

**An investigation into the role of a registered nurse during a patient
admission to a hospice**

Flora Cameron Thain Watson

Student ID: 2228608

Faculty of Health Sciences and Sport

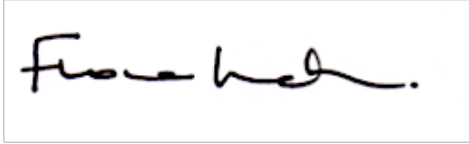
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Declaration

I declare the work in this thesis to be my own, except where otherwise stated.

A rectangular box containing a handwritten signature in black ink. The signature is written in a cursive style and appears to read "Flora Watson".

Flora Cameron Thain Watson

30th November 2021

Abstract

Title: An investigation of the role of the registered nurse during a patient's admission to a hospice.

Background: Patient admission is an integral part of nursing work where nurses and patients can engage in the mutual exchange of information. Previous studies found a gap between nursing theory and clinical practice concerning the nursing admission process that required further exploration.

Aim: To investigate the role and contribution of the registered nurse in patient admission to a hospice.

Methods: A qualitative, multiple case study research design provided an opportunity for an in-depth exploration to gather detailed information from participants in a real-life context. Data collection occurred between June 2018 and January 2019 within a hospice in Scotland. Each case included observation of the admission, semi-structured interviews with those who participated in the admission interview, review of the patient record and field notes. Cases (n=5) were analysed using constant comparison, cross-case analysis, and thematic analysis.

Results: The nurses displayed a wide range of skills and behaviours during a patient's admission to a hospice setting, with three behaviours featuring prominently:

1. The phrase '**Getting to Know**' was used by nurses to describe how they developed their understanding of the patient and their situation.
2. '**Assessing**' involved gathering information from multiple sources to help identify the patient needs and meet organisational care objectives.
3. The nurse was responsible for '**Interpreting**' information obtained during the patient admission and summarising the data into written and verbal reports that accurately reflected the patient's history.

Conclusion: New knowledge emerged to reveal that patient admission in a hospice setting is a shared and continuous process that extends beyond the initial discussion between the patient and the registered nurse. The nursing work involved is a sophisticated aspect of practice that requires a collaborative approach by the nursing team. The conceptual map helps to summarise the overarching proposition and the core constructs by reframing what we recognise as the registered nurse role in patient admission.

Keywords: nursing, patient admission, palliative care, hospice and case study.

An earlier version of this abstract was accepted for the RCN International Nursing Research Conference in September 2021 including a virtual concurrent presentation (Appendix 1)

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Chapter One: Introduction

In Scotland, 1.2 million people were admitted to a hospital setting during 2019/2020 (Public Health Scotland 2020). For every patient admission, a nurse will be involved in or responsible for a process or procedure that admits the patient to the clinical setting. And yet, our understanding of the role of the registered nurse during patient admission is unclear. To contextualise the problem addressed in this thesis, I will outline the background evidence and policies related to patient admission and nursing practice. An overview of palliative care is provided to help set the scene and build an argument to support the need for a study to investigate the registered nurse's role in patient admission within a hospice setting. The gaps between nursing practice and nursing theory related to patient admission are presented along with a rationale for the study. The chapter closes by presenting an outline of the structure for this thesis.

1.1 Patient admission

Patient admissions are a regular and frequent occurrence within hospital settings. The section begins by presenting patient admission from the nurse's perspective to help explore the nursing role related to this aspect of nursing work. The patient perspective then follows, and the section concludes by presenting the terms used to characterise patient admission as an event in nursing practice.

1.1.1 Patient admission from a nursing perspective

Patient admissions to hospital settings predominantly fall into two main categories, with unplanned admissions (49%) exceeding planned admissions (11%) (Public Health Scotland 2020). A planned or routine admission is when a patient attends the hospital for investigations, treatment, or care on an arranged date. In contrast, unplanned admissions are unscheduled events and occur when patients require urgent or emergency treatment and care. A patient arriving for either type of admission to a healthcare setting can expect to be seen by nursing staff for a structured meeting to undertake an initial assessment (Lister, Hofland & Grafton 2020).

A small number of nursing textbooks that focus on fundamental aspects of nursing care include a section dedicated to patient admission as a feature of nursing work. The narrative varies from welcoming the patient to a new environment (Burton, Smith & Ludwig 2018) to a comprehensive patient assessment (Lister, Hofland & Grafton 2020). For example, the Royal Marsden Manual Online (10th Edition) provides guidance that includes obtaining the patient's

health history, a physical exam and considering the patient's needs from a physical, psychological, spiritual, social and cultural perspective (Lister, Hofland & Grafton 2020).

Physiological measurement, identification of risk, developing a therapeutic relationship, and reaching a nursing diagnosis are also referred to as necessary within the parameters of an assessment during patient admission (Lister, Hofland & Grafton 2020, Lippincott 2015). There is a clear emphasis on assessment including consideration of other elements of the nursing process, such as planning, implementation and evaluation (Howatson, Standing & Roberts 2015). As a result, establishing good communication during the first interaction with the patient is also deemed necessary to support the nurse to gather the required information (Howatson, Standing & Roberts 2015).

The information gathered by the nurse forms the basis of a nursing assessment which helps formulate a nursing diagnosis and an individualised plan of care (Howatson-Jones, Standing & Roberts 2015). Other data sources, such as family members, other healthcare professionals and medical records may also be accessed to help supplement the information obtained by the nurse (Arnold & Boggs 2015). In addition to gathering data to identify needs, the initial contact with the patient also provides an opportunity to establish a therapeutic relationship (Lippincott 2015). In the next section, hospital admission from the patient perspective is presented.

1.1.2 Hospital admission from a patient perspective

Stress and anxiety on admission to hospital from a patient perspective have been explored since the mid-1960s onwards (Anderson, Metz & Leonard 1965; Elms & Leonard 1966; Franklin 1974). Patient responses to hospital admission can range from a fear of the unknown to a loss of control and the loss of identity (Franklin 1974; Burton, Smith & Ludwig 2018). Early studies recommended that nurses shift away from a task-oriented approach and adopt an approach focused on understanding the patient (Elms & Leonard 1966, Franklin 1974). There is also an expectation that nurses have a responsibility to help reduce anxiety on admission by quickly establishing a rapport with the patient (Burton, Smith & Ludwig 2018).

Contemporary nursing practice promotes a person-centred approach using the nurse's ability to provide individualised care that respects the person through mutual trust and understanding by developing a therapeutic relationship (McCormack and McCance 2016). Person-centred care involves promoting patient involvement through participation which is considered central to good nursing practice by nursing regulators and professional bodies (NMC 2018, RCN

2014). Nevertheless, admission to hospital continues to induce anxiety among patients regardless of the setting or situation and nurses have a professional duty to respond and reassure (Price 2017). One of the first procedures a patient will encounter after arrival in the clinical setting is a face-to-face meeting with a nurse. In the next section, the terminology used to describe the admission event or procedure is presented.

1.1.3 Terms used to describe patient admission

An early account of the nursing role in patient admission describes the opportunity for the nurse to orientate the patient to the hospital environment and undertake an evaluation of the patient's physical and emotional condition (Elms & Leonard 1966). In comparison, contemporary descriptions focus on the opportunity for the nurse to obtain baseline data as part of an assessment (Lister, Hofland & Grafton 2020; Lippincott 2015; Burton, Smith & Ludwig 2018).

Admission procedure, admission process, admission assessment and admission interview can all be found in nursing literature to describe the same aspect of nursing work (Arnold & Boggs 2015; Lister, Hofland & Grafton 2020, Lippincott 2015, Burton, Smith & Ludwig 2018). Subsequently, the application of different words and phrases to describe patient admission in practice adds to the ambiguity regarding the nursing role. However, the phrase 'admission interview' implies a more reciprocal arrangement between the nurse and patient than procedure, process and assessment. Although the term 'admission interview' is not used widely, it does help to define a specific aspect of nursing work. Therefore, the phrase 'admission interview' will be used in this context throughout the thesis.

1.2 Policy context

Few policy documents provide specific guidance on the nursing role in patient admission. However, a guideline produced by the National Institute for Health and Care Excellence (NICE) referred to the work involved in patient admissions as one of the determining factors when considering safe staffing levels in adult inpatient wards in acute hospital settings (NICE 2014). Although considered a one-off activity, a routine admission can take a nurse between 20 to 30 minutes to complete and longer for those patients with complex needs (NICE 2014).

From the point of arrival, nurses begin to assess a patient's needs by gathering information to help identify nursing priorities and provide a person-centred approach using evidence-based nursing interventions (Nursing and Midwifery Council 2018). In addition, the Royal College of Nursing sets out eight principles for nursing practice that describe what is necessary to provide

good nursing care (RCN 2018). The principles encompass core aspects of nursing similar to the professional standards set by the Nursing and Midwifery Council (2018). Both documents promote person-centred care, patient safety, professionalism and team working as core elements in nursing practice (NMC 2018; RCN 2018).

Providing high-quality healthcare requires a governance framework supported by risk management to ensure patients receive safe, effective and person-centred care (Scottish Government 2010). Over the last decade or so, the Scottish Patient Safety Programme (SPSP) has supported the development of a range of initiatives to help improve and promote patient safety in healthcare settings from the point of admission onwards. Programmes of work have included identifying the deteriorating patient, preventing falls and reducing the incidence of pressure ulcers (SPSP 2021).

Baseline data is gathered on admission to help identify risks and mitigate against harm during a stay in hospital (SPSP 2020). A range of standardised tools are available for use with permission to amend and adapt documents to meet local organisational requirements (Healthcare Improvement Scotland 2021). Registered nurses undertaking admission interviews as part of their nursing work are expected to observe and adhere to professional standards and organisational requirements while delivering safe, effective and person-centred care (NMC 2018; RCN 2018; Scottish Government 2010).

In this section, it is evident from the outline of nursing policy that patient admission is rarely mentioned as a specific feature of nursing work. And yet, within the broader context of professional standards and guidelines, the admission event is recognised as a fundamental starting point for nurses. The contradiction between nursing policy and professional standards highlights a lack of insight and understanding of the nursing role in patient admission. The next section presents patient admission within the clinical context of palliative care.

