community now and into the future, a nurse-led HITH model is being considered (Department of Health [DoH], WA, 2021).

A nurse-led model for HITH services aligns with international literature and is influenced by a lack of available medical practitioners. Schober and Affara (2006) reviewed the extensive changes within Finnish healthcare that resulted from a shortage of doctors. A similar situation has been the driver in some OECD countries, including Canada, Australia, the USA, and the UK. Australia's projected major doctor shortage by 2030 is evident by a projected 25% reduction in the general practitioner workforce (Delamarie & Lafortune, 2010; Deloitte Access Economics, 2011; Scheffler & Arnold, 2019; Socha-Dietrich & Dumont, 2021).

Medical shortages are not new and have been the motivator for many OECD countries to educate nurses further and to stretch the limited fiscal resources in some specialities. Alternative models of care are needed to be articulated to ensure that appropriate and timely health responses are in place. Publication of the *Australian*

*Stronger Rural Health Strategy: Strengthening the Role of the Nursing Workforce* (Department of Health, Australian Government, 2021) resulted in increased access to training for NPs in rural and remote areas (Australian Institute of Health and Welfare, 2019). Various systematic reviews support improved patient outcomes from care delivered by an extended RN scope of practice (American Nurses Association, 2010, as cited in Hamric & Tracy, 2019; Laurant et al., 2018; Litchman et al., 2018; Newhouse et al., 2011). A variety of literature supports the notion that similar reasoning has been used in the USA and the UK to advance the scope of practice for RNs, as indicated in Figure 2.1.

Figure 2.1

*Guidelines on Advanced Practice Nursing - Novice to expert education flow* [a]


[a] From *Guidelines on Advanced Practice Nursing* (ICN, 2020, p. 17).

According to Dela Marie and Lafortune (2010) and Florian et al. (2021), the rationale for advancement was to fill the gaps in healthcare in rural, disadvantaged, or highly populated areas where there are insufficient medical doctors in primary and secondary care. Laurant et al. (2018) and Newhouse et al. (2011) proposed that filling the gaps in healthcare was the main reason for extending practice. However, Benton et al. (2017) suggested otherwise. They argued that advanced practice results in increased patient acuity and that increased nursing knowledge had improved patient access to services and their health outcomes. In Australia, the acute health-care sector nurse-led clinics have historically been used for patients who are medically stable but who still require considerable support to regain their maximum health (Clinical Excellence Queensland, 2017; Pelz et al., 2019). These clinics enable nurses to have greater responsibility over patient care, to work autonomously rather than under the direction of medical staff, and to work holistically with patients on rehabilitation, counselling, and discharge planning (Clinical Excellence Queensland, 2017; Fedele, 2020). This model aligns with current and future HITH service planning.

Considerations for the role and function of the RN must be considered to ensure viable and appropriate skills and education in preparation for role and service expansions.

A Sydney-based community-nurse-led Hepatitis B clinic demonstrated that nurse clinics are feasible, acceptable, and safe (Pritchard-Jones et al., 2015). Nurse-led services give people more choices regarding whom they wish to consult and where they want to receive treatment. Nurse-led clinics have proved effective in areas of low medical access, for instance, areas with a high rate of homelessness or where services cannot be provided by a medical practitioner (Fedele, 2020). Nurse-led supported HITH services could value add in sexual health, continence management, asthma, Parkinson's disease, and breast cancer to avoid delays and waiting lists for hospital admissions (Fedele, 2020).

The HITH RN has the autonomy to lead care and to prioritise areas of care required by the individual as part of an extended acute-care plan at home (Caplan et al., 2012). Caplan et al. (2012) argued that HITH delivers specialised acute nursing care that is patient centric, providing the most appropriate care for the individual, in the most appropriate place (their home) by suitably skilled and knowledgeable RNs. Greater consideration of the scope and role of the HITH nurse is needed to understand the applicability of the HITH RN in the Australian healthcare context and how this may, in future, align with a nurse-led services approach in the community. The potential to reduce cost and support doctor shortages is demonstrated in Australia by Kamalakanthan and Jackson (2006), Battineni et al. (2021), and Gilissen et al. (2021).

The report by Caplan et al. (2011) and the Deloitte report (2012) both argued that increased HITH nurse-led services was one of the ways of maintaining fiscal acuity while delivering specialised acute-nursing care. To understand, develop, and support the required clinical reasoning, decision making, and clinical skills to progress the feasibility of nurse-led HITH services, the role and function of the HITH RN need to be clearly and carefully articulated. The scope of practice currently aligns with the NMBA-required scope of practice and RN Standards of Practice. There is a need to determine whether advanced practice or skill extension are required, and the research associated with this doctoral work is intended to obtain information from RNs about their current role and function to establish a base for future workforce progression.

## 2.10 Scope of Practice: The Australian Context

HITH Nursing is complex and multifaceted, and it encompasses collaborative and independent practice as per service guidelines and are comparable to others, globally (American Academy of Ambulatory Care Nursing [AAACN], 2011, 2014, 2017, 2021; DoH, NSW., 2018; DoH QLD, 2022; Vaartio-Rajalin & Fagerström, 2019). The AAACN embeds ambulatory nursing using evidence-based practice and clinical expertise from RNs (AAACN, 2019).

The HITH position requires collaborative critical thinking skills and the interpretation of complex information to guide the team caring for patients in the home setting (Kleinpell & Hudspeth, 2013; Vaartio-Rajalin & Fagerström, 2019). Figure 2.2 depicts how HITH RNs undertake a typical patient assessment and discussion from hospital admission in preparation for transfer to acute-care delivery at home (Contandriopoulos et al., 2015). This highlights the process of critical thinking from initial contact with the patient to HITH transfer and discharge from HITH to primary-care follow-up.

Figure 2.2

*Typical HITH nursing assessment processes*


The process includes all aspects of nursing assessment and care planning with consideration of additional areas of HITH assessment where clinical skills and treatment are provided in the patient's home. This transfer process includes a patient assessment that is holistic, considering family supports, carer needs, at-home mobility, and health-and-safety concerns for both the patient and staff member.

HITH RNs aim to provide evidence-based, safe, expert, compassionate, and autonomous patient-centric care that follows the standards set by the Nursing and Midwifery Board of Australia (NMBA, 2018, 2020a, 2020b). The scope of practice at

a functional level of HITH RNs includes facilitating the coordination of patient-centred care, communicating using innovative tools, and collaborative reporting of an individual's condition to appropriate members of the multidisciplinary team (Contandriopoulos et al., 2015; Greenfield et al., 2013). Nsiah et al. (2019) and Kalaitzidis and Jewell (2015) in their studies described HITH RNs' advocacy as supporting patient safety and quality care. The HITH RN practises in an inclusive decision-making realm with other individuals where patient education and coordination of ongoing care and ancillary services are prioritised (Choi, 2015; Kalatizidis & Jewell, 2015; Nsiah et al., 2019). Hospital in the Home RNs demonstrate the ability to manage complex issues, with strong clinical, educational, and advocacy skills for acute-care patients who would have otherwise been admitted to hospital (Mick & Ackermann, 2000; Vaartio-Rajalin & Fagerström, 2019). The areas identified are multifaceted and complex, but do not currently always align with the role and function in practice. This research is intended to reveal the experience of those working as HITH RNs to assist in consolidating these concepts with practice.

The Australian Nursing and Midwifery Council (ANMC) developed professional structures and standards, creating a national regulatory framework founded on the legislative and regulatory framework of the International Council for Nurses (ICN, 2010; QNC, 2010). The goal of defining the scope of practice by the ICN (2010) is to assist the public to understand the attributes of the nursing role and the role functions in various practice settings. These standards provide the basis for nursing practice and align with National Standards for Practice in Australia. Using the ICN definition as a guide, the Australian state and territory nursing boards worked to formulate nationally agreed standards, codes, and guidelines for general nursing practice. These standards, codes, and guidelines form the National Registration and Accreditation Scheme (2009) to protect the public by ensuring that RNs are competent and safe to practise (Australian Nursing Federation [ANF], 2015; Health Practitioner Regulation National Law, 2009).

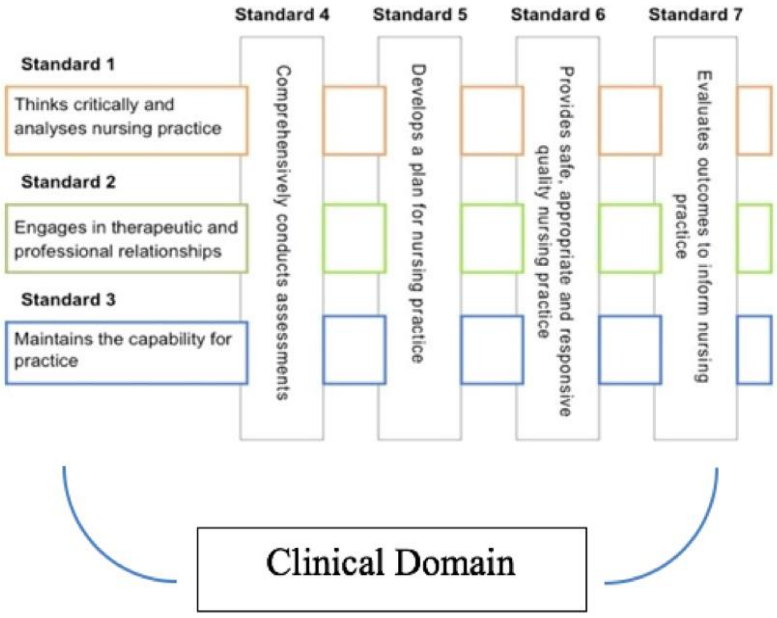
The Nursing and Midwifery Board of Australia (NMBA) has set seven standards that guide the practice of RNs (NMBA, 2020a). These standards provide parameters that define the role of RNs and align with the ***scope of practice*** definitions for RNs (NMBA, 2020a). Furthermore, these NMBA standards require RNs to interpret and practise them consistently within their own work environment. Figure

2.3 outlines the specific requirements of the NMBA (2020a), with the standards of practice in three phases.

National registration commenced in 2010 by APHRA, a centralised body supported by the Australian Nursing and Midwifery Federation (ANMF) and the NMBA (2010). National registration brought consistency to the Australian registration system that is comparable to UK national registration (Launder, 2019; NMC, 2015, 2018).

Figure 2.3

*Standards of practice for RNs*[a]




[a] Based on the Standards of Practice for RNs by the Nursing and Midwifery Board of Australia (2020a), Melbourne.

Additionally, researchers (Bourgeault & Grignon, 2013) and professional bodies such as the ANMF (2015) agreed that the introduction of national registration in Australia solved registration inconsistencies across states and territories and reduced the impact of extrinsic factors such as geographic areas on the scope of practice for RN roles and functions (DoH, 2021; Department of Health, SA, 2013; Long, 2021). The national approach also implied the introduction of standardised nationally accredited education programs through the Australian Nursing and Midwifery Accreditation Council (Australian Nursing and Midwifery Accreditation Council

[ANMAC], 2019). The legislative and regulatory framework, which has become known as the "scope of practice" describes and encompasses the full range of roles and activities that RNs are permitted to undertake (NMC, 2015, updated 2018), described in ways that define features of the role and function of the Australian HITH RN. HITH RNs have gained the basic qualification as all RNs do. However, to date there is no HITH specific post-graduate qualification. The courses undertaken are varied and not all to the same standards. It is the same issue for the required standard competencies. Therefore, it is almost impossible to be advanced practice nurses without standardisation of educational requirements.

Implementation of advanced-practice nursing roles has been synonymous with a plethora of nursing terminology, for instance, clinical nurse specialists, and clinical nurse consultants. These terms suggest a variety of levels of autonomy, ranging from the role of RN to the role of NP. In some Australian states and territories, levels of practice between the RN and NP roles are described clearly. However, the titles of clinical nurse specialist (CNS) and clinical nurse consultant (CNC) are not regulated by the NMBA (2020d, 2020f), and the scope of practice of the CNS and CNC varies between states and territories (Pugh & Scruth, 2021).

Australian advanced-nursing roles continue to appear in an ad hoc fashion, and not as a national regulated initiative. Ad hoc approaches to advanced practice have led to the issues highlighted by Douglas et al. (2018) and McConnell et al. (2012) in Northern Ireland, and Gannon et al. (2019) in Canada, revealing that Australia is not alone in failing to adequately define advanced-practice roles. As a result of their study, Douglas et al. (2018) concluded that nurses employed in nurse-led clinics across Queensland often do not meet the criteria for advanced-practice nursing, and in Northern Ireland the introduction of emergency NPs was not associated with the clinical support or study time required to make the position successful and viable (McConnell et al., 2012). However, this was before the NMBA (2020d, 2020f) generic advanced-practice fact sheet, published in 2020, that provided hospital and health services role development guidance by introducing advanced-practice roles relevant to HITH. Nonetheless, in New Zealand, Adams and Carryer (2019) and Carryer and Adams (2022), argued that NPs continue to have issues with policies that do not support New Zealand's strategic direction for primary healthcare stipulated in the New Zealand Health Care Strategy 2016. In Australia, the development of advanced practice roles proliferated with minimal expectation about uniformity of terminology.

Scanlon et al. (2012) argued that this ad hoc development would be problematic and that it would take years to unravel the approach Australia has taken to the development and evolution of new nursing roles to meet expanding healthcare demands.

Barriers and enablers were outlined by Smith et al. (2019) for APNs at a micro and meso level, especially in rural areas Their research suggested that increased community support and collaboration with local health service managers is required. The roles need appropriate funding and less 'medical' gatekeeping on the advancement of nursing. Especially, as 'medical' gatekeeping was overcome during the pandemic COVID with Pharmacists administering COVID vaccines. At the macro level, state health policy and practice are essential, with support for education and endorsement when the scope of the role has been discussed and agreed on. Smith et al. (2019) argued that their study outcomes are transferable to major cities and regional areas to assist in the planning of new roles at all levels of practice and service.

Feringa et al. (2018) raised concerns about the levels of scope of practice. They found that 38–73% of their participants stated that they were working to full capacity. This 35% range in capacity suggests a state of confusion and lack of role clarity in relation to the role and role function of RNs. This confusion is a common experience for HITH RNs with a multitude of titles, position descriptions, and variations in competency skills. The inconsistencies and lack of clarity regarding an RNs role function in practice causes confusion, creating the potential for personal and professional liability, alongside the potential for missed care due to insufficient funding or limitations in scope. Some services are very generic and can work with different patient cohorts daily, whereas other services are more specialised, for instance, in chemotherapy, palliation and paediatrics with general services in rural and remote services. This is not unlike the international experience and warrants greater discussion concerning the role and function of the HITH RN (Feringa et al., 2018). Italy and America are the leaders in home hospitalisation for patients with decompensated heart failure (Voudris & Silver, 2018). Voudris and Silver (2018) concluded that HITH is suitable for rehabilitation, titration of medication, continuing education, nutrition, and psychosocial support for patients with decompensated heart failure.

## 2.11 Professional Liabilities

Hospital in the Home nurses need clarification about their role function to prevent personal and professional liabilities. There is evidence of real risk from discrepancies in role function and the legal requirement to work within the boundaries of the NMBA Standards for Practice (NMBA, 2020a). There is literature that outlines the constraints that force or encourage HITH RNs to work below their full scope of practice (Feringa et al., 2018). Researchers have agreed that the proficiencies and definition for advanced practice is of global importance (Cant et al., 2011; ICN, 2020; Schrober, 2016). Leach and Tucker (2017) argued that non-standardised care results from a low proficiency in locating and using the best scientific knowledge and facilitating a reduction in liability. Shoghi et al. (2019) argued for a level of preparedness for advanced practice that includes a context-based curriculum, interactive collaboration, and standard clinical guidelines. They also suggested that nurses need additional and supplementary education to make the most of interactive partnerships with other healthcare professionals and the public. Shoghi's (2019) research shares the experience of RNs in practice to assist in learning about their perspective of skill, education, and experience (Shoghi et al., 2019).

Many researchers, including Shoghi et al. (2019) have undertaken research to further contest, or gain clarity in relation to, advanced practice terms using the advanced practice nursing tool (Chang et al., 2012; Duffield et al., 2009; Duffield et al., 2011a; Gardner, Duffield, Doubrovsky, & Adams, 2016; Gardner, Duffield, Gardner, & Batch 2017a; Gardner Duffield, Gardner, & Doubrovsky, 2017b). Many eminent researchers while seeking to standardise nursing titles, imply that RNs have the knowledge and skills to delineate between standard RN practice and advanced nursing practice (Chang, Gardner, Duffield, & Ramis, 2012; Duffield et al., 2011a; Gardner, Duffield, Doubrovsky, & Adams, 2016; Harvey et al, 2019; Shoghi et al., 2019). Optimisation of the scope of practice for RNs has not evolved since the NMBA guidelines for advanced practice were issued (NMBA, 2020d, 2020f). What remains is a lack of clarity leading to role confusion and conflict within nursing and other healthcare professions. De Cherrie (2019) stated that this was evident globally when the term "Hospital in the Home" could not gain a consensus on what it entails. Such disparity led the RNs' Association Ontario (Healthcare Excellence Canada, 2021) to develop and implement *A Toolkit: Implementation of Best Practice Guidelines*. These

research outcomes suggest that intrinsic factors that influence individual organisations to define the RN role function in practice are a requirement for work–life balance, designated study time, and access to expert healthcare knowledge (Brideson, Glover, & Button, 2012; Gannon et al., 2019; Kaasalainen et al., 2011). Schofield et al. (2010) and Salmond and Echevarria (2017) suggested that indeterminate expectations of the role and its functions are the main contributors to the lack of clarity in defining HITH RNs' role, particularly advanced practice roles.

## 2.12 The Donabedian Model

The Donabedian model is a conceptual model that focuses on evaluating quality of care. Components of the model comprise of structure, process, and outcomes (Donabedian, 2005). The delivery of care forms the context for the structure, including the buildings, staffing, financial status, and equipment. Process indicates the agreed care path between the HealthCare provider and the patients. Lastly, the effects of the agreed care path on the health of the individual patient and the local population. The Donabedian model allowed for a restructuring of role functions, thus enabling each role to be identified with its corresponding core competencies (Fulton et al., 2019). The model assists in describing the roles and responsibilities of advanced nursing, derived from developing specialist knowledge, skills, and abilities to manage a patient's care across the full continuum of innovative care services from ill-health to wellness. This requires role-specific competencies, population-specific understanding, and a need to meet advanced nurse standards (Egerod et al., 2021; Emergency Nurse Association, 2020; Fukada, 2018). For the HITH RN, structure is evident in the semi-autonomous/autonomous role that exists in current complex healthcare systems. Teamwork, education, and interprofessional communication are required (Ryan et al., 2017; WHO, 2010g, 2020e). Trusting relationships need time to develop, no matter the level or extent of experience of the advanced-practice provider, because previous experiences may influence perceptions of successful integration (Orchard et al., 2012). Attum et al. (2021) discussed how nursing needs to change to meet societal expectations with care expansion into the community. Without considering the role function and how the position will fit into an established department, the scarcity of support for new roles is likely to be realised (Contandriopoulos et al., 2015; Jakimowicz et al, 2017). McConnell et al. (2013) found that emergency-NPs did not

have the support or level of education required to fulfil the advanced-practice nursing-standards requirements of the Nursing and Midwifery Board, Ireland (2017).

The Donabedian model was used to highlight the RNs' roles in an American academic medical centre, which introduced a clinical nurse specialist role alongside other nursing roles (Sanchez et al., 2019). However, it proved difficult to differentiate what each position title and role function entailed, particularly between nurse specialist and nurse educator, both of which are valuable roles. In their study, Sanchez et al. (2019) outlined the primary importance of, and need to know and understand, the role and function of the RN to be able to advocate and change systems for the better. The Donabedian model enables this quest for the right information through determining or defining structure, outlining the process, and coming to an outcome (Gardner, 2014).

The position descriptions were identified by Sanchez et al. (2019) as failing to meet the criteria required for clinical nurse specialist role functions in the academic medical centre that they investigated. However, such ambiguity in specialist nursing roles is revealed in the literature with questions about role and function and how these align with nurse-led services and advanced clinical care and decision making (Contandriopoulos et al., 2015; Cooper & McDowell, 2019; Fulton et al., 2019; Jakimowicz et al., 2017). Clinical nurse specialist and nurse educator roles were adjusted to refocus the nursing efforts in practice to the needs of their consumers (Contandriopoulos et al., 2015; Jakimowicz et al., 2017). The new position description described by Contandriopoulos et al. (2015) and Jakimowicz et al. (2017), integrated the clinical nurse specialist into practice with greater ease. Aligning with Contandriopoulos et al. (2015) and Jakimowicz et al. (2017), and Caruso et al. (2019) argued that disrupting practice is the way forward to demonstrate a nurse's value. HITH RNs need to find and present evidence of advanced practice to establish their role within acute care. However, processing the evidence takes time, and confusion might continue within the multiple layers of position descriptions and services (Contandriopoulos et al., 2015; Leary et al., 2017; Vaartio-Rajalin & Fagerström, 2018). Using the Donabedian model through a further review of the literature in relation to the scope of practice and role of the RN requires exploration (Gardner et al., 2014).

## 2.13 Advanced Practice Registered Nurse

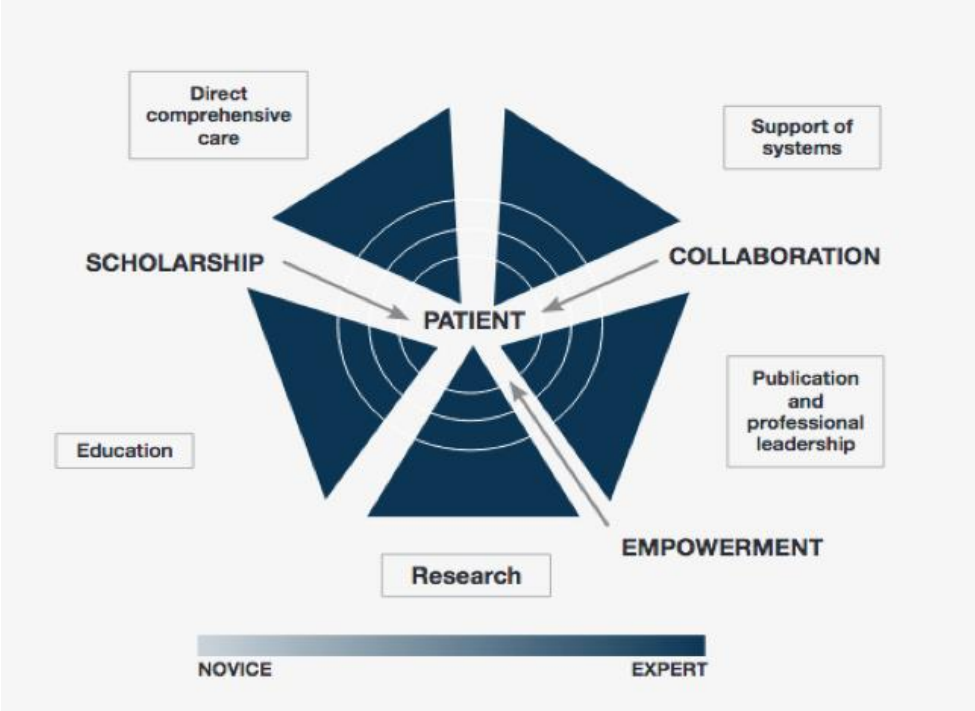
Following the establishment of national registration across states and territories in Australia, greater education consistency and increased professional status continued (NMBA, 2020c). Cant et al. (2011) reported that the terms "advanced nurse" and "nurse practitioner" were indistinguishable, with the designation dependent on the needs of the health service (IOM, 2010). In 2017, the definition of advanced practice was still being debated at the Australian Advanced Practice Symposium (Chief Nursing & Midwifery Officers Australia [CNMO], 2017), with controversy continuing about what constitutes extended practice in the Australian nursing context. Australian nursing bodies continued reviewing the inconsistent terminology that confuses the profession, the public, policymakers, and the overall healthcare system (CNMO, 2017). The 2017 Australian symposium on advanced nursing practice discussed the blurred lines regarding advanced practice, and the availability of award definitions and job descriptions was found to be limited. Moreover, it remains difficult to find consistency. Duffield et al. (2011a) argued that the failure to provide clear, adequate definitions and pathways for advanced nursing practice is responsible for the blurring of roles and responsibilities in practice settings. Bryant-Lukosius et al. (2004) addressed the concern with the continuum of advanced-practice nursing and suggested that, to meet global population needs and consumer expectations, greater transformation is essential. Like the regulatory bodies for the Republic of Ireland and New Zealand, Australia sought an approach that monitored the extended scope of practice career pathways. Thus, the National Council for the Development of Nursing and Midwifery was formed (DiCenso et al., 2010; DoH Ireland, 2015; DoH Ireland, 2016; Longley et al., 2007). The Australian Advanced Practice Symposium in 2020 aimed to make the definitions clearer (CNMO, 2020). The symposium outlined advanced practice not as a particular role or specialisation, but rather as a "level" of practice. Figure 2.4 demonstrates the strong model of advanced practice as a level of practice across the five domains of clinical care, education, research, professional leadership, and support systems (Clavelle & Prado-Inzerillo, 2018; Gardner et al., 2016). Ideally, academic preparation for advanced nursing practice should begin with the minimum of a relevant postgraduate qualification in nursing (Clavelle & Prado-Inzerillo, 2018; Gardner et al., 2016). Gardner, Duffield et al., (2016) identified

Australian advanced nursing in their SCaN project as being consistent with the strong model of advanced practice in Figure 2.4.

The number of nursing specialisations is increasing, offering a variety of employment opportunities (Garrison et al., 2018). Furthermore, the need for life-long learning to meet the demands of private and public hospitals, residential aged care in community settings, and acute and nonacute settings is expected to be included in continuing professional development requirements (Department of Health, South Australia, 2013; Mlambo et al., 2021; Qalehsari et al., 2019; Queensland Health, 2018). The increase in education needs and a more formalised professional practice approach to education is consistent with the international literature, but the practical implications still require consideration. The variations in role title, function, and scope are evident.

Figure 2.4

*Australian Advanced Practice Symposium - The strong model of advanced practice* [a]



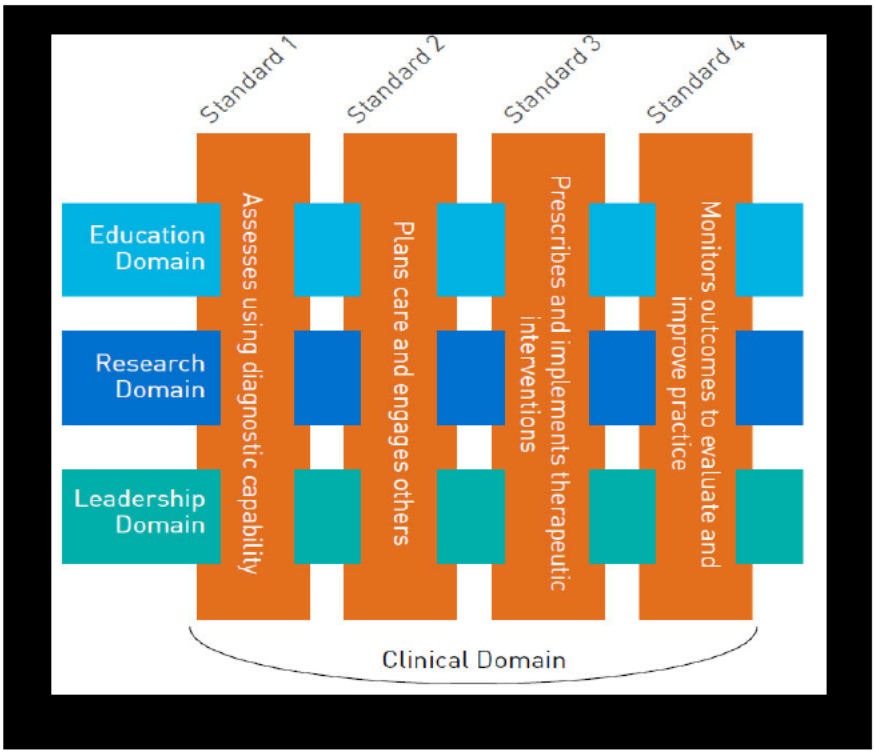

[a] Taken from Australian Advanced Practice Symposium (2020d p. 9).

According to the strong model of advanced practice (CNMO, 2020), postgraduate education must be combined with clinical experience to develop the attributes and skills needed for advanced practice nursing. Tools are available for nurse's self-assessment to discover what individual professionals need to focus on in

their practice (Gardner et al., 2017a, 2017b), however, these are subjective. For instance, a nurse with many years' experience may state they are average, thus considering that there is always something new to learn. Others with less experience could state they are experts in their field. Pathways to specialisation vary from generalist to a specific area of practice and depend on the quality and complexity of developmental experiences, not length of service (Aaron & Andrews, 2016; Maier & Aitken, 2016; NHS Scotland, 2012; NHS Scotland, 2021; Pan American Health Organization, 2015). Figure 2.5 depicts the differentiation between specialist and generalist along the development continuum of novice to expert pathway (Benner, 1984).

Figure 2.5

*Nurse Practitioner standards for practice* [a]




[a] Taken from *Nurse Practitioner Standards for Practice* (Nursing and Midwifery Board of Australia, 2014, p. 2).

In Australia, "NP" is the only legislated role to be recognised as advanced practice and recordable on the Australian Health Practitioner Regulation Agency (AHPRA) public register. NPs work to RN standards of practice and must also meet

the NP Standards of Practice across four domains. These domains are clinical, leadership, education, and research. The clinical domains are represented in Figure 2.5.

A World Health Organisation report (WHO, 2015) documented global criticisms on the scope of practice regulation accomplishments for advanced-nursing practice across all domains. This is shown in Figure 2.5. In 2018, three major global organisations came together to discuss how a quality health service could be delivered across the world (WHO, World Bank Group, & OECD (2018). The WHO (2020g) issued a key facts page for nurses and midwives while waiting for the updated global strategic direction 2021–2025 (WHO, 2021a) changing management structures by assisting nurses and midwives to attain higher standards of care. Research about the National Disability Insurance Service (NDIS) in the Australian context by Wilson et al. (2019) suggests that consistency of terminology is problematic in relation to the accuracy of patient care and funding of the NDIS. Pulcini et al. (2010) undertook a cross-sectional descriptive survey to describe trends in developing the roles NP-APN roles. The survey involved 91 nurses responding from 32 countries. The main barrier to obtaining information was the level of support received by 70% of Nurse Managers, 67% of doctors, and 68% of Government Health Departments.