1.3 Palliative care

The World Health Organisation (WHO 2016) definition of palliative care remains internationally recognised and advocates for a holistic approach that 'improves the quality of life of patients and their families, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems'. Therefore, the focus for health and social care staff providing services to patients nearing the end of their life is to deliver compassionate care that promotes comfort and dignity regardless of age, diagnosis or location (Petersdorff et al 2021; Scottish Government 2015). In the following sections, the

palliative care context is presented first followed by a consideration of palliative care nursing and then specialist palliative care settings.

1.3.1 Context

In Scotland, figures regarding the place of death in 2016 found that 50% of patients died in hospital, with 23% dying at home, 18% in a care home and 4% in a hospice setting (Finucane et al 2019). Whereas many people state a preference to die at home, the trend regarding deaths in a hospital setting remains relatively unchanged in England and Scotland (Petersdorff et al 2021; Clark et al 2014). Recent reports suggest the demand for palliative care will continue to increase due to an increasing population and rising life expectancy, albeit with co-morbidities due to both long-term and chronic conditions (Dixon et al 2015; Petersdorff et al 2021; SPPC 2021).

For patients with palliative care needs, as their illness progresses and problems arise, preferences regarding the preferred place of care can change and result in admission to a hospital or hospice setting (Gomes 2018). In Scotland, hospices work in partnership across health and social care settings to provide a range of services including inpatient facilities, day-care and supporting patients at home (Hospice UK 2020). As a result of this collaborative approach, hospices often focus on the provision of specialist palliative care. In addition to providing direct clinical services, hospice teams also offer advice and support to help guide palliative care developments within their communities and at a national level (SPPC 2021).

The care of dying patients and their families often become the primary responsibility of the nurse team regardless of the setting (Johnston 2005). Similarly in a hospice or specialist palliative care setting the nursing team are responsible for planning, delivering and managing patient care from the point of arrival until discharge or death (Sutherland and Stevens 2008). The following section considers palliative care in relation to the nursing role and patient admission.

1.3.2 Palliative care nursing

Palliative care nursing involves holistically assessing patient needs by providing and reviewing individualised care to improve quality of life and enable a dignified death (Walshe, Preston and Johnston 2018). A wide range of healthcare settings delivers palliative care, with care provided by nurses with differing levels of knowledge and expertise (Fitch, Fliedner and O'Connor 2015). However, well-trained, competent and confident staff can bring professionalism, compassion and skill to palliative care situations (National Palliative and End

of Life Care Partnership 2021). A patient with palliative care needs should not be defined or labelled by their illness as each brings a set of individual difficulties which are unique to them and their family (Milligan 2018).

On arrival to a hospice setting, the nursing team will often be the first to meet the patient and their relative. Treating the patient as a whole and not just the physical symptom of their illness is a core principle of the holistic approach adopted by hospice staff (Sutherland and Stevens 2008). The initial assessment of patient needs begins during hospice admission procedures and forms an early foundation for developing the plan of care especially as the majority of patients will have complex holistic needs (Walshe, Preston & Johnston 2018). Hospice care, more commonly referred to as specialist palliative care, is discussed in the next section.

1.3.3 Specialist palliative care

In Scotland, approximately 1% of the population dies each year, although not all of those people require specialist palliative care services (Dixon et al 2015). When a patient's health declines, most palliative care is delivered and planned by health and social care teams in the community and hospital settings (SPPC 2021). However, for those patients with more complex needs, specialist palliative care is accessed via hospices, NHS specialist units and specialist teams within acute hospital settings (SPPC 2021).

The overall public perception of hospices is positive, with over 90% of people recognising their significant role in providing palliative and end-of-life care with dignity (Hospice UK 2017). Patients with life-limiting illnesses often experience numerous hospital admissions, and data shows a high percentage of patients in an acute hospital setting are in the last year of life (Clark et al 2014). There are 14 independent hospices in Scotland and six specialist palliative care units that provide services for people with complex palliative care needs (SPPC 2021). Referral processes are agreed on an individual basis between the hospice and the corresponding health board. Often arrangements for admission and transfer are on a planned basis, with emergency admissions occurring infrequently.

The assessment and provision of holistic care to ensure patients' and families' physical, social, emotional, and spiritual needs are met, where possible, is an essential principle in palliative care (Scottish Government 2008). Admission to a specialist unit for palliative or end-of-life care often produces additional anxieties and concerns for patients and their families. Understanding disease status and prognosis, preferences regarding future plans, and consideration of other existential feelings are fundamental to a thorough patient assessment

(Fleming, Hardy & Taylor 2018). Although patient admissions to specialist palliative care settings are rarely an emergency, the trajectory of their illness is unpredictable, and situations can change unexpectedly. Therefore, sensitive conversations between healthcare staff and patients are attended to during or shortly after admission.

Although patient admission is acknowledged as a regular feature of nursing work, it is an aspect of practice that has been overlooked by policymakers. A holistic approach is regarded as fundamental in palliative care nursing and begins as soon as a patient arrives in a hospice. And yet, our understanding of the registered nurse's role during a patient admission to a hospice setting has not been explored.

1.4 Background to the thesis

After several years working as a clinical nurse specialist in primary care, I returned to an NHS specialist palliative care unit to take up a position as a senior charge nurse. The new role involved demonstrating effective leadership through four key areas: ensuring safe and effective clinical practice, enhancing patient experience, managing and developing the team's performance, and contributing to the delivery of the organisation's objectives (Scottish Government 2008). Patient admissions were a daily occurrence, with the nursing team primarily responsible for newly arrived patients. One of the registered nurses on duty would be assigned to 'admit' the patient, and the nursing work involved was factored in alongside their workload for the day.

I found the language used by nurses to describe the nursing work linked to patient admission curious and confusing. Nurses rarely described the face-to-face event as an 'admission assessment' or 'admission interview'. For example, I regularly heard nurses use the phrase "off to do an admission" in the clinical setting. Also, the term 'admission' was applied separately by nurses as a descriptor to categorise the patient as new rather than referring to the patient by name. Therefore, the term admission was used to describe both the patient and as a label to classify a specific aspect of nursing work.

There was also a shared understanding among the nursing team that a patient admission, specifically the admission interview, could take up to an hour to complete. The nurse would meet the patient at the bedside with the required documentation to gather and record the information exchanged during the face-to-face event. Although the initial discussion occurred at the patient's bedside, nurses would regularly describe 'finishing off an admission' as a separate episode that happened towards the end of their working day, removed from the patient.

In the senior charge nurse role, local and national initiatives focused on ensuring the delivery of high-quality, effective and person-centred care were key values to be promoted in practice and among the nursing team (Scottish Government 2008, Scottish Government 2010). Therefore, reflecting professionally on patient admission and the numerous expectations on nurses as part of admission procedures led to questions concerning our understanding of this important aspect of nursing work.

1.5 Rationale for thesis

Patient admission is a recognised and regular feature of nursing practice. However, the body of literature on the registered nurse's role in patient admission appears limited especially when considered with the frequency in which patient admission occurs in clinical practice. In addition, the language to describe patient admission in nursing is diverse and includes the use of interchangeable terms (Lister, Hofland & Grafton 2020; Lippincott 2015; Burton, Smith & Ludwig 2018). Other fundamental nursing concepts are also closely linked with patient admission, such as providing a person-centred approach and developing the nurse-patient relationship (Lippincott 2015; Burton, Smith & Ludwig 2018).

Nurses form the largest single profession in the NHS, and modern healthcare is moving towards new ways of working where nurses have new responsibilities for managing episodes of patient care (Scottish Government 2017a). In addition, transforming nursing roles and reforms to health and social care are highlighted as policy documents in Scotland and will guide future ways of working in healthcare (Scottish Government 2016; Scottish Government 2017b). Therefore, opportunities to develop a better understanding of nursing work through research will help to support and inform future changes to the nursing workforce, and contribute to developments in patient care in hospice settings (Philips, Johnston and McIlfatrick 2020)

Figures and trends predicting patient admissions for palliative and end-of-life care confirm that numbers are expected to increase (Dixon et al 2015; Finucane et al 2019; Public Health Scotland 2020). A wide range of healthcare settings are involved in providing palliative and end-of-life care, from acute hospitals to care homes. However, only a small percentage provide specialist palliative care (SPPC 2021). A hospice setting provides a different clinical environment to explore the nursing work involved in patient admission.

This chapter has presented the background relating to the nursing role in patient admission and considers a particular clinical perspective, that is, palliative care settings. The importance and originality of this study are that it will explore the role of the registered nurse during a patient admission in a hospice setting and help advance our understanding of a recurring element of nursing work.

1.6 Structure of the thesis

In the second chapter of the thesis, a literature review begins by considering how the nursing role in patient admission is described in nursing literature and policy documents, followed by an outline of the search story and the subsequent examination and appraisal of the available evidence. In addition, the main themes to emerge from the literature review are presented. Chapter three begins by setting out the underlying theoretical perspective and rationale for selecting the methodological approach to answer the research question. Next is an overview of the research designs considered and a justification for applying a multiple qualitative case study design. A detailed overview of the case study design and selected framework applied is also provided. The chapter concludes by discussing ethical considerations and presents the procedural processes and methods applied related to sampling, recruitment, data collection and analysis.

Chapter four presents the study findings, beginning with contextual data related to the hospice setting and the sample. Next, case summaries are provided to help illustrate the findings on a case-by-case basis. The chapter then discusses analysis across the cases as a whole and the key themes to emerge from the study. The final chapter leads with a conceptual map to illustrate the main findings, followed by a discussion that considers the implications for practice, education and further research. The strengths and limitations of the study are incorporated in the final chapter. Finally, the thesis closes by presenting the main conclusions drawn from the study.

Chapter Two: Literature Review

2.1 Introduction

In Chapter One, the patient admission interview was presented and discussed as a regular and important aspect of nursing practice. This chapter begins by considering descriptions of the nurses' role in patient admission within nursing textbooks in section 2.2. The search story details the strategy implemented and a brief synopsis of the results in section 2.3. In section 2.4, the papers included in the literature review are appraised and discussed using subsections to present the key themes identified, with less prominent themes addressed in section 2.5. The chapter concludes with a summary of the key points and justifies the need for further research regarding the role of the registered nurse in patient admission in a hospice setting.

2.2 Descriptions of nursing admission within nursing texts and policy documents

The Collins English Dictionary (2021) definition of the word 'admission' includes using the term as a variable noun to describe 'the act of entering a place' (Collins English Dictionary). When considered in a health care context, the term patient admission describes the act of entering the clinical setting and the processes or procedures initiated as a consequence. Physical and online searches began by focusing on nursing textbooks that considered fundamental elements of nursing care. For example, textbooks that included the words 'manual' or 'procedures' in their title.

The available information varied from a brief overview to detailed descriptions of patient admission from a nursing perspective (Lister, Hofland and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015). All of the textbooks reviewed referred to the need for an initial patient assessment, with only one defining the assessment as an interview (Lister, Hofland, and Grafton 2020). Descriptions of nursing admission focus on assessment, with an emphasis on physical aspects (Lister, Hofland and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015).

All of the nursing texts provided guidance on what an admission assessment should involve with a distinct focus on physical aspects but also referred to the psychological well-being of the patient. Good communication, building a rapport and establishing a therapeutic relationship were all cited as important features of the assessment interview (Lister, Hofland, and Grafton 2020). At the same time, Lippincott (2015) suggested that effective admission routines and showing concern for the patient could positively reduce anxiety and promote

cooperation. Randle, Coffey and Bradbury (2009) described the quality of the first interaction between the patient and nurse during the initial assessment as instrumental to the relationship that developed. Other key concepts were also cited, for example, communication skills and developing the nurse-patient relationship. The general nursing textbooks present a narrative describing model admission procedures, but there is uncertainty if this reflects what occurs in practice.

Nursing policy, procedures and guidelines produced by professional bodies were reviewed to establish the current guidance available on patient admission for nurses. For example, the Nursing and Midwifery Council Code (NMC 2018) states that registered nurses should 'make sure that people's physical, social and psychological needs are assessed and responded to'. However, the NMC guidance is not explicit to patient admission and no other policy documents are reported on this area of nursing practice. The following section describes the search story of the literature review, with an overview of the search strategies used and a synopsis of the results.

2.3 Search story

Patient admission represents an aspect of nursing work that occurs after the patient has arrived in a healthcare setting (Lister, Hofland and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015). However, healthcare staff use the term 'patient admission' to describe both an event and a procedure in practice. Consequently, there appears to be an inconsistency between how a patient admission occurs in nursing practice and how the term is applied theoretically. The initial focus of the literature review was the nursing event that occurred when a patient was 'admitted' to a hospice or specialist palliative care setting. An exploratory search tested the initial search terms and produced one paper that reported on a quality improvement initiative to develop admission procedures within a hospice setting (Roberts et al 2005).

To provide a broad overview of the existing evidence, with fewer restrictive inclusion criteria related to the area of interest, a scoping review approach was employed (Joanna Briggs Institute 2015). The scoping review aimed to clarify the concepts in the literature related to the role of the registered nurse in patient admission and identify the gaps in knowledge (Arksey and O'Malley 2005). Searches of the literature had proved challenging and search terms were repeatedly reviewed and expanded (Appendix 2). A systematic literature review employs a narrower focus to allow for rigorous analysis however the scarcity of literature available would have rendered a systematic review problematic (Synder 2019). While a traditional literature review considers the current literature using a narrative approach to report findings, the same

level of in-depth analysis as a systematic review is lacking (Grant and Booth 2009). For this study, a scoping review allowed for the identification of available literature and narrative commentary on the quantity and quality of the studies using principles laid out by the Joanna Briggs Institute (2015). The next section describes the search strategy and methods applied for the literature review.

2.3.1 Search strategy

For the scoping review, the searches were conducted in a rigorous, systematic manner to identify and review the published literature on the nursing role in patient admission. The searches were conducted using an iterative process of online library services via STIRGATE and the NHS Knowledge Network between April 2015 and May 2016 and reviewed annually to consider any added literature. The databases accessed included were CINAHL, MEDLINE, PsychINFO and Psychology and Behavioural Sciences Collection.

The primary search began by encompassing the terms 'nursing', 'adult', 'admission', 'palliative care' and 'patient participation', all combined with 'AND'. Combining these search terms produced one result however when the 'all text' field option was selected, the results surged into many thousands (n=18,000+). The key search terms and subject fields were adjusted successively to search the literature as finding literature proved challenging systematically.

Search results were also screened based on PRISMA guidance (Moher et al 2009), with titles and abstracts read to assess if the nursing admission interview was explored as part of the study. The approach allowed for a simple appraisal process to help quickly eliminate irrelevant papers. Due to the scarcity of literature available, the clinical context was expanded to include hospital settings rather than limit to palliative care settings. Results using amended search terms continued to produce varying results, ranging from single figures to hundreds. A librarian from the university also provided their professional view on the search strategy applied and gave assurances that the key search terms were appropriate. A synopsis of the searches conducted was noted for accuracy and consistency (appendix 2).

The inclusion criteria for the literature review were peer-reviewed studies related to the nursing admission interview within the context of nursing practice within inpatient settings, for example, acute hospitals or a hospice setting. Exclusion criteria were minimal and included studies that reported using the English language and relating to adults. Critical appraisal of the resulting papers followed the Critical Appraisal Skill Programme: Qualitative Studies

Checklist (2018) to help determine quality and rigour. In addition, the inclusion and exclusion criteria helped refine the larger sets of results (see Table 1).

Table 1: Inclusion and exclusion criteria for literature search results

	INCLUSION	EXCLUSION
Topic:	Specific reference to the nursing admission interview and/or process	Application of term 'admission' descriptively or collectively
Participants:	Nurses / Patients / Relatives / Carers	Limited to Medical Staff and/or Allied Health Professionals only
Setting:	Inpatient areas e.g. hospital setting / palliative care unit / hospice	Community setting including residential home settings e.g. care home, nursing home
Language:	Reported using the English language	Non-English
Time Period:	None	None

Studies reporting from a community setting such as the patient's home or a care home were excluded. The search strategy aimed to capture literature that reported on inpatient areas rather than settings regarded as residential facilities. While processes within a care home setting may have similarities to hospital admission, the individual enters the facility to become a permanent rather than temporary resident. The following section provides a synopsis of the results.

2.3.2 Synopsis of results

The final results produced 14 papers for inclusion in the literature review, using twelve primary research studies and two articles reporting on projects which applied quality improvement methodology. Due to the limited number of papers available, the decision was taken to include the two quality improvement reports. All of the papers included reported on the nursing admission interview, or an aspect within inpatient healthcare settings, with two papers reporting on a different aspect of the same investigation (Jones 2007, Jones 2009).

The geographical location of the studies included Canada (1), Northern Europe (4), the UK (6) and the USA (3). All of the studies were set within an inpatient setting, including general adult wards (9), psychiatric units (2), care of the elderly wards (1), an oncology setting (1) and a hospice (1). The 12 primary research studies examined the topic from a range of participant perspectives: nurses only (n=5), nurses and patients (n=5), patients (n=1), and nurses,

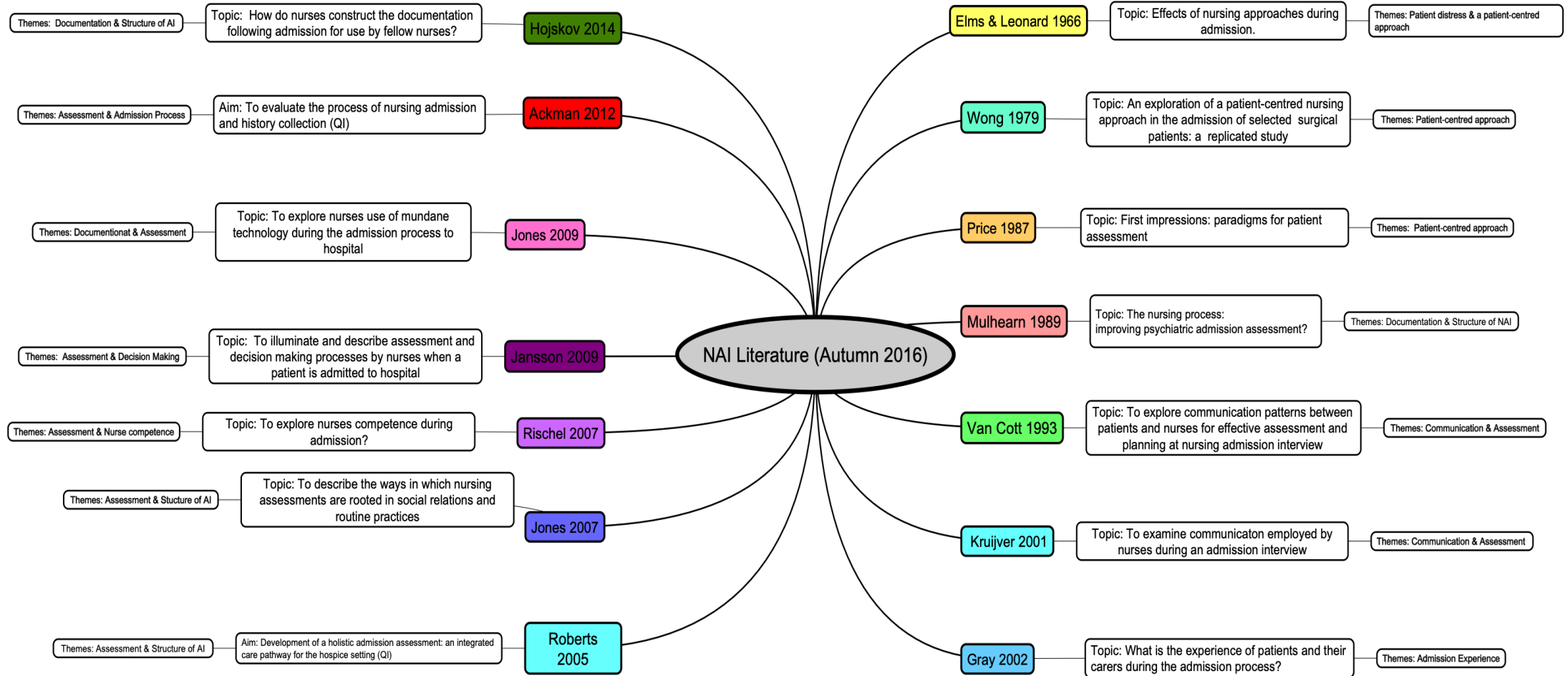
patients and carers (n=1). The original publication date of the fourteen papers ranged from 1966 to 2014.