The most significant change to nursing in Australia occurred with the restructuring of the Australian nursing profession (ANMC, 2012; ICN, 2010) in which support was given to nurses. An extensive heterogeneity of researchers has explored and examined the scope, boundaries, and standards of practice related to RNs and advanced practicing RNs over the past decade (Benton et al., 2017; Cashin et al., 2017; Chang et al., 2012; Duffield et al., 2011b; Fealy et al., 2018; Frohmader et al., 2018; Gardner et al., 2013; Kleinpell et al., 2014). Stasa et al. (2014) argued that the exploratory research outcomes from the above researchers have assisted in confusing the nursing profession further. For example, they argued that "advanced nursing practice" and "advanced practice nursing" are interchangeable terms. The term "advanced practice nurse" is an overall term that includes NPs and Clinical Nurse Specialists (CNSs) in North America (Donald et al., 2010). However, apart from the term "NP" in Australia, the knowledge and skills required for any other position title are not regulated because they are not recordable on the AHPRA register (NMBA, 2017). Therefore, there are RNs in Australia working within unregulated position titles and role functions. The NMBA Standards for Practice (2020a) outlines activities that

RNs are permitted to undertake, which became known as "the scope of practice". Scope-of-practice guidance directs accountability and responsibility for decision making and actions taken, or not taken, by RNs at all levels of practice (NMBA, 2020a, 2020b, 2020c). The guidelines apply not only to HITH RNs, but to RNs at all levels of practice (NMBA, 2020a, 2020b, 2020c). The ICN (2020) has provided definitions regarding advanced practice terms to align with health drivers.

Local and international political influences and lobbying continue to influence the transfer of knowledge and skills in nursing-care standards by gaining input from nursing groups. Walsh et al. (2015) outlined higher autonomous roles are the negotiator or the go-between in establishing communication between health professionals to ensure that patient care is consistently excellent. The UK, in comparison with Australia, opened opportunities for the development of new nursing roles, that is roles that used the skills of advanced practitioners (Francis, 2013; National Council of State Boards of Nursing [NCSBN], 2012). These advanced roles include Clinical Nurse Educators, NPs, Cancer-care Information Specialists, Lead Nurses, Haemodialysis Managers, Colorectal Nurses, Nurse Consultants, and Clinical Nurse Specialists. Multiple stakeholders, including nurses, employers, tertiary educators, and the DoH supported the development of these advanced practice roles (Royal College of Nursing [RCN], 2005). Pearson et al. (1992) wrote about the emergence of nurse consultants or consultant nurse roles that was later reviewed and updated in 2009 (Pearson, 2009).

Aligning with the Pearson et al (1992) and Wright (1992) emphasised the need for enhanced clinical credibility of nurse consultancy. Furthermore, Doody (2014) and Fernadez et al. (2017) suggested that following both the Standards of Practice for RNs, and those Standards for Nursing at a higher level is significant for Nurse Consultants. The term "Nurse Consultant" was often used interchangeably with the term "Advanced Practitioner" (Manley, 1997). A similar role that emerged from the publication *Modernising Nursing Careers* was that of nurse consultant (Jones et al., 2015). Internationally, extensive work has been undertaken on the nurse consultant role from as early as the 1990s (Pottle, 2018). Sheer and Wong (2008) reported that the Netherlands had extended the scope of practice for RNs. By 2018, Florida included clinical nurse specialists under the title "advance practice nurses" (Geddie, 2019a, 2019b, 2019c; Tracy et al., 2020). The higher roles were introduced to strengthen and

influence leadership in nursing and to prevent the loss of clinical expertise (Clavelle & Prado-Inzerillo, 2018; Major, 2019; Scully, 2015; Wuerz, 2017).

## 2.14 Professional Competence

Professional competence at varying levels is required for each nursing position. Professional competence includes an individual's ability to provide the best healthcare plan for patients through professional decision making, interactions, and clinical leadership in communications with team members (Church, 2016; Fukada et al., 2018; Hill, 2022). Rouhi-Balasi et al. (2020) concluded that professional nursing autonomy is achievable through developing patient-focussed professional competence. HITH nursing services lack professional autonomy, and Skår (2010) discussed the importance of power in decision making with the patient. He argued that freedom to make decisions is required in nursing clinical judgements and is essential for professional autonomy. In contrast, Wang-Romjue (2018), in his meta-analysis, suggested that autonomy from a nursing perspective is derived from being the sole provider of patient care. Autonomy in practice has great significance in professionalism and assumes a certain level of knowledge, skills, and experience (Asakura et al., 2016; Nouri et al., 2017).

Several researchers have concluded that grounding professionalism in autonomous nursing involves ethical values, standards, and regulation—all of which require critical reflection (Doost et al., 2016; Mathibe-Neke, 2020; Mohamed et al., 2020; Tanaka et al., 2016). However, Rowland (2016) suggested that professionalism is difficult to define, and researchers use different approaches to assess and evaluate nurses' professionalism. Schaeffer (2013), along with Ibrahim and Qalawa (2016), suggested that professionalism involves intelligence, integrity, maturity, and thoughtfulness when applying knowledge and skills in nursing roles. Donmez and Ozsoy (2016) and De Braganca and Nirmalab (2017) describe nursing professionalism as a distinctive attribute for professional development, and Scully (2015) suggested that nursing leadership is another essential distinctive attribute. Discrepancies in the definition of professional competence are noted. However, consistency in the application of knowledge, intelligence, and maturity seem to prevail.

## 2.15 Leadership

Nursing leadership is expected at all levels within RN roles (Salvage & White, 2019, Scully, 2015). RNs' positions and functions generally include a leadership component. Ashton (2012) and Lamb et al. (2018) asserted that leadership potential is within the capabilities of all RNs. Boykin and Schoenhofer (2013), Lamb et al. (2018), and McBride (2019) argued that leadership should be embodied as part of the scope of practice for RNs in their roles and role functions. Nevertheless, leadership roles remain dependent of the position title. Leadership reinforces integrity, communication skills, teamwork, appreciation of diversity, and problem solving (Clavelle & Prado-Inzerillo, 2018; Dragon, 2019; Major, 2019). A few researchers have suggested that strong leadership and positive workplace cultures have helped to enhance the role of nursing away from hierarchical managerial structures (Davidson et al., 2020; Eddy et al., 2016; Williams et al., 2015).

Lack of leadership impacts on how managers can efficiently lead their department. For instance, managers often fail to transition new employees into their role (AAACN, 2014; AAACN, 2017). In turn, good leadership increases nurse satisfaction in relation to competence and skill development in specialist subjects (Heinen et al., 2019; Jankelová & Joniaková, 2021). Without strong leadership, HITH service delivery is not sustainable (Major, 2019) as there is an association between nursing leadership and quality, safe patient care (Scully, 2015). Therefore, the development of nursing leadership skills is crucial in aiming to attain and maintain first-class acute care at home service (NMBA, 2020a, 2020b, 2020c; Pearson et al, 2015). D'Amour et al. (2012) suggested that a lack of nursing leadership will lead to unfulfilled engagement with scope of practice. Nurses must be aware of the policies that affect them, warned D'Amour et al. (2012). Otherwise, Nurses will not be heard or heeded, when contributing their nursing knowledge to policy-making decisions (Salvage & White, 2019). Lord Willis (2012) encouraged leadership at all levels of nursing to make the most of current economic drivers. Furthermore, Ashton (2012), Bayliss-Pratt and Fenton (2017), and Ó Lúanaigh and Hughes (2017) collectively supported Lord Willis's (2015) view about leadership, arguing that "raising the bar" in nursing competence, knowledge, and skills for HITH RNs is the next step forward in pursuing extended scope of practice (Hill, 2017). Leadership creates opportunities,

and opportunities are necessary for delivering innovative, patient-centric care along with knowledge and skills across any nurse-led service in Australia.

## 2.16 Knowledge Requirements

Other than a degree in nursing, there are no other specified requirements from the NMBA for RNs to practice. There may be skills and knowledge expected by the employer, but as previously discussed most RN education is self-directed. HITH has the potential to be nurse-led or, at a minimum, an area of care, where semi-autonomous, self-leading RNs practise, once an education pathway has been developed.

The lack of specific educational, clinical, and theoretical training can have devastating consequences for patient outcomes, the healthcare professional, and the service. Some HITH services have protocols for RNs to work within, whereas others do not. McConnell et al. (2013) noted that 97.6% of the Emergency NPs reported working within protocols like those in a later study by Douglas et al. (2018). The results from the research by McConnell et al. (2018) challenged the perception of Emergency NPs with respect to their status as advanced practitioners None of the 70% of respondents had a master's degree in nursing or similar. That statistic became significant when 81.3% stated that clinical work took up most of their work time. For Advanced Nurses, such a high clinical workload leaves minimal time to undertake the other functions of leadership, education, and research that are crucial components of advanced-nursing practice. In a series of articles, Barton (2012a, 2012b, 2012c) highlighted future development and governance for advanced practice. These roles were supported by the An Bord Altranis (The Nursing Board; 2000), and by Hanks (2000), McGee, and Castledine (1999), Schrober (2016), and Wright et al. (1991). These authors argued that Advanced Practitioners should use specialised knowledge and skills in clinical practice, management, teaching, and research while acting as consultants across a variety of settings.

A cause for concern for HITH RNs is the varying contexts of patient treatment and care daily due to differing home environments and situations in which care is provided. The working environment can lead to conflicting interpretations of RN standards of practice (Kieft et al., 2014). Moreover, it is essential that these nurses work within the seven NMBA standards (NMBA, 2020a) and observe these standards for practice in conjunction with other NMBA nursing codes, guidelines, and the

decision-making framework (NMBA, 2018, 2020a, 2020b, 2020c). For instance, RNs may find themselves outside service protocols, even though they may have the practical skills and equipment to unblock a Central Venous Access Device (CVAD), but no theoretical education to support this skill (Cross, 1981). Consideration about how to proceed necessitates reflection on an RN's critical thinking skills.

Professionalism is essential because subcultures in and between professional groups can hinder the flow of information, especially if language and communication patterns differ (Dhungana et al., 2020; Ghadirian et al., 2014). The European company *Clever Together* wanted to see positive transformation in the healthcare system. The Clever Together report (Willis, 2019) was commissioned by Health Education England. (HEE). Willis (2019) reported that the results align with the recent publications calling for action to standardise advanced practice issues, address issues of status, and address workforce planning (ACN, 2021; ICN, 2021).

In 2012, Howell argued that RNs require education at a higher level but questioned whether that meant a higher academic degree or improved clinical knowledge and skills, or a blend of both. This debate was further supported by Schwartz (2019) report of the independent review of nursing education. This review highlighted the need for interprofessional education and consideration of generalist and specialist roles in nursing. For HITH RNs, a blended format for education is likely to be the most beneficial in Australia because of the large geographic distances of practice and for the diversity and variation in roles that exist. Additionally, the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2010) has endorsed and evaluated a format comparable with the knowledge and skills framework that is linked to the National Health Service (NHS, 2017), career framework in the UK. Furthermore, Thompson et al. (2019) set out a future for nurse education that included legal and regulatory influences in a healthcare environment that are important when working as a sole practitioner in a patient's home. D'Amour et al. (2012) ignored the assertion by Castledine (2004) that underutilisation of RN scope of practice, knowledge, and skills led to the suboptimal provision of patient care. However, nurses can lead transformative healthcare changes by participating as members of an interprofessional team to provide seamless, affordable, and quality care (Salmond & Echevarria, 2017; Schwartz, 2019).

Standford (2016) used a qualitative cross-sectional design of focus groups and questionnaires to find that such a framework could highlight the strengths and

weaknesses of everyone so that targets could then be set to improve or limit practice. Educational services also benefited from the study results, providing a clear structure for new NPs to maintain their nursing competencies. A clear structure would help prevent legal and ethical issues arising in the nursing workplace, sometimes from small issues but where inconsistencies in nursing approaches exist (Chastain & Burhans, 2016; General Nursing Council, 2015). Any issues arising might result in civil or criminal proceedings, and Buppert (2021) further suggested that those who are not using contemporary practice may face disciplinary action, civil, and/or criminal proceedings. A consistent knowledge framework is needed to assist and guide RNs working in HITH roles to ensure an informed and consistent approach to care coordination, reporting and delivery.

## 2.17 Continuing professional development (CPD)

A demonstration of competence is important when deciding what constitutes scope of practice according to the ICN (2015), ANMF (2015) and the NMBA (2018). Pringle's (2009) assertion that nurses could "do harm" by default aligns with later studies undertaken by Berget et al. (2019) and Kobos et al. (2020). These studies highlight the importance of standardised education for nurses regardless of their current knowledge and experience, concluding that additional education optimises safe practices. In another study, Galligan and Wilson (2020) argued that targeted education focuses on bridging the gaps between problem solving and complex care scenarios using e-learning, classroom discussions, and teaching in the clinical environment—perspectives shared by Kobos et al. (2020) and Schwartz (2019). Targeted education challenges the misconceptions and knowledge gaps in applying theoretical knowledge to the everyday practice of nursing. Galligan and Wilson (2020) and Schwartz (2019) suggested that targeted education improves patient care.

Standard Three of the RN standards of practice highlights RNs as needing to maintain their capability to practise for optimal patient care (NMBA, 2020a; Ross et al., 2013). All NMBA policies, standards, and guidelines clearly state that RNs are accountable for maintaining their competency to practise (NMBA, 2014, 2018, 2020a, 2020b, 2020c). Many researchers present the relationship between professionalism and clinical competency (Nguyen et al., 2018; Shahruddin et al., 2019). Choperena et al. (2019) added to what other researchers have presented, stating that consideration of reflective practice and narratives in education may also enhance the development of

professional competencies. The authors of the IOM (2010) report asserted that interdisciplinary evidence-based practice accounts for optimal patient-centric care, and they concluded that interdisciplinary education is the way forward. For specialised training services such as HITH, the focus should be on education and professional competencies to improve patient-centred care.

HITH RNs currently lack a clearly documented specified clinical education pathway or continuing professional development (CPD) requirement other than the requirements for annual registration that all RNs undertake. Recruitment of HITH RNs occurs from differing hospital acute areas, for instance, medical, surgical, and emergency and nongovernment community nursing services, and RNs' skill sets may vary from one service to another. Nurses of all levels and career stages need a framework to help them assess and translate their knowledge into practice (Coventry et al., 2015; King et al., 2021). Wensing and Grol (2019) argued that nursing research is needed and should include a wider mix of academics, educators, and nurses to make the research outcomes beneficial to nursing's professional structures and patient outcomes. This premise is supported in the review of nurse education conducted by Schwartz (2019).

Several authors agreed that education and CPD are key factors in improving and maintaining professionalism in nursing, especially in relation to communication, intervention management, and leadership skills (Diaz et al., 2019; Fernandez et al., 2017; Filipe et al., 2014; King et al., 2021; Mlambo, 2021). Simulation-based training and education were found to increase communication and teamwork, (Diaz et al., 2019; Sami, et al., 2019; Webster-Henderson, 2021). Positive personal attitudes to CPD lead to RNs extending their role function in the practice.

The need for positive emotional intelligence for the continuing development of professionalism in nursing was emphasised by Castelino and Mendonca (2021). Education plays a significant role in nursing's professional identity and leads to improvements in patient care and job satisfaction (Karadag et al., 2016; Landis et al., 2020; Piil et al., 2012; Rasmussen et al., 2018; Wills et al., 2018). Furthermore, the Australian College of Nursing recently undertook a trans-Tasman study to develop NP standards (ACN, 2021) to mitigate the differences in NP education, leadership, and empowerment. Several authors have described education, training, and CPD as central to extended scope of practice (Gutiérrez-Rodríguez et al., 2019; NMBA, 2018;

O'Connell et al., 2014; Pollard et al., 2020; Rasmussen et al., 2018). Nevertheless, nurses need to have self-motivation to undertake and ensure the relevance of CPD to their current practice (Davidson et al., 2020). For instance, nurses since 2020 have needed relevant, reliable, and up-to-date information about the COVID-19 pandemic to support themselves, colleagues, and their patients throughout this anxious time around local and international responses to the pandemic (ACN, 2020b; DoH Vic, 2021; Kennedy, 2021; NMBA, 2020e; WHO 2020a, 2020b, 2020c, 2020e, 2021b).

## 2.18 Summary of the literature

The above historical examination of the emerging area of care provided by the HITH RN provides insight into a role that is encapsulated in providing acute care in the community. The importance of HITH RNs in practice with a reduction in inpatient bed days, a service in the person's home rather than as an inpatient, produces greater autonomy, increased skill set, and work satisfaction for the nurse. The ability to lead teams and to demonstrate clinical competence and an advanced level of practice is noted by eminent researchers referred to above. Nevertheless, ongoing debates about role title and function prevail. The literature shares the supporting and challenging concepts of nurse-led roles in a country that adheres strongly to a medically dominated healthcare system with nursing registration founded on a nurse generalist role. The myriad of role titles and role expectations challenge autonomous care when working in an interprofessional team due to potential scope-of-practice conflicts and lack of role definition relative to the professional work required. Registration standards provide a scope of practice and recognition for the RN in Australia with a professional scope of practice consistent with any work area. The advanced practice skills evident in HITH RN services are not acknowledged in the Australian context where generalist approaches prevail. The need for leadership, professional competence, and increased education, knowledge, and continuing professional development is evident. The lack of authority in role definition is clear. The definitive feature is the philosophy of caring, of providing for patients, and in achieving patient outcomes for those receiving acute care in the community. More work is needed, and foundational knowledge attained to clearly articulate the role and function of the professional nurse working in hospital in the home services. Clearly, care coordination, leadership and advanced practice occurs under a caring domain of patient care. The alignment with Watson's (1979) caritas philosophy is evident.

## 2.19 Conceptual framework

The philosophy and science of caring (Watson, 1979) underpins this research. First, it is important to understand the definition of nursing. Nursing, as defined by the ICN (2021), remains current today, was written as Henderson (1959) stated:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health, its recovery, or to a peaceful death the client would perform unaided if he had the necessary strength, will or knowledge … . Help the client gain independence as rapidly as possible.

This definition has been used to define a nurse in this research. Nursing is a caring profession, with each of the elements of Henderson's (1969) definition outlining the unique role of the nurse in assisting an individual at varying life events where care is required. The definition links with the caritas understanding in Watson's (1979) philosophy and science of caring framework. The evolution of nursing has incorporated systems that meet human needs, that change, that are problem solving, and that assist in decision making. Contextualising different theories and nursing concepts assists in developing greater areas of care in a supportive, caring approach based on the historical lessons and theories arising from research (Nightingale, 1869).

## 2.20 Implications for practice

Nurses are advocators of care; the patient should be considered first, only second to the safety and wellbeing of the nurse (Nsiah et al., 2019). Watson's theory strengthens the passion of HITH nursing about what it means for patient care because it delves into the completely "caring" aspects of nursing. Watson's theory provides HITH nurses with inspiration to continue becoming the best nurses they possibly can, for every patient met on their journey, for their colleagues, for the organisation, and for themselves. Patients require their idiosyncrasies to be considered during their need for care. All HITH patients deserve their own personalised care, and it is the HITH RN that is present in the individual's home that provides this care.

The impact on HITH nursing and why HITH Nursing should embrace Watson's philosophy for continuing patient care includes care, self-care, and continuous learning. Using Watson's caring theory benefits patients because, through

it, the nursing team gains a better understanding of patients' cultural and socioeconomic viewpoints, resulting in patients having increased empowerment in how and when their care is delivered. This intricate role of the nurse empowers individuals to become health literate and to consider their own needs whilst receiving care at home. Nurses' understanding of their patients stems from having a nursing philosophy relevant to their nursing and personal beliefs, values, and ethics concerning patient care, and has proved essential for the nursing profession's approach to patients (Nsiah et al., 2019).

## 2.21 Watson's philosophy and science of caring framework

HITH RNs' capability to care for those acutely unwell in what they regard as home aligns with the philosophy and science of caring framework (Watson, 1979). The theoretical framework acts as a guideline with the aim of portraying a strong sense of nursing roles and scope in practice in contemporary nursing. Pajnkihar et al. (2017, p. 12) specified that "stronger emphasis on caring theories is imperative during both nursing education and life-long learning so that a substantial core of expertise relating to caring theory-based practice can exist". The philosophy is viewed and enacted in the interlinking of theory and practice. In this sense, nursing requires carative, not just curative, factors (Bvumbwe, 2016).

Watson (1979) provided a contemporary approach to nursing theory. She proposed that nursing is characteristic of a human's better qualities, for instance, kindness and sensitivity (Alligood, 2018). Assessment includes the observation, identification, and a problem review, thus creating a hypothesis. Care entails care plans with allowance for variation in plans, with interventions along with the collection of observations and samples to support the care provided. Watson's (1979) framework provides a fundamental philosophical guideline for understanding the caring manner while recognising and responding to scientific evidence supporting care from the role of the nurse. Watson's (1979) theory emphasises the human aspects of nursing as being melded into the art and science of nursing practice.

### 2.21.1 Patient-focused nursing care

Gonzalos (2019), following Watson's approach to theory, suggested that human caring and caring science portray a strong sense of systematic use relating to decision making in the role of HITH RNs as the delivery of acute patient hospital-level

care in alternative settings is recognised. Like Nightingale (1859), 140 years later, Watson (1979) highlighted the importance of patient-focussed nursing care and discussed the usefulness of understanding scope in practice. Watson (1979) distinguished between the curative stance of medicine (doctors) and the carative nursing process (nurses), with the latter emphasising how nurses are prominent in increasing health and maintaining the wishes of their patients. This carative component of the philosophy is aimed at helping a person to live a healthy independent life.

Watson's (1979; 1997) original theory encompassed 10 carative elements, including a humanistic-altruistic system of values; faith, hope, and sensitivity to oneself and others; helping-trusting, human caring relations; and an acceptance of positive and negative feelings. The complete table of Watson's carative elements is available in Appendix B. The notion of carative nursing was not forgotten in care decisions, with the inclusion of problem solving; transpersonal teaching and learning; and corrective mental, physical, social, and spiritual wellbeing— all regarded as part of being human.

In her theory of caring, Watson (1997) proposed that humans are not objects and that they are part of the larger workforce as well as self, others, and nature, and this is where preserving patient dignity by caring for people at home is important. Watson's (1979; 1997) theory focusses on being a caring human that leads to the potential for healing through a caring transpersonal relationship for both parties, the giver of care and the receiver of care. Watson's caring science philosophy is concerned with embracing the positive energy that flows from an integrated mind, body, and spirit that is both rewarding and mutually satisfactory for the patient and the nurse. Both personal and professional lives continue simultaneously, and every experience or situation increases knowledge. With the increased knowledge, nursing philosophy may change slightly.

Nurses engaged in "being present" are knowingly able to optimise a patient's ability to heal from within. This is reflective of the one-to-one interaction that the HITH RN engages with patients in the community. Florence Nightingale's vision of a nurse is for nurses to put their patients in the best position to be able to self-heal, thus being carative not just curative. Using Watson's caring theory (1979, 1997) as a framework for this research is key because HITH RNs practise the art of caring, providing compassion to patients and families to ease their distress in a supportive environment in which they can heal with dignity. Dunning et al. (2021) concluded that

organisational values and the values in the work environment should include the wellbeing of the patient and care and safety of RNs that need to be aligned with values of improving patient care and safety and to be supportive of nurses in practice. Dunning's (2021) research supports Watson's caring theory, helping nurses to expand their own passion for nursing on both professional and personal levels, as Watson asserted that caring reenergises life and surges our capabilities.

### 2.21.2 **Nursing capability**

Nursing's capabilities lie within the four major concepts of human caring in Watson's theory: the human being, health, environment/society, and nursing. Watson defined the human being as "a valued person in and of him or herself to be cared for, respected, nurtured, understood, and assisted; in general, a philosophical view of a person as a fully functional integrated self" (Watson, 1988, p. 14). Societal values influence caring behaviour and goals, both personal and professional, according to Watson (2008). RN care improves patient outcomes and patient satisfaction. Because nurses are positioned to be the heart of healing, caring becomes contagious, evoking awareness and intuition. Caring can be positive and inspirational becoming the "gorilla glue" in long-lasting relationships for human belonging (Watson, 1979).

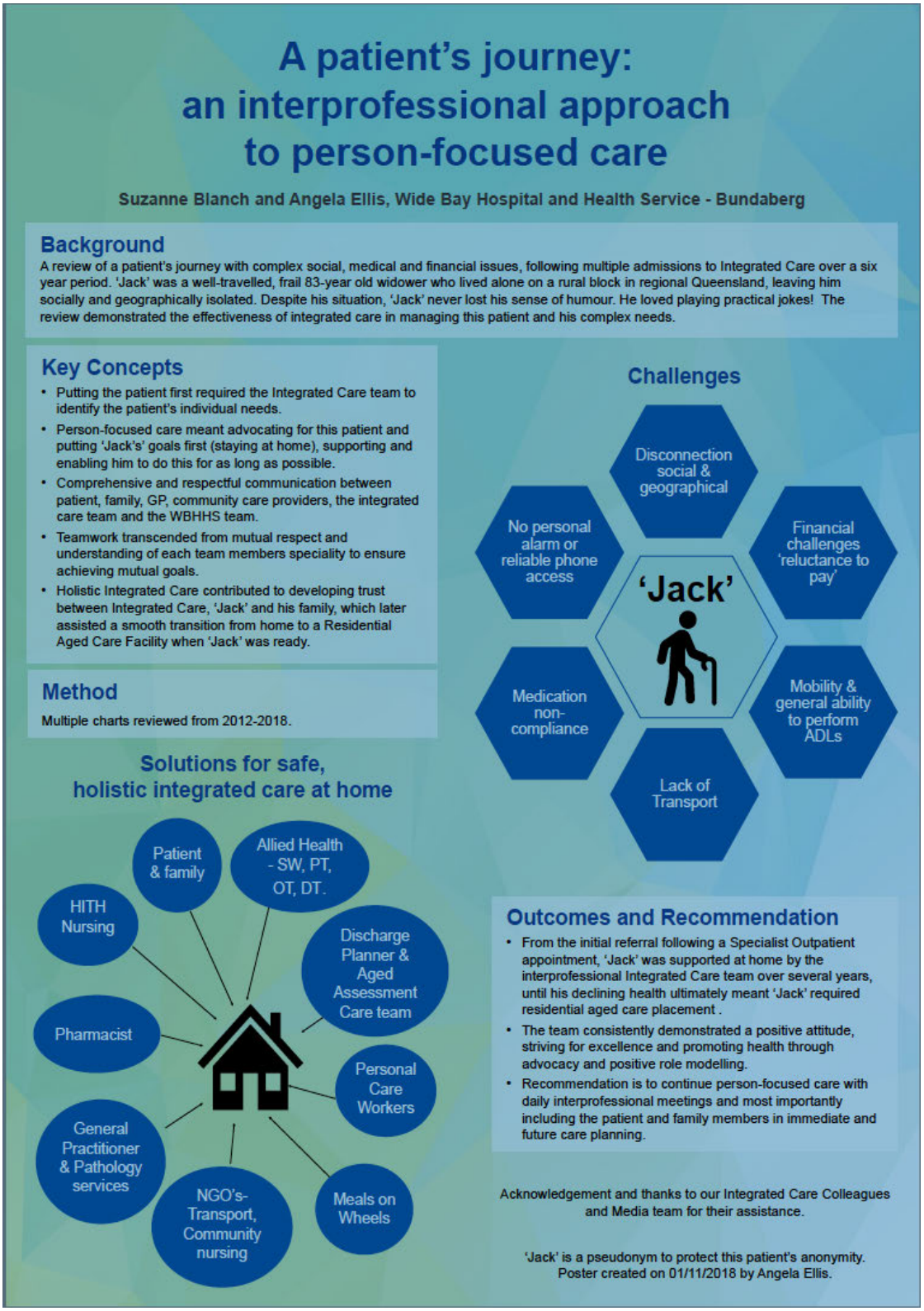
Watson's (1997) philosophical work regarding 10 carative factors guides nursing practice, and for that reason I will use her caring factors as a theoretical framework to underpin the individual and professional experience of the participants in this study. HITH nurses encompass Watson's caritive factors by implementing individualised care; observing their patients; and assessing, evaluating, reviewing, analysing, and interpreting outcomes in the social and environmental context of a person's home. The carative care plan is adjusted according to a patient's current level of wellness, and plan for discharge or further assistance once at home, consequently, creating a culture of putting patients first, prioritising care for and with individuals in their own home setting whilst interacting and care planning with a broader interprofessional health care team. Healthcare team communication increases patient knowledge through timely patient education and consultation.

Increasing communication regarding education, planning, and expected health outcomes with the patient and healthcare teams it is beneficial to use real-time electronic health records. Point-of-care technology also increases the timeliness of collaboration and communication that benefits the patient and professionally the

interprofessional communication channels (Booth et al., 2021; Hinder, 2018; ICN, 2018; Queensland Government, 2019; Vinayak & Brownie, 2018). Caring at home is what makes HITH nursing the best place for healing and a poster presentation in Figure 2.6 represents a patient's journey in a HITH service led by nursing staff and highlights Watson's theory of caring science. Figure 2.6 indicates some of the ways HITH nursing creates a healing environment for the patient.

Figure 2.6

*A poster example of interprofessional patient care collaboration* [a]




[a] This figure is from a poster presentation at the HITH Annual Scientific Conference, Brisbane (Ellis & Blanch, 2018)

Watson (1999, p. 75) emphasised that caring practice is crucial in nursing … "nursing is a human science of individuals and individual health–illness experiences mediated by professional, personal, scientific, aesthetic, and ethical human care activities". Nevertheless, a supportive environment can be lacking on busy hospital wards where time prioritisation overtakes time for stop, listen, and understand patient needs in more depth or detail. Patient satisfaction surveys reveal holistic patient-focussed care is variable (Deloitte Access Economics, 2011). Pajnkihar et al. (2017) shared Watson's caring science philosophy as one that sees nurses in a caring patient relationship being empowered by the environment that meets all the fundamentals of life for that individual.

### 2.21.3 A nursing philosophy fit for Home in the Hospital

Watson (1988) provided one theory of nursing: the theory of care that aligns with studies and research that is used today. The theory is the philosophy that nurses are not just nurses but are people with a goal to provide optimal and individualised patient-centric care. HITH aligns closely with Watson's (year) patient-centric approach to provide a supportive framework to maintain a caring environment with appropriate resources. Furthermore, Watson's approach to nursing becomes entwined with education (Franjić, 2020; Gonzalo, 2021; Watson, 2008) linking nursing as both an art and a science where ongoing learning and knowledge attainment is a core element (Castledine, 2010).

Empathy and caring are at the heart of the HITH RN's practice. Such attributes provide the human component that situates HITH nursing apart from others, which is why HITH patient satisfaction is higher for multiple reasons. Officers in the clinical excellence unit, Queensland (2021) stated that HITH provided a cost-effective method to increase hospital-bed capacity, as HITH being "without walls" is flexible and sustainable during times of increased acute-care demand, but with little "bricks and mortar" expenditure. This has been evident with the use of HITH RNs throughout the current pandemic. Watson's approach illustrates how to get to know the patient and how to care for patients physically, emotionally, and spiritually in a sensitive supportive healing environment.

By conducting HITH patient care using the 10 Carative Principles, the care provided develops a helping and trusting relationship between patient and care provider (Pajnkihar et al., 2017). HITH RNs have insights into the patients' lives and

the social determinants that affect patients' health and wellbeing as they visit the patient's environment to attend care. HITH RNs have an appropriate knowledge base and experience for their role and role function however this is only noted not mandated through professional role obligations other than the AHPRA registration standard guidelines within the competency standards of the RN in Australia. RNs in HITH nursing roles can have independent analysis and decision-making capacity while communicating and collaborating with an interprofessional team to provide excellent patient and family care however this currently is outlined in individual position description rather than as a role descriptor more broadly in Australia. Maintaining interprofessional communication and collaboration requires a commitment to continuing education on communication awareness and nursing leadership skills for the delivery of optimal patient care in an ever-changing healthcare system. Collaborating respectfully assists to develop quality skills and practice. Building a trusting relationship between nurse and patient enables patients to have the confidence to express both positive and negative feedback.

With care delivery to a patient at home, HITH RNs must uphold the professional scope of the RN by keeping informed of issues and information that affect the nursing profession and their individual practice. Therefore, HITH RNs must continue to practise within the Professional Standards for RNs (NMBA, 2020a) and increase educational priorities as practice changes arise. HITH functions provide professional nursing the essentials to give patient-focussed care, and Watson's 10 caritive factors influence these (Watson, 2008).

HITH RNs and nurses more generically are among the most trusted profession (Gaines, 2022). They are expected to provide the patient, the family, and the community with practical education that supports and promotes health and wellness practices (Haddad & Geiger, 2021; Östman et al., 2019). The essence of nursing, according to Watson (2008), is the cultivation of a caring attitude for patients, patients' families, their colleagues, and themselves—and this is a must for HITH RNs. Douglas (2010, 2011) concurred with Watson (2008) by concluding that delivering care without caring for co-workers is wrong. Hill and Broady (2019), in the report for the NSW Carers Advisory Council, acknowledging that carers' wellbeing is important, as is the wellbeing of nurses, without which neither party can care for the patient ethically or safely.

## 2.22 Chapter Summary

The literature review has explored the historical context of the HITH RN role in Australia from its historical beginnings until now. The evolution of the role has appeared in the Australian health care system however remains with limited role and scope as an area of advanced practice or specialisation. Nursing regulation and competency standards of the RN identify with generic competency standards for the RN. The literature has been reviewed in relation to nurse led services and professional liabilities of the RN. Advanced nursing practice is discussed in the context of service expansion and the defining role of the HITH RN. Professional competency and leadership are defined as a key contributor to care coordination for the HITH RN role and yet one where advanced practice and leadership qualities are not prescribed through post graduate education or skill development. The need to identify with increased knowledge, specialist skills and continuing education plans was identified. Each of these areas share a picture of the challenges and barriers to the role of the HITH RN where role and function is described as an advanced practice role and yet where the regulatory boundaries of practice remain with the generic competency standards for the RN in Australia. The literature identifies challenges and the inherent need for more knowledge and understanding of the role and function. The literature supports advanced practice standards and the specialisation of HITH nursing practice where knowledge, leadership and continuing professional development is supported. The conceptual framework provided through Watson's caritas of caring is presented. The caring paradigm offers linkages and alignment to support the caring and practical foundations of the HITH RN as physical and social provider and coordinator of care. The literature has defined an advanced scope of practice supported through a caring paradigm where questions remain unanswered and where the experience of HITH RNs can add to the literature to define the parameters of the role in practice. The research methodology will be presented in Chapter 3. It is this methodology that seeks to share the experience of HITH RNs and their voice to aid in discovering the role and function in practice.

# CHAPTER 3: RESEARCH METHODOLOGY

In this chapter, I present the traditions of qualitative research and explore whether a phenomenological methodology is acceptable for enhancing knowledge about nursing as a profession, and to understand the HITH RNs' role and function in practice. I include exploration about the level of potential bias that the researcher has over the study and the research design. I also demonstrate how Gadamer's hermeneutics was implemented during the study while using Braun and Clarke's (2006) six principles of thematic analysis to analyse the data.

The chapter explores the qualitative research paradigm and its relevance in the research study (section 3.1). The chosen methodology of phenomenology is defined in section 3.2 with the historical perspective provided in section 3.3. The extension of the broader methodology of phenomenology is discussed in section 3.4 defining descriptive and hermeneutic phenomenological perspectives. Section 3.5 and section 3.6 discuss the hermeneutic methodology and section 3.7 the link between the methodology and the research aim. The fit relating to the research is outlined in section 3.8. The chapter commences with a discussion relating to qualitative research.

## 3.1 Qualitative research as a research choice

Traditionally, qualitative methods offer an effective way of analysing data from the perspective of experience. Qualitative methodology is considered fluid and flexible and is sometimes viewed as a precursor to quantitative studies because of the capacity to increase understanding, identify priorities, and describe experiences and relationships (Hennink et al., 2020; Holloway & Wheeler, 2016; Streubert & Carpenter, 2011). Qualitative research differs from quantitative research by identifying trends without using numerical values (Liamputtong, 2019).

There are five standard qualitative methodologies, comprising phenomenology, ethnography, case study, grounded theory, and action research and several others that offer research paradigms of description and understanding. Many differing qualitative methodologies exist that may be suited to the research question. For instance, narrative research has its strengths in the ability for storytelling from the perspective of one or two participants and ethnographic studies could explore the HITH RN in practice. Qualitative methods enable rich descriptions that include detailed context, setting and

quotations. Narrative research weaves a sequence of events to create a cohesive story, one of "opportunities for innovation". The research question seeks to understand the HITH RNs experience of their role function and scope in the context of their clinical practice. Interpretive phenomenology provides the methodological context to enable the voice of participants to be heard and to be thematically analysed for trends, interpretations, and emerging concepts. This methodology is appropriate as it allows the researcher to stay true to the participant and share their experience, their stories and their context whilst analysing the datasets for like concepts and experiences. For this reason, I have chosen this methodology to explore the research question: What is the HITH RNs' experience of their role and function in practice?

Qualitative research seeks to gain insight into people's attitudes, behaviours, and reasons that influence their behaviour (Liamputtong, 2019). Qualitative research facilitates better understanding and new perspectives surrounding a phenomenon (Hennink et al., 2020; Holloway & Wheeler, 2016; Liamputtong, 2019; Polit & Beck, 2021). The methodology is more "rounded" in that it focuses on questioning the why and how, plus the what, where, and when about a phenomenon (Creswell, 2017; Creswell & Creswell, 2018; Hennink et al., 2020). It also elucidates and helps to understand the phenomenon, in contrast to making a causal determination or prediction (Hennink et al., 2020; Polit & Beck, 2020). For these reasons, qualitative research continues to emerge as the most frequently used method for conducting studies within the nursing profession. The use of qualitative research is supported by evidence-based practice advances in the development of nursing knowledge and answers a range of questions concerning human responses to actual or potential issues (Hennink et al., 2020; Polit & Beck 2020, 2021). Thus, the analysis of qualitative research data constitutes a form of narrative to add knowledge to known scientific enquiry (Hennink et al., 2020; Streubert & Carpenter, 2011; Webb & Roe, 2007).

The three qualitative methods of ethnography, grounded theory, and phenomenology share common characteristics of enquiry. They can be used to make sense of the lived experiences of the participants through adaptations from the social sciences (Hennink et al., 2020; Liamputtong, 2019). For example, ethnographic research focuses on culture and customs, grounded theorists investigate processes and interactions, whereas phenomenologists describe the "life world" through consideration and illumination of phenomena (Polit & Beck, 2020, 2021).

Any qualitative data collected enables understanding of the meaning, interpretations, and lived experiences of the participants; in this instance, the role as HITH RNs in Australia (Creswell, 2017; Creswell & Creswell, 2018). The primary focus of phenomenology is to describe, explore, and explain the phenomena being studied; that is the lived experience of individuals (Cohen et al., 2007; Streubert & Carpenter, 2011). An interpretative approach is based in the social reality of qualitative research, so it is the personal life story, and the 'what' and 'how' of the experience (van Manen, 2016). A phenomenological study commences with identifying the phenomenon together with evidence from reviewing the literature.

I selected a phenomenological design for this study because it ensures that the research focuses on understanding individuals' experience working as HITH RNs (Streubert & Carpenter, 2011). Furthermore, the data aids the development of research questions for quantitative studies or supports already-existing quantitative data sets (Hennink et al., 2020). Phenomenology is one of the key qualitative research methods used to gain understanding into perspectives, both individual and collective experiences.

## 3.2 Understanding Phenomenology

> "Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so."
>
> Douglas Adams and Mark Carwardine, *Last Chance to See* (1990).

I sought to conduct between 10 – 15 interviews with HITH RNs from across Australia. The methodology is reflective in nature and can be restricted by a limited time frame, financial constraints, geographical restrictions, or a limited number of interviews (Marshall & Rossman, 2015). Liamputtong (2019) and Green and Thorgood (2018) claim that there are discrepancies regarding sample sizes for qualitative research and suggest that as few as five participants are optimal for qualitative studies and the acquisition of rich data. In this method, the focus is on the depth of the interview and the data collected in describing their lived experiences in depth. Analysis imitates the following structure commencing with a naïve reading, moving forward to word-by-word and line-by-line analysis to extract collective codes and themes that share an experience (Streubert & Carpenter, 2011; Webb & Roe,

2007). Analysis undertaken in this way ensures consistency in terminology and assists in reducing researcher bias.

The aim of phenomenological research is to widen the field of knowledge. The research method is about exploring boundaries, enabling the researcher to ask questions that aim to widen the field of knowledge about a phenomenon (Denzin & Lincoln, 2017). Neubauer et al. (2019) suggested that the phenomenological lived experience argues and points the way forward by providing a greater understanding of personal experience. The phenomenological lived experiences are those that reveal the immediate, not an experience anticipated (Streubert & Carpenter, 2011; Webb & Roe, 2007). Tewksbury (2009) suggested by analysing the data the argument evolves as the researcher probes the associations. Moreover, often the researcher becomes immersed in the lived experiences of participants to the extent that intuition becomes a factor. The "lived experience", known as intuiting in phenomenology, commences when the researcher starts to gain knowledge about the phenomena as described by the participants (Husserl, 1970; van Manen, 2014). Phenomenology evolved over many years with the addition of several adaptations by key qualitative theorists.

### 3.3 Phenomenology: The early years

Plato, Socrates, and Aristotle were early philosophers and are considered the precursors of phenomenology (Praveena & Sasikumar, 2021; Shosha, 2012). van Manen (2014) stated that they did not develop theories related to reality by asking questions. Edmund Husserl, a German philosopher, and mathematician further developed phenomenology suggesting questions such as "what is the experience like and what is the meaning?" (Hesse-Biber & Leavey, 2016). Husserl is considered the father of phenomenology (Cohen et al., 2007). From the first decade of the twentieth century, Husserl began writing that philosophical phenomenology was a human science emerging from nonmaterialistic views. He believed that phenomenology accentuated the "lived" experience (Cohen et al., 2007; Hesse-Biber & Leavey, 2016). This Husserlian method of enquiry is "descriptive" or eidetic phenomenology, generating a broad characterisation of a phenomenon through gaining knowledge about how people experience it (Dowling, 2007; Hesse-Biber & Leavey, 2016). Descriptive phenomenology, also known as transcendental phenomenology, can be divided into four stages: bracketing, analysing, intuiting, and describing (Wojnar & Swanson, 2007).

## 3.4 Descriptive versus hermeneutic phenomenology

Reiners (2012) stated, that Husserl's question, "what do we know as persons?" is aimed at sculpting descriptive phenomenology into a science through the experience of perception, thought, memory, imagination, and emotion. Husserl used the concept of bracketing to maintain objectivity by disregarding researchers' preconceptions of the participants' lived experience. He believed it was necessary to prevent corruption of a participant's comment. Therefore, preventing a tainted description of the phenomena studied (Streubert & Carpenter, 2011). Bracketing is part of phenomenological reduction to withhold prior knowledge of the phenomenon. Bracketing means the researcher must identify and keep predilections and beliefs in abeyance to enable openness and to avoid intrusions when exploring the phenomenon under study (Greenhalgh et al., 2019). Often researchers keep a journal to bracket their preconceptions to ensure these perceptions do not influence the research (Hesse-Biber, 2016; Streubert & Carpenter, 2011).

Heidegger, a student of Husserl, augmented Husserl's theories of descriptive phenomenology in the book, *Basic problems of phenomenology* when he wrote "[Dasein] finds *itself* primarily and constantly *in things'* (Heidegger, 1988, p. 159). Later, he went on to answer such questions as "what is being?" In his book *Being and Time*, Heidegger (2010) developed a philosophical methodology known as hermeneutic phenomenology or interpretive phenomenology to discover the meaning of being for humans (Dowling, 2007). Heidegger stated, "phenomenology means, to let what shows itself be seen from itself, just as it shows itself from itself. That is the formal meaning of the type of research that calls itself phenomenology" (Heidegger, 2010, p. 32). He also described *Leib* as being-in-the-world, so one could perhaps look at a spoon for the first time and use it to dig the earth. However, most know it is a utensil used for stirring or eating food. Heidegger went on to explain the meaning of 'ology' or 'logos' is to let something be seen and the phenomenon is "that which shows itself in itself". Thus, Heidegger sought to gain a deeper understanding and interpretation of the human experience (Reiners, 2012).

The term hermeneutics originated in the seventeenth century when used as a method to interpret biblical and classical literature (Packer, 2017; Wills, 2018). Heidegger identified a seven-stage interpretive phenomenology approach designed to elicit a wider understanding of the paradigm. The first stage is transcribing the

recording and gaining clarification from participants about their original comments, thus adding richness to the data. The second stage involves studying the interview data by reading, summarising, and noting any emerging themes. Stage three involves analysing issues that emerge from selected transcripts and allocating these issues into group themes. On receiving confirmation from participants, comparing, and contrasting the descriptive text begins to reveal shared meanings. The identification of patterns and merging of linked themes are stages four and five. The final stages include gaining input from the interpretative research specialists and requesting the participants to validate the final draft of the proposed findings prior to writing the hermeneutic phenomenological results (Creswell, 2017; Creswell & Creswell, 2018; Praveena & Sasikumar, 2021; Shosha, 2012; Wojnar & Swanson, 2007).

Hermeneutic phenomenology assumes that humans experience the world through language. Language provides understanding and knowledge from data gathered via in-depth interviews (Benner, 1994; Carpenter & Suto, 2008; Greenhalgh et al., 2019; McConnell-Henry et al., 2009). Heidegger (2010) believed that hermeneutic phenomenological researchers should maintain a journal to record their lived experience and preconceptions surrounding a participant's interview to ensure they remove their previous knowledge or individual perceptions of the phenomenon. Instead, the researchers acknowledge these insights to elicit an understanding about how people live and interact with others (Reiners, 2012; Streubert & Carpenter, 2011). For example, the researchers' experience of death within a family can assist them to relate to the lived experience of the participants who may have experienced death in a family (Dowling, 2007; Streubert & Carpenter, 2011; Webb & Roe, 2007).

Hermeneutic phenomenology involves the researcher constantly moving back and forth to examine and re-examine the data (Polit & Beck, 2020). This process of moving back and forth constitutes the hermeneutic circle of understanding. This circle is intended to increase transparency and direction by revealing concealed meanings in the phenomena studied (Wojnar & Swanson, 2007). As such, interpretative phenomenology assists researchers to understand the emergence of data interpretation to lessen the gap between the known and the unknown (Streubert & Carpenter, 2011; Webb & Roe, 2007; Wojnar & Swanson, 2007).

## 3.5 Extension of the hermeneutic circle

I identified with Gadamer, Heidegger's protégé, who disagreed with the idea that only science could attain truth. Additionally, Gadamer argued that a person's background, culture, beliefs and biases, community, and history are vehicles to access the truth (Dowling, 2007; Gadamer, 2013). Furthermore, Gadamer (2013) asserted that the truth is an exchange of views found in history and disclosed in poetry whereby the researchers' language and history are intertwined to gain clarity and perspective of the phenomenon (Dowling, 2007; Gadamer, 2013). Gadamer (2013) elaborated on Husserl's take on phenomenology by re-examining phenomena, re-reading, and re-understanding, thus bringing the truth another step closer and extending the hermeneutic circle of understanding (Gadamer, 2013). For example, a mother can have empathy, understanding, and insight of a mother in a similar situation even in situations with different nuances. In this study, I am a HITH clinical nurse, so I can have empathy, understanding, and insights into the differing roles and role functions of other HITH RNs in Australia.

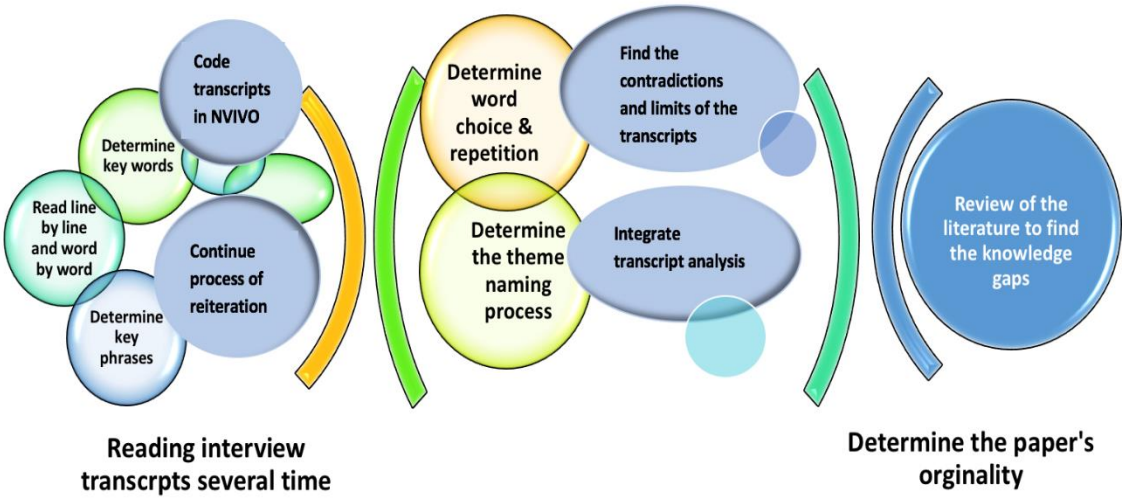
## 3.6 Phenomenology and thematic analysis

There are different approaches to gaining rich data: phenomenology that uses inductive analysis and hermeneutic phenomenology that uses deductive analysis. There are many shared analytical tools and methods with other qualitative research approaches. Data collection methods for qualitative research can include observation, focus groups, interviews (either face-to-face or by telephone), field notes, audio recordings, and journals (Greenhalgh et al., 2019; Liamputtong, 2019; Polit & Beck, 2021). Semantic coding and theme development are reflective of the explicit content of the data, a generic technique (Byrne, 2021). Byrne (2021) suggested that the data is "a framework of thematic ideas" (Byrne, 2021, p. 38). Byrne (2021) suggests that researchers can ensure that their coding is reliable by using coding notes and observations, definitions of the codes, and other notes about the codes. Such a set of procedures ensures the coding is consistent. Byrne (2021) also argued that a thematic framework is a commonly used approach to thematic coding and identifies line-by-line coding with constant comparison as very useful. He also stressed that researchers need to remain flexible and not tied to their initial codes, that is, "not to become too tied to the initial codes you construct" (2021, p. 46). Lack of focus can have detrimental effects on data analysis that purports to be credible qualitative research.

(Nowell et al., 2017). Therefore, using Braun and Clarke's (2006) rigorous and relevant thematic analysis framework systematically will increase the credibility of the research process, especially when describing and explaining the process of analysis that links with the research aims and data analysis process as shown in Figure 3.1. The diagram outlines the hermeneutic process of data analysis as described by Gadamer with the inclusion of Braun and Clarke's (2006) thematic analysis framework to guide the write out of the emerging themes.

In this research, the overall aim is to explore and describe the lived experience of RNs employed within the Australian HITH environment in relation to their role function in practice settings. The process of data analysis linked intricately with Gadamer's philosophy seeks to gain greater insight into the experience of the HITH RN in practice.

Figure 3.1 *Abridged process of thematic analysis using interpretive phenomenology* [a]




[a] Adapted from Braun and Clark (2006)

## 3.7 The link between the methodology and the research aim

Scope of practice for RNs refers to procedures, actions, processes, and qualifications that define a nurse's practice (ICN, 2020). This study is focused on gaining current lived experiences of RNs employed in HITH services. There is little known about the views of RNs and their perceptions of their own practice in this domain, particularly, in a context where HITH is a rapidly developing concept in patient care across Australia. Defining the role function and scope in practice for RNs

enables greater clarity from the perspective of those living and working in the role each day. The outcomes of this research will provide the capacity to further enhance the role and its functions as more will be known from those working within, rather than from presumptions of those not intricately engaged.

Secondly, further data will be analysed through a critical review of the participants' position descriptions and demographic information. A critical review and analysis of the participants' position descriptions using Braun and Clarke's (2006) thematic analysis will intensify the richness of the data gained from the in-depth semi-structured interviews. Braun and Clarke's (2006) thematic analysis will be used throughout the data analysis process. They distinguish between two levels of themes: semantic and latent. The position description analysis produces semantic themes.

### 3.8 A research method fit for nursing.

Over the past three decades, hermeneutic phenomenology has assisted healthcare professionals, and importantly nurses, to provide quality patient care (Streubert & Carpenter, 2011). Hermeneutic phenomenology has assisted the researcher to describe and validate the experiences of caring and healing, looking at individual lived experiences and the whole person being the HITH RN (Benner, 1994; Parse, 2012; Reiners, 2012). Phenomenology is the study of the perceptions, feelings, and lived experiences of the participants. Further, hermeneutic phenomenology offers the opportunity to describe personal lived experiences through relationships that HITH RNs have with their environments, patients, and their role as RNs in practice (Cohen, Kahn, & Steeves, 2007; Streubert & Carpenter, 2011). For instance, hermeneutic phenomenology facilitates observation of patient and carer relationships, and is part of the exploration of being a carer or being cared for (Webb & Roe, 2007; Wojnar & Swanson, 2007). Transposition of participants' insight into a strong textual form brings forward the phenomenon, thus affording opportunities to develop an in-depth, meaningful understanding and assessment of the participants' lived experiences through an understanding of what shapes their practice and RN lifeworld (Wojnar & Swanson, 2007). Gadamer (2013) suggested keeping a journal to record any prior knowledge of the participants' activities to prevent personal bias in relation to the phenomenon. The aim of a journal is to add wealth and insightfulness to the study.

Gadamer (2013) argued that research is not undertaken in isolation from the researcher's past experiences. He argued that past experiences can enrich the analysis

as the research occurs within the environment in which any researcher lives and because of this the researchers cannot bracket their knowledge and experiences. The researchers' journals include their HITH clinical nurse position description, naïve reading notes, concept maps during the analysis process, and the fact that I can hear my own voice similarly to the comments made by the participants. These are the reminders to prevent personal bias in this study.

Using thematic analysis as an iterative movement between data and the development of themes can have weaknesses. The weaknesses need balancing by the ability of thematic analysis to capture and articulate the insights of those involved in the research. The thematic analysis takes the raw data and looks for codes, which, when collated, form a theme. One weakness is that researcher could tweak and shape the data to provide a better alignment with the framework used (Streubert & Carpenter, 2007). Therefore, looking for codes and themes requires the researcher to work through this stage with delicacy using the tool NVIVO© to validate the codes, cross-analysis, and supporting each theme with quotes from participants. The focus of healthcare research should capture the phenomenon of interest and the lived experience. Gadamer's hermeneutic circle fits with Braun and Clarke's (2006) thematic analysis principles in that the participants as individuals can explain how and why they view something. The principles add congruence with process and structure to guide the analysis where checkpoints and authenticity can be challenged and further supported by the transcripts of each RN in the analysis phase of the research.

Broad capturing of themes supported by the voice of the HITH RN transcripts enables the findings to be of significance to healthcare providers, policymakers, and researchers as a strong voice from practice is provided (Streubert & Carpenter, 2007; Webb & Roe, 2007). Further, qualitative research is relevant to health research because it includes topics such as decision making and practitioner–patient interactions (Webb & Roe, 2007). The defining characteristic of in-depth semi-structured interviews is that the flexibility and fluidity gained from each participant allows the researcher to discover the meaning of the participants' opinions, thoughts, and ideas, that is, their experience (Miller & Glassner, 2011; Webb & Roe, 2007). The use of standardised open-ended questions in interviews allows for enhanced comparability of the data collected. The rigidity of previously prepared formal questions discourages flexibility and fluidity, leading to a loss of the essence of the lived experience discussed (Liamputtong, 2019; Redmond & Suddick, 2012). The use of in-depth semi-structured

interviews empowers participants to discuss their experiences through sharing their insights and stories surrounding key areas of their practice as HITH RNs (Barbour, 2013; Coombs et al., 2012). Moreover, in-depth semi-structured interviews using open-ended questions are considered the most appropriate method to elicit responses adding more depth and richness to the data gathered. Semi-structured questions are used to enhance interview techniques and are essential to building rapport with participants (Brinkman & Kvale, 2018; Creswell, 2017; Creswell & Creswell, 2018; Liamputtong, 2019). I will explore the HITH RN role through their current experience now, not in the past or the future. This requires me, as the researcher, to understand data collection processes, the methods used, and the participant selection process.

## 3.9 Chapter Summary

This chapter has presented the methodology of choice, hermeneutic phenomenology. The reason for the choice has been defined with the rationale clear and relative to engaging with HITH RNs to identify their experience of their role in practice. Gadamer's hermeneutic phenomenological approach guides the research and structures the context in hearing from the RNs directly engaged in HITH services and providing acute care for individuals in their home. This chapter has articulated the link between this chosen methodology and the research question and aim. The next chapter presents the research design for this study, including how the methodologies are used to explore the experiences of RNs regarding their concept of the role of a HITH RN.

# CHAPTER 4: RESEARCH DESIGN

## 4.1 Introduction

In this chapter, I introduce the research design in section 4.2. The process of participant selection (section 4.3), recruitment (section 4.4) and consent (section 4.5) are discussed. Data collection in the form of participant interview (section 4.7.1) and content analysis of position descriptions (section 4.7.2) are outlined. The researchers position in the research (section 4.8) and ethical considerations (section 4.9) are discussed. Research integrity, rigour and credibility are defined and discussed in sections 4.13 – section to 4.18 inclusive. Confidentiality and privacy are outlined and linked with data storage requirements in section 4.20.

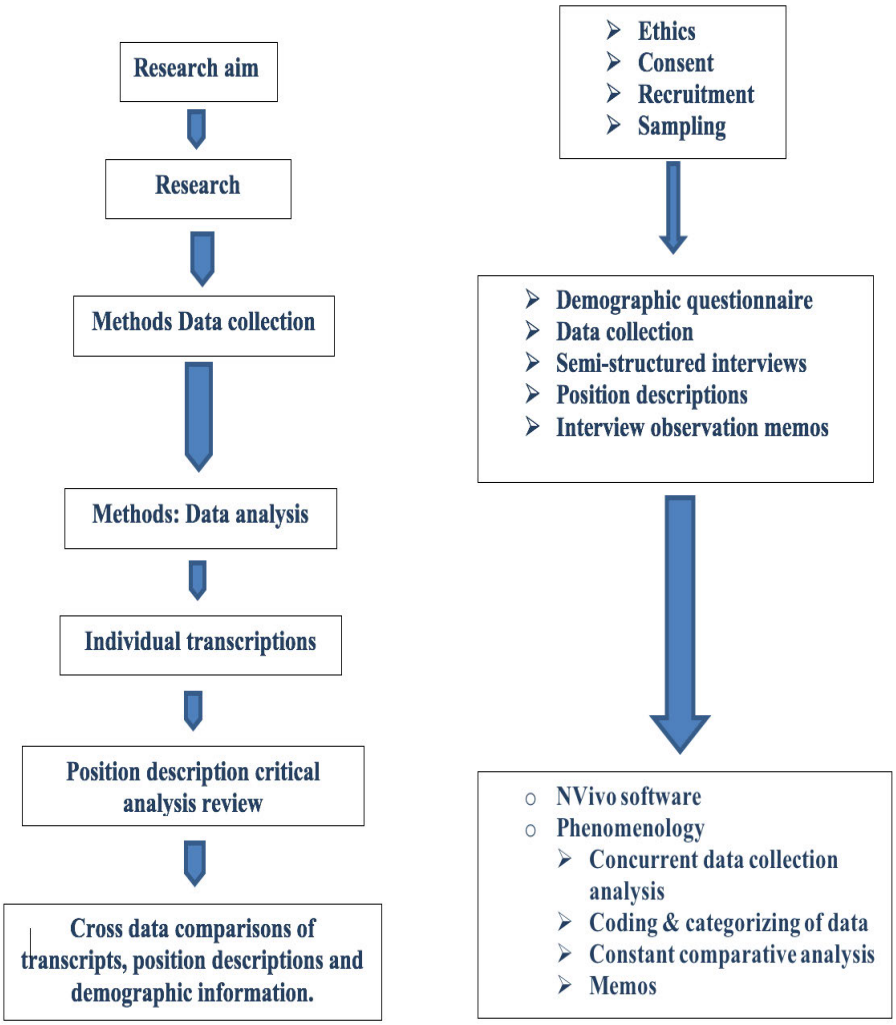
## 4.2 Research design

The research design included the ability to gather information directly from HITH RNs working in a hospital in the home service in Australia. Two points of data collection were involved in the research design. The first included interviews with HITH RNs through semi-structured in-depth interviews to gather the RNs perspective of their role working in a HITH service. The second source of data collection was through a content analysis of each HITH RNs position description. Collectively the collection of data enabled the experience firsthand from HITH RNs in practice in the Australian health care setting.

An email was sent to all members of the HITH Society inviting RNs from all States and Territories in Australia to participate in the research. The participants volunteered to be involved in this research, and as such they made the contact to enquire about participating in this study through direct email with myself. I forwarded all the information the participant needed to make an informed choice as to whether to participate or not. The information included samples of questions, the amount of time the interview may take, a request for demographic information, and a copy of their position description. Once I collected the demographic information and position descriptions, The research is guided by the research aim and question and follows the process outlined in Figure 4.1.