Of the 12 primary research papers, only three reported specifically on the nursing admission interview (Jones 2007; Jones 2009; Jansson, Forsberg and Pilhammar 2009). The remaining studies examined a range of different topics that connected to, or occurred as part of, the nursing admission process; 'nursing approaches during admission' (Elms and Leonard 1966), 'patient-centred nursing approach' (Wong 1979), 'paradigms for patient assessment' (Price 1987), 'improving psychiatric admission assessment' (Mulhearn 1989), 'communicative competence during nursing admission' (VanCott 1993), 'communication skills with simulated cancer patients' (Kruijver et al 2001), 'admission procedures in elderly care' (Gray, Cavanagh and Mowat 2002), 'new patterns of professional competence' (Rischel, Larsen and Jackson 2007) and 'transformation of admission interview to documentation' (Højskov and Glasdam 2014).

The research approaches used were predominantly qualitative (n=9), with others using a mixed-methods approach (n=3). The primary research studies using a qualitative approach employed a range of methods: Grounded Theory (n=3), Action Research (n=1), Observational Techniques (n=1), Conversational Analysis (n=1), Policy Ethnography (n=1), Sociolinguistic Microanalysis (n=1) and Case Study (n=1). The final fourteen papers included in the literature review were summarised in a table to help with comparison and appraisal (see Table 2). In addition, a mind map helped to provide a visual summary of the key themes identified from the literature review (Figure 1).

Searches for new or updated literature have been undertaken periodically from the original search date. Search terms have focused on 'nursing', 'admission', 'patient' and 'adult' with limits set to find articles published in English between 2011 and 2021. No new studies that focus on the role of the registered nurse in patient admission have emerged.

Figure 1: Key Themes from Literature Review Oct 2016



2.3.3 Terms applied to describe patient admission

The language used in nursing textbooks varied with 'admission routines' (Lippincott 2015), 'assessment interviews' (Lister, Hofland, and Grafton 2020) and 'patient assessment' (Randle, Coffey and Bradbury 2009). The terms used in the nursing textbooks were all applied within the context of patient admission and the nursing role. The papers included in the literature review also used a variety of terms, such as 'admission assessment' (Mulhearn 1989; Rischel, Larsen and Jackson 2007; Ackman et al 2012), 'nursing approach' (Elms and Leonard 1966; Wong 1979) and 'admission interview' (Price 1987; VanCott 1993; Kruijver et al 2001; Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014).

The range of terms used across the literature confirmed that patient admission is not defined as a distinct area of nursing work, despite the regularity within a range of practice and clinical settings. For my study, the term 'admission interview' was selected to help distinguish between a specific nursing event and general admission processes.

Table 2: Summary of papers included in the literature review

Lead Author / Place	Year	Setting / Sample	Aims / Research Questions (RQ)	Design / Method	Key Findings	Comments
Elms, R. (USA)	1966	<p>Acute Hospital:</p> <p>Gynae Ward</p> <p>Sample Size:</p> <p>75 patients</p>	<p>Hypotheses:</p> <p>Patients will express greater satisfaction with admission, and their expectations of nursing care will be surpassed more often if they receive an individualised nursing approach.</p> <p>Study Focus:</p> <p>Nursing admission & Patient-centered approach</p>	<p>MIXED METHODS:</p> <p>Non-participant observations & measurement of physiological parameters & patient interviews.</p>	<ul style="list-style-type: none"> - Physiological measures (Pulse & Respiratory Rate) and interviews support the hypothesis that a patient-centred approach helps to relieve patient distress due to admission. - Other physiological measures are difficult to evaluate (BP & Temp) - Patients who received a patient-centred approach felt their expectations about nursing care were surpassed. - Delegating the responsibility of admitting patients to personnel unprepared to evaluate and alleviate distress may not be therapeutic to the patient. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - The methods applied were applicable at that time but would be questioned from an ethical perspective today e.g. inclusion of 'role-play' for the task-based approach. - The patient-centred approach was provided by the nurse researcher involved in the study therefore some potential conflict between roles. - Measurement of physiological parameters & their meaning would not be considered as significant now - No data linked to palliative care