Figure 4.1

*Research design*




## 4.3 Participant selection and sampling

The eligibility criteria required applicants to be RNs and employed in HITH services in Australia. This ensured that the experience being collected through in-depth interviews was focused on the RN. To achieve this selection of participants a process that used a purposive sample of HITH was used. All HITH RNs were contacted through the Australian HITH Nurses Association. From the initial purposeful sample, the researcher interviewed all participants that expressed interest. To enable a voice from HITH RNs in both metropolitan and regional settings, further emails were sent to HITH RNs in specific states and regional areas to ensure that this voice and the HITH RN experience was captured. The selection process was chosen as it can be

synonymous with qualitative research. The study had predefined criterion to ensure that a standardised and methodical approach was achieved. The criterion is outlined in Table 4.1. Employing purposive sample allowed recruitment from a broad range of potential participants to specifically focus on the role, skill set, and understanding of the HITH RN in practice. Only participants meeting these criteria have the knowledge and understanding of HITH RN scope of practice. The participants were of different ages, genders, cultural backgrounds, education levels, and geographical locations in Australia, therefore this allowed me to strive for rich narrative data from varied localities and settings across different health jurisdictions.

Table 4.1
*Participant selection and sampling criteria*

| Criteria | Participant selection to meet both sampling criteria | Australian states & territories | Number of participants |
|---|---|---|---|
| Criterion | RNs who are knowledgeable and aware of their role and role functions | 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 | | |
| Position titles | All position titles will be included for RNs working specifically in HITH services | | |
| Expertise | RNs employed in HITH services | | |

Recruitment entailed the Australasian HITH Society emailing all members to inform them about the study to ensure a wide and inclusive national approach was used. The invitation to participate (Appendix C and D) provided a brief explanation of the study and details about the amount of time involved in the interview/s (which would be approximately 45–60 minutes). The HITH RN members contacted me directly for more information to avoid any third-party involvement that may identify a particular participant. I aimed to recruit 10 to 15 participants from across Australia within the specific inclusion criteria. My aim was to gain at least one participant from each state or territory, with a representative from rural, regional, and metropolitan areas in the larger states and territories. However, participants from rural areas, were

hindered by the potential of being recognised due to the small number of nursing staff in rural services. The one rural participant withdrew consent post-interview, therefore not included in the data analysis.

## 4.4 Recruitment

Participants from each state or territory in Australia were recruited to gain a broader perspective covering metropolitan and regional health services across all jurisdictions. The inclusion of 10–15 potential participants allow for participant withdrawal without data quality being compromised. This small cohort of HITH RNs is consistent with phenomenological research and remains true to the methodology (Frechette et al., 2020). The purposive and small participant sample can better target the phenomena and through in-depth interviews gain rich insights into the role and function of the HITH RN (Frechette et al., 2020).

If the participants met the sampling criteria, they could volunteer to participate in the study. The recruitment process relied on potential participants contacting me directly following the initial email correspondence. Once contact was made, a broader explanation was provided about the purpose of the study, and the time requirements. The range of means for interviewing was identified (e.g., teleconference, Skype, or face-to-face), and the most suitable method was agreed on. I forwarded participant information forms (see Appendix E) using the communication method that the participant requested (e.g., email or hard copy via Australia Post). The techniques and process employed to engage the proposed number of participants in this study was complex due to the small number of RNs employed in HITH nationally. A limited number of potential participants were sought for in-depth interviews for analysis of the participants' experiences.

## 4.5 Consent

Consent to participate information included a request from me, as the researcher, to the RN HITH Society members to participate. This process gained initial HITH Society support and enabled advertising to recruit participants at a national level. The poster invitation to participate (Appendix D) for RN colleagues working in HITH services in Australia who are not HITH society members. Support from HITH Australasia Society was sought because this was a requirement to gain Human

Research Ethics Committee (HREC) approval. Once approval was confirmed by the USQ HREC, contact was made with potential participants as outlined in Appendix G. The underlying principle of confidentiality in research means that consent is secured for the purpose for which data are collected. Obtaining informed consent verbally and in writing was viewed as valid when the participants were competent to consent, have sufficiently and easily understood the information, and where participant consent was voluntary (Liamputtong, 2019; National Health and Medical Research Council [NHMRC], 2015, p. 16; Polit & Beck, 2021).

All RNs who agreed to participate completed and signed a consent form (see Appendix F). Consent forms were attached to the participant information sheet. Completed consent forms were returned to me as scanned documents and I stored them electronically on a password-protected computer (see Polit & Beck, 2021). Consent forms were stored separately from transcripts of recordings to increase anonymity and confidentiality of the participants (see Greenhalgh et al., 2019). Provision of relevant information is to comply with the fundamental ethical research process, especially if participants did not meet the recruitment process. This process was used to reduce bias and ensure an ethical approach that maintained participant confidentiality.

The participant consent included process should they wish to withdraw their interview from the data collected. This information included how participants could withdraw (before data analysis) from the study if they so choose, as once data had been analysed it was not possible to extract data specific to one participant (Liamputtong, 2019, Greenhalgh et al., 2019; Polit & Beck, 2021). This is consistent with interpretive phenomenology and data analysis processes (Liamputtong, 2019, Greenhalgh et al., 2019; Polit & Beck, 2021). Withdrawal meant their data would be excluded from the analysis and as such this request was needed prior to data analysis commencing. Participants were advised that withdrawal would not incur any judgement from the HITH Society Australasia, their employer, the University of Southern Queensland, or me as the researcher (see Adams et al., 2007; Hesse-Biber & Leavey, 2016, NHMRC, 2015, pp.12–21).

### 4.6 Data collection

Data collection was scheduled between 2015 and 2018 however due to researcher illness this was extended until 2020 with an anticipated sample of 12 to 15 participants employed as HITH RNs within Australian HITH services. Individual

audio interviews were estimated to be between 45 and 60 minutes. The interviews were undertaken in a variety of settings. Two interviews were conducted face to face in a place of the HITH RNs choice. One interview was conducted on the phone, and the remainder were via video call, some of which took place in their workplace (at their request) and others from home.

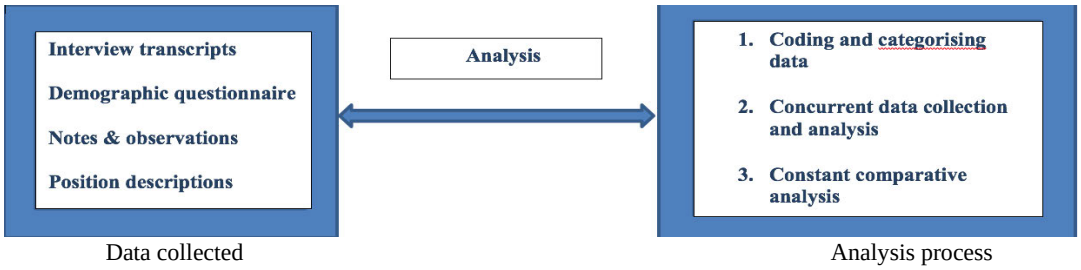
During the interview timeframe the participants would also be asked generic role questions relating to their length of service in HITH and current role title, the service area and region, their age group, and education level. The purpose for this data was explained and the interview process and the reason for the researcher-designed demographic survey outlined (Appendix G). Demographic information acknowledged the participants' background and enabled the interviews to commence with simple, getting-to-know-you questions before commencing with more detailed information.

The participants were additionally informed that they had the right to ask questions, the right to refuse to give information that they were not comfortable to provide. During this review of the participants' demographics and their rights and responsibilities, my aim was to gain an open communication built on a level of rapport with them. The initial interviews concluded that the RNs who agreed to participate were enthusiastic and interested in the research study and wanted to share information in the form of careful and considered answers to the interview questions and anecdotes that added value to the experience of the HITH RN in practice.

I used open-ended interview questions to encourage the participants to tell their story and by inductively probing the participants with questions that sought a participant experience through a shared example (Gadamer, 2013). Their perceptions of the motivators or potential barriers, standards, regulations, and educational levels required regarding their roles as HITH RNs within the acute, subacute, and community-based settings were explored (see Johnson & Rowlands, 2012). Probing questions were used to elicit the open sharing of experiences around the topic about which I sought information. The participants helped to create a rich set of views and experiences in practice. In the research design, I considered all aspects of the function of the role, the clinical governance structure of the setting, the role descriptions, and the coordination and care in practice within a multidisciplinary health care team. Figure 4.2 displays a simple overview of the data collection and analysis procedures.

Figure 4.2

*Adapted overview of data collection and data analysis* [a]




[a] Adapted from Braun and Clarke (2006, p. 35).

Table 4.2 outlines the phases of data collection and analytical techniques used in this study, including demographic information that set the context for the participants' responses along with their individual position descriptions.

Table 4.2
*Phases of data collection and analytical techniques*

| Phase | Data collection | Analytical techniques |
|---|---|---|
| One (Continuous throughout the study) | Document review: review of literature on register nurse roles and functions, including advanced practice and NP roles from across Australia and the globe.<br>Review of national and international nursing policies, regarding standards of practice and professional nursing practice relating to RNs, advanced practice nurses and NPs. | Literature review and synthesis |
| Two | Semi-structured interviews.<br>Interviews are voiced recorded carried out via online meeting platforms.<br>Gain a deeper insight of working within a HITH service as a RN, their experience, challenges and successes of the role and function undertaken. | Thematic analysis using Braun & Clarke's (2006) framework within Gadamer's Hermeneutic Phenomenology (2013)<br>Web-based data analysis software NVIVO supported |
| Three | Position descriptions critical analysis<br>Analysis of commonalities, differences and key concepts arising in the position description of HITH RN. | Thematic analysis using Braun and Clarke's (2006) framework.<br>Content/comparative analysis.<br>Web-based data analysis software NVIVO supported. |
| Four | Demographic questionnaire. Analysis of key nursing and personal demographic information. | Comparative analysis against others at same level<br>Web-based data analysis software NVIVO supported |

Maintaining notes throughout the research interviews allowed me to record nonverbal information or significant details from interviews or events that could aid in data analysis. For example, after an interview I noted any behavioural or nonverbal cues (de Lera & Domingo, 2007) that may enrich the data I obtained (see Bryman, 2015; Liamputtong, 2019; Polit & Beck, 2020, 2021). Notes through a journaling process were useful to assist in preventing bias in interpretation that could influence my interpretation (Jootun et al., 2009). Using notations and journaling ensures it is not my thoughts or imagination of events that occurred during the interviews, but rather relying on my memory as a reflective process (see Chilisa, 2019; Padgett, 2012, 2016).

## 4.7 Data analysis

The participant's data was transcribed verbatim by the student researcher. This approach allowed the researcher to gain an overall impression of the participants perceptions of their scope of practice. I revisited the transcripts to check that identified patterns were supported, checking for potential relationships among the emerging patterns. The data were constantly reviewed through a manual analysis in the initial naïve reading stage of analysis. At this initial point, notes and information of relevance were captured through labelling, highlighting, and reading of each transcript. This initial analysis was then re-evaluated in a more structured and consistent process and using NVIVO©, a database analysis that assists in grouping like comments and where quotes can be retained to enable like data to be grouped and labelled.

### 4.7.1 Thematic analysis of interviews

The interview protocol provided an avenue for rich depiction from participants sufficiently experienced to understand their role and role function as HITH RNs. Each interview was transcribed verbatim into writing and confirmed by participants prior to data analysis commencing. This member checking process aligns with the method and ensured the accuracy of the written transcript by the participant themselves. This process also enabled participants to ask for an amendment to, or removal of a statement from the transcript, though no requests to alter transcripts were received.

Careful transcriptions and analysis of the interviews allowed me to identify recurring patterns through careful reading, and reflection of each transcript multiple times, and as I listened to the interview's multiple times. The data were coded, analysed, and grouped into themes. The analysis was conducted using the principles

and practice of hermeneutic phenomenology where I commenced analysis with naïve reading, then progressed to exploring areas of commonality to find codes that can be merged into themes.

Thematic analysis involved coding and grouping codes and identifying key themes and subthemes. The themes captured the essence of the participants' experiences, enabling me to note similarities and combine them to examine the underlying assumptions that shaped the semantic content of the data (see Guest et al., 2012). The process employed is reflective of, and consistent with, the principles of interpretative phenomenological analysis and illustrates the process employed to analyse the data related to the experiences of HITH RNs and their perceptions of their scope of practice. I followed the procedures described in Table 4.3 when analysing my data.

The six phases of thematic analysis according to Braun and Clarke (2006) (see Table 4.3) were used as a guiding principle as each possible generated code was grouped into appropriate emerging themes. Even with thematic analysis, constant comparative analysis occurred through systematic continuous comparison (see Figure 3.1 in Chapter 3 and Table 4.3).

Table 4.3
*Data analysis process descriptions* [a]

| Data analysis | Description of the process used |
|---|---|
| Familiarisation with the data | Transcribing data as necessary, reading and re-reading delving into the data, noting initial thoughts |
| Generating initial codes | Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code |
| Searching for themes | Collating codes into potential themes, gathering all data relevant to each potential theme |
| Reviewing themes | Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis |
| Defining and naming themes | Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme |
| Presenting theme evidence | The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis |

[a] Adapted from Braun and Clarke (2006, p. 35).

### 4.7.2 Content analysis of position descriptions

Analysis of the position descriptions was conducted using the Braun and Clarke (2006) thematic analysis framework. The analysis was undertaken manually and then again using NVIVO© as an extra tool. I took time to familiarise myself with the six-step process of the thematic analysis framework. Each position description was entered into NVIVO© where I began line-by-line coding. This permitted a comprehensive thematic review of each aspect of the position description content identifying common themes from the text.

## 4.8 Researcher's positioning in the findings

I have experience and knowledge as a HITH CN. Creswell (2017) indicated that I should disclose my understanding of HITH nursing to the participants but invite them to explain their meanings as these could be different from mine. Reflexivity enhanced the awareness and transparency and was required in this study. Throughout the interpretation processes, I preserved transparency through notes, journaling, and diagrams of the participants' thoughts to conduct an in-depth nuanced enquiry that resolved any inconsistencies. As I was employed within a HITH service, bracketing was not possible in the quest to explore participants' views of their scope of practice. Critical consciousness is necessary when I aimed to gain a collective understanding from thoughts, feelings, beliefs, behaviours, and attitudes is problematic without critical consciousness. (Jemal, 2017). Therefore, I should disclose my employment status and journal my thoughts after each interview and throughout my journey. By positioning myself as the researcher in this study I could interpret the participants views on HITH RN practice in a unique way (professional nursing standards consisting of person-centred approach with empathy, patience, consistency and listening).

## 4.9 Ethics

I gained the University of Southern Queensland Human Research Ethics Committee ethics clearance (HREC-H15REA113) before making any contact with potential participants. As part of the HREC approval I had to gain support from the HITH Australasian Society Committee and Queensland Health exemption (see Appendices I, J, K). 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 withdrawal form was included in the information pack, as this is part of my risk management strategy.

### 4.10 Risk management

Contingency strategies were developed to identify areas of risk to protect the welfare of the participants. A central ethical concern in this study is protection of the participants' personal and professional interest and wellbeing. Furthermore, ethical principles of respect for autonomy, nonmaleficence, beneficence, and justice guided me throughout this study (Greenhalgh et al., 2019; Liamputtong, 2019; Polit & Beck, 2021). The HREC application outlined strategies to safeguard participants' rights and protect participants confidentiality and privacy. Figure 4.1 in Chapter 4 describes the research design that I followed.

### 4.11 Potential risks

Risks were minimised in the project because all participants were fully informed about the research process and participation was voluntary. All participants were able to seek support from me, or through their organisations support services. No potential participants had a reporting relationship to me with respect to their employment or personal association. Being mindful of participants' concerns regarding the interviews and the transcripts all gathered information that was treated with the utmost privacy and confidentiality, to reassure the participants and to comply with the NHMRC ethical standards of research practice.

### 4.12 Researcher notes and reflexive practice

I made notes and diagrams throughout the project with the aim of avoiding bias, especially during data exploration. Conceptual mapping of data aided my node and code generation and analysis in NVIVO© made my thoughts and interpretations known. Observational notes that I made during the interviews reflected verbal and nonverbal nuances. Documentation encouraged me to reflect on the participants' thoughts after the interviews. My notes consisted of concept maps, models, and diagrams of emerging connections. A checklist functioned as a memory aid to facilitate data collection and analysis.

## 4.13 Research integrity

I used several strategies to reinforce rigour to ensure the integrity of my research. NVIVO© was a tool that enabled me to create an audit trail of all the data I gathered. The data included the literature, the participants audio interviews, and transcripts. I was able to map and journal my thoughts to reveal the connections to the outcome found in the data analysis using the depth of data in NVIVO© that I had included. The process of the methodology, trustworthiness, and any other documents such as HREC application (Appendix H, I, J), invitations to the participants (HITH email and subsequent further information) (Appendices C, D, E), and letters to the HITH Society Committee (Appendix K), are an important part in ethical research and areas that I fully developed prior to any interviews taking place.

## 4.14 Credibility

I enhanced credibility by demonstrating engagement with the participants by requesting the participants to read their transcript, correct, add, or amend prior to data analysis. Opportunities for participants to withdraw from the study were clear at the outset. Credibility refers to how I represented and interpreted the participants views (see Polit & Beck, 2020). Supporting research credibility was demonstrated by engagement, my methods of observation, and the audit trails I kept within the data sets (see Cope, 2014).

I observed the participants' emotions, although I acknowledge I am not a body language expert. My interpretation of their emotions provided added depth to my study. My notations facilitated open reporting of both negative and positive results, enabling my interpretation to remain free from bias, thus providing an accurate account of the phenomenon studied which is consistent with the literature (Greenhalgh et al., 2019; Polit & Beck, 2021).

## 4.15 Confirmability

Because the interviewees were HITH RNs who had good knowledge of what scope of practice means to them, I provided sufficient time for each HITH RN to consider their answers and I used prompting questions to gather more detail where needed, thus enabling me to learn about the lived experiences of the participants through their shared accounts. All participants agreed to me emailing them with their individual transcript. They were encouraged to review it for accuracy and to add,

remove or amend any statements they wished. None of the participants asked for an amendment or removal of a statement, when the reviewed transcripts were returned prior to commencement of data analysis. One participant did withdraw from the study as previously stated in Section 4.3. Member validation reflects on the strength and direction of the relationship between variables. Accuracy is the credibility of the research (Cohen & Crabtree, 2008; Johnson et al., 2020). For instance, I was a HITH RN and known locally both professionally and personally, which aids transferability of reason and knowledge into the writings associated with data analysis. Transferability means the final findings have meanings applicable to the readers' experiences and the phenomena of interest. In essence, I needed to provide sufficient details about the phenomenon under exploration and its background to enable transferability (Polit & Beck, 2021).

### 4.16 Dependability

Guidance was obtained from an experienced supervisor throughout this study, increasing the prospect of dependability in this research. Discussion on data analysis was supported and guided by the supervisory team. An audit trail of transcripts and my journal are part of the decision trail that ensured I achieved dependability (see Cohen & Crabtree, 2008). Auditing processes added to the dependability of the research data. Auditing is enhanced because I used NVIVO© as a tool to house and code throughout the data analysis process (see Carpenter & Suto, 2008; Liamputtong, 2019).

### 4.17 Transferability

The study has afforded evidence that transferability was accomplished. Transferability occurred as I outlined, justified, and explained the recruitment and sampling process, as well as the way the participants were contacted, the number of participants, and the data collection method (see Bryman, 2015; Creswell, 2017; Creswell & Creswell, 2018; Liamputtong, 2019; Padgett, 2016; Polit & Beck, 2021). Each of these variables is consistent with the research methodology.

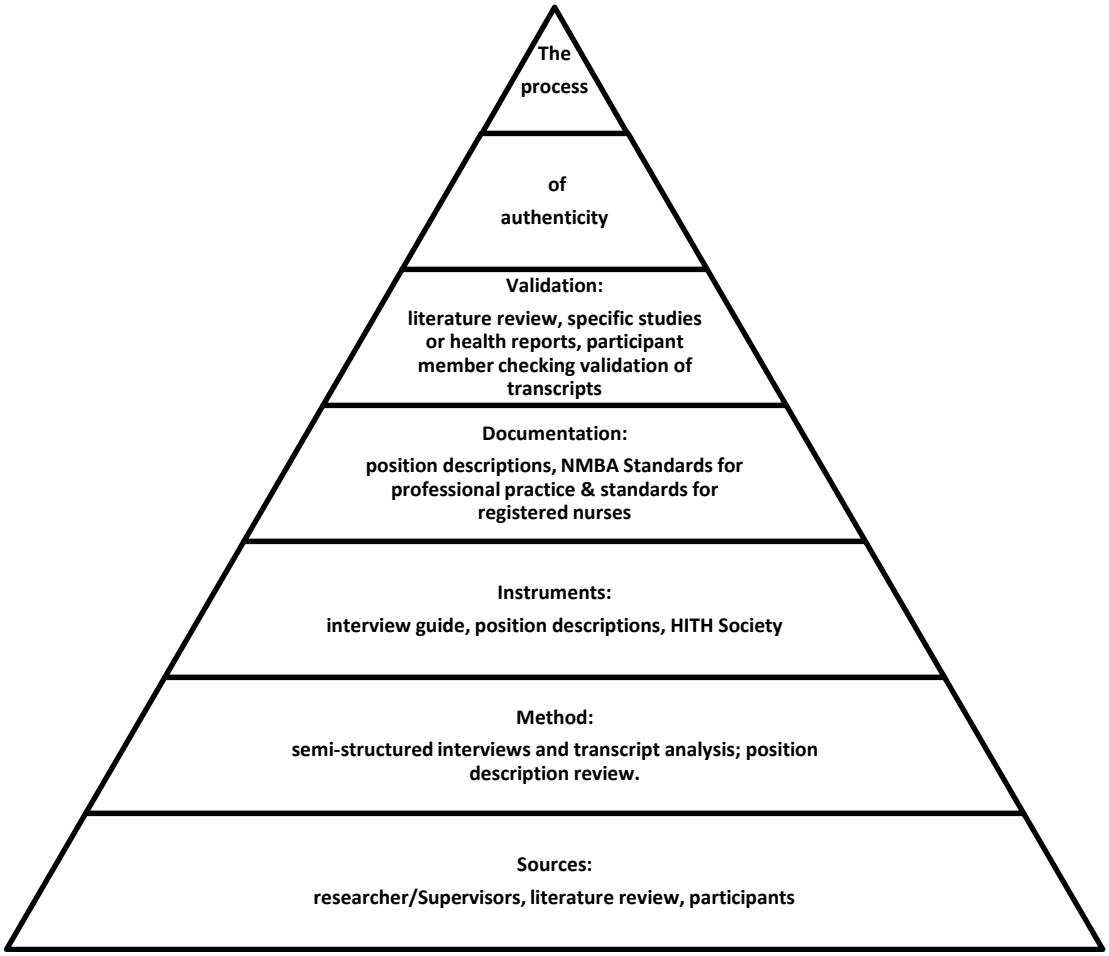
### 4.18 Authenticity

Reporting descriptive approaches leads to authenticity because the reader can understand the participants' experiences through their use of language. This process

engages the reader in gaining an accurate and descriptive understanding of the experiences of participants. Authenticity refers to how I express the participants' sentiments using descriptive reporting allowing the readers to comprehend the essence of the experience through the participants' language (Polit & Beck, 2021). Figure 4.3 summarises what is entailed in authenticity. This process encouraged interpretation of the phenomena and promoted the disclose of the research outcomes in a consistent and structured manner. In this study, I used methodological authenticity as noted in Figure 4.3.

Figure 4.3

*Defining the process of authenticity*




Authenticity increases the credibility (as discussed above) of research findings (Polit & Beck, 2021). The combination of the interviews, literature review, and other documentation ensures biases are overcome. Authenticity also helps explore and explain complex human behaviour, offering a balanced explanation to readers (Polit & Beck, 2021). A variety of datasets helps to explain differing aspects of a phenomenon and explain the results of the project. Authenticity enriches, refutes,

confirms, and clarifies the phenomenon; in this research it concerns whether the HITH RN role and role function is outlined and shared.

### 4.19 Confidentiality and privacy

Anonymity and confidentiality are ensured for all participants (see Greenhalgh et al., 2019; Liamputtong, 2019; NHMRC, 2015, sections 1, 2, 3.1 & 3.2; Polit & Beck, 2021). Maintaining confidentiality and privacy was important when discussing the research at a conference presentation or in a public forum or in the presentation of data in the results section of this thesis. Data sets, including the transcripts and data analysis, were shared only between me and the supervisory team. Confidentiality included providing anonymity for the participants whereby all documentation, publications, and data were deidentified. Additionally, all participants were given pseudonyms, so that only I was aware of their identity (see Liamputtong, 2019). Labelling audiotapes by pseudonym was also undertaken. Access to the identity of the participants, the audio-recorded interviews, and transcriptions, including RN and location details, was limited to me.

### 4.20 Data storage

Materials including data collected, journaling, consent, and participant-related documents relevant to this study was secured following NMHRC recommendations (NMHRC, 2015, p.27). This involves securing the data for 5 years and ensuring that the data is accessible to only me and, where relevant, the principal and associate supervisors, at my discretion. Destruction of the audio recordings of the interviews will occur at the 5-year point after data collection is complete. Electronic data are stored on a password-protected laptop or desktop, and all paper versions, transcripts notes, position descriptions, and demographic surveys will be stored in a locked cabinet that only I can access (see Bryman, 2015; Herzog, 2012). At established timeframes before, during, and after data collection, the transcripts were reviewed by the principal supervisor for accuracy and consensus of data analysis. All measures to protect and uphold the principles of beneficence and human dignity were consistent with protecting the participants' privacy, and the merit of the research.

## 4.21 Conclusion

In this chapter, I outlined the research design and the process used for participant selection and sampling, recruitment, and consent. Processes surrounding the collection of data from HITH RN interviews and the process of analysis of position descriptions is discussed. The thematic analysis of the interview, and content analysis of position descriptions is outlined. The researcher's positioning in the findings including ethical and risk management strategies is outlined to mitigate potential risks. The reflexive practice of taking researcher notes and journaling is provided. I have presented the essence of credibility, confirmability, dependability, transferability, and authenticity associated with the research. In the next chapter, I present the analysis and findings of the research, including quotes from the RNs specifically outlining the role and function of the RN, and the emerging themes that arose from the interviews. Chapter 6 then outlines the results of the position description analysis and their meaning to the HITH RN role and function.

# CHAPTER 5: INTERVIEW RESULTS

## 5.1 Introduction

This chapter is underpinned by the research methodologies outlined in Chapter 3 and research design described in Chapter 4. In this chapter, an interpretive hermeneutical analysis is presented of the results that I collated into emerging and defining themes. The data is presented using pseudonyms for each participant to ensure anonymity and to add realism to the descriptive results presented. Naming of the participants created a personal connection to the experience shared and aligned with the phenomenological methodology used.

Demographic information is presented in section 5.2. I will present the results through both a descriptive and interpretive lens commencing in section 5.4. with the initial search for meaning. The results arising from the interviews are presented according to the three emerging themes. Section 5.5, the theme of professionalism is presented. This theme has three subthemes of accountability and responsibility (section 5.5.1); rules and regulation (section 5.5.2) and autonomy and leadership (section 5.5.3). Theme 2 knowledge is presented in section 5.6. The subthemes of mentorship and guidance (section 5.6.1), lifelong learning (section 5.6.2) and research and innovation (section 5.6.3) are presented. The final theme of responsiveness (section 5.7) is presented with two subthemes that includes responsive to patient needs (section 5.7.1) and the authority and autonomy in decision making (section 5.7.2). The chapter commences with the presentation of the demographic background of participants.

## 5.2 Demographic background of participants

Eight full-time and four part-time HITH RNs participated in the research, totalling 84.5 years of registered-nursing experience. The specific attributes of the participants are outlined in Table 5.1.

Table 5.1

*Participant attributes*

| Position title | Age group | Male/ Female | State & area | Years in HITH | Qualification | Currently studying | Full / part time |
|---|---|---|---|---|---|---|---|
| CN | 36–45 | Female | QLD Regional | 13 | BSc. Nursing | Yes | FT |
| NM | 56–65 | Female | QLD Metro | 8 | Hosp trained, BSc. Nursing | No | FT |
| Nurse co-ordinator | 25–35 | Female | VIC Metro | 2 | MSc. | No | FT |
| CNC | 46–55 | Female | NSW Metro | 9 | BSc. Nursing | No | PT |
| CN2 | 36–45 | Female | SA Metro | 2.5 | BSc. Nursing | No | FT |
| CN | 46–55 | Female | QLD Regional | 1 | BSc. Nursing | No | FT |
| NM | 46–55 | Female | VIC Regional | 13 | MSc. | No | FT |
| NM | 46–55 | Female | NT Metro | 3 | MSc. | Yes | FT |
| CN | 36–45 | Female | WA Metro | 2 | BSc. Nursing | No | PT |
| CNS / RN | 56–65 | Female | VIC Regional | 15 | Dip Nursing Hosp trained RN | No | PT |
| CNS | 56–65 | Female | ACT Regional | 10 | BSc. Nursing | No | FT |
| RN | 46–55 | Male | TAS Metro | 6 | BSc. Nursing | No | PT |

There was only one RN from Tasmania, where the nurses work in rotation in HITH positions. Of the three HITH RNs who worked in Victoria, there were differences in education as two were hospital trained with one with a postgraduate qualification. However, one had completed a Diploma in Nursing and the other a master's degree. The Northern Territory was represented by one RN, titled a nurse coordinator. South Australia was represented by a Clinical Nurse 2 (CN2). This title

stood alone from other role titles in Australia, however, upon analysis it was determined the role and scope remained like others. A clinical nurse consultant (CNC) was interviewed from Sydney, and two clinical nurses (CNs) and a nurse manager from Queensland participated in the research. Western Australia was represented by a CN, and the ACT by a clinical nurse specialist. Although a variety of position names were presented by the participants, their role and duty statements were similar in many ways.

The participants had varying lengths of service and role positions. The years of employment within HITH services as an RN ranged from 1 to 15 years. None of the participants had NP status. The participant attributes aligned with the average age of a nurse in Australia, at 49 years (AHPRA, 2020). Eight participants were older than 46, three of whom were aged 56 to 65. Only one participant was in the 25–35-year age group. The participant male to female ratio was 92% female and 8% male, which is like Australian data from AHPRA that indicates almost 88% of RNs identify as female, with just under 12% as male (APHRA, 2020).

### 5.3 Interviews

Data analysis commenced with an initial read of the transcripts followed by re-reading to capture the participants' experiences. This read of the interviews identified key words and statements used by the participants to describe their experience. This process of initial reading, re-reading and identification of key words and initial thoughts was cyclical and consistent with Gadamer's hermeneutic cycle process of naïve reading.

The HITH RN role was described by participants as being *autonomous*. The HITH RNs indicated they were the one who *brings knowledge to the discussion*—a *coordinator and communicator between the patient, their family, and healthcare providers*. These key words/statements were highlighted in each of the interviews and expressed the key message of elements of their function in the HITH RN capacity. They viewed the HITH RN role as a *complex entity* where *understanding was required*. This stage of analysis shared the initial thoughts arising through the HITH RNs voice and a descriptive analysis of the transcripts.

### 5.3.1 Familiarity with the data

I became very familiar with the content of the interviews, the key constructs arising and the initial beginning concepts of the HITH RNs role, scope, and function that started to evolve. The initial words appearing are presented in Figure 5.1.

Figure 5.1

*Initial words arising from the transcripts.*

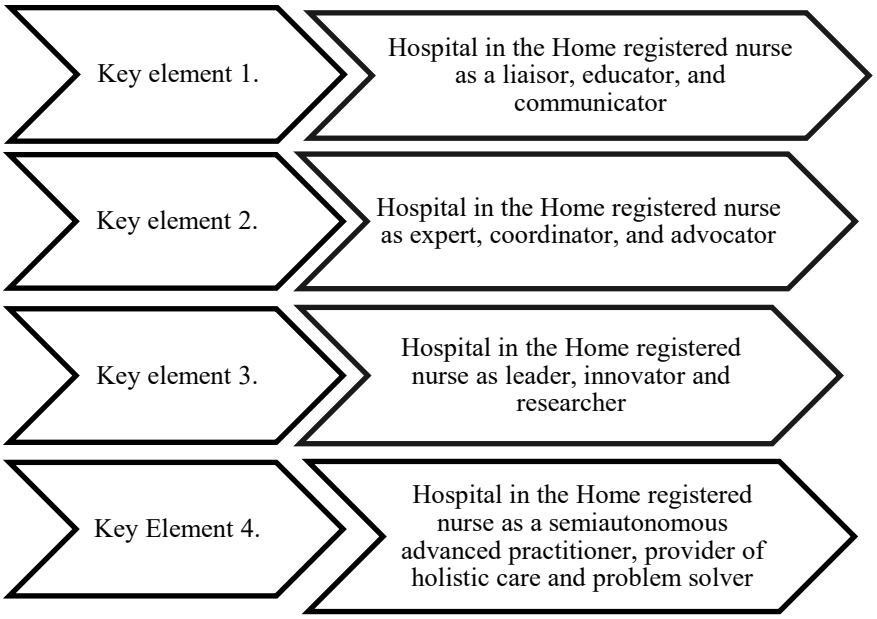

The key words were supported by the participant direct comments. The interviews were added to NVIVO© to enable coding into common areas of discussion. This cyclical review of the transcripts in NVIVO© revealed initial areas for consideration that is further outlined in the initial stage of data analysis. During the first stage, I focused on RNs as decision makers, including the responsibilities of daily practice. These responsibilities included current knowledge, the need for advanced skills, coordination of care, education, and communication. This initial steps in data analysis shaped the more detailed search for meaning in the text and led to the next step in data analysis.

## 5.4 Hermeneutic analysis: Searching for meaning.

I continued with a cyclical analysis in NVIVO© using the hermeneutic process until I identified four key elements of the RN role corroborating that the HITH RN role and role function. The results could be divided into four elements with each of these highlighted in Figure 5.2.

Figure 5.2

*Naïve reading: Initial four elements of a RN role*




The four elements of the HITH RN role shared the broad context of the role in practice. Further analysis was still needed as meaning was only partly uncovered at this time. An interpretation was required that enabled the meaning of the experience to be shared in more depth and detail. This analysis was based on the participants' interviews and linkage of commonalities across the transcripts. **Three themes emerged titled professionalism, knowledge, and responsiveness.** Each theme shared concepts that had previously emerged in the naïve reading and initial analysis. The interpretive lens enabled similarities to be grouped into subthemes that represented the shared experiences of participants. The subthemes enabled me to explore, analyse, and interpret the findings to obtain insights.

The initial key words were associated with the three emerging themes as these provided an initial story from each participant. Each key word was linked to an area of analysis and these concepts are shared in Figure 5.3. Complex words that shared stories from participants were evident in the initial analysis and included words like expert communicator, listener, educator, accountable, professional, and decision maker and evidence in practice, a conduit between health service, consumer, and community, and working in an autonomous role in community.

Figure 5.3

*Key words arising from initial stage of analysis.*


In this initial stage of analysis, the key words were linked with each other to identify more detailed nodes in NVIVO©. I used a process of data drilling until all nodes were exhausted from the interviews provided. Further data drilling and joining of like nodes occurred. This process continued until the emerging themes became clear. Three final themes emerged: **professionalism, knowledge, and responsiveness**. The remainder of the chapter shares a synopsis of the overarching theme followed by a more succinct summary of results. Each of the subthemes presented in the results shares interpretive and descriptive findings using the pseudonym for participant names where quotes are used.

## 5.5 Theme 1: Professionalism

The theme **professionalism** includes the explicit need for accountability, responsibility, rules, and regulations. The theme shares the need to exhibit accountability and responsibility in the HITH RN role, especially where complex assessment, decision making and two-way accountability between the patient and the nurse exist. This is evident in the assessment, planning, and sharing of information to enable appropriate decision making and was a dominant area of practice highlighted

in the interviews by HITH RNs. The theme, professionalism, focuses on how participants interpret their role and function in the workplace when initiating, coordinating, and providing care. This professionalism extended to include rapport and communication with members of a multidisciplinary team when referral and consultation was required for a patient.

Six of the 12 participants considered whether RNs understood their personal and professional accountability and responsibilities in patient care. Seven participants held similar views surrounding RNs acknowledging possible limitations in their role due to the need for role expansion. These participant narratives highlighted what care provision was needed, and their capability to provide said 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. These participants expressed the need to decline duties unless discussion occurred, and finalisation of an extended scope could be achieved. Three participants raised the moral obligation 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 duty statements.

Professionalism within nursing proved significant, with nine participants commenting about how they felt valued by other healthcare professionals as interprofessional team members. Typically, participants provided insight regarding their scope of practice when delivering patient care. Professional identity was discussed by all participants. These discussions included the ethics and values attached to nursing. Discussion points were inclusive of ethical values and their importance to guard against personal and professional patient abuse.

Another element was complex care communication which made for frequent discussions with a patient's doctor. All participants mentioned needing to contact a 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 despite being fully aware of the treatment needs but restricted by professional boundaries. In each of these cases, once the order was received, care was provided by the HITH RN. This raises a question about the validity of extended or advanced scope of practice for commonly arising requests. Portraying a face of professionalism to allay patient anxiety and communicate clearly to the GP is essential. Professionalism in

communications and in role function as care coordinator and collaborator was expressed as an everyday issue.

Professional accountability includes responsible delegation to other healthcare workers and collaborating with healthcare team members. The focus of care ensuring that patient care priorities were completed, and that the patient was safe and comfortable. The professionalism demonstrated by the participants aligned with the NMBA Competency Standards (2020c). These standards focus on coordination, collaboration, and high-level decision-making practices.

### 5.5.1 **Subtheme 1 – Accountability and responsibility**

Accountability and responsibility make up a significant part of the HITH RNs' scope of practice in providing safe, appropriate care that remains the same regardless of whether the patient occupies a hospital bed or is receiving acute care at home. Two participants, Gemma and Melitta said that boundaries are important for patient safety. Gemma's statement that "RNs need to practise within guidelines, policies, procedures, legal guidelines, and boundaries; however sometimes this is not possible due to regulatory or policy directions relating to the care we can provide (sic)". Gemma suggested that "all RNs should be utilising their knowledge and skills to work within the full capacity of the scope of practice of RNs". This highlighted the need for a better understanding of what RNs can and cannot undertake as part of accountable and responsible practice in the HITH RN role. However, despite the guidelines of regulatory authorities, three participants (Carrie, Melitta, and Kirra) queried whether HITH RNs work to their full capacity. For instance, as suggested by Janice, "some RNs do not practise within or up to the full capacity of their scope due to a fear of challenging doctors' orders". Melitta expressed concerns that some RNs are "reluctant to ask for help" and "search for knowledge using questionable sources". Melitta commented that she would discuss the following with new nurses:

> If you are not sure, ask to be shown. If you are still not happy, ask again and again until you are happy with the response. If you feel you should not be doing something – stop. Ask. Take leadership advice…. Is there any evidence base that this was an appropriate action to take or did the healthcare professional get it from Google? Google is scary. The number of Googlers is scary. Too many people—doctors, nurses, and patients—use Google as a tool for research…. We must maintain a high standard. The care is often

> complex…. The pressure is on when it is you that needs to respond. It is not good, though, to look for a quick answer. It is good to go to the most appropriate source.

Lydia argued that "the RNs' scope of practice involves different roles. Their responsibilities are dependent on their employers and clinical area of practice." Gemma held a similar view:

> I have nurses who practise in many different HITH specialty roles and general roles in the same setting. It depends on the patient, the requirements, and the area of isolation they live. It also depends on what, if any, other members of the health team are visiting. There are so many parameters to consider.

Another participant, Jasmine, stated: "The role of the RN is varied depending on areas of work and specific experience, education, and skills that a nurse has obtained", and Lydia, also said that "the nurse's role is to ensure all care is taken to address their (patients) daily requirements". These statements highlight the different understanding of practice that RNs require depending on the clinical area of practice in which they work even though all are employed in the capacity of a HITH RN.

Similarities in scope of practice did exist. However, every experience referred to by the participants articulated a different scope or function level, with some functions aligning with general duties statements and other functions aligning more with advanced practice and the need for greater education and knowledge in the area. Delia reported when she became a manager, her scope changed "with increased autonomy and more delegation required". Warren said that, when working on the ward, his scope was limited, but when seconded to Hospital in the Home, his RN role changed "to making decisions singularly rather than in a group or team". This shift in clinical area by one RN highlights the differences in care and care decision making between specialties.

Balance of power and dominance were identified as barriers to HITH RNs' role and function. Janice noted that dominance is often dictatorial. She said, "Doctors dictate 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". Physician dominance was referred to again when assessing patients and deciding whether to transfer inpatients to HITH services, especially if a patient had complicated care requirements. Melitta

said that patients should have a choice of where their acute care is delivered when she stated, “Patients should not be restricted to hospital care if they have any healthcare complications that can be managed in a HITH service”. She continued by saying, “Hospitals are over-crowded, waiting lists are enormous, and therefore HITH is the way forward for acute healthcare”.

The participants’ insights to autonomy and clinical decision making are incorporated within an RN scope of practice (Cornick et al., 2018, NMBA 2020b). Melitta states 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” therefore, implying critical thinking is an everyday function of the RN. Despite the ability of the nurse, “doctors are sometimes irritated when their orders are questioned,” stated Janice. Nevertheless, Carrie said that “under a medicalised HITH care model, “nursing roles and role functions are controlled by the level of accountability and responsibility allowed”. This is related to the second subtheme: rules and regulations.

### 5.5.2 **Subtheme 2: Rules and regulations**

A consideration of rules and regulations confirmed that the participants perceived a gap between their role and function when undertaking nursing care and the NMBA’s regulated scope of practice (NMBA, 2020a, 2020b, 2020c). These results indicated the need to revisit the meaning of the term “scope of practice” to improve nurses’ understanding in this area. Understanding and competence, as visualised by the participants suggested that scope of practice alters when the speciality area or their position or role title changes.

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. Melitta claimed: “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.” Gemma also highlighted her understanding of safe patient care and her scope of practice:

> If nurses do not practise within their scope, they may then be liable. Scope sets standards, and conditions on how nurses can practice, and without that regulation may perform unsupported skills that may be detrimental to patient care. 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.

Gemma alluded to the predetermined boundaries of the RN scope of practice. She considered that "if she steps beyond these boundaries" she would be "unprotected and her actions may cause harm to patients and to the reputation of the health service". This subtheme shares a common thread in the need for strong nursing leadership, which leads to the final subtheme of autonomy and leadership.

### 5.5.3 Subtheme 3: Autonomy and leadership

Without a certain amount of autonomy, there is no scope to be a leader. Autonomy in the scope of practice is attached to senior nursing positions who are expected to take on leadership responsibilities. Leadership in many other professions is through planned career steps via successful examination results or completion of required courses. Nursing leadership affects the level of patient care benefits, particularly in areas of low population that do not have the same attraction for doctors as high-density cities. Good leadership is known to improve patient outcomes yet formalised training in leadership and management is not a requirement. Delia's and Janice's views aligned in this sub theme with Delia sharing:

> 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.
>
> Delia stated: "Autonomy increases with knowledge and skills gained through education collected over years of working within the RN scope of practice."

Eleven of the 12 participants referred to their role being crucial in acute hospitalised care delivery at home. According to Delia, the HITH RN role provides "direction and guidance from the NMBA and other nursing bodies". Warren said: "A RN is strongly guided by hospital protocol, legislation, by the government, NMBA governing standards that set the guidelines for nurses and midwives". His statement aligned with that of Delia, who had many years of nursing experience, the last eight within the Hospital in the Home specialisation. Delia stated: "Scope of practice needs to be within the bounds of the Australian Health Practitioner Regulation Agency (AHPRA)". However, leadership can have a negative or positive effect on staff and

patient outcomes; negative leadership styles lead to a lack of nurse empowerment and leadership skill development at junior levels (DoH, 2010; RCN, 2012). Melitta and Delia are of similar understanding that advanced nursing role and scope in practice have elements of professional leadership, education and research woven into their clinically based practice. Delia mentioned her experience working within the enrolled nurse scope of practice and that she found that this changed with "more accountability and responsibility being required when I became a RN," as she had to direct and lead a team. Melitta referred to a comment "in the 1990's nurses are not taught to question and learn", and this gap creates leadership opportunities that Melitta reported as a crucial necessity to resolve, to effectively deliver innovative, patient-centric care.

Leadership should be part of the scope of practice to reinforce integrity, communication skills, teamwork, appreciation of diversity and problem-solving. Moreover, the different perceptions and the inexactness raised concerns regarding HITH RNs' current practice, as indicated by Carrie regarding "an increased degree of autonomy". In contrast, with a combined experience of 22 years (9, 3, and 10 years) as HITH RNs. These three participants with differing years of experience, clinical level and areas of employment have different views about autonomy that may the reasons for their differing views. Janice noted that "a level of earned autonomy can come with experience or trust from managers or other healthcare disciplines," gaining trust to lead a team. The perception from Violet that "autonomy is earned in such a way that was not backed by undertaking specific education or research" highlighted an inconsistency compared with other participants in how the role is perceived and how position descriptions limited autonomy in their practice. For instance, Janice said that "the more experienced the RN, the broader their scope of practice is; in my reality, however, the more restrictive it is in my PD." This situation was also referred to by Melitta and Violet. Moreover, the inference was that patients benefitted from this earned autonomy and leadership. Increased knowledge led to higher levels of nursing practice, and these nurses led the healthcare teams.

### 5.6 Theme 2: Knowledge

**Knowledge** identifies with being an expert, as people who are very knowledgeable about and have extraordinary skills in their area of work, having capacity and capability for autonomous practice and being innovative in role conduct and function. Participants were unanimous in their quest to continue gaining more

knowledge as each year of practice progressed. However, they were clear that, even with an increase in knowledge and capacity, their scope of practice remained static. Three subthemes emerged in knowledge including mentorship and guidance, lifelong learning, and research innovation. Each of these are discussed below.

### 5.6.1 **Subtheme 1: Mentorship and guidance**

Mentoring and guidance in the form of information sharing is an important part of nurse education according to the participants. Carrie suggested that mentorship and guidance of nursing staff is an appropriate and useful way to "share expertise and to increase competence and confidence of staff, particularly given the role of the RN was viewed as the educator in the service". All participants viewed mentorship or supporting and guiding staff as central to their role in the HITH service where they were employed.

One participant, Melitta, said that she "encourages nursing staff to search for journal articles, abstracts, and courses to underpin their practical skills, to increase their knowledge". She stated: "When staff come to me for an answer, I teach them how to check out databases, how to learn where to appropriately find information, and how to start the research process to assist in their practice".

Identification of mentorship and guidance of staff within the HITH RN team is a crucial area in which the HITH RN demonstrates the capacity to lead and act as a mentor as hinted by Lydia when she stated,

> Seeking advice from senior nurses should be a safe and supportive option ensuring the boundaries of nursing practice for safe, prioritised care exist for the patient. Being a mentor means staff can turn to you to ask for help, thus ensuring that their level of autonomy remains within their scope of practice.

Melitta states she acts as a mentor for other nursing staff who, as mentees can ask for advice or direction without fear of retribution. She calls herself 'the safe clinician'. Melitta and two other participants believed that mentorship increases a staff member's confidence and competency through support and permission to be autonomous. Melitta conveyed her concerns regarding the "reluctance of some RNs to ask for help. Instead, they search for knowledge using questionable sources". She commented that she would discuss the following with postgraduate RNs as a preparatory guide to anyone new to the service:

> If you are unsure, ask for a demonstration. If you are still unsure, ask again until you are happy with the response. Listen to your gut feelings and stop

> what you are doing if it feels wrong. Ask. Take leadership advice. Question whether there is an appropriate evidence-based action to take. Do not just act. Think, justify, and act with authority based on the best evidence-based practice and, if needed, senior staff advice.

Carrie stated that her role involved working according to one's comfort level, stating: "Nurses practise within … their comfort zone." With similar years of HITH experience and grade to Carrie, Lydia's stated: "I restrict my role function in practice to tasks I can comfortably undertake." Lydia explained that, although her comfort zone included "medication administration through peripherally inserted central catheter (PICC) lines, portacaths, wound care, and debridement, I am uncomfortable with negative pressure dressings". Melitta also said, "I work within my knowledge boundaries and comfort level. Though practice is not a comfort level, it is a legislative requirement for registered practice" and commented further that "mentoring helps junior nurses or less confident nurses learn how to liaise with the interdisciplinary team appropriately". Nonetheless, other participants, Carrie, Lydia, and Kirra had differing perspectives. Kirra suggested that they "undertook duties that they felt comfortable in doing".

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 is generally thought that knowledge increases with postgraduate education, online certificated courses, reading, and mandatory training. There was 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, I noted that in all participant transcripts the notion of mentorship was based on an "informal process led by an individual RN, rather than through a consolidated, coordinated formal mentorship program." The more formalised aspects of mentorship and learning were evident in Subtheme 2, lifelong learning.

### 5.6.2 **Subtheme 2: Lifelong learning**

Lifelong learning is crucial to maintaining professional judgement and clinical decision-making capacity. Participants believed learning is necessary to improve knowledge and skill development on an ongoing basis to remain current in practice.

However, participants identified the problematic access to education and lack of HITH-related postgraduate education opportunities. Financial support, staff availability, and time were identified by participants as reasons for not attending or completing education. Nevertheless, the participants said that during home visits, HITH RNs work in isolation, semi-autonomous in their 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" and the "busy" team approach in health services. Other reasons included a lack of connectivity of devices, scheduling, and the capacity to manage critical out-of-hospital emergency processes. Kirra stated that, when employed to work as an RN on a hospital ward, they "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.

Trina said that HITH RNs must be "able to communicate and advocate for their patients". The participants attached "autonomy in scope of practice" to senior nursing positions and, according to Shelley, "in many other professions it 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". Another participant, Jasmine, 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 within the RN's scope of practice."

Shelley stated that "RNs must understand their limitations of knowledge, skills, and education level". It is not as simple as understanding their limitations. They must relate their limitations to the work that they undertake. Shelly added that "nurses must consider their workload and whether they have the skills and knowledge to deliver safe patient care". Delia said that the focus of the term "scope of practice" meant "delivery of quality and safe care within the knowledge and skills that a RN can safely practice".

Gemma suggested that "all RNs should use their knowledge and skills to reach the full capacity for their roles as RNs". Her statement surrounding boundaries highlighted the need for a better understanding of the limits to the work that RNs can undertake. She stated: "RNs must practise within guidelines, policies, procedures, legal guidelines, and boundaries." Defining these parameters in the specialty of the HITH RN appeared ambiguous and ill defined. Delia said that "more work is needed in this space".

### 5.6.3 **Subtheme 3: Research and innovation**

Innovations in practice are gained from a wide reading base, team discussions, networking, conference attendance, and engagement in research. Melitta commented on the foundation of excellent safe patient care. She justified her evidence-based practice ensuring RNs stay safe: "Sometimes you need to step outside your comfort zone safely." Melitta also said:

> RNs need to know [how to find evidence and apply it to everyday working life] where is the evidence or is it evidenced based and in current practice? If so, how do we know? It is currently a matter of personal responsibility rather than service innovation in practice.

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 Melitta, Delia commented that role "functions of RNs involve clinical decision making". Thus, according to her, 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, achieving best practice provides a suggestion that research or the use of best practice derived from research is needed. RNs are essential in providing observation, communication, and coordination that reduces adverse patient outcomes. Each of these is an essential part of a nurse's role, according to Delia. She stated:

> Nurses should look to gain more knowledge and evidence-based practice by undertaking pilot studies to provide new and innovative ideas for delivering safe, optimal patient care" that is "responsive to patient, service, and self needs.

Participant experience shared the need to know more, to gain more knowledge and to apply this in practice. The theme research and innovation is based on the premise that participants sought to gain and use evidence-based practice. Evidence based practice is achieved through the innovation and application of best practice

standards. Best practice standards are attained through new knowledge identified in research.

The participants' perspectives varied due to differences in locality, population density, and population service requirements. Lydia talked about HITH service changes. HITH services are the new kid on the block and are therefore often only a small service, and usually begin without any thought to developing research questions that could expand their patient cohort. As Delia said: "HITH is small. However, the time is opportune for HITH services and HITH nursing knowledge and skills to revolute [sic] with research and innovations to improve patient outcomes."

Innovations in practice occur following an expanded reading base, through team discussions, building networks, conference attendance, and participating in research. According to Delia, each of these activities is an "essential part of a nurse's knowledge, leading to evidence-based practice and designed to deliver safe, optimal patient care". RNs are ethically, and duty bound to provide optimal patient care. Provision of patient-centric care means using the most up-to-date guidelines and challenging the "norm" through research projects. Melitta expressed her concerns with using Google to find answers:

> Too many people, including doctors, both registered and enrolled nurses, and patients use Google as a tool to inform patient care, rather than ask a more experienced colleague or their healthcare practitioner or go to the latest and most up-to-date research.

The scope of practice is intended to keep nurses safe while delivering evidence-based care. Melitta further stated: "If you just do anything you want, regardless of where it is from or where you learned it, then there are no boundaries." She continued, emphasising the point that:

> Nurses should understand their role and its functions so that they can safely practise. If they cannot practise safely, then nurses need to ask questions, attend education, and upskill to ascertain what decisions they can make and what is safe for them to undertake. This is our professional responsibility.

This theme shared the need to use innovation and research to inform practice. It was evident from the participants that linkage of the HITH RN role needed to include the capacity to explore best practice and to have the opportunity to expand this knowledge into practice.

## 5.7 Theme 3: Responsiveness

**Responsiveness** is part of the RN professional responsibilities**.** 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 they 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 the autonomy and authority in care and decision-making as key to the success of the role. Two subthemes emerged in relation to responsiveness: responsive to patient needs, and autonomy and authority.

### 5.7.1 Subtheme 1: Responsive to patient needs

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" (Delia) and "Hospital in the Home provides a clear framework for RNs to deliver care to those with more complex needs in the community setting" (Kirra). These statements emphasised the need for appropriate and responsive care. This care often requiring an extension to the base role of the HITH RN, to be more responsive in areas of required clinical care. Nursing is a dynamic and diverse profession that is, according to Janice, a "balance of service requirements, years of experience and educational qualifications". RNs must therefore maintain their knowledge and expertise regarding core competencies using specific updates in clinical skills and knowledge according to their employer and their current position and role title.

As Janice said:

> My role functions have developed through past experiences and the medical team who trust my judgement. If HITH RNs are to be recognised, respected, and included, there needs to be core advanced education available for HITH nurses.

Areas of practice aligned with the HITH RN needing to be responsive to patient needs and to act on the results and patient knowledge without informing the medical team. This extension to practice and critical thinking aligns with Masters' or Doctorate-educated nurses or those in specialised areas that need an appropriate qualification. The participants shared their role function experiences in ways that illustrated interstate role function differences. One participant, Gemma, indicated that "RNs undertake result interpretation such as pathology and report these results to the doctor—however, only if they are out of normal limits". The experience voiced by Gemma outlines the need to "report all reports and await medical advice". It was other HITH RNs that expressed the need for a more advanced scope of practice that included capacity in the decision-making process relating to patient care.

### 5.7.2 **Subtheme 2: Authority and autonomy in decision making.**

RNs should be able to make decisions using the guidance provided by the NMBA (2020b) guidelines. Using the professional title "RN" means working within the level set by the guidelines. Carrie stated: "Nurses must be more accountable for their actions. It is unacceptable for nurses to say they do not know without trying to improve their knowledge."

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" (Trina). Such professional knowledge and skills come from a combination of mandatory competencies and postgraduate education, mandatory updates, journal reading, research, and years of experience. Participant statements indicate that, "without guidance from all professional sources, the quality of patient care delivered by RNs would decline sharply".

The participants had mixed views about HITH RNs' awareness concerning their role, and role function within the workplace. Lydia argued that "changing roles are challenging from one healthcare area to another, or according to the position they

hold in the workplace". According to Melitta, Kirra, Delia, Gemma, and Janice, a "medicalised model of care" existed with a "lack of HITH nursing recognition by other healthcare professionals". Janice and Violet discussed the lack of recognition of HITH RN knowledge and skill levels, through other healthcare professionals misunderstanding HITH RNs to be general community nurses who care for non-acutely ill clients. This 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. Differing perceptions led Kirra to articulate what she thought was a process of defining the scope of practice of HITH RNs in Australia. She stated that:

> HITH RN scope of practice is sometimes undefined … as autonomous practitioners need a more clearly defined job description for specifically for HITH…as some work as HITH nurses is 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.

Melitta stated: "Safety first! I work within my boundaries." For her, boundaries are her level of authority and autonomy required and something she completely complied with. The PD will state what her employer expects from the position in keeping with the NMBA (2020a) standards for professional practice. Her responses were specific and highlighted the importance of reviewing the literature to identify the evidence needed to be an expert (authority) on the matter at hand, and to ensure the care HITH RNs provide is patient centric and outcome oriented. Carrie had a similar view to Melitta when Carrie suggested that "RNs must know when to question or challenge doctors' orders; they need to think critically and reflect on the decisions made using the NMBA's decision-making framework".

HITH RNs "analyse and appraise the actions they have taken in the care of patients" according to Gemma. Janice suggested that "problem solving for RNs is an advanced analytical problem-solving skill as HITH RNs are responsible for the care they give or do not give outside the normal zone of an acute hospital". Gemma commented that HITH RNs "have a broad range of nursing skills". Their roles have a certain level of authority and are autonomous when discussing and assessing patients for their suitability before acceptance as a HITH patient. These comments align with the theme of knowledge and the requirement for lifelong learning and postgraduate

education in the specialty aspects of the role of the RN. They also speak of a RN that has the autonomy and authority to act in situations and contexts in practice in the best interest of the patient. Moreover, Gemma reported "as a coordinator, RNs contribute to ensuring the quality of care to the individual patient". The need for the authority to enable supported decision making and accountability in the practice of the HITH RN was seen as a key component of the role. Gemma said that "changes are necessary to RN assessment and evaluation processes." Gemma suggested that "RNs are responsible for interpreting results such as pathology and we have a duty of care to follow up on these results, but not to decide whether to inform the doctor or not." The statements from Delia and Carrie further emphasise the extended base role of the HITH RN in alignment with their existing scope of practice in the defined broad position description. Delia said:

> RNs' scope of practice ensures delivery of the most optimal appropriate care for the best outcome for patients, keeping in mind quality and safe care.

According to Carrie:

> HITH RN scope of practice provides a clear framework for nurses to deliver care. However, areas of higher-level accountability could be considered with an advanced practice opportunity.

The HITH RN provides the continuity of home-based patient care between the patient and the doctor. According to Delia, the HITH RN has a "wider scope of practice in relation to the roles occupied, as opposed to the defined boundaries of practice for RNs", and this, according to Janice, was:

> … particularly taking into consideration of autonomous practice with an interprofessional team, complex decision making, and interpretation of results with liaison with the relevant healthcare provider.

The participants were clear regarding the scope of practice of the HITH RN being complex and requiring an extension from the typical role of the RN to one where more complex decision making that occurs in the more autonomous setting of a patient's home. The participants conveyed a need to assess patients at an advanced

level and then provide an interpretation and critical decision in a collaborative approach with members of the inter-professional health care team. For the HITH RN it is necessary to know when it is imperative for doctor notifications to occur. Furthermore, HITH RNs should know what specific areas of practice can be undertaken without a follow-up to the relevant interprofessional expert. HITH RNs were regarded as the pivotal link between health services, the doctor, and the acutely ill patient at home. It was this link that was key to keeping the patient safe and well at home and outside of the acute-care inpatient system.

## 5.8 Summary

This chapter contains a synopsis of the three main themes and subthemes of professionalism, knowledge, and responsiveness. The participants' highlighted the concept of professionalism regarding their role and function as a HITH RN. Moreover, the main themes and subthemes included the accountability and responsibility evident or perceived in their role. The restrictions on HITH RNs through a medical governance framework that hinders the participants' professional expectations of their role is outlined. The second theme highlighted the HITH RNs' expectations of their role. The participants found it essential to continue seeking knowledge. They believed that they required a deeper knowledge to manage patient-care parameters effectively and efficiently. The subtheme of lifelong learning shared the need for an ongoing pathway of learning and a career structure that recognised the importance of this subtheme in the overall research. Being responsive was the final theme. Responsiveness means HITH RNs must be able to respond quickly and accurately when working in an autonomous capacity outside the acute-care hospital setting. The restrictions and barriers to being responsive, were identified as most challenging. The authority to practise autonomously is not approved for any RN unless a NP. Therefore, to extend nursing practice beyond this level is challenging for HITH RNs. A need for greater delineation of the advanced scope of practice was identified as a future need to explore further.

This led me to the need to review the position descriptions of participants to understand where alignment and limitations arose. The position description content analysis is outlined from the perspective of role titles and reporting obligations, position qualifications, and duty statements that link with the themes formed from the

interviews. In Chapter 6, I analyse the position descriptions, provided by the participants, that the HITH RNs work within.

# CHAPTER 6: CONTENT ANALYSIS POSITION DESCRIPTIONS

## 6.1 Introduction

In this chapter, I present the content analysis I performed with the Hospital in the Home (HITH) RN position descriptions (PDs). In the process of participant interviews, it became apparent that the breadth in the PDs volunteered by the participants required greater exploration. All 12 participants shared their formal PDs. At this point in the research, I separately, reviewed each PD description for content, key responsibilities, and the RN duty statement. A thematic analysis was conducted using Braun and Clarke's (2006) framework to identify the commonalities in content and the points of difference.