<p>Wong, J. (CANADA)</p>	<p>1979</p>	<p>General Hospital: Elective Surgery</p> <p>Sample Size: 35 patients</p>	<p>RQ: To explore patient welfare before & after the use of a patient-centred nursing approach on admission to hospital.</p> <p>Study Focus: Nursing admission & Patient-centered approach</p>	<p>MIXED METHODS: Measurement of physiological signs & Patient Welfare Inventory</p>	<ul style="list-style-type: none"> - Positive differences between pre-admission and post-admission physiological welfare. - Patients reported a positive reaction to the admission procedure using a patient-centred approach. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Study replicated the work of Elms & Leonard (1966) but added determining patient perceptions as a new perspective - Limited information regarding ethics, recruitment & data analysis - Recognises limitations of some of the measurement tools used e.g word score checklist - Conclusions similar to the original study despite being 10+ years later - Recommends an experimental design for future studies which seems at odds with key findings around the patient-centred approach - No data about admission process as focus on the approach - No data linked to palliative care
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<p>Price, B. (UK)</p>	<p>1987</p>	<p>Acute Hospital: Medical & Surgical Wards</p> <p>Sample Size:</p> <p>Phase 1: 60 nursing documents</p> <p>Phase 2: 36 student nurses</p> <p>Phase 3: 32 participant observations</p>	<p>RQ: To identify patient assessment criteria as employed by student nurses.</p> <p>Study Focus: Nursing admission & Student Nurses assessment</p>	<p>QUALITATIVE: A primary research study using Grounded Theory</p>	<ul style="list-style-type: none"> - Student nurses employ both normative & interpretative paradigms in their assessment of patients. - Several variables were identified that had a significant effect on the length of the admission interview e.g. gender - Nursing assessment strategies minimise the essentially subjective quality of the admission interview 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Researcher had worked with students previously to establish an 'empathic relationship'. Possible effect on researcher's objectivity. - Adds a new perspective regarding patient admission e.g. student nurse role - Results limited to nurse education - No data linked to palliative care
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<p>Mulhearn, S. (UK)</p>	<p>1989</p>	<p>Acute Psychiatric Wards</p> <p>Sample Size:</p> <p>Exploratory Phase: 18 RNs</p> <p>Evaluative Phase: 20 Patients, Admitting Nurse & Patient Record</p>	<p>RQ's: Do qualified nurses feel that the current admission assessment assists the formulation of patient profiles?</p> <p>Is a systematic method of collection and recording patient information useful to the nurse in identifying patients' nursing needs?</p> <p>How acceptable to patients are the questions in the structured assessment interview?</p> <p>Study Focus: Nursing admission & Assessment & Process</p>	<p>QUALITATIVE: A primary research study using Action Research</p>	<ul style="list-style-type: none"> - Exploratory investigation suggested the quality and standards of care were compromised due to nurses' lack of basic knowledge about the holistic approach and the absence of a suitable assessment form. - The structured assessment forms appeared to assist in the collection of individualised patient information. - Varied response between the staff across the two wards - Facilitated formation of the nurse-patient relationship and assisted in the collection of information 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Limited information regarding study design and data analysis - Not clearly discussed how the patient perspective contributed to the study findings - Recognises the limited body of evidence but fails to expand on how study findings could help develop practice or policy beyond the specialty - No data linked to palliative care
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<p>VanCott, M. (USA)</p>	<p>1993</p>	<p>Acute Hospital: Medical & Surgical Wards</p> <p>Sample Size: 20 Admission Interviews</p>	<p>RQ: To explore communication patterns between nurses and elderly patients during a time when nurse-patient interaction is critical for effective assessment and planning of patient care.</p> <p>Study Focus: Nursing admission & communication skills / patterns</p>	<p>QUALITATIVE: A primary research study using Sociolinguistic Microanalysis</p>	<ul style="list-style-type: none"> - Patients perceived nurses as giving them individualised attention during the admission interview. - Patients expressed confidence that the nurse understood their needs and that care would be appropriate. - Patients felt the manner in which they were approached was very important. - Patients did not question any of the information provided. -Task-oriented communication approaches risk failing to explore the psychosocial needs of elderly patients 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Recruitment of nurses proved difficult, impact on study not explained - Limited discussion on how the study contributes to the existing evidence base - Recognises further research, with other patient populations, would help to build on the findings - No data linked to palliative care
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<p>Kruijver, I. (NETHERLANDS)</p>	<p>2001</p>	<p>A simulated environment with simulated patients</p> <p>Sample Size:</p> <p>53 Admission Interviews</p>	<p>RQ:</p> <p>To investigate the balance of affective and instrumental communication employed by nurses during an admission interview with recently diagnosed cancer patients.</p> <p>Study Focus:</p> <p>Nursing admission & communication skills (simulated patients)</p>	<p>MIXED METHODS:</p> <p>A primary research study mixed methods approach</p>	<ul style="list-style-type: none"> - Nurses predominantly employed instrumental communication - Affective communication did occur but was more related to global affect ratings such as agreements and paraphrases than to specific affective behaviour such as showing empathy, concern and optimism. - Findings agree with existing literature that shows an imbalance in nurses' use of communication, characterised by an overwhelming medical concern and neglect of emotional components. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Participants were rewarded with training in communication skills which could have influenced recruitment. - No explanation why the admission interview was interrupted at 20 mins or what 'admission procedure' involved - Uncertainty around the validity of using simulated patients is acknowledged - Conclusions are brief with a limited discussion regarding implications for practice and future research - No data linked to palliative care
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<p>Gray, E. (UK)</p>	<p>2002</p>	<p>Care of the Elderly Wards.</p> <p>Sample Size:</p> <p>16 patients and their carers</p>	<p>RQ:</p> <p>What is the experience of patients and their carers during the admission process to care in the elderly rehabilitation / medical assessment ward?</p> <p>Study Focus:</p> <p>Admission process & patient / carer experience</p>	<p>QUALITATIVE:</p> <p>A primary research study using observational techniques</p>	<ul style="list-style-type: none"> - Emerging concerns were with 'information', 'communication' and 'maintaining identity & relationships' - Common concerns were identified and informed the production of 14 good-practice recommendations to be used for standardising and improving care. - Length of stay predicted at first ward round and noted/audited on discharge - Patient diary introduced along with pilot of 'Getting To Know Me' document - Patients' and carers' expectations of admission are now noted and documented in a structured way in the care plans. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Large sections of the paper focus on the selected research approach rather than provide details regarding the actual research design - Limited reporting & discussion of findings - Some of the recommendations don't fit with the original research question & appear to be more aligned with a quality improvement project - No data linked to palliative care
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<p>Roberts, S. (UK)</p>	<p>2005</p>	<p>Hospice</p>	<p>AIM: Development of a holistic admission assessment</p>	<p>QUALITY IMPROVEMENT PROJECT</p> <p>Main Focus:</p> <p>Admission process & Introduction of Integrated Care Pathway (ICP)</p>	<ul style="list-style-type: none"> - Structured format of the new assessment helps to ensure a holistic approach to assessing patient's needs upon admission - Development process led to a cohesive approach - Reduced duplication across practitioner assessments - Structured format guides staff through the process 	<p>*Paper reports on QI project rather than a primary research study.</p> <p>Clear structure describing rationale, development process and conclusion.</p> <p>The main driver for the study was a more effective and structured assessment of patient needs & multidisciplinary ownership of subsequent care plan</p>
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<p>Jones, A. (UK)</p>	<p>2007</p>	<p>Acute Hospital</p> <p>**Sample Size:</p> <p>5 acute hospital wards / 185 hours of observational data</p>	<p>RQ:</p> <p>To explore the initial nursing assessment of patients being admitted to hospital.</p> <p>Study Focus:</p> <p>Nursing admission & Assessment</p>	<p>QUALITATIVE:</p> <p>A primary research study using Policy Ethnography</p>	<ul style="list-style-type: none"> - The practice of nursing assessment deviated substantially from the idealised rhetoric found in some nursing literature & policy. - The bureaucratic routines developed by nurses proved problematic when considering the patient-centeredness of the assessment interaction. - A deference style of questioning adapted by nurses, imposed restrictions on patients' possible actions & shaped how the respondent should speak. - The topical flow of conversation lacked any apparent logic. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Acknowledges some additional information may have helped with 'readability & transferability' of findings e.g. nurse's experience - Limited details regarding patient and contextual information although the focus of the study is on nursing work involved - Conclusions focus on the contrast between nursing work, routines and patient-centred care. - Highlights how nursing work in practice deviates from theory. - Participant views were sought as an observational study - No data linked to palliative care
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<p>Rischel, K. (DENMARK)</p>	<p>2007</p>	<p>Acute Hospital</p> <p>Sample Size:</p> <p>4 RN's 12 Admission Assessments</p>	<p>RQ: To explore nurses' competence as revealed during an admission assessment.</p> <p>Hypothesis: Less-experienced nurses use a structure and more-experienced use intuition and experience when assessing a patient.</p>	<p>QUALITATIVE: A primary research study using Participant Objectivation (Bourdieu)</p> <p>Main Focus: Nursing admission & nurse competence</p>	<ul style="list-style-type: none"> - Irrespective of the length of experience, nurses showed both general & individual patterns of competence that did not correlate with a particular level in the Benner Model - Differences in performance seemed to be related to personal capacity rather than having been gained by nursing experience. -Initial hypothesis is not confirmed 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Nurse participants were selected based on experience e.g. experienced (>5yrs) and inexperienced (<1yr) however authors did acknowledge competence as an 'ambiguous concept' - Recognition that nursing competence cannot be measured by observation of the admission assessment alone - Authors acknowledge findings are not universally transferable - Discussion regards impact for further studies is limited - Some issues with translation noted in the paper affect readability and transferability - No data linked to palliative care
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<p>Jansson, I. (SWEDEN)</p>	<p>2009</p>	<p>Acute Hospital</p> <p>Sample Size:</p> <p>19 RN's</p>	<p>RQ:</p> <p>To illuminate and describe the assessment and decision-making process performed by nurses who formulated individual care plans including nursing diagnosis, goals and interventions or who used standardised care plans when a patient was admitted to their ward for care, and those who did not.</p>	<p>QUALITATIVE:</p> <p>A primary research study using Grounded Theory</p> <p>Main Focus:</p> <p>Nursing admission & assessment & decision-making</p>	<ul style="list-style-type: none"> - The main concern for all nurses was to obtain a foundation for planning nursing care during their admission interview with the patient. - Nurses who adopted a nursing perspective used critical thinking in their assessment & decision-making process to arrive at a nursing diagnosis. - Nurses with a medical perspective did not use critical thinking to provide nursing care, as they did not intend to formulate nursing diagnoses. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Study aim is confusing as aligned with many concepts - Authors acknowledge sampling did not follow Grounded Theory methodology - Discussion regards findings lacks depth at times - Recommendations for further research are not clear - Some issues with translation noted in the paper affecting readability and transferability - No data linked to palliative care
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<p>Jones A. (UK)</p>	<p>2009</p>	<p>Acute Hospital</p> <p>**Sample Size:</p> <p>See Jones's 2007 study</p>	<p>RQ:</p> <p>To explore nurses' use of mundane technology (paper-based records) during the admission process of patients into hospital and whether the use of such technology affects the extent of patient participation during the admission process.</p>	<p>QUALITATIVE:</p> <p>A primary research study using Conversational Analysis</p> <p>Main Focus: Nursing admission & documentation & patient participation</p>	<ul style="list-style-type: none"> - Nurses' decisions to shape the assessment interview around the structure & layout of the assessment document served to suppress the expression of the patient concerns whilst minimising patient participation. - A more balanced approach towards technology & its effects on nursing suggests further research is needed into how nurses learn to use & then apply their understanding of paper-based (& electronic) technology to their daily practice. - The assessment was 'frequently punctuated' by the nurse reading or writing in the admission document & patients rarely interrupted the nurse when this happened. A patient-led discussion was curtailed. 	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Aim focused on the effect of nursing records on patient participation during the admission process. - Not clear if this study was part of the original work by Jones (2007) as not explicitly stated but the sample and recruitment are identical. - Jones acknowledges there is some contradictory evidence from the study regarding patient participation - Multiple factors within each admission dyad may have affected findings e.g. the nurse, the patient, contextual background - Presents a strong argument for further research to consider how technology affects nursing work - No data linked to palliative care
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<p>Ackman, M. (USA)</p>	<p>2012</p>	<p>Acute Hospital</p>	<p>AIM: To modify the initial nursing inpatient assessment process & increase efficiency</p>	<p>QUALITY IMPROVEMENT PROJECT</p> <p>Main Focus: QI Nursing admission assessment & process</p>	<ul style="list-style-type: none"> - New process resulted in more time with patients - RNs reported increased satisfaction with patient assessment as the new process reduced duplication 	<p>*Paper reports on QI project rather than a primary research study.</p> <p>The project was undertaken over a large community healthcare system incorporating performance improvement methodology which is explained well throughout</p> <p>The main driver for the project was to address the replication of work between nursing and medical staff as part of the admission process</p>
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<p>Hojskov, I. (DENMARK)</p>	<p>2014</p>	<p>Acute Hospital</p> <p>Sample Size:</p> <p>5 patients</p>	<p>RQ:</p> <p>To examine how nurses constructed written documentation of the patient and their course of treatment for use by fellow nurses.</p> <p>Main Focus:</p> <p>Nursing admission & documentation</p>	<p>QUALITATIVE:</p> <p>A primary research study using Case Study Approach</p>	<p>- Nurses' reports on newly admitted patients to colleagues were based on three key elements:</p> <p>[1] Admission interview followed the nurse's predefined agenda based on the document used</p> <p>[2] Information obtained from patients' medical notes was significant</p> <p>[3] Nurses appeared to have preconceived views regarding the patient as an object rather than an individual</p>	<p>Limitations / Critique:</p> <ul style="list-style-type: none"> - Some contradiction regards the 'predefined agenda' of nurses and the use of VIPS model as standard practice - Findings are described as 'hypothetical' and data from the study to support discussion is limited - Not clear that findings from this study would support the recommendation for a larger study - Proposal for field study but talks of challenging practice during patient-nurse interactions - Translation issues were evident throughout the paper which resulted in concerns regards the credibility of reported findings - No data linked to palliative care
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2.4 Key themes

The final papers included in the literature review were appraised, with key themes emerging about the role of the nurse in patient admission. In this section, the themes are presented beginning with those which appeared most frequently. Despite admission being recognised as an important element in nursing textbooks, there are only a few studies which explore patient admission and none from a palliative care perspective. The small body of existing literature focused mainly on the themes of assessment, documentation, and the structure of the admission interview.

2.4.1 Assessment

Within nursing textbooks, assessment appears as a core feature of patient admission procedures. The information gathered should help formulate a nursing care plan as part of the nursing process (Lister, Hofland and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015). Nursing staff also have a responsibility to ensure the information gathered forms the basis of an ongoing assessment that is “integral to the safety, continuity and quality of patient care, and fulfils the nurse's legal and professional obligations in practice” (Lister, Hofland, and Grafton 2020).