The initial analysis is presented in section 6.2 and the role titles and reporting obligations (section 6.3) and position qualifications (section 6.4) identified in each position description presented. The unit descriptions are provided (section 6.5), and the duty statements analysis shared (section 6.7). This process was conducted in NVIVO and required a line-by-line review of each position description, the collation of codes where similarities and points of difference were identified and a final identification of key themes. The key responsibilities identified in all position descriptions were further themed for their areas of likeness and disparity. The theme of care is shared with each of the subthemes defined in section 6.8. The key responsibilities identified in the position descriptions have been analysed with results presented in section 6.9. The completeness of themes identified in the position description content analysis is presented in section 6.10. The position description analysis commences with an initial analysis of position description role structure.

## 6.2 Initial analysis

The content analysis of the position descriptions was conducted using Braun and Clarkes (2006) thematic analysis process. NVIVO was used to identify common threads and concepts appearing in the position descriptions. Initial analysis identified considerable variability in the role title, scope, and reporting frameworks within the PDs of HITH RNs. The provided PDs included role titles of RN, clinical nurse, clinical nurse consultant, and nurse manager. Interestingly, other than the role of RN to clinical

nurse, the skill set, PD, and functions in the roles were equivalent. There were points of difference between RN qualifications and reporting obligations. The duty statements at initial review showed areas of commonality with key words of "care" and "coordination" becoming apparent. The initial analysis was inclusive of a varied and multipronged approach that has the HITH RN reporting to a variety of positions and of varied documented scope-of-practice parameters. On completing of data analysis, I revealed aspects of role purpose that had several overarching themes. These overarching themes were **care, expert advice, and coordination requirements**.

## 6.3 Role titles and reporting obligations

Each role title and corresponding reporting obligation was captured. The collective summary of the 12 PDs indicated a total of nine differing role titles for the RNs working in a HITH position. Six titles related to formal management positions, with the term "coordinator" or "manager" appearing in the role title. The remaining positions were titled "clinical nurse" or "clinical nurse consultant", with one PD identified as a "HaH RN", implying more of a clinical function rather than a management and clinical foci. Each role and reporting obligation are identified in Table 6.1.

Table 6.1

*Role and reporting obligations of participants*

| Role title | Reporting obligation |
|---|---|
| Clinical Nurse Manager HITH | Community Director of Nursing |
| Nurse Unit Manager Acute Care @ Home | Operationally – Director Health@Home<br>Professionally – Nursing Director |
| Clinical Coordinator | Nurse Manager, Hospital in the Home |
| Senior Case Coordinator | Clinical Nurse Consultant Manager |
| Manager, Home Based Services | Executive Director |
| Clinical Nurse Consultant | Director of Nursing<br>Operationally and strategically Nurse manager |
| Clinical Nurse Consultant | Director of Nursing |
| Clinical Nurse | Clinical Nurse Consultant |
| HAH RN | Clinical Nurse Consultant Manager |
| HITH Clinical Nurse | Nurse Unit Manager |
| Clinical Nurse Consultant | Nursing Director |

Participants were employed under the auspices of a variety of PDs, all identifying with the primary responsibility of a HITH RN. The primary PDs outline several role titles for HITH RNs who complete the same work function. These include RN, clinical nurse, clinical nurse consultant, and nurse manager. Three RNs had completed a master's in nursing, with all other participants except one having completed a Bachelor of Science Nursing degree. The RN with a diploma in nursing was a hospital-trained RN who opted not to undertake a Bachelor of Science Nursing, which was acceptable for her current employment.

## 6.4 Position qualification requirements

Each PD identified the minimum qualifications for the HITH RN position. All PDs required the incumbent to be a RN registered with the Australian Health Practitioner Regulation Authority (AHPRA). Three PDs were explicit in the need for specific experience. For instance, "the RN must have a minimum of three - or five-years' full time equivalent, acute, and community nursing experience." A further PD contained the need for "significant post registration experience in acute or community nursing", and another required "postgraduate experience in a relevant field". The definition of "relevant field" was not provided.

Three PDs explicitly stated the need for a "postgraduate qualification in management or business at master's level" and one further at a "minimum of certificate level". The relevant field of the certificate level was not defined. One PD highlighted the need for "experience in management with or without a qualification". It was not clear whether this was or wasn't a requirement. Postgraduate qualifications were identified as "highly relevant" or "highly desired" in six PDs other than the three PDs where management or business qualifications were needed. In these cases, no explicit discipline area of study was indicated, with commentary referring to broader areas of nursing, allied health, human services, or other relevant fields of clinical practice.

## 6.5 Findings from the Analysis - Hospital in the Home unit description

The next phase of analysis involved a content analysis of the duty statement of the RN role. The duty statement shared the main roles and accountabilities in the position. The HITH RN clinical areas outlined in the PD were similar in context across all PDs. The main areas of responsibility identified in the unit description were

accountability, clinical leadership, and care coordination. I have presented the main areas identified as subcategories.

## 6.6 Position description content analysis

The content analysis occurred across the five topic areas in the position description. These included the statement of duty, the key responsibilities, the organisational role, workplace behaviours and professional responsibilities. An analysis of the PDs occurred that corresponded with each of these five topic areas. Commonalities in responsibilities were identified using initial NVIVO©. Five themes arose from the analysis of the duty statement of the HITH RN and these areas are shared in Figure 6.1. Figure 6.1 also shares the results of the analysis of the key responsibilities in the PD. These results and their sub-categories are presented and align in many instances with the themes arising in the participant interviews.

Analysis of the PD topic areas and the results are outlined in Table 6.2. Further analysis followed of each topic area with a more explicit evaluation of each code arising.

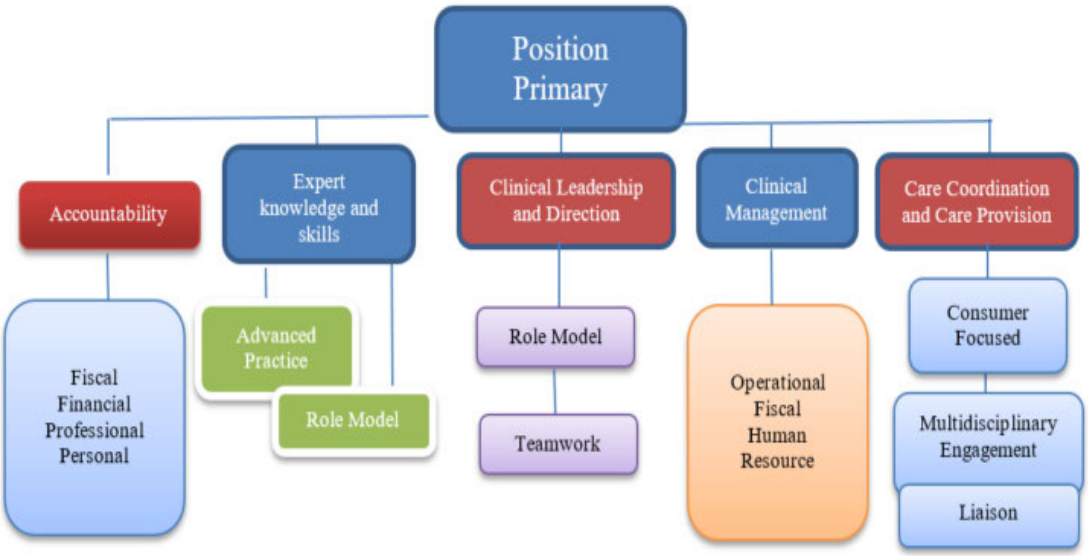



Figure 6.1

*Results of the analysis of the key responsibilities in the position descriptions*

Table 6.2

*Key areas and codes arising from the position description data analysis.*

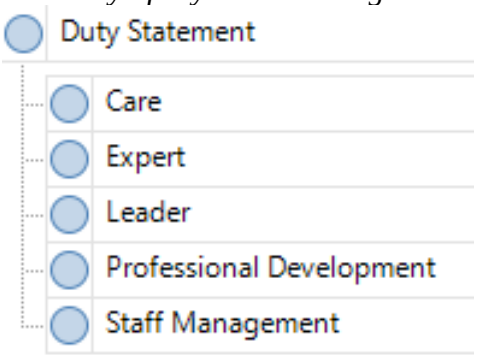
| Key areas arising in the data | Key codes |
|---|---|
| Statement of duty | Expert; Leader; Professional Development; Care; Staff Management |
| Key responsibilities | Accountable; Change Agent; Communicator; Coordinator; Leader; Responsible; Professionally accountable; Decision Maker |
| Organisational 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 |

## 6.7 The duty statement and emerging themes

The first key area was the duty statement. The evaluation of the duty statement was conducted through a process coding and of thematic analysis in NVIVO©. Five key areas emerged that specifically related to the duty statement key areas in the role description for the HITH RN. These areas are highlighted in Figure 6.2. Each area is described and discussed in this chapter.

Figure 6.2

*Summary of key areas arising in the analysis of the duty statement*



## 6.8 Theme 1: Care

The first theme arising from the PD analysis was care that shared both similarities and disparities across all position descriptions. Care was described as the provision of skills and duties to fulfil the needs of the patient. All duty statements included key aspects of care from assessment, implementation, and evaluation perspectives. Care was defined as any form of assessment, planning, care provision, or evaluation of care. Sub-themes arose in 'care' with three areas of care provision identified:

1. Participation in patient care
2. The leadership to coordinate and analyse care requirements.
3. The professional direction and outcomes of care.

Each area was identified in more detail from the exact wording used in the PDs. The results of this analysis are shown in Subsections 6.8.1, 6.8.2, and 6.8.3 below.

### 6.8.1 Subtheme 1: Participation in patient care

The first area noted is "participation in patient care". This theme was visible in all PDs. A primary focus of participation in care was seen in the delivery of services and the coordination and support to other staff and patients in the provision of care. The subtheme, participation in patient care focused on the facilitation of unexpected patient deterioration and how this was managed and coordinated by the HITH RN. Patient deterioration at home needs swift action as it would in a hospital setting. However, the difference is that in the hospital there is a "crash team" whereas, in the patient's home this is limited to the HITH RN. This means "000" needs to be activated and emergency-based cardiac or respiratory action begun or any other intervention that is required including liaising with the medical team. The critical aspect here was the engagement of the RN in patient care from inception through to evaluation.

Engagement from the HITH RN in all aspects of care provision demonstrated key areas of leadership from the HITH RN. The areas of leadership were seen in the sharing of expertise and guiding staff with care provision requirements to achieve optimal patient care. The HITH RN was described in many areas of the position description as 'expert'. A HITH RN expert was an RN with the skills, understanding and knowledge to be able to autonomously make decisions relating to care in the absence of a broader team to seek advice. The need for the HITH RN to know, understand and fulfil cares at a high level was spoken of in the interviews and identified

in the position description analysis. Patient care included working in partnership with the broader health community to ensure that the patient was seen by the right health practitioner when needed. The National Law (2009) is explicit that care needs to be provided that is safe for the community. The HITH RN PD is clear that RNs provide guidance, explain care requirements, and educate other staff on the key aspects of patient care. The PDs were broad and generic in nature and did not present any area of specific advanced practice. Exact wording used in the PDs is inclusive of:

1. **Participation in patient care**

- Delivery of community based acute & post-acute clinical care.
- Clinical practice, advise, and consultation to clients.
- Liaise, coordinate, and plan care with other health professionals.
- Provide appropriate support for clients.
- Recognise and act on expected or unexpected client clinical deterioration through advice from appropriate health professionals.
- Facilitate continuity of care.

### 6.8.2 Subtheme 2: The leadership to coordinate and analyse care requirements.

Leadership and coordination in care was the next sub-theme I identified. For the HITH RN, leadership was demonstrated through working in partnership with other staff, community general practitioners, and allied-health personnel. Leadership was demonstrated in the autonomous approach and ability to problem solve independently. Leadership was demonstrated in the capacity of the HITH RN to make decisions and to communicate these effectively with both the patient and a health professional. An area of leadership was expressed with communications across health teams and within local care teams while maintaining collegial relations. Extending knowledge and expert assessment were terms used in the PDs that referred to more complex communication processes. “Appropriately manage and coordinate care” was referred to when discussing patient care, options, and referrals with the patients and their families or significant others. This is reflected in the themes of professionalism and responsiveness that were identified in the analysis of the participant interviews. Leadership was elaborated on within the interviews with HITH RNs discussing the concepts and activities surrounding mentorship and guidance or leading in practice and in professionalism.

Specific wording in the PDs included:

**2. Leadership to coordinate and analyse care requirements.**

- Implement the nursing clinical practice supervision model for all nursing staff.
- Safe delivery
- Work in partnership
- Improve outcomes for people with health issues requiring hospital in the home services, their families, and carers through leadership.
- Education and support of other professionals
- Extending their knowledge and skill
- Expert assessment
- Appropriately manage.
- Care in accordance with standards and training

### 6.8.3 Subtheme 3: The professional direction and outcomes of care

Professional direction and outcomes were inherent in each of the PDs. The daily work and ongoing coordination of teams of staff provided a level of professional direction to staff, patients, and families. The word accountability was mentioned in all PDs. The need for evidenced-based practice was clearly outlined in all PDs. The need for professional, accountable, and well-educated RNs who maintained sufficient practice hours and ongoing education, and the use of evidence in the decision-making process was clearly outlined in 80% of PDs. Each of these aspects again align with the National Law (2009) and the need for safety for the community. This theme explicitly aligns with the themes of autonomy and leadership from the HITH RN interviews and with the knowledge attained from HITH RNs and shared informally and formally with staff through mentorship and education. The level and extent of each of these areas could be considered in an advanced scope of practice. However, the HITH RN PDs in this study aligned with the generic competencies of the RN (NMBA, 2020a). An alignment was noted in the participants' experiences however, a dichotomy prevailed with the HITH RNs interviews that outlined a need for greater advanced scope of practice recognising advanced assessment and care parameters. Specific wording in the PDs was inclusive of:

**3. Professional direction and outcomes of care**

- Evidenced based practice.
- Professional nursing direction
- Role is accountable.

- Quality evidenced based.
- Improve outcomes for people with health issues.
- Patient safety, optimise outcomes.

The second theme arising was of expert. The PDs included the idea of "expert", and the previous broader leadership area was refined to include aspects of the "leader", "staff manager", and with responsibilities in "staff development". I have provided a more in-depth review of the results in the theme – expert decision maker.

## 6.9 Theme 2: Expert decision maker

Expert decision maker was defined as providing care coordination using evidence-based practice from highly skilled and knowledgeable RNs. Generally, HITH RNs are critical thinkers in decision making as well as act as an educator and coordinator of care due to level of expertise and skills in their area. The expert in terms of the HITH RN was seen as the care provider who had the expert knowledge, decision-making capacity, and skill to determine which practitioner needed to be consulted and in what manner. The HITH RN was viewed as the central person for unregulated or enrolled nursing staff to contact at times of need in making decisions relating to care. The emerging theme of "expert" was seen by the client and families who were advised to contact the RN when situations relating to their care required clarity or confirmation or where a request for a review was required. The wording used in the PDs was explicit using the words "expert", "knowledgeable", "contemporary", and "extending skill base" to describe the role in context of being an expert. Specific wording related to being an expert decision maker that was identified in the PDs are provided in the following list:

- Demonstrates expert clinical knowledge of contemporary nursing practice and theory related to community based acute and post-acute care;
- Support the community nursing and allied health staff in the provision of safe, effective, appropriate evidence-based hospital in the home care;
- Enhancing and extending knowledge and skill base through the provision of expert assessment, consultancy, care planning and education;
- Expert assessment, critical thought, and decision-making capacity;

- Provide advanced level clinical skills and knowledge in home-based acute and post-acute nursing.

### 6.10 Theme 3: Leader

A theme of "leader" appeared in the PD analysis and similarly in the transcripts of RN experiences. The analysis defined the leader as the person who provides the support, clinical expertise, coordination, accountability, and engagement within a multidisciplinary team in providing consumer-focused health care. Several PDs were explicit in stating that a management or business qualification was desired. The following list contains the specific elements relating to leader of teams and the self that were present in all the PD statements:

- Lead and manage quality within service delivery to ensure meet client needs and goals;
- Responsible for providing operational leadership, supervision, and support for a designated team of Care Team Leaders and the Client Services Co-ordinator (this was apparent in all PDs);
- Well-developed communication (written, verbal and listening) and interpersonal skills to develop effective relationships (this was apparent in all PDs);
- Coordinate, formulate and direct policies relating to the provision of patient care or speciality services;
- Have a vision and develop a plan for continuous improvement, thoroughly investigating and identifying needs for improvement and driving the implementation of improvements, whilst remaining flexible and open to change;
- Utilising transformational leadership skills and change management strategies to engage the team to strive for high quality patient care outcomes through evidence-based practice;
- To lead the successful reform process.

Many aspects of the concept of leader were apparent in all PDs. The need for complex communication skills and advanced evidence-based practice capability were key elements of leadership. The need for ongoing education and currency in practice became apparent in the participant interviews and was present in the PDs. The need to lead care and care decisions was clear and presented in the theme of care. The ability of the HITH RN to provide safe and autonomous care is linked with the concept of clinical leader as all aspects of care and liaison in and across the interdisciplinary team was needed.

### 6.11 Theme 4: Professional development

The fourth area arising in the PD analysis related to professional development. Professional development was focused on the education of peer RN staff and enrolled nursing staff, and, in many instances, unregulated health care workers. The concept of increasing the decision-making capacity of staff working in the HITH environment was an important aspect in the staffing profile. This was particularly important because much of the care was provided autonomously in the community by the HITH RN. The areas of professional development link to the assurance of care provision from an evidenced-based perspective. Specific commentary that related to professional development and leading self and teams in a HITH service is included in the following list:

- Measure, support, coach and develop employee and self-performance through regular active participation in both peer and 360$^{o}$ performance reviews;
- Proactively develops self and others, supporting learning and sharing information with others.

Interestingly, the concept of ongoing self-development is referred to as “proactively develops self”. However, articulation of what this entails is not made explicit in any PD.

### 6.12 Theme 5: Staff management

The final theme related to staff management. Staff management was referred to in all PDs from RN to clinical nurse and clinical nurse specialist. The concept of care coordination, staff management, and clinical direction was clear. The direct and

noted line of accountability was defined in all PDs. Key responsibilities were identified that were inclusive of being a change agent, having professional responsibility and accountability in nursing actions. These, relating to energising a team and building a desired culture, are demonstrated in the following list:

- Lead and manage compliance to program standards set for Models of Care;
- Lead and manage change in work culture and practice;
- Managing resources and delivering volumes of care within allocated budgets;
- Lead and manage staff by fostering and committing to patient safety and quality in the delivery of health care by maintaining and evaluating safety and quality practices and initiatives.

Staff management was a key duty in all PDs. The extent of this management was broad, from team development to compliance monitoring. The vast array of operational management terminology is suggestive of human and fiscal resource management in some of the PDs. This was extended to include quality assurance monitoring and audit management. This added a complexity to the role and increased the need for more advanced patient care to one of managing others in roles that explicitly report to the HITH RN. Further work and more explicit detail are needed in what this really means for the role of the HITH RN in practice. A career structure that shares the roles and career direction does not appear in the PDs to align with the area of staff management.

### 6.13 Key responsibilities in duty statements

For the final stage of the PD review, I sought further analysis of each of the key responsibilities arising in the duty statement highlighted in the PDs. The analysis I undertook revealed six key responsibilities. The six key responsibilities identified in the duty statements are:

1. Professional accountability
2. Change agent.
3. Communicator
4. Coordinator
5. Leader
6. Responsible entity

The next section of analysis provides a summary of each of the key responsibilities identified in this final section of analysis of the PDs pertaining to the HITH RN. The first area is professional accountability.

### 6.13.1 Key responsibility 1: Professional accountability

Professional accountability was expressed through the expectations that the RN is registered with AHPRA. This is a clear distinction in all PDs and aligns with the Nursing and Midwifery Board of Australia's (2018) *Competency Standards for the RN*. This is a legal requirement for all RNs and one that was explicit in all PDs. The PDs shared areas of responsibility and where knowledge and expertise as a registered practitioner is required. The wording in the PDs was suggestive of a culture where growth, improvement and adaptation to workplace environments was needed to improve patient outcomes. However, it relies on the staff member to show what is needed, often reviewing patient care outcomes in their own time, to request extra equipment, or care pathway improvements.

### 6.13.2 Key responsibility 2: Change agent

Change agent was associated with the role of the HITH RN when changes to clinical practice were required to improve a patient's outcome. Change agent was also the capacity of the HITH RN to seek new knowledge to provide skills using evidence-based practice. The HITH RN was regarded as responsible for policy and procedure maintenance, and education of others was noted in nine PDs. The initiator of change and coordination of change processes was a key role of the HITH RN in eight PDs. The remaining four PDs included areas of procedural change, education, and upskilling.

### 6.13.3 Key responsibility 3: Communicator

The role of the RN was pivotal in the communications between staff, with the patient and to broader members of the interdisciplinary healthcare team. The PDs indicated that the key responsibility of the HITH RN was as a central portal for clinical communication. It was the HITH RN role that brought together all elements of care in the patient's home. The communication required to achieve this was interlinked with different agencies, individuals, and larger health service providers. The

communication was seen as a measure of success in a complex chain of communications with the integral component being the HITH RN.

### 6.13.4 Key responsibility 4: Coordinator

Care coordination was identified in all twelve PDs. The role of the HITH RN was seen as the care provider and coordinator in the clinical team. One PD titled "Registered Nurse hospital in the home" indicated a greater engagement with care provision than all others. The remaining PDs elaborated on a coordination role. A coordinator was viewed as the overarching organiser of specific care requirements, the facilitator of the appropriate healthcare staff, and the assessor and evaluator of the outcomes of this care with an individual in their home. The term "coordinator" also referred to the HITH RN who produced and managed rosters, client allocation, and care prioritisation strategies.

### 6.13.5 Key responsibility 5: Leader

The HITH RN leader was described as the influencer of others with the capacity to encourage and engage others in care delivery. The leader provided the influence that extended to leading teams, influencing practice through evidence, and guiding and mentoring staff to learn more. The key responsibilities in the HITH RN PD were outlined as maintaining high-quality standards in care assessment, implementation, and evaluation. This was further elaborated with the key responsibilities sharing the need for assessing risk and in educating others in quality evidence-based practice, and indicative of higher order process than the HITH RN title belies.

### 6.13.6 Key responsibility 6: Responsibility

Responsibility was seen as having the duty to deal with complex care issues and being able and responsive to care needs and care delegation requirements. Responsibility arose in all PDs and included all areas of overarching authority. This was inclusive of leading care, educating staff, defining rosters, and in care coordination principles and practices. This key responsibility aligns with the expectations of a RN measured through the NMBA (2018) competency standards and aligns with professional responsibility and overarching registration requirements.

### 6.13.7 Position description content analysis discussion

The PDs have been discussed and are outlined. I found this analysis an important parameter in the exploration of the role of the HITH RN in practice as this process was important to identify the similarities and differences from HITH RN experiences and their identified role description. The PDs 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 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 an overwhelming level of professional accountability required.

The duty statements in the PDs highlight five areas of importance. Care is an overarching principle and the most relevant area in the PD of the HITH RN. Care coordination and the management of human and fiscal resources are elements in the fundamental practice of the HITH RN. The HITH RN interviews concurred with this analysis. Staff development was noted in all the PDs, seeing the HITH RN role as the connection between care and evidence-based practice. The HITH RNs are providers of education, the mentors, and the leaders who can answer questions arising from all levels of staff. The analysis of the PDs has provided a consensus with the experiences collected and analysed in the HITH RN interviews. Staff development was noted as an area of self-development and one where the HITH RN sought greater engagement and support from their workplace in the interviews.

Following the completed analysis, I concluded that the position descriptions concurred with some of the elements of the HITH RN interview outcomes. A generalisation in the PDs was noted that included clinical, management, quality, and care parameters. A vagueness in wording and role title and function exists and there is no specific reference about what differentiates a HITH RN from other RNs or, for that matter, a CN, a CNC and in one PD a 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 PDs were very broad, However, there are consistent references to leadership, care coordination, accountability, extended care, and communication. There is minimal reference to innovation, career pathways, or self-development. It is these

differences and similarities that offer greater insight into the collective role of the HITH RN in practice.

This chapter has provided the analysis of the position descriptions sharing a broad theme of care with five distinct subthemes of participation in care; leadership to coordinator and analyse care requirements, professional direction, and care outcomes. Subthemes continue with expertise in decision making, leader, professional development, and staff management. Key responsibilities were identified with areas of professional accountability, change agent, communicator, coordinator, leader with attributes of responsibility. Chapter 7 provides a discussion that links the outcomes of the themes arising from the analysis of the interviews and the content analysis of the position descriptions. The similarities, nuances and barriers will be discussed.

# CHAPTER 7: DISCUSSION

## 7.1 Introduction

In this chapter, I discuss the results presented in Chapters 5 and 6. The culminating results are the shared voice of the HITH RN participants and position descriptions analysis associated with the HITH RN. The perspectives share the professional role of the HITH RNs in practice, the role requirements, and their scope of practice. The results link with the literature discussed in Chapter 2 that discussed the multifaceted role of the HITH RN in the Australian health care system context. The emerging horizons are presented including three overarching themes of professionalism, knowledge, and responsiveness. The themes are presented with an overview of the findings that share the key elements of the discussion. The overarching themes of professionalism (section 7.3), knowledge (section 7.4) and responsiveness (section 7.5) are discussed with an overview of these emergent findings presented (section 7.6). Emerging horizons

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, and specialisation, skill, and knowledge are identified. **Three core themes of professionalism, knowledge, and responsiveness are discussed within this chapter.** These themes emerged from the hermeneutic analysis of the interviews and were further outlined in the analysis of each component of the position descriptions. The discussion in this chapter includes the challenges to the HITH RN role and the new horizons emerging from linking the literature with the results arising from both the interviews and the PD analysis.

## 7.2 Overarching theme 1: Professionalism

Professionalism refers to the explicit need for accountability and responsibility. I attempted to understand the HITH RN experience and the associated influence of personal values and beliefs in sustaining a professional nursing scope of practice. The outcomes of the findings in chapters 5 and 6 elaborate on the need for HITH RN to exhibit leadership, accountability, and responsibility for both oneself and the overarching responsibility of delegation of staff. The 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 et al., 2016; De Braganca & Nirmala, 2017; Donmez & Ozsoy, 2016; Ghadirian et al., 2014; Ibrahim & Qalawa, 2016; Ó Lúanaigh, 2015; Nouri et al., 2017). This premise aligns with the conceptual framework presented by Watson and the nature of caring.

The nursing framework identifies a core set of seven domains (standards) of quality healthcare in relation to an RNs' role, responsibility, and scope of practice (NMBA, 2020a). Each standard articulates RNs' responsibilities and the need for understanding these as necessary to provide safe, quality patient care. RNs are critical to observation, communication, and coordination all of which are required to reduce or prevent adverse patient outcomes. The semi-autonomous role of the HITH RN further expands on this concept whilst acknowledging the need for increased decision making and skill components when care is provided outside the acute care setting.

There are commonalities in the findings reported that are congruent with the literature about how RNs perceive their role and role functions (Cant et al., 2011; Feringa et al., 2018; International Council for Nurses [ICN], 2020; Nursing and Midwifery Board Australia [NMBA], 2020a, 2020b, 2020c; Schrober, 2016; Standford, 2016). The role of the HITH RN resembles scattered building blocks where more work is required to build alignment in position description, role, and function, particularly to the level of the advanced, autonomous practitioner. **This research affirms that greater policy development and position description alignment and consensus is needed.** Alignment and consensus on clinically appropriate HITH RN position descriptions will enable clarity of practice at the skill and knowledge level commensurate with advanced practice for HITH acute-care provision in the community (ACN, 2019). The linkages, commonalities, and disconnections between the interviews and position descriptions highlight the need for better consistency and professional alignment in the HITH RNs' professional practice and its articulation in practice in Australia.

Commonalities exist in the data analysis of the interviews and baseline employment requirements with respect to the level of education that HITH RNs require. Eleven of the 12 participants had a bachelor's degree in nursing science and were employed within a HITH service. This is consistent with international literature and the formalised specialist HITH RN role (McHugh & Lake, 2010; IOM, 2011).

More work is required in the Australian context to formally align professional requirements with the HITH RN role to ensure a minimum skill set at time of employment. Dissonance for the HITH RN exists because there is not a unified framework of responsibilities for maintaining standards of expertise in relation to length of service, courses attended, and pre-employment and continued HITH educational requirements. A formal career structure is supported through robust education opportunities, and this is evident in the international literature (Howe, 2016a, 2016b; Weston, 2022; Whisner et al., 2022; Willis, 2015) and requires consideration for transference to the Australian context. This formed a noted gap in the analysis of the HITH PDs and was expressed as an area where more development was needed.

A degree of generalisation in the role and function of the HITH RN was ascertained: A vagueness in clarity of wording regarding role title and function exists, and no specific reference is available that enables a HITH RN to be differentiated from other RNs in general medical or surgical acute care practice. HITH RNs uses their level of acute care knowledge and skills in a non-hospital-based environment. Disparity existed in the generalisation that appears in the HITH RN position descriptions. More work is needed to understand the terms of primary healthcare and hospital healthcare particularly in relation to HITH services and the RN. Such understanding is important to HITH RNs in nursing teams because a distinction between the similar titles may have consequences for the patient and nurse. Understanding the terms is crucial for the delivery of safe, competent, and quality patient care of an acute nature in a community setting. 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 of their role and function is disparate to the broad, generic position description that is meant to align with the role. This creates a barrier to improving care provision for patients and a barrier for professional development and recognition of autonomous practitioners for the HITH RN.

Advocating for the patient is a significant part of their role, as is making critical decisions when a patient's condition deteriorates (Australian College of Nursing [ACN], 2017; NMBA, 2020a, 2020b, 2020c). Regulatory guidelines assist RNs to remain within the limitations of their knowledge, skills, and education, viewing their positions from a legal perspective, while granting them the capacity to work at the

level required of the RN in HITH practice. This professional autonomy was highly regarded as a key indicator in the interviews traversed across all domains. The decision-making capacity and autonomy of the HITH RN appeared to be greater than the descriptive outline in the generic position descriptions. A disparity between the two areas of analysis were noted.

The scope of practice for RNs is guided in Australia by predetermined boundaries outlined by a national professional body, the Nursing and Midwifery Board of Australia (NMBA, 2020a). Even with increased autonomy, the NMBA (2020b) scope of practice requires RNs to remain within the limitations of their knowledge, skills, and education from both professional and legal perspectives. Nursing practice is graded in Australia by the degree of competency and experience that a nurse has, and there is a perceived understanding that there will be an added level of autonomy within the specific role because of prior experiences in emergency rooms, community, medical, and surgical departments. Though again no specific HITH educational requirements are outlined in the organisational positional descriptions.