A number of the papers included in the literature review considered assessment specifically within the context of patient admission (Price 1987; Jones 2007; Jansson, Pilhammar and Forsberg 2009), while others focused on improvements to nursing assessments and documentation (Mulhearn 2005; Roberts et al 2005; Ackman et al 2012; Højskov and Glasdam 2014). Nursing competence around the assessment undertaken during patient admission was also studied (VanCott 2993; Rischel, Larsen and Jackson 2007).

Price (1987) reported on different approaches employed by student nurses during patient admission interviews. For example, a ‘normative’ approach appeared quite pragmatic compared to an ‘interpretative’ approach that was more interactive, although both may be evident throughout the patient admission (Price 1987). In comparison, a study by Jones (2007) found that the structure of the assessment during a patient admission followed a pattern where the nurse asked questions, and the patient responded rather than being conversational.

A medical perspective was found to influence the nurses' assessment during an admission interview (Ackman et al 2012; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). Jansson, Pilhammar and Forsberg (2009) reported that nurses who adopted a medical rather than nursing perspective focused more on gathering and recording patient data than

applying critical thinking. Other contextual factors which influenced the nursing approach were reported in other studies and included the patient's age and gender (Price 1987), workplace pressures (Mulhearn 1989; Jones 2007) and the nurse's personal view (Højskov and Glasdam (2014).

Improvement projects to enhance nursing assessments undertaken as part of the nursing work within patient admission were reported by Mulhearn (1989), Roberts (2005) and Ackman et al (2012). Modifications to the admission documentation supported nursing staff in capturing relevant patient information that helped identify needs and plan care (Mulhearn 1989; Ackman 2012). However, the modifications were unique to each study as Mulhearn (1989) introduced new sections while Ackman (2012) removed sections.

Two studies explored nursing competence as a specific subject linked to assessment during an admission interview. VanCott (1993) examined the communication patterns between nurses and older patients and found that breakdowns in communication could result in important information being missed from the assessment data obtained. While Rischel, Larsen and Jackson (2007) explored how nurses' competence was revealed during an admission assessment. Benner's model of competence guided the analysis of the findings and found that individual patterns did not correlate with the model. However, both studies offer no clear explanation regarding the distinction between assessment and nursing competence.

Together these studies provided important insights into assessment and also highlighted the significance of recording information obtained during an admission interview. Documentation emerged as a separate theme within the literature review and is presented in more detail in the next section.

2.4.2 Documentation

Nursing documentation and how it influenced the admission interview is featured in several papers included in the literature review. Mulhearn (1989) and Roberts et al (2005) focused on how a structured document could help improve nursing assessment during patient admission. A different quality improvement project by Ackman et al (2012) also focused on documentation but emphasised improving efficiency around the nursing work related to the patient admission.

Ackman's quality improvement project (2012) was driven by the desire to reduce the time taken to complete the nursing assessment documentation. In addition, factors such as duplication, accuracy, and effectiveness supported the plan to evaluate and develop the nursing admission process. The nursing admission process included assessing current problems, previous history, a physical examination, and identifying potential risks for the patient similar to the definitions provided earlier.

Preliminary work with focus groups revealed that the nursing history interview had become routine and deemed a one-off task, with the rationale unclear as some of the information gathered was rarely used (Ackman et al 2012). In addition, modifications to the nursing admission documents reduced the duplication of information recorded during an examination by a physician. As a result, nurses had more time to interact with the patient, increasing the number of patient problems identified (Ackman et al 2012).

Other studies also found that changes to the documentation increased interactions with patients (Mulhearn 1989; Roberts et al 2005). There are several similarities reported between Mulhearn (1989), Roberts et al (2005) and Ackman et al (2012) about improving documentation and nursing admission however it is important to consider the contextual differences for each setting. For example, Ackman et al (2012) focused on developing efficiency around admission within a large healthcare system while Roberts et al (2005) considered a holistic approach in an independent hospice setting. While improvement work has highlighted some specific aspects of patient admission our understanding of the nursing work involved as a whole remains poorly understood.

Documents utilised by nurses as part of the admission process included the patients' medical records (Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). The information obtained by the nurse supported their nursing assessment by providing details regards diagnosis, medical history and planned treatments. In one of the studies, information gathered via the patient's medical records was given greater significance by the nurse than that obtained directly from the patient (Højskov and Glasdam (2014)). These results are similar to those reported by Mulhearn (1989), Roberts et al (2005) and Ackman et al (2012) who also noted the influence of medical models on the design of nursing admission documents.

VanCott (1993) reported that nurses were determined to complete the admission documents and unintentionally missed information that would help to build a holistic patient assessment. Similarly, Jones (2007) reported how the 'need to complete the nursing record was seen to

orchestrate the encounter', that is, the nursing admission interview. Furthermore, in studies by Højskov and Glasdam (2014) and Jansson, Pilhammar and Forsberg (2009) the agenda for the admission interview was defined by the nurse who formulated pre-printed headings on the nursing document beforehand. Although, the behaviour of the nurse in the studies by Højskov and Glasdam (2014) and Jansson et (2009) may be related to a specific nursing model used in both settings, namely, 'VIPS' (an acronym for key goals of nursing care).

The way the admission interview was introduced and conducted by the nurse, and the influence of a pre-structured nursing record, contributed towards the amount of interaction between the nurse and the patient (2007; Jansson, Pilhammar and Forsberg 2009; Jones 2009; Højskov and Glasdam 2014). The structure and layout of the admission document also shaped nurses' decisions and could, at times, suppress the opportunity for the patient to express or verbalise any particular concerns (Jones 2009). In addition, two Scandinavian studies found that access to the patient's medical notes also influenced the nurse-patient interaction with reports of the medical information available being rated highly by nurses (Jansson et al 2009; Højskov and Glasdam 2014).

Several studies reported the influence of documentation on the nursing admission interview but from differing perspectives. For example, quality improvement projects by Roberts et al (2005), Ackman et al (2012) and an action research study by Mulhearn (1989) all reported on work to develop a structured approach to improve nursing admission procedures, with a particular focus on documentation. Other studies reported that documentation affected nursing admission procedures through reduced patient involvement (Jones 2009), missed opportunities (VanCott 1993), standardised approaches (Wong 1979; Jones 2007; Højskov and Glasdam 2014) and a reliance on medical information (Jones 2007; Jansson, Pilhammar and Forsberg 2009; Ackman et al 2012; Højskov and Glasdam 2014).

These studies have highlighted a range of factors that can affect the quality of information documented however the research to date has often considered a specific aspect of patient admission rather than focusing solely on the admission interview as an event. Other factors identified within the literature review which also influenced the admission interview are presented in the next section.

2.4.3 Structure of the nursing admission interview

In addition to how documentation affected the nursing role in patient admission, other factors reported were the individual preferences of the nurse, the environment and nurse experience.

For example, nursing staff involved in admission interviews used their discretion to decide on the order or sequence of questions asked rather than stick rigidly to the format of admission documents (Price 1987; Mulhearn 1987; Jones 2007; Jansson, Pilhammar and Forsberg 2009). Other studies found that nurses used nursing documentation to guide their topic selection which controlled the agenda of the admission interview rather than responding to the patient individually (Kruijver et al 2001; Jones 2007; Højskov and Glasdam 2014).

Several of the studies found the nurse would adopt a personal style during admission interviews (Price 1987, Kruijver et al 2001; Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). Price (1987) reported that student nurses adapted their assessment in response to different variables, for example, patient age and the type of admission. While Jones (2007) found that following an assessment framework rigidly prevented the nurse from thinking critically during the admission interview. Similarly, Jansson (2009) reported that nurses who did not apply critical thinking simply entered the data obtained into the patient record.

All the studies were conducted within acute hospitals but only a few referred to factors that were related to the clinical setting, such as noise levels (VanCott 1993), workload pressures (Mulhearn 1989; Jones 2007) and interruptions (Jansson 2009). One study considered a different factor by exploring the level of experience of the nurse. Rischel, Larsen and Jackson (2007) found no clear association between length of experience versus the level of competence and therefore no influence on the quality of the admission interview. Other studies disclosed nurses' experience but did not make any specific association between this and their role in nursing admission interviews (VanCott 1993; Kruijver et al 2001; Jansson 2009).

The studies included in the literature review all considered admission interviews between a registered nurse and a patient. Variations to this dyad in practice are acknowledged, such as healthcare support workers, student nurses and advanced nurse practitioners. Although, the literature search included 'nursing' as a search term, research on the subject to date has focused on the role of the registered nurse. The previous section discussed how the key themes of assessment, documentation and structure can influence nursing work in relation to admission interviews. Other less prominent themes which emerged from the literature review are discussed in the next section.

2.5 Other themes

In contrast to the key themes presented earlier, communication, person-centred care, the nurse-patient relationship and patient involvement appeared less frequently as themes in the literature review. However, there are some important comparisons when considered with the role and contribution of the registered nurse.

2.5.1 Communication

Only two of the fourteen papers included in the literature review explored communication specific to the nursing role in admission interviews, although other studies commented within a general context. VanCott (1993) explored communication patterns between nurses and patients during the admission interview. The study found that most patients felt the nurses had understood them, leading to appropriate individualised care. The patients also expressed confidence in the nurse who admitted them. However, VanCott (1993) also highlighted that nurses who did not actively listen to the patient's sometimes lengthy narrative could potentially miss opportunities to identify their physical and psychological needs.

Kruijver et al (2001) also explored nurses' communication skills during the admission interview, using simulated cancer patients. The main focus is on two categories described as instrumental and affective communication. Attending to practical aspects during the admission interview appeared to be the priority for the nurse, with the behaviours demonstrating empathy and concern less obvious (Kruijver et al 2001). An instrumental approach dominated the balance between the two categories and resulted in the nurse leading the discussion during the admission interview. However, Kruijver et al (2001) acknowledged that the validity and reliability of using simulated patients to assess communication skills were not customary.