The study by Byrne (2021) aligns with the experiences captured by the HITH RNs who seek greater acknowledgement of autonomy in practice, scope, career planning, and processes of lifelong learning. Aligning with the current stance that participants shared about increased autonomy, RNs must stay within the limitations of their knowledge, skills, and education from both professional and legal perspectives (NMBA, 2020a). Buppert (2021) discussed the legal and ethical issues of unskilled, untrained, or undereducated nurses managing various treatments and assisting patients with their decision-making capacity. The premise of care was highlighted by all participants as central to core nursing skills. The need for holistic care that respects the rights and advocates for the individual was at the fore of all participants and aligned with the caring philosophy of Watson (2008).

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 (MacNaughton et al., 2013; Niezen & Mathijssen, 2014). However, in the nursing professions, the need to expand the scope of practice is real. Extension of the scope of practice determines whether RNs can work to a higher level in a specialist area. Ongoing education may be required 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 (ACN, 2019; Birks et al., 2016, 2018b). In some instances, extensions to scope of practice occur based on technological advances or the need for the inclusion of new skills and new knowledge. Participants identified the frequent need to work in areas that require role extensions in comparison with RNs in other settings particularly when noted increases in complexity of patient care was identified. This need is further heightened by the need to provide at-home care to patients with COVID-19 or associated complications (Burns et al., 2020; DoH UK2021; WHO, 2020a, 2020b, 2020c, 2020e, 2021b).

A professional shift was noted by participants in the use of HITH nursing services since 2020. The advent and prolongation of the COVID-19 pandemic has seen a shift in HITH RN roles. My research highlights an increased and expanded scope and clinical expertise synonymous of autonomous practice (Diez-Sampedro et al., 2020; Stucky et al., 2021). Communication is regarded in all position descriptions as essential. Likewise, RNs maintaining currency, clinical advancement, and communication are essential for successful patient outcomes (Diez-Sampedro et al., 2020; Stucky et al., 2021; Weston, 2010). The historical perspectives of the HITH RN role have changed over time with more acute care now being provided in the community (ANF, 1999; Silver Chain Group, 2021). The research supports this perspective and highlights the need for more defined career structures and education pathways. The research also notes that more work is needed to refine generic position descriptions into more succinct professional statements that align with advanced practice knowledge, skill, and competency.

The participants in this research were aware of the role and role functions that underpin NMBA guidelines (NMBA, 2020a, 2020b). However, often their level of decision making remains constrained by the need to consult with a doctor before proceeding with a clinical intervention when the care requirements are obvious to the HITH RN. Nursing remains in a medically driven healthcare system; therefore, the participants suggested their scope of practice has been thwarted by being medically governed (Berget et al., 2019; Kobos et al., 2020). Nonetheless, Nursing professionalism strives for greater autonomy and for the HITH RN to engage in more aspects of clinical nursing specialisation when caring for acutely unwell patients at home. The autonomy in the role is central to the leadership capacity and decision-making capacity of the RN. Leadership is crucial for quality and safe patient-centric care (ACN, 2017, 2020a, 2020b; Lamb et al., 2018; McBride, 2019). The position

descriptions (PD) suggest that a leadership qualification (level unspecified) would be desirable, or experience in a previous leadership position would be advantageous. Nevertheless, the PD did not specify the level of leadership qualification or experience. Accordingly, Boykin and Schoenhofer (2013) and McBride (2019) argued strongly that leadership should be part of the scope of practice to reinforce integrity, communication skills, teamwork, appreciation of diversity, and problem solving (see also ACN, 2017; NHS Leadership Academy, 2013; Reinhard & Hassmiller, 2012). This was further supported in the interviews. Omoike et al. (2011) stated the integrity of leadership also impacts on nurse satisfaction concerning competence and skill development.

The participants identified the desire to align their role and role function with ongoing development in advanced practice. Their desire and a demand by the public for increased nursing knowledge and skills to enhance the professional scope of practice of health professionals arose for several reasons. The first is a need for more Advanced Practice Nurses (Donald et al., 2013; Harris, 1998; ICN, 2015, 2107, 2020; Kleinpell et al., 2014; NHS Employers, 2021; Woo et al., 2017). The second involves the economic drivers for healthcare and technological advances (Harris, 1998; Pepito & Locsin, 2019; Robert, 2019). There is a drive to escalate the number of HITH nursing services, to explore more nurse-led clinic opportunities. Since 2013, there have been several opportunistic openings to push for more nurse-led clinics. These openings include fewer doctors migrating to Australia, and fewer Australian-trained medical practitioners per capita of the population and the ongoing medical workforce concerns related to the COVID-19 pandemic. However, the issue of doctor shortage in rural areas, sexual health, and general practice positions is not a new phenomenon (RCOBGYN, 2013; Simmonds et al., 2017). Therefore, increased knowledge and skills provide the base for expanding the position and role functions of the HITH RN. The determination of an advanced scope of practice by RNs working in a specialist area, with ongoing education would ensure understanding, competence, and certification of advanced scope of practice, therefore increasing HITH RNs autonomy in practice (Fealy et al., 2018; Kerr & Macaskill, 2020; Soh et al, 2021; Van Schothorst–van Roekel et al., 2021).

The standards of practice are set within the NMBA Standards of Competence for RNs (NMBA 2020a). The NMBA standards should be read together with the Code of Ethics and the Code of Conduct publications. These standards and codes, along with

other published practice guidelines, form a framework for RN accountability and responsibility irrespective of the area of nursing. The professional practice framework, grounded in the RN's scope of practice and responsibilities for quality patient healthcare, lacks content validity and contributes to understanding of how HITH RNs perceived their role in healthcare. It encompasses practice-based domains of quality that are specific to nursing and represents HITH RNs with broad responsibilities for optimal patient care rather than the specificity of the specialisation role.

Nevertheless, the participants in this research had different experiences and argued that their scope of practice extends beyond the provision of general nursing care, moving toward advanced practice. Their experiences suggested that HITH RNs provide general consultations in patients' home on issues about their current admission and are expert practitioners in promoting patient and staff safety. The HITH RNs outlined they provide succinct and timely information, education, and ongoing training for nurses, as well as for patients, families, and carers in their homes or in an aged-care environment. Furthermore, the participants' views suggest that HITH RNs provide management and team support, including the coordination and delegation of duties and assessment of staff competencies before assigning duties. It is an extension to the scope of practice of the HITH RN that aligns with the theme "HaH RN as semiautonomous, advanced practitioner".

An extension of practice to include interpretation of pathology results and report these to the doctor is what many RNs do. Moreover, with the additional RN's knowledge of the patient, this could enhance patient outcomes when undertaking critical thinking with advanced skills as part of an extended team environment. However, to act on the results without informing the medical team is an extension of practice and critical thinking that aligns with NPs and falls outside the realm of a HITH RN scope of practice. The current HITH RN role exists in accordance with the scope of practice generically for an RN in Australia. The extension of the role of the HITH RN should be considered in areas where safe, advanced practice could occur to optimise patient outcomes. It is an extension to the scope of practice of the HITH RN that aligns with semi-autonomous, advanced practitioners, not with complete autonomy, that is having the authority to decide and the freedom to act within their professional nursing-knowledge (Oshodi et al., 2019; Pursio et al., 2021). Advanced nurses are communicators, coordinators and leaders who use evidence-based practice

and work independently. These parameters are evident in the results, nevertheless, they are restricted by their current role descriptions and scope.

The HITH RN decision-making process supports safe, non-traditional nursing actions. It was Kennedy et al. (2015) who suggested encouraging innovative practice that enhances autonomy, and again, moves toward advanced practice. An example of this is following a clinical pathway with criteria-led discharge for the treatment of uncomplicated cellulitis (Shepperd et al., 2016). Criteria-led discharge planning enables RNs more autonomy in patient care decisions and complex care management. Greenwood's (2010) argument that nursing roles involve managing complex patient care using professional nursing services. Complex care requires presenting the multidisciplinary team with concise, timely reports regarding a patient's progress. Sekse et al. (2019), who argued that nurses have coordinator characteristics in healthcare systems linking different levels of health care and professions to patient and family. There is limited doctor input, suggesting that HITH RNs take a lead clinical role when undertaking daily patient assessments and care provision in a collaborative yet consultative approach to care.

The Australian HITH RN lacks autonomy and higher-level of practice acknowledgment in comparison with their equivalent roles internationally (AAACN, 2016; 2021; Lee & Titchener 2016; Lee, Pickstone, et al., 2017; Xu et al., 2019). Like the Emergency NPs in Northern Ireland, the Australian HITH Nursing workforce may benefit from establishing the identity of all nursing roles using the Donabedian model (Donabedian, 2005; McConnell et al., 2013). The model has a three-component approach for evaluating the quality of care that is underpinned with a measurement for improvement. The three components are structure, process, and outcomes. Measurement for improvement has an additional component focused on balancing measures and documenting outcomes (Raleigh & Foot, 2010). The Donabedian model provides a structure to assist in defining the variety of position titles and scope of practice that exists for HITH RNs and provides a structure for greater alignment and definition with clear measured outcomes. The research is clear that the professional role of the HITH RN requires greater definition and delineation to ensure that there is a consistent approach to the role and role functions in the Australian HITH healthcare context.

## 7.3 Overarching theme 2: Knowledge

***Knowledge*** determines semiautonomous RN practice in which critical decision making and innovation in care provision is needed to respond to acute patient needs in the home. My research has revealed an underappreciation that the HITH RN scope of practice involves the application of evidence-based nursing. Recent studies suggest that HITH RNs have a sizeable nursing position that is open to interpretation and limitations (Baldwin et al., 2013; Cashin et al., 2015). The HITH RN role is particularly challenging, when the PDs differ on position, role titles and accountabilities. A greater consistency is required to ensure that nurses are educated, knowledgeable and with decision making capacity.

Despite having the NMBA (2020c) guidelines, there are no specific HITH-related postgraduate courses for RNs seeking to transition to HITH services. Following the introduction of tertiary education and national registration, the RNs' scope of practice continues to be a critical issue as education remains as being self-determined, with no clinical career pathway from novice to expert. Blair (2018) has addressed the differences between certification and educational requirements for advanced RN practice, emphasising that advanced practice will influence nurses to guide policy, global health, and leadership roles. There is a need for HITH RNs to be identified as leaders in management, policy directions, and managing complex health conditions of patients from assessment, to care delivery and evaluation. These elements have been shared by the participants in their interviews and are noted in the position descriptions analysis.

There is limited evidence that states the education standards required for HITH RNs. Participants expressed a need to be self-led in determining suitable education to enhance practice. An onus on the HITH RN was evident in the position descriptions where the HITH RNs are responsible for team leadership and the provision of education, mentoring of junior staff, the provider of in-services, and the educator for the service. The role of staff mentor is not new to RNs who regularly undertake mentoring and teaching of nursing students and preceptorship positions (Birks et al., 2018a; 2018b). Baseline education requirements are outlined but not deemed essential with the need for greater definition and career planning. Education current is a self-led and self-determined process rather than a professional requirement for continuing professional development as a HITH RN with a specialisation career pathway.

Informal professional development can be attained through the HITH Society Australasia's annual scientific conference. This conference targets an interprofessional /interdisciplinary group working in HITH services. Other conferences may have interesting topics that maybe relevant to any RN. No explicit education exists for the HITH RN in postgraduate study other than generic courses in nursing, specific wound management, or chronic illness. The individual nurse education requirements are based on personal and professional judgement or workplace-specific requirements for education of HITH RNs rather than an identified career pathway. I identified that the need for a different level of clinical expertise and associated education to move from a generalist RN position to a HITH specialised RN. The participants in this research identified that a transfer of practice for RNs delivering acute hospital-level care directly in the community (patient's residence) is a vastly different setting where autonomy and clinical decision-making are at the fore, particularly when patient observations and alerts are received via technology (Irani et al, 2018; Levine et al., 2018, 2020, 2021; Strømme et al., 2020).

My analysis of the position descriptions identified the need for prior RN experience and a preference for a postgraduate qualification. There has not been a definitive determination as a prerequisite rather a desirable addition to the HITH RN PD. The participants expressed a desire for both experience and postgraduate education. This need for education and experience will bring about changes in clinical education, skill, knowledge, and career trajectories. The research noted that participants believed that their scope of practice does not have a tiered career structure toward an advanced practice or NP level. The lived experience of the 12 HITH RNs I interviewed indicates that patient care deviates from traditional patient nursing care in hospital beds to acute patient care delivery in the patients' residences. This is consistent with the literature (Burke et al., 2021; Levine et al., 2018, 2020, 2021; Montalto et al., 2020; Peter MacCallum Cancer Centre, 2021).

Ongoing professional education for patient safety and professional currency is required (NMBA, 2018). However, specific education relating to the specialisation is not outlined by the Hospital in the Home Society Australasia or at the individual state, territory, or service level. RN role function and scope in practice necessitates providing evidence-based nursing care within the abilities and skills of the nurses without stepping outside the scope of practice (Aroke, 2014; NMBA, 2020b). Nevertheless, embracing new ways of working could be beneficial provided that the safety of the

patient and nurse are uncompromised. There is a need to educate nurses regarding their scope of practice, their increased responsibility, and need for advanced critical thinking skills to improve safe clinical practice, and there is a need to prevent "blurring" of scope in practice expectations. A recommendation to develop an education framework for HITH RNs is outlined in Chapter 8.

The statements by participants appeared to be in line with many known nursing guidelines (NMBA 2018). Based on formalised education and career pathways, the clinical domains of practice have greater consistency with the National Nursing and Midwifery Standards for the RN (NMBA, 2020a). Roche et al. (2013) stated that there is international growth in advanced practice nursing (APN) roles. Roche's (2013) study identified position descriptions that appeared linked to industrial legislation and to a pay structure rather than skill, knowledge, and expertise. The study revealed that like the HITH RNs, there was variability in the level of practice both within and between the clinical nurse consultant (CNC) grades as well as significant differences in position description requirements.

## 7.4 Overarching theme 3: Responsiveness

***Responsiveness*** in care decisions was deemed important and reflective of diverse autonomous working environments that use timely and adaptable decision-making processes. One similarity that Australian HITH services have in common is they all provide acute care to adults and children at home (Page et al., 2018). The international literature shares a more streamlined service approach in HITH with a staffing skill mix of higher-level nurses having undertaken specialised training (Lee, Pickstone, et al., 2017; Lee & Titchener 2016). Participants in this research had more differing education levels, varying years of experience, and variability in position-description requirements. It was clear that the HITH RN sought greater knowledge, skills, and recognition of the work undertaken to be responsive to patients requiring acute care in the community. Without such recognition, the scope of practice for HITH RNs will not sustain the development of HITH services as an acute care speciality.

HITH RNs provide nursing care in the community that aims to be person-centred, timely and based on the premise of quality care and improving patient outcomes (Arendts et al., 2011; Barnard et al., 2016; Frohmader et al., 2018). The HITH service often operates within a multi-disciplinary team. Some teams have an RN lead, while others may be allied health or medically led (Kivic & Hines, 2020).

Information surrounding the patient's medical and social history guides the proposed plan of care within a multidisciplinary approach to medical treatment delivered through RN care to individuals in the community (Kivic & Hines, 2020).

My research demonstrates the inconsistencies in HITH RN position descriptions and the broadness in HITH role descriptions. Growth in the HITH RN role and function warrants clear and accurate position descriptions that set out roles and align with the standards of practice for the care provided when working in different environments. Recognition of the more advanced, complex care requirements, the leadership of teams, management of operational and fiscal resourcing, and base advanced practice education requirements is needed.

The position descriptions were inconsistent in role and function both through the participants individual interviews and the position description analysis. The interviews concluded that inconsistencies in HITH experience and expertise was noted with varying degrees of training apparent. What was clear in the interviews was the autonomous nature of the role and the professional responsibility that ensued. Many researchers have highlighted that autonomous role were not developing at the same pace in Australia (O'Baugh et al., 2007; NSW Health, 2011) as in the United Kingdom (UK), with the implementation of nurse consultants (advanced practice) in 1999 and modern matrons or service directors remain in many health sectors throughout the UK (Bent, 2004; Bufton, 2005; DoH, 1999). The ICN (2020) stated that:

> Advanced nursing practice guidelines aim to provide a clearer and more common understanding of the components of APN to key stakeholders, the public and other health care professionals. They assist countries in the development of policies, frameworks and strategies that will support APN initiatives around the globe.

Utilising the NMBA (2014, 2018) guidelines for Advanced Practice discussed in Chapter 2, the key elements of an advanced career framework (refer to Figure 7.1 above), could be mapped to the role of the HITH RN. The results of this research form the base for this initial work. The additional areas of the HITH RN role in the more complex care requirements, leadership domains, and additional education requirements in HITH services could be further defined with specification of career pathways. This approach would be consistent with the updated global strategic direction 2021–2025 for nurses and health professions (WHO, 2021a). The

participants' comments indicate that they perceive the HITH RN role as advanced nurses. Although nursing guidelines are available, it was evident that there is the need for clarity and definition in relation to the specific scope of the role in HITH practice settings.

My research highlighted the key components for the HITH RN in accountability and decision making that clearly aligned with NMBA competency standards more broadly. The authority in decision making did not extend further than the generic role and scope of the RN in practice in accordance with the NMBA competency standards (2020a). The need for a more specialised and advanced practice role and this requires greater consideration and alignment with more specialised knowledge, and decision-making practices.

The research revealed that transitioning from other forms of nursing practice to HITH RN positions is associated with being informed, responsive, independent and with the autonomy to make complex decisions. A standardised clinical education pathway to assist transition into a HITH RN role is not evident. The research outcomes showed wide interpretations about the current role of HITH RNs as patient-centric care provider, care coordinator, and care partner however one where self-led education was mentioned however not elaborated upon.

The interviews with HITH RNs identified the requirement to be responsive to changes in practice, increases in knowledge of disease processes, the potential for deterioration of the patient, and practicalities of professional safety while working independently in the home context. This resonates with advanced practice and the need for strong leadership (Vaartio-Rajalin & Fagerström, 2019). There is much to know and understand with a responsibility on critical thought, decision making and professional leadership in coordinating and delivering care (Gray et al., 2018a). At all times, the focus on optimal patient outcomes is essential. There is no support in a client's home when things go wrong, so it is critical that early detection, notification, and response to potential problems from the HITH RN occurs (Gray et al., 2018a; Gray et al, 2018b; Strømme et al., 2020). The capacity to know patient presentations and the required course of action is a direct responsibility of the HITH RN in a consultative manner with a patient's doctor (Gray et al., 2018a). The attributes of professionalism, knowledge, and responsiveness are highlighted as direct themes in my research.

The HITH RN role is complex. The participants described their role as an extension of the typical role of the RN, with increased complex decision making

occurring in the more autonomous setting of a patient's home. The HITH RN is the central link between health service, the doctor, allied health, and the patient and at times, the carer. It is these links that are important in keeping a patient safe and well at home (Gray et al, 2018a). The HITH RN provides the link between deterioration in care and the communication with the doctor through a process of assessment and clinical decision making (Vaartio-Rajalin & Fagerström, 2019). The participants in this research expressed a need to assess clients at an advanced level using interpretation and decisive thought processes in relation to collaborating with other healthcare professionals including at which point doctor notification was required Asmirajanti et al., 2019; Gardner et al., 2014; Navacchi & Lockwood, 2020).

Employers and service providers expect nurses to be the responsive, requisite personnel in healthcare delivery, to undertake a vital role in the provision and coordination of care, with an aim to reduce and prevent adverse events, while optimising productivity and patient outcomes. These expectations are aligned with the Australian Commission for Safety and Quality in Health Care (ACSQHC) and best evidence and clinical standards for organisational quality and safety (ACSQHC, 2019). There is a need for nurses to measure, check, and report on the appropriateness and effectiveness of the acute healthcare provided at home to inform healthcare quality improvements (Asmirajanti et al., 2019; Gardner et al., 2014; Navacchi & Lockwood, 2020). Before the pandemic HITH RNs have proved crucial in their capacity to provide care at home. Their capability to undertake care at home during the pandemic has seen HITH services and their RNs flourish. As new technologies and equipment have become available it is likely the HITH RNs and HITH services will remain highly engaged in delivering care at home.

## 7.5 Overview of findings

The results indicate a mismatch between scope of practice, role function and the emerging themes in the position descriptions derived both from the HITH RN interviews and the content analysis completed in this research. The outcomes suggest a dissonance between scope of practice in position descriptions and the emerging themes from the experience of HITH RN participants, however, there are some commonalities within the known literature. The outcomes secondly suggest a dissonance between position description outlines and HITH RN experience. Currently, 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, ideology, and educational status.

The interviews revealed a divergence in career pathways to become a HITH RN as well as a need for education pathways from novice to expert in the HITH RN role. The findings impact RNs regardless of their role function and move towards a dedicated career pathway with levels of education, competency, and confidence that share the caring philosophy in nursing. Watson's caring philosophy underpins the research and is integrated in the themes that emerged. The assumption of caring overarches the research findings. This caring belief extends across the HITH disparities. The disparities include role functions and education levels that should lead to autonomy, respect, and acknowledgement of critical thought in clinical decision making in practice. The outcomes from my research align with Watson's caring philosophy and the need for nursing to be responsive and educated in this practice domain. Governance structures are a way of determining 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 reasoning is shared from the experiences of the HITH RN participants.

The evidence for the three major emerging themes of professionalism, knowledge, and responsiveness is overwhelming. Most participants discussed the functions associated with their role when responding to their scope of practice. Their role and how they work within their role when delivering patient care differed between participants. In contrast with other countries, there are gaps in the current literature regarding the scope of practice for HITH RNs in Australia compared with similar health care systems. Considerations are needed in the Australian healthcare context that offers the HITH RN clarity in scope, role, and function consistent with the findings of the research and the international literature.

## 7.6 Chapter Summary

It is essential that all levels of RNs are provided with opportunities to practise to their full capability, while remaining within their scope of practice. RNs must also explore opportunities to broaden their knowledge, skills, and overall potential in care

provision and management. RNs need to take some control of their education and practise enhancement 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 structures that support the professional nurse in practice. The final chapter presents my thesis conclusions and recommendations.

# CHAPTER 8: CONCLUSIONS

## 8.1 Thesis summary

Using an interpretative phenomenological approach, in this research I explored RNs lived experiences of their role and role function in a Hospital in the Home (HITH) service in Australia. Data from the participant demographics and the critical review of the position descriptions were added to the data gained from the semi-structured interviews. The use of phenomenology as a methodology encouraged deep reflective interviews rather than quantity in the numbers of interviews.

Specifically, in this research I explored the role and the functions in two ways:

1. A qualitative phenomenological approach in which I used semi-structured interviews to gain different participant perspectives to understand HITH RNs' roles and functions.
2. A critical evaluation of participant position descriptions in which I identified key elements and differences in key position indicators.

Gadamer's interpretive phenomenological approach and a thematic analysis based on the Braun and Clarke (2006) framework provided a way for me to analyse and interpret the data. A content analysis of the position descriptions provided more depth to the analysis and shared commonalities and disparities between practice and role function.

The research was underpinned by outlining the background, the aims, and the significance of the study (Chapter 1); a narrative literature review (Chapter 2); an outline of traditional qualitative methods (Chapter 3); and the research design (Chapter 4). The findings presented in Chapter 5 and Chapter 6 are aligned with relevant literature to make explicit the contributions of this study. The research has revealed the factors that affect the HITH RN role and function in practice in Chapter 7. The interconnectedness of the position descriptions and the experiences gained from the RN interviews reveals the linkages, commonalities, and disconnections between the two areas of analysis that have been presented through the themes that emerged. In the analysis of interview transcripts, three overarching themes emerged: **Professionalism, Knowledge, and Responsiveness** along with associated subthemes. These overarching themes also linked with themes in the position descriptions, where the concepts of **care, expert decision maker, and leader** were apparent. Position

descriptions were analysed in a semantic content analysis format. Analysis of the PDs highlighted a dissonance between documented role functions and the interpretive analysis.

This research adds new knowledge for the nursing profession that highlights areas of commonality with the generic scope of practice for RNs regardless of speciality. The research showed that the participants want a more extensive role, than what is allowed within their current PDs. **HITH RNs seek greater knowledge, education, and the professional traits of autonomy, accountability, and professional judgement in clinical decision making to form the base of a future extended role**. Overall, the phenomenological study revealed a dissonance among the participants regarding their perceptions of the scope of practice of RNs and what was outlined in the position descriptors. This lack of harmony caused a note of frustration that could be identified in the participants' nuances, phrases, and expressions when sharing their perceptions about their scope of practice.

Taken as a whole, the participants were **ambiguous concerning their understanding of the HITH RN role and role function in practice**. Areas of professionalism, knowledge, and responsiveness arose in the analysis as underpinning elements in the HITH RN role. The significance of the HITH RN scope in practice, perceptions of understanding their professionalism within their current role, the processes, and accountabilities have been dismantled, considered, and discussed.

## 8.2 Strengths of this study

The strengths of the study align with the principles and practices of the hermeneutic phenomenological research method and data analysis. At the time of the interviews, data collection, and analysis, I was a clinical nurse employed in a HITH service. Therefore, the participants' comments resonated with my own experiences as I could hear, at times, their words match with my own thoughts, feelings, and perceptions. Journaling was used as part of the research process to ensure a level of authenticity in the process. Acknowledging the inclusion of the researcher in the topic in hermeneutic phenomenology has a way of bringing understanding to the topic. This personal awareness and understanding of the topic are viewed as a strength in the phenomenological research presented. Maintaining transparency was important. Therefore, I made notes and diagrams to produce an in-depth enquiry that would resolve any inconsistencies.

The size of the study is reflective of phenomenological study samples and reflects HITH RNs in all Australian states and territories, with two or more participants coming from larger geographical locations that have both regional and metropolitan services. The selection of HITH RNs was achieved through purposeful sampling and participant criterion, thus ensuring that all participants met a baseline RN standard, and met the purposive sampling criterion, before inclusion in the research. Therefore, there was the wealth of knowledge gained from the experiences shared. The strength of the participants was in the levels of experience and the varied geographical locations of the HITH RN roles that were included. I undertook the research, data analysis, and presentation of findings to ensure the purity of the HITH RNs' perceptions, their anonymity and confidentiality, and protection of the participants' personal and professional interests.

## 8.3 Limitations of the study

While considering the study's outcomes, it is of value to present its limitations. It is difficult to assume generalisability from this study. HITH is a newer service in comparison to medical or surgical specialties and as such it is likely that the number of medical or surgical nurses exceed those employed in HITH services. This limits participants available for research in this space to know or understand the topic in question through professional knowledge, breadth, and clinical competence as a HITH RN.

It was disappointing that the male-to-female ratio was lower than AHPRA's national RNs statistics. There was only one male (8.33%) to eleven (91.67%) female participants, therefore, not quite the national male to female ratio in nursing, which is 11% male to 89% female. A greater representation of male HITH RNs would have been preferred. All attempts to attract male participants proved unsuccessful. It was not known what the ratio of HITH RNs are male so true reflection is not able to be ascertained.

No participants were NPs, and this may have had an impact on the results arising in the interviews. However, the specific numbers of HITH NPs in Australia remains low and perhaps warrants a further research project to ascertain the strength of the role in the HITH service. The HITH society were asked to resend email requests specifically targeting NPs, nevertheless, none came forward for inclusion. Finally, limitations existed in the ability for the researcher to undertake face to face interviews

with participants. Interviews via video technology was fraught with network issues therefore, interrupting the flow of the researchers questioning and the participants answers. This approach did require patience from both the researcher and the participants however did not prevent the collection of data and member checking ensured that any addition, removal, or alteration in an individual's responses could occur prior to data analysis.

## 8.4 Implications

The implications arising from this research are timely. The ongoing need for acute care in the community because of the pandemic is clear. It is an opportune time for RNs to explore their role and role functions in HITH practice settings. The implication from this study **provides more insight into the role and function of the HITH RN in the Australian healthcare context**. This context and the associated findings enable the HITH RN to further advance the role, acknowledge and determine educational requirements, and develop position descriptions reflective of the role, through opening discussions that lead to policy development, scaffolded education, and career pathways. It is recommended that the HITH-IG members lobby Nursing alliances such as ACN, ANMF, QNMU to facilitate access to local and federal government policy advisors and regulatory bodies to drive change in the identified scope of HITH RNs in practice. It is recommended that HITH RNs scope of practice be aligned with a level of competence, experience, skill, and knowledge of a semi-autonomous practitioner not dissimilar to allied health professionals.

The findings sought greater clarity and understanding of the HITH RN role and their professional responsibility in practice. The decision-making process of the HITH RN while practising in an autonomous capacity requires the decisions at point-of-care in a timely and appropriate manner. It is this decision-making that links with the themes arising in the research of professionalism, knowledge, and responsiveness. It is timely to **consider education pathways, advanced practice parameters, and leadership capacity in the role**. It is timely to discuss changes that are required to support the HITH RN in practice in a role function that is reflective of the semi-autonomous nature required in the position. The HITH Society Australasia and the HITH-IG members will gather support from HITH Allied Health professionals and the medical staff members to enable greater reach regarding HITH Nursing potential. The plan to

formulate a HITH career pathway with a supported education plan will be challenging work however initial work has begun. The team have established a working party prior to the final thesis submission. It is recommended that the extension to the research involve a translation in practice implementation and evaluation of a revised position description in practice inclusive of the key elements arising from this research.

Nevertheless, HITH RNs need to understand the positive attributes of their roles for the nursing profession and future nursing roles in Australia. Staff and patient safety are at risk if the role and role function do not gain a more defined context. The greater the discrepancies in role orientation and position description clarity, the greater the risk of error in practice. Sufficient implications were found in this qualitative study to **recommend discussions surrounding the influences and complexities faced by the HITH RN in everyday practice**.

My research and that conducted by Francis et al. (2013), NCSBN (2012), and Pearson (2009) illuminated the dichotomy in practice that exists for RNs who are engaged in similar areas of healthcare delivery. These researchers noted that dichotomy creates confusion and challenges in practice that are better avoided. **Adaptation and adjustment of new position titles and role functions is needed to meet the demands of growing healthcare trends** and the shift to greater utilisation of the HITH RN. Inconsistencies and a myriad of titles added layers of confusion to clients and to the nursing professional working in the HITH service.

The implications for HITH RNs provided insight into the continuing professional development requirements regarding role relevance. Additionally, the individual understanding of RN scope of practice is at the forefront of every decision-making process. A further implication of working below or outside the scope of practice is the ramifications of disciplinary actions and potential legal consequences. **Clarity in role function** provides the HITH RN with the capacity to know boundaries and to engage in suitable patient outcomes at a more needed and advanced level. The ability to answer point-of-care questions from the HITH RN alleviates patient anxiety and RN workload.