The studies by VanCott (1993) and Kruijver (2001) differed significantly as one focused on older patients admitted to an acute hospital setting in the United States and the other used simulated cancer patients in admission interviews in the Netherlands. Both studies commented on nurse behaviours and how the nurse led the discussion during admission interviews similar to findings reported in other studies (Jones 2007; Jansson, Pilhammar and Forsberg 2009). While the studies reported the nurse led the admission interview, there were several important differences in terms of attending to the patient as an individual. In the next section, the behaviours and skills employed by nursing staff during admission interviews concerning a person-centred approach are presented.

2.5.2 Person-centred care

An early study by Elms and Leonard (1966) reported on the effect of different nursing approaches during patient admission to a hospital setting. Patients were assigned to three groups, one of which provided patients with a patient-centred nursing approach while the other groups experienced a task-oriented approach. The study hypothesis was founded on patients experiencing a patient-centred approach would have the stress associated with hospital admission alleviated and express greater satisfaction. The term 'patient centred' appeared in several early studies included in the literature review (Wong 1979; Mulhearn 1989; Roberts 2005; Jones 2007; Jansson 2009). The term is comparable with 'person-centred' care, which refers to similar principles in current nursing practice and healthcare.

Elms and Leonard (1966) found that patients who received a patient-centred nursing approach instead of a task-oriented approach reported that the nursing care provided had exceeded their expectations. However, the authors noted that all patients in the study expressed satisfaction with their admission and attributed this finding to an unwillingness of patients to be critical at such an early stage of their hospital stay (Elms and Leonard 1966). One of the data collection methods in the study by Elms and Leonard (1966) involved obtaining and monitoring vital signs, that is, blood pressure, pulse, and respiration rate, for comparison before and after admission. However, the findings did not show any significant differences between the three groups. The authors recognised that a range of other factors may have affected individual patient results, for example, the surrounding environment.

The overall findings suggested that a patient-centred approach might help patient welfare but the authors concluded that further research was necessary as the results were inconclusive (Elms and Leonard 1966). Wong (1979) replicated the study by Elms and Leonard (1966) and found positive differences in the patient's physiologic welfare in similar admission situations. However, the relevance of the reported findings is uncertain in the present day due to our knowledge and understanding of the wide range of factors that can affect physiologic measurements. Wong (1979) also found, similar to Elms and Leonard (1966), that the patients reported favourably on the use of a patient-centred approach during hospital admission. Although other than implementing an additional data collection tool, it is unclear what the study added in terms of new knowledge on the subject.

VanCott (1993) reported that patients felt the nurses had shown a personal interest in them and thus had experienced individualised attention. Nonetheless, it is unclear what the patients' meant by the term 'individualised attention' as it may have differed from person-centred care. In contrast, Jones (2007) found that the nursing work involved in patient

admission and the routine approach adopted by nurses was in opposition to the principles of person-centred care. Furthermore, Jansson, Pilhammar and Forbes (2009) reported that in terms of providing person-centred care, the nurses all focused on the physical and social needs of patients with emotional and cultural needs overlooked. The nurses in the study openly reported that they would omit questions that enquired about the patient as a whole as they felt unrelated to the care they provided (Jansson, Pilhammar and Forbes 2009).

The opportunity to discuss events that led to the need for admission and discover the patient's understanding of their current situation was considered essential for developing an individualised nursing care plan (Kruijver et al 2001; VanCott 1993). While Jones (2007) concluded that the assessment of patients on admission to a hospital setting in practice varied significantly from the descriptions provided in the nursing literature. The contradiction noted between nursing theory and clinical practice has raised questions about the quality of information obtained and the lack of a person-centred approach during admission (Jones 2007; Jansson, Pilhammar and Forsberg 2009; Jones 2009).

2.5.3 Nurse-patient relationship

Nursing textbooks refer to patient admission as an opportunity for the nurse-patient relationship to begin and develop (Lister, Hofland, and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015). In addition, several of the papers included in the literature review commented generally on the nurse-patient relationship within the context of the admission interview as a feature of nursing practice (Price 1987; Mulhearn 1989; VanCott 1993; Jones 2007; Jones 2009; Jansson, Pilhammar and Forsberg 2009; Kruijver et al 2001).

A few studies did make specific reference to the nurse-patient relationship as part of their findings (Mulhearn 1989; Kruijver et al 2001; Jansson, Pilhammar and Forsberg 2009). For example, Mulhearn (1987) found that adopting a patient-centred approach through a structured assessment document helped to facilitate the nurse-patient relationship. However, several factors were also reported as influencing the development of the nurse-patient relationship. These ranged from behaviours that neglected patients' emotional and psychosocial needs (Price 1987; VanCott 1993; Kruijver et al 2001; Jansson Pilhammar and Forsberg 2009) to limitations that arose as a consequence of a standardised or routine approach (Jones 2007; Jones 2009; Højskov 2014).

A number of the studies highlighted the admission interview as an opportunity to influence and develop the nurse-patient relationship (Kruijver et al 2001; Jones 2007; Jones 2009; Jansson,

Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). In terms of specific findings, Kruijver et al (2001) reported that the balance of communication during the admission interview was weighted towards the provision of information rather than building trust through effective communication skills. Similarly, Jones (2007) found that nurses adopted a distinctive style which resulted in an approach that deviated from both policy and nursing literature. The findings from these studies indicated the nurse-patient relationship could affect patient participation in the admission interview which is discussed in the following section.

2.5.4 Patient participation

None of the studies included in the literature review specifically examined the topic of patient participation during an admission interview. However, factors that affected patient participation during the admission interview were identified and discussed in some papers (Kruijver 2001 et al; Jones 2007; Jansson, Pilhammar and Forsberg 2009; Jones 2009). Behaviours that encouraged patient participation were rarely used with nurses often focusing on admission documentation (Jones 2009), adopting routine approaches (Jones 2007) and displaying communication styles that limited meaningful interaction (Kruijver et al 2001). A small study by Højskov and Glasdam (2014) reported that the nurses did not document any information that was individual to the patient and described nurses as not considering patient involvement as an important issue. Patient participation as a theme within the studies included in the literature review overall was minimal.

The themes presented in this section and section 2.4 share several key features across the literature reviewed which can also be linked with core nursing concepts thus adding to the ambiguity regarding the nursing role in admission interviews.

2.6 Conclusion and rationale

This chapter has demonstrated the admission interview between nurses and patients is a regular aspect of nursing practice described as an opportunity to assess patient needs, plan nursing care, and develop the nurse-patient relationship (Lister, Hofland and Grafton 2020). Of the fourteen papers included in the literature review, all research studies were conducted within hospital settings. Two of the papers included were reports on quality improvement project work linked with patient admission (Roberts et al 2005; Ackman et al 2012). The existing literature relates to studies that took place between 1966 and 2014. No new studies have been added to the evidence base in the last decade, despite advances in nursing roles, and as a result contemporary evidence for this area of nursing practice is lacking.

Five papers included in the review presented data from older studies that explored patient admission interviews and provided a foundation for how the nursing role has evolved and responded to nursing developments (Elms and Leonard 1966; Wong 1979, Price 1987; Mulhearn 1989; VanCott 1993). Only two studies have explored the nursing admission interview as a distinct event (Jones 2007; Jansson, Pilhammar and Forsberg 2009). The remaining papers reported on specific subjects within the admission interview: communication skills (Kruijver et al 2001), admission procedures (Gray and Cavanagh 2002), professional competence (Rischel, Larsen and Jackson 2007), documents and patient participation (Jones 2009) and construction of written documents (Højskov and Glasdam 2014).

Although the literature search produced a limited number of primary research studies, the main body of evidence included papers from high-quality, peer-reviewed international journals. The research designs were appropriate to the study methodology, with detailed reporting of findings and recommendations for practice. However, a number of the papers included in the review were from other countries, and some translation issues were evident (Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). Two papers reporting on quality improvement papers were also included due to the limited body of evidence available (Ackman et al 2012; Roberts et al 2005).

To date, studies that have explored patient admission as a distinct nursing event examined nurse-patient interaction (Jones 2007; Jones 2009) and the processes around nursing assessment and decision making (Jansson, Pilhammar and Forsberg 2009) from a generalist perspective. While the narrative in general nursing textbooks refers to the range of knowledge and skills required to undertake patient admission, no studies have explored the role and contribution of the registered nurse in patient admission from the perspective of a hospice or palliative care setting.

Evidence-based approaches to clinical practice aim to integrate the best available evidence to support the delivery of appropriate care, proficiently and effectively, and ultimately better attend to patient needs (WHO 2017). A holistic and person-centred approach are core principles in the provision of high-quality palliative nursing care and yet our understanding of the nursing role in patient admission is limited to a relatively small body of literature.

In the previous chapter, patient admission was discussed and highlighted as an area that warrants further examination. A study to explore the role of the registered nurse during a patient admission to a hospice setting will help to generate new knowledge and add a new dimension to the existing evidence base. After considering the background literature and presenting the rationale for the study, the next chapter discusses the study aims, research methodology and design

Chapter Three: Research Methods

3.1 Introduction

The chapter briefly describes theoretical perspectives and how my beliefs and assumptions support the selected research approach, with a rationale for a qualitative approach provided in section 3.3. The research questions which guided the study are presented in section 3.4. In section 3.5 an overview of different qualitative research designs are presented including a justification for the selected research design of case study.

Next, the selected case study framework is presented with a description of how it was applied to this study. Ethical considerations are discussed in section 3.6 with methods for recruitment, data collection and data management detailed in sections 3.7, 3.8 and 3.9. Finally, the approach to data analysis using the selected case study framework is provided in section 3.10 and concludes with a summary.

3.2 Theoretical perspectives

Creswell (2014) advises that researchers consider research design and methods and reflect on their theoretical perspective when planning a study. A researcher's own beliefs and assumptions will influence how they approach the study design, data collection, analysis and the presentation of results (Bryman 2012). Various terms have been used to describe a researcher's theoretical or philosophical orientation about the world, such as worldviews, paradigms and perspectives (Cresswell 2014; Gray 2014).

Social constructivism provides a worldview where lived experiences and interactions with others are constructed to provide multiple realities (Creswell 2013). By seeking to understand the world in which individuals live and work, there is a continual state of construction and reconstruction where individuals adapt to their situation (Bryman 2012; Gray 2014). The constructivist perspective relies on broad and general questions to help construct meaning around the phenomenon from the participant's view of the situation (Creswell 2014).