## 8.5 Recommendations

The discussions arising from the research findings identified several factors that influence the role and role function of the HITH RN. One factor is the capacity of HITH RNs to engage in conversations with their employers, their colleagues, and

national nursing bodies to gain greater consistency in the content and focus of position descriptions. The interview and the position description analysis highlights inconsistencies in role and role function. Future considerations for position descriptions need investigating, including working closely with the NMBA and Australian HITH Society to align HITH nursing position descriptors (key skill set and education level) with the guidelines supporting practice.

This study highlights the challenges, motivators, and inconsistencies that appear in HITH RN standards of practice and everyday practice parameters. This study revealed considerable overlap in role functions and a noticeable lack of leadership in differing position descriptors. I would **recommend discussion and action with local and national bodies to attain consistency in position-descriptions and to enable clarity in scope and function of the HITH RN role**. **It is recommended that the HITH-IG members lobby Nursing alliances such as ACN, ANMF, QNMU to facilitate access to local and federal government policy advisors and regulatory bodies to drive change in the identified scope of HITH RNs in practice.** This has implications for the development of policy that has the potential to further advance the role, reward achievement, and develop consistency in role clarity and consolidation in position descriptions in health services.

With COVID-19 and the expanded use of the HITH RN to keep patients at home, it is necessary to consider timely, efficient, and cost-effective principles of care. Enabling an advanced scope of practice increases nursing satisfaction, the quality of consumer outcomes, and service efficiency. This consideration requires more consultation and discussion and inclusion of recognised international led practices in the conversation. Recommendations that include open, transparent discussion on HITH advanced practice roles and action from a national perspective would be advantageous. The recommendations include development of services that focus on improving transition to HITH RN practice, where further discussion, and evaluation methods are warranted, and a career structure determined. Maximising HITH RN scope of practice could provide a starting point for education specifically addressing the challenges and solutions for a HITH RN specialised approach. For viable changes in HITH education pathways, the pathways will need mandating and the support of the health system, the regulatory body (NMBA) and professional nursing unions and associations. **It is recommended that HITH RNs scope of practice be aligned with**

**a level of competence, experience, skill, and knowledge of a semi-autonomous practitioner not dissimilar to allied health professionals**.

The HITH RNs spoke of the importance of communication and interdisciplinary collaboration in the interests of patient care. There is a **need to review the medically dominated governance models**, with the known guise that shortages in the medical workforce exists and that with increased educational requirements an advanced scope of practice could be considered. Medical 'gatekeeping' is difficult to address. It is recommended that further work be undertaken in this area to actively engage with political advisors, medical, nursing, and allied health professionals with the intent to address skills shortages and in turn, increase the role and scope of the HITH RN in practice.

A nursing led, combined interdisciplinary model of governance or at the very least a joint model of care delivery that acknowledges and supports the acute care at home service for the HITH RN is needed. A full table of recommendations has been presented. Table 8.1 contains recommendations for consideration with descriptor, rationale, and desired outcome.

Table 8.1

*Recommendations arising from the research.*

| Recommendation | Descriptor | Rationale | Desired outcome |
|---|---|---|---|
| Formation of a HITH Interest Group HITH RNs<br><br>Include collaborative partnerships. | Invitation to all HITH services in Australia for representation on a committee to encourage advancement of role and professional concerns of HITH RNs<br><br>Includes key members of the HITH Society Australasia, **nursing regulatory bodies, unions and other professional associations to lobby state and federal health departments** ensuring consistency in role & role function projects | A consolidated approach enables consistency in practice and care provision.<br><br>HITH will benefit from a skilled and knowledgeable workforce.<br><br>A consolidated approach allowing the professional voice to be heard; linked with policy directions national nursing bodies | Increased exposure of HITH RNs and the relevant practice issues that require attention.<br><br>Greater collaboration opportunities<br>Alignment with national health strategies and workforce direction projects |
| Review current inconsistencies in position descriptions through committee and professional body | Development of consistent approaches to the role and role function of HITH services | Assurance that RN positions align with national competency standards and scope of practice | Enhances RN autonomy in practice.<br><br>Provides clarity of understanding of the role |

| | | | |
|---|---|---|---|
| engagement, such as NMBA, ACN, ANMF, QNMU, and other professional associations | | | and function of the HITH RN |
| Increase scope of practice orientation and nurse-led HITH education pathways | RNs working in HITH services are required to be professionally responsible and self-led in day-to-day education needs and self-care | .<br>The RN needs to consider professional and personal practice responsibilities.<br><br>Personal parameters inclusive of self-education plans. Seeking PDP required (day-to-day) and being responsive to attend. | Increase RN skill, knowledge, and capability.<br><br>Improve patient outcomes.<br>Improve staff satisfiers.<br><br>Initiate a pathway for lifelong learning and career planning to be instigated |
| Open pathways for transparent discussion on advanced practice roles for HITH RNs with all interested parties. | Open conversations to include a 'round table' workshop to define advanced practice in the realms of HITH nursing | Provide nursing leadership principles for AP discussions. AP in semi-autonomous HITH RN roles increases accountability, responsibility, and responsiveness to patient care. Patient outcomes and staff satisfaction improve. | Determine reasonable areas of practice and decision-making that would be suitable for inclusion in an 'advanced practice' scope for HITH RNs.<br>Determine baseline education requirements to support the AP scope. |
| **A defined and mandated education scaffold is required.** | **With nursing regulatory bodies, unions and other professional associations** develop education and career pathways consistent with the identified role and function **that are mandated** Education providers should consider AP education pathways for HITH RNs. The inclusion of clinical supervision requires consideration in education models | Education increases knowledge and patient care proficiency.<br><br>Education increases competence and confidence of nurses in practice | Increased confident and competent advanced practice HITH RNs |

There is growing recognition that successful integration of roles requires careful planning and attention with organisational support for HITH services (RCN, 2018). A HITH interest group (HITH-IG) has been created following discussion between me and the HITH board of directors to take the recommendations from this study forward. The HITH-IG will assist to define the key skill set and attributes required for HITH RNs with a clear purpose and objectives for HITH advanced nursing practice roles with consideration of multi-disciplinary teams, and how these roles will be integrated into existing services. Once completed the defined skill set will

form the basis of future discussions on how HITH Nursing teams use AP roles in their locality.

The participants described inconsistent experiences regarding their clinical knowledge and education level. This raised questions about professional preparedness for the role. The formation of nursing development strategies that focus learning with HITH RNs through preferred courses or defined educational opportunities is needed. HITH RNs and tertiary education facilities need to explore, consider, and map postgraduate education opportunities. An Australia-wide accredited online postgraduate certificate or diploma would provide the same opportunities to extend knowledge, practice, and decision-making capacity of HITH RNs, giving consistency to an education pathway and career structure. This recommendation requires further consideration and discussion with a tertiary education provider.

In this thesis, I have presented the outcomes and recommended strategies linked with national and international literature to share recommendations for improvement and alignment with Australian RN scope of practice requirements. The research shares the need to consider areas of advanced practice. I have emphasised that advanced practice includes influencing policy, global health, and a leadership role in today's interprofessional teams. Additionally, educational requirements for advanced RN practice are presented. Establishing frameworks for education and career progression have been suggested.

The role and role function of HITH RNs in Australia are multifaceted and complex, encompassing splintered terminology and role expectations in providing patient care. My recommendation that provisions of **consolidating broad position descriptions to one of advanced practitioners consistent with the results of this research would enable the roles and responsibilities of the HITH RN to improve clinical outcomes for patients and professional satisfaction**. My study's exploration identified challenges that exist in the day-to-day role and function of the HITH RNs. The outcomes with respect to a patient's welfare, guide and enhance the HITH RNs capacity in the Australian nursing context. There are implications for policy development, position descriptions and especially **the need to build an education pathway to support HITH RN development are apparent**. The nursing profession, current health systems and the users of the HITH health service would benefit from **clarity surrounding the terminology used to define position and role titles regarding the scope of practice for HITH RNs**. The Australian nursing profession

**would benefit from using a redefined skills framework** to clarify the position and role titles of RNs to meet contemporaneous practice and for the future. The research has highlighted the areas of commonality, and disparity. The need for a more advanced practice role is needed to meet contemporary health care demands needed from acute care services at home. Redefining the principles of the HITH RN role at this advanced level has implications for policy and practice. The advanced care practice rewards achievement and develops role clarity that enables the provision of acute care in the community through a collaborative, timely, efficient, and effective approach.

## 8.6 Future research

Future research is anticipated that seeks to implement the outcomes of this research into practice. Implementation of the research recommendations will offer a start to delivering a consistent approach to HITH PDs and potential pathways to progression of the role in a more autonomous manner. Consistency is a step toward the autonomous practice role that the HITH RN outlined in the interviews. This would help to resolve the current inconsistencies in key skills, skill levels, and educational levels that exist in the role and role function of HITH RNs that were identified in this research.

With similar benefits, HITH services could review Benner's (2001) novice to expert model specifically to the HITH RN role development. Studies that enable more detail and depth to add to this new knowledge would be worthy specifically to continue evidence for advanced practice roles. There is a potential to adapt the Australian Advanced Practice Nursing Self-Appraisal (***ADVANCE***) Tool to gain the depth and breadth in understanding HITH RNs' scope of practice, thus clarifying what roles and functions are essential at each nursing level from RN to clinical nurse and clinical nurse consultant. This could strengthen the research outcomes and provide supportive datasets to add to career development pathways and advanced practice parameters.

## 8.7 The researcher's learning curve

There are many things that I thought I knew about HITH nursing. However, in hindsight I knew only a small portion of what I needed to know. What has transpired is that my passion for nursing remains undiminished, whether relating to gaining more

nursing positions, better education, or creating more advance-practice nurses along a career and education trajectory.

This study has demonstrated the lack of leadership in position descriptions, where leadership should be at the forefront of every decision made, and the lack of clarity between nursing levels, from RN Grades 6–7. The study demonstrated the passion and commitment to direct patient-focussed care that was held by the participants, regardless of the number of patients, their varying diagnoses, complexities, and co-morbidities, within their home environments. There is much to learn from the voice of participants and timely learning that listening and fully engaging in what is really being said can contribute to improving nursing practice. This practice aligned with Watson's caring philosophy and the inherent need to improve patient outcomes in a manner that offers the nursing role of care, consideration, and responsibility.

## 8.8 Conclusion

This thesis presents the experience as expressed and interpreted while practicing in the role of HITH RNs. The purpose of this research was to understand how Australian HITH RNs perceived their role and function in practice. Using an interpretative phenomenological approach, I explored RNs' lived experiences of their role function and scope. Participant demographics and a critical review of the position descriptions of the participants added to the data collected from the semi-structured in-depth interviews. A thematic analysis process provided a way to analyse and interpret the data. The outcomes and recommended strategies that emerged from the data link with the literature. The thesis shares the conclusions reached by me in relation to the literature narrative that had commonalities linking to the contributions in relation of the participants and their PDs. The participants lived experience of the perceptions regarding their scope was extremely challenging. Three fundamental themes emerged including the need for nursing professionalism that involves accountability and responsibility; leading and working within the rules and regulations set by the NMBA, and the participants employer. The second theme, knowledge is underpinned by research and innovation, education meaning life-long learning, which includes mentorship and guidance. Lastly responsiveness to patient needs, at times of requiring acute care at home and especially in times of crisis, (COVID-19 pandemic). The

responsiveness of the RN was clear and the authorisation to make autonomous decisions in practice was clearly outlined as an area where improvement is needed.

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# APPENDICES

## Appendix A

### Specialisation Examples of Hospital in the Home Programs

- Neonates - Mater at Home. https://www.mater.org.au/health/services/mater-at-home
- Paediatrics - Royal Melbourne Children's Hospital
- Spinal units- Madaris, L. L., Onyebueke, M., Liebman, J., & Martin, A. (2016). SCI Hospital in Home Program: Bringing hospital care home for veterans with spinal cord injury. *Nursing Administration Quarterly*, *40*(2), 109–114. https://doi.org/10.1097/NAQ.0000000000000150
- Intensive care at home –https://intensivecareathome.com/mechanical-home-ventilation-guidelines/
- The Oncology Hospital at Home - Nathan R. Handley and Justin E. Bekelman. (2019). *Journal of Clinical Oncology 37*(6), 448-452
- Oncology at Home services available from -The Peter Mac Centre, Melbourne
- Medibank. (2021). Medibank's Chemotherapy at Home trial. https://www.medibank.com.au/health-support/health-services/medibank-at-home/chemotherapy/
- Palliative care at home- https://www.health.gov.au/initiatives-and-programs/greater-choice-for-at-home-palliative-care-measure
- Palliative care in the bush - https://palliativecare.org.au/story/palliative-matters-palliative-care-at-home-in-the-bush/

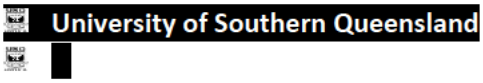
# Appendix B

## Watsons Ten Caritas Process

| Caritive Factors | Caritas Process | HITH Nursing Process |
|---|---|---|
| 1. "The formation of a humanistic-altruistic system of values" | "Practice of loving-kindness and equanimity within the context of caring consciousness" | Inclusion of all regardless of place in society, creed, sexual orientation, culture |
| 2. "The instillation of faith-hope" | "Being authentically present and enabling and sustaining the deep belief system and subjective life-world of self and one being cared for" | Giving and receiving information – a two-way flow between patient and family with the healthcare system. |
| 3. "The cultivation of sensitivity to one's self and to others" | "Cultivation of one's own spiritual practices and transpersonal self, going beyond the ego self" | Ensuring own physical and mental health well-being are in order, to ensure sufficient self-resources to give to others |
| 4. "Development of a helping-trust relationship" became "development of a helping-trusting, human caring relation" (in 2004 Watson website) | "Developing and sustaining a helping trusting authentic caring relationship" | Not answering personal calls when with the patient, giving them your full attention. |
| 5. "The promotion and acceptance of the expression of positive and negative feelings" | "Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit and self and the one-being-cared for" | Communication, listening and hearing what the patient has to say. |
| 6. "The systematic use of the scientific problem-solving method for decision-making" became "systematic use of a creative problem solving caring process" | "Creative use of self and all ways of knowing as part of the caring process; to engage in the artistry of caring-healing practices" | Ensuring decisions made include patient, family and carers and ensuring the decision is made to improve the patients' health |
| 7. "The promotion of transpersonal teaching-learning" | "Engaging in genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within others' frame of reference" | Include the patient in aspects of care they can do for themselves and being aware of the circumstances of the patient. |
| 8. "The provision of supportive, protective, and (or) corrective mental, physical, societal, and spiritual environment" | "Creating healing environment at all levels (physical as well as nonphysical, subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated)" | HITH Registered Nurses must employ holistic and culturally sensitive evidence-based theory and practice in the assessment, implementation, and evaluation of the nursing process |
| 9. "The assistance with gratification of human needs" | "Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind body spirit, wholeness, and unity of being in all aspects of care" | HITH Registered Nurses will always consider the wellbeing of the patient first, and foremost. The nurse must act as an advocate in all areas that affect the patient. |
| 10. "The allowance for existential-phenomenological forces" became "allowance for existential-phenomenological spiritual forces" (in 2004 Watson website) | "Opening and attending to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one-being-cared for" | HITH Registered Nurses must always practice with empathy and caring are at the heart of the practice. |

# Appendix C

## Invitation to Participate




Dear Colleague,

AN INVITATION to TAKE PART IN A PROJECT

My name is Angela, and I am employed as a clinical nurse within a *Hospital in the Home* program, in Queensland Australia. I have an interest in undertaking a project to explore the scope of practice and role function of Registered Nurses who are currently employed in a similar setting.

The reason I am writing is to ask you if you would be willing to have an interview with me about your experiences as a registered nurse working in HITH. I would like to hear about your ideas and views regarding your role and function including scope of practice and your experience as a HITH RN.

This interview should take approximately 45-60 minutes and it would be at a mutually agreed time. We could get together via phone or Skype or meet face-to-face if it is possible. We can arrange to meet at a mutually agreed time and location.

The aim of this project is to:

- Provide insight into Registered Nurses experiences of their Scope of Practice and your experience as a HITH RN.
- Create awareness surrounding the Scope of Practice of Registered Nurses in HITH services throughout Australia.
- Develop an understanding of the role and function of the HITH RN in Australia

Anything you say to me will be strictly confidential and no one other than myself will know we have had this discussion. Your identity and personal details will never be revealed to anyone.

I have also attached a poster that I ask you to place where it can be easily read, which invites your Registered Nurse colleagues who not HITH Society members to participate in this study. I thank you in anticipation of your assistance. If you are interested in speaking to with me or would like more information, I have included my contact details below so that you can let me know that you might be willing to speak to me about this topic. I hope you will consider chatting to me and I look forward to hearing from you.

Kind regards

For more information contact: Angela Ellis

# Appendix D

## Invitation to Participate Poster

AUSTRALIA [redacted]

AN INVITATION to TAKE PART IN A RESEARCH PROJECT?
The purpose of this project is to explore the experiences of the role, function, and scope of practice for Registered Nurse working in HITH services through qualitative research.
The aim of this project is to:

- Provide insight into Registered Nurses experiences of their Scope of Practice.
- Create awareness surrounding the Scope of Practice of Registered Nurses in HITH throughout Australia.

You are being asked to voluntary participate in a 45–60-minute interview about your experiences of Registered Nurse role, function, and scope of practice.

The interview can occur via  , teleconference, Skype  , or at a mutually agreed time and place to maintain your confidentiality. All your personal details will be de-identified. Nothing you say will be identifiable or be repeated to anyone else.

Please do not hesitate to ask any  about the project either before participating or during the time that you are participating. I would be happy to share the findings with you after the project is completed. Your name, however, will not be associated with the project findings.
If you are interested in speaking to with me or would like more information, I have included my contact details below so that you can let me know that you might be willing to speak to me about this topic.
I hope you will consider chatting to me and I look forward to hearing from you.
For more information contact:
Angela Ellis, [redacted]

# Appendix E

## Participant Information Sheet

[redacted] University of Southern Queensland

**Project Details**

| | |
|---|---|
| Title of Project: | The lived experience of Hospital in the Home Registered Nurses: A phenomenological study into their Scope of Practice. |
| Human Research Ethics Approval Number: | H15REA113 |

**Research Team Contact Details**


| Principal Investigator Details | Supervisor Details |
|---|---|
| Mrs. Angela Ellis | Associate Professor Jennifer Kelly |
| Email [redacted] | Email: [redacted] |
| Telephone: N/A | Telephone: [redacted] |
| Mobile: [redacted] | Mobile: N/A |


**Description**

This project is being undertaken as part of a PhD.

The purpose of this project is to explore your description of your experiences of the Scope of Practice as a Registered Nurse through a qualitative research method. This includes:

- What are the sources of this information and how do the perceptions of Scope of Practice manifest itself in the everyday lived experience of Registered Nurses?
- What traits enable and motivate Registered Nurses (RN) to extend their Scope of Practice?
- What, if anything, are identified as barriers to extending the Scope of Practice of Registered Nurses in HITH services across Australia?
- Examine, explore, and define the role function and Scope of Practice of Registered Nurses employed in a Hospital in the Home services across Australia.

The aims of the project are to:

- Outline current literature on the Scope of Practice for Registered Nurses.
- Provide insight into Registered Nurse understanding of the Scope of Practice of Registered Nurses.
- Create awareness of the impact on Scope of Practice of Registered Nurses beyond current knowledge of the researcher and literature currently available.

The research team requests your assistance because only you as a Registered Nurse can describe your experience of the Scope of Practice of Registered Nurses when employed within an Australian Hospital in the Home program.

**Participation**

Your participation will involve a discussion that will take approximately 45-60 minutes of your time. The interview can be undertaken by teleconference, Skype session or at a mutually agreed location, and at a date and time that is convenient to you. Questions will include:

- How would you explain the role and function, scope of practice of HITH Registered Nurses?
- Can you describe your role and scope of practice challenges and enablers as a HITH RN in your current workplace?

The interview will be audio recorded.
Your participation in this project is completely voluntary and you are not obliged to participate. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected from you be destroyed, up to the point where data analysis has begun as individual responses may not be extractable.
Your decision whether you take part, do not take part, or to take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland, your employer, HITH Society Australasia or the researcher.
Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected about you be destroyed. If you do wish to withdraw from this project or withdraw data collected about you, please contact the Research Team (contact details at the top of this form).
Your decision whether you take part, do not take part, or to take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland, your employer, HITH Society Australasia, or the researcher.

**Expected Benefits**

It is expected that this project will not directly benefit you. However, it will lead to a greater understanding of the Scope of Practice of Registered Nurses working in Hospital in the Home.

**Risks**

As this research involves qualitative interviews there exists a time imposition for participants. It is expected that each interview will be for a duration of approximately 45mins to 60mins. Time imposition is perceived as a minimal risk.
Participation in an interview many present a social risk should the researcher be known personally and/ or professionally to the participants in Queensland. In the instance where a Registered Nurse knows the researcher, voluntary participation will be confirmed prior to the interview commencing. There are no other foreseeable risks associated with this research.
Regarding the time imposition, the researcher will remain flexible with availability to ensure scheduled interviews do not impact on the participant's day or their workplace. Where possible the interviews will be outside of work hours, or if not possible, the interviews will be at a mutually agreed time between the participant and their manager.
Participants interacting with the researcher may feel they are at social risk if they know the researcher personally and/or professionally as above, voluntary participation will be re-confirmed prior to the commencement of an interview. Additionally, the researcher will be mindful of the participants concerns and will reassure participants all information gathered is private and confidential and de-identified using a pseudonym.

**Privacy and Confidentiality**

All comments and responses will be treated confidentially unless required by law.

- You will have the opportunity to verify your comments and responses prior to final inclusion.
- The audio recording and written transcripts will be destroyed after five years as per the standard Human Research Ethics requirements.
- Audio recording will be stored securely on a password-protected computer.
- Only the researcher will have access to raw data.

- It is possible to participate in the project without being recorded; however, audio recording will ensure significant information is not omitted that could be beneficial to this project.
- Any data collected as a part of this project will be stored securely as per University of Southern Queensland

**Questions or Further Information about the Project**

I would like to ask you to sign a written consent form (enclosed) to confirm you agree to participate in this project. Please return your signed consent form via email to the Researcher prior to participating in your interview.

Please refer to the Research Team Contact Details at the top of the form to have any questions answered or to request further information about this project. If you have any concerns or complaints about the ethical conduct of the project, you may contact the University of Southern Queensland

**Concerns or Complaints Regarding the Conduct of the Project**

Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au. The Ethics Coordinator is not Queensland's Research Data Management policy. Thank you for taking the time to help with this research project.

Please keep this sheet for your information.

# Appendix F

## Participant Consent Form

### Consent Form for USQ Research Project Interview

| Project Details | |
|---|---|
| Title of Project: | The lived experience of Hospital in the Home Registered Nurses: A phenomenological study into their Scope of Practice. |
| Human Research Ethics Approval Number: | H15REA113 |

**Research Team Contact Details**


| Principal Investigator Details | Other Investigator/Supervisor Details |
|---|---|
| Mrs Angela Ellis | Associate Professor Jennifer Kelly |
| Email: [redacted] | Email: [redacted] |
| Telephone: N/A | Telephone: [redacted] |
| Mobile: [redacted] | Mobile: [redacted] |


**Statement of Consent**

**By signing below, you are indicating that you:**

- Have read and understood the information document regarding this project.
- Have had any questions answered to your satisfaction.
- Understand that if you have any additional questions, you can contact the research team.
- Understand that the interview will be audio recorded.
- Understand that I will be provided with a copy of the transcript of the interview for my perusal and endorsement prior to inclusion of this data in the project.
- Understand that you are free to withdraw at any time, without comment or penalty.
- Understand that you can contact the University of Southern Queensland Ethics Coordinator on (07) 4631 2690 or email ethics@usq.edu.au if you do have any concern or complaint about the ethical conduct of this project.
- Are over 18 years of age.
- Agree to participate in the project.

| | |
|---|---|
| Participant Name | |
| Participant Signature | |
| Date | |

**Please return this sheet to a Research Team member prior to undertaking the interview.**

# Appendix G

## Participants Demographic Survey

**This questionnaire has been designed to gain basic background information on all participants. It will be used to enhance the data collected from your interview. Please complete and return with your signed consent form.**

**Q1. What is your gender?**

☐ Male$_1$
☐ Female$_0$
☐ I would rather not say

**Q2. What is your age?**

☐ 25-35 years old$_2$
☐ 36-45 years old$_3$
☐ 46-55 years old$_4$
☐ 56-65 years old$_5$
☐ I would rather not say

**Q3. How would you classify yourself?**

☐ Australian (white)$_U$
☐ Australian - Indigenous
☐ Asian / Pacific Islander
☐ Other ……
☐ I would rather not say

**Q4. Which of the following best describes the area you work in?**

☐ Rural
☐ Regional
☐ Metropolitan
☐ I would rather not say

**Q5. How many years have you been employed in Hospital in the Home**

---

**Q6. What qualifications have you obtained / completed?**

☐ High school graduate, or
☐ Hospital certificate
☐ Diploma or the equivalent
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate degree
☐ Other
☐ I would rather not say

**Q7. Are you currently studying?**

☐ YES
☐ NO
☐ I would rather not say

**Q8. Are you currently…?**

☐ Employed for wages – Full time ☐ Part time ☐

☐ Self-employed
☐ Casual work- how many hours per week on average do you work_____
☐ Other
☐ I would rather not say

**Q9. What is your position title?**

☐ Registered Nurse- post grad RG
☐ Registered Nurse RN
☐ Clinical Nurse CN
☐ Clinical Nurse Specialist CS
☐ Advanced Nurse AN
☐ Clinical Nurse Consultant CC
☐ Nurse Practitioner NP
☐ Nurse Manager NUM
☐ Nurse Leader NL
☐ Clinical facilitator CF
☐ Other- please state_____
☐ I would rather not say

**Thank you for completing this questionnaire. Please return to the researcher prior to your interview via email [redacted] or post to 6 Sundance Place, Bargara, QLD 4670**
**Thank you for your continuing agreement to participate in my study.**

# Appendix H

## Human Ethics Approval USQ

**OFFICE OF RESEARCH**
Human Research Ethics Committee
PHONE +61 7 4631 2690| FAX +61 7 4631 5555
EMAIL ethics@usq.edu.au

UNIVERSITY OF SOUTHERN QUEENSLAND AUSTRALIA

5 June 2015

Mrs Angela Ellis
6 Sundance Place
BARGARA QLD 4670

Dear Angela

The USQ Human Research Ethics Committee has recently reviewed your responses to the conditions placed upon the ethical approval for the project outlined below. Your proposal is now deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* and full ethical approval has been granted.

| | |
|---|---|
| Approval No. | **H15REA113** |
| Project Title | The lived experience of hospital in the home registered nurses: A phenomenological study into their scope of practice |
| Approval date | 5 June 2015 |
| Expiry date | 5 June 2018 |
| HREC Decision | **Approved** |

The standard conditions of this approval are:

(a) conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC
(b) advise (email: ethics@usq.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project
(c) make submission for approval of amendments to the approved project before implementing such changes
(d) provide a 'progress report' for every year of approval
(e) provide a 'final report' when the project is complete
(f) advise in writing if the project has been discontinued.

For (c) to (e) forms are available on the USQ ethics website:
http://www.usq.edu.au/research/ethicsbio/human



Please note that failure to comply with the conditions of approval and the *National Statement (2007)* may result in withdrawal of approval for the project.

You may now commence your project. I wish you all the best for the conduct of the project.

[redacted]
**Annmaree Jackson**
Ethics Coordinator

Copies to: u1058068@umail.usq.edu.au

# Appendix I

## Human ethics extension approval

Dear Angela,

Project: H18REA113 (v1) - The lived experience of hospital in the home registered nurses: A phenomenological study into their scope of practice. I am pleased to inform you that your amendment has been approved. Your new expiry date will be 05 June 2019

If you have any questions, please contact the ethics office. (Human.ethics@usq.edu.au)

Kind Regards,
If you have any questions or concerns, please do not hesitate to contact the Ethics Office.

***Nikita Kok***
**Ethics Officer**
Office of Research I University of Southern Queensland
Toowoomba I Queensland I 4350 I Australia
Ph: +61 7 4631 2690 I Fax: +61 7 4631 1995
Appendix J: Ethics extension approval.

# Appendix J

## Queensland Health Ethics Approval

Hello Angela

Thank you for submitting the USQ HREC approval (H15REA113) and associated HREC application form for your study *The lived experience of hospital in the home registered nurses: A phenomenological study into their scope of practice*. I have reviewed the documents and based on what has been provided to me I am satisfied that you will not require a Queensland Health HREC review as:

- All interviews are being conducted out of work hours.
- All contact is being made through the Hospital in the Home Australasia Society not through Queensland Health
- Participants are reflecting on their own personal opinions and not Queensland Health work practices.

If any of the above should change, then you will be required to seek a Queensland Health HREC review and research governance authorisation to undertake the study with Queensland Health nurses.

Good luck with your study!

Regards

Sara

**Sara Gray**

Principal Policy Officer

**Health and Medical Research Unit | Healthcare Innovation and Research Branch | Clinical Excellence Division**

**Department of Health | Queensland Government**

Level 1 15 Butterfield St Herston QLD 4006

PO Box 2368 Fortitude Valley BC QLD 4006

t. 07 3328 9088

e.HMR_REG@health.qld.gov.au |www.health.qld.gov.au

# Appendix K

## Recruitment Assistance Request– HITH Society Australasia

Att: Barbara Farrelly- Hospital at Home

Flinders Medical Centre, Flinders Drive, Bedford Park, SA 5042

3 March 2015

Dear Barbara

As a member of the Hospital in the Home (HITH) Society Australasia, I am writing to you to gain assistance from the Society with a study I would like to conduct. I have an interest in undertaking a research project to explore the experiences of Registered Nurses (RN) employed within Australian Hospital in the Home services. I would like to describe the perceptions of RN regarding their Scope of Practice.

I plan to undertake a qualitative study whereby I would interview 15 to 20 RN employed in HITH services either via Skype or face-to-face. At present I am preparing my application to USQ's Human Research Ethics Committee (HREC), and I need to confirm and clarify the recruitment of participants. Therefore, I am writing to you to formally request the assistance of HITH Society to recruit participants for this project.

This study could benefit from engaging all levels of Registered Nurses however it is important for you to know that participation of staff in this study will not impact on service delivery or the HITH Society. All interviews will be organised outside of working hours at a time that is deemed suitable and agreed to between the participant and myself. I have attached the project outline and an overview of the study to aid understanding and provide further details.

May I take this opportunity to thank you for your time and consideration of my request for HITH Society assistance and support with this request. I look forward to hearing from you at your earliest convenience.

With kind regards

Angela Ellis / [redacted]

6 Sundance Place, Bargara, Queensland 4670