Bryman (2012) describes how constructivism as an ontological position links with the epistemological position of interpretivism and how both are associated with qualitative research approaches. Interpretivism respects the distinctiveness of humans where the social world is constructed differently with different meanings for each person and the situation (Bryman 2012; Thomas 2016). A contrasting worldview is positivism, where deductive theory builds hypotheses around what is already known and precedes data gathering (Bryman 2012). Positivism and postpositivism represent worldviews often associated with a scientific approach

where problems are studied to assess causes, effects and outcomes using observation and measurement to develop knowledge (Cresswell 2014). Table 3 provides a summary of the major elements for each worldview presented.

Table 3: Comparison of Worldviews (Cresswell 2014 p6 – modified from source)

Postpositivism	Constructivism
<ul style="list-style-type: none"> ▪ Determination ▪ Reductionism ▪ Empirical observation and measurement ▪ Theory verification 	<ul style="list-style-type: none"> ▪ Understanding ▪ Multiple participant meanings ▪ Social and historical construction ▪ Theory generation

The literature review presented in Chapter 2 highlighted the limited body of evidence available regarding the role of the registered nurse in patient admission. The focus of my research study was to build understanding and generate new theory by adding a new perspective from palliative care nursing. Bryman (2012) describes a deductive approach as relying upon existing theory to generate hypotheses to test or guide data collection and was not appropriate for my study.

An admission interview is a distinct event in nursing practice that occurs regularly in clinical settings. However, each patient admission involves different individuals and circumstances. Therefore, adopting an evolving research design that sought to understand multiple realities and consider participants' views were important considerations (Robson 2011). My personal position and theoretical assumptions align with a constructivist worldview by seeking to understand the context within which practice occurs and how those individuals live and work in that world (Cresswell 2014). An inductive approach also provided the opportunity to adopt a research design that would contribute to our understanding by interpreting data from the field (Cresswell 2014; Thomas 2016).

3.3 Rationale for a qualitative approach

Admission is a recognised and regular feature of nursing work (Jones 2007). Yet, the literature review found that few studies have explored the role of the registered nurse in patient admission. Early studies used a quantitative approach to measure physical parameters to establish a correlation between patient anxiety levels and admission to hospital (Elms and Leonard 1968; Wong 1979). In specialist palliative care settings, contextual factors related to admission can be heightened due to sensitivities linked to patients with life-limiting conditions. However, patients and staff in these settings should have the same opportunities

to participate in research by contributing towards and developing practice in palliative and end-of-life care (Addington-Hall 2002; Farquhar and Phillips 2018).

A qualitative approach emphasises generating theory by studying participants in their setting through observation and gathering details of their experience (Cresswell 2014). For example, exploring questions around life experiences, beliefs, motivations, actions, and perceptions of patients and staff supports interpreting and understanding human experience (Moule and Goodman 2014). However, other authors have argued that a qualitative approach is too subjective, difficult to replicate, lacks transparency, and the scope of the findings may be restricted (Bryman 2012; Gray 2014).

Specialist palliative care services are available to a relatively small number of patients within the wider palliative care patient population (Clark et al 2014; Dixon et al 2015). Grande and Todd (2000) found that the patient population in specialist palliative care settings was small and encountered difficulties with recruitment, high attrition rates, and ethical approval. However, working with smaller numbers in qualitative studies provides a greater level of detail of the participants' understanding and interactions in a specific setting (Silverman 2013).

A qualitative approach also provided an opportunity for an interpretative inquiry where the study focused on understanding the 'meanings that people are constructing of the situations in which they find themselves' (Thomas 2016 p204). A flexible study design also helped explore the participants' views of an admission interview within a real-life context and add a new perspective to the existing evidence base (Robson 2011). The following section presents the research questions which subsequently guided the research design employed for the study.

3.4 Research questions

My research study aimed to investigate the role of the registered nurse during a patient's admission to a hospice. The central purpose of any research is to answer questions related to the phenomena being explored (Robson 2011). The research questions were as follows:

1. How does an admission occur between a registered nurse and a patient in a hospice?
2. What is the role and contribution of the registered nurse during an admission of a patient to a hospice?

3.5 Research design

This section considers qualitative research designs beginning with action research, followed by phenomenology, ethnography, and case study. The section closes with a justification for adopting a case study design and provides a summary of the case study framework by Thomas (2016).

3.5.1 Action Research

Action research is defined as an inquiry, which attempts to describe, interpret and explain a situation or event resulting in an intervention to bring about or introduce change (Froggatt and Hockley 2011). A central feature of action research is influencing or changing practice using a collaborative and interactive style that links the theory and practice gap (Robson 2011; Hegney and Francis 2015). The approach should result in a partnership that helps those involved raise questions about understanding their work and consider how processes of change may be implemented to help resolve the problems identified (McDonnell and McNiff 2016).

There is an emphasis on participation by working with those involved in an educational and empowering way (Froggatt and Hockley 2011). A cyclical process of inquiry involves key stages of planning, action, observation and reflection. Reflection is a critical part of an action research design that allows the group to consider what has already been accomplished, review the data analyses and identify outcomes to plan for the next cycle (Hegney and Francis 2015). The cycles are then repeated until the research questions or objectives have been achieved.

There were several factors to examine when considering action research as a research design to investigate the nurse's role in patient admission. The direction of an action research study should result from mutually agreed goals between the researcher and those involved (De Chesnay 2014). A lack of independence between the researcher and the participants is acknowledged as a potential conflict of interest that may affect the study results (Waterman et al 2001). In contrast, if all parties involved are classed as 'insiders', the study then lacks the observations of 'outsiders' who may be more critical in their role and help challenge from a more naïve perspective (Hegney and Francis 2015).

Other criticisms of an action research design include findings limited to that particular setting, methodological arguments regarding the rigour of the data generated and the techniques used for analysis (Bryman 2012; Robson 2011; Hegney and Francis 2015). A key aim of action

research is to bring about change or improvement within the context and setting of the study (Froggatt and Hockley 2011). Action research focuses on an identified problem that requires further investigation, and it was not clear what problems existed concerning the role of the registered nurse in patient admission. Therefore, an exploratory research design was required to help explain how the phenomenon occurred in nursing practice rather than identifying and investigating a specific problem.

3.5.2 Phenomenology

Phenomenology refers to a research design, a philosophy and an approach that attempts to understand human behaviour by describing and interpreting human experience within the same phenomenon (Moule and Goodman 2014). There is an emphasis on developing an understanding of the shared experience of the phenomenon and what the participants have in common through their subjective and objective experiences (Creswell 2013). Participant selection ideally includes a diverse group of participants to enhance the possibility of collecting unique stories of their experience of the phenomena (Laverty 2003).

Data collection methods often involve multiple in-depth interviews with participants until saturation is achieved or no new information is obtained (Creswell 2013). Researchers aim to use a phenomenological approach to provide an accurate description of the phenomena from the participant's perspective (Groenewald 2004). Creswell (2014) refers to the description as providing an 'essence' to represent those who experienced the phenomenon.

Few studies have explored the role of the registered nurse in patient admission, and none have included the patient as a participant. The phenomenon under investigation for my study was specific to exploring the role of the registered nurse during patient admission to a hospice. As a phenomenon, patient admission has been described as regular nursing work driven by processes to follow or a bureaucratic task (Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014).

Each patient admission to a hospice setting is unique and warrants an individualised approach where shared experiences of the phenomenon may be limited. Also, the patients have a life-limiting illness and consideration of the potential for repeated and in-depth interviews was deemed neither practical nor sensitive to the setting.

3.5.3 Ethnography

Ethnography is a design of inquiry coming from anthropology and sociology. The researcher becomes immersed in the study setting to help explore and explain human experience and their social world (Holloway 2008). The main features of ethnography focus on the researcher studying and understanding the behaviours, actions and events of a group of people as a participant-observer (Robson 2011). The roles of participant and observer are fundamental in ethnographic fieldwork and involve mental, physical and emotional work to help the researcher gain 'an insider's view' (Atkinson 2015).

The research design is driven by existing theory, which the researcher uses to formulate new questions and support the need for further understanding (Holloway 2008). Data collection involves producing field notes, diaries and memos to record the researcher's observations, interactions and interpretations (Holloway 2008). Other sources of data may include interviews and documentary evidence. Analysis is an ongoing and progressive process as data generation helps inform and reshape the research questions in a cyclical rather than linear manner (Holloway 2008).

Some recent ethnographic studies have simplified their approach by employing a single strategy for data collection, sometimes referred to as 'mini-ethnographies' (Robson 2011). However, Atkinson (2015) argues that 'micro' studies fail to reflect the complexity of everyday life in the natural setting, a central feature of ethnography. For novice researchers, challenges include a high level of personal commitment, understanding of sociological and anthropological perspectives, and a willingness to be flexible and reflexive in the researcher role (Atkinson 2015; Creswell 2013).

The role of the registered nurse during a patient admission does not fit with studying a culture-sharing group where the interaction between participants is over prolonged periods. Also, ethnographic studies often involve large numbers and extensive fieldwork. As a result, concerns around funding, resources and data management need to be considered (Creswell 2013). In addition to practical aspects, there were also potential methodological issues relating to multiple interviews with participants and finding common features across patient admission. However, case study provides a research design that can include ethnographic elements in the study design (Robson 2011; Thomas 2016).

3.5.4 Case study

Case study is the final research design discussed concerning a study to investigate the role of the registered nurse during a patient admission to a hospice. Case study offers a research

design of an investigative nature where the purpose is to undertake an intensive examination of a case to develop an in-depth understanding (Bryman 2014; Rowley 2002). Patient admission is a regular and customary aspect of the nursing role in a hospice setting, yet the work involved is poorly understood. Case study provides a flexible approach that helps provide an in-depth examination of complex issues within real-life contexts (Crowe et al 2011; Carolan, Forbat and Smith, 2016).

A methodological strength of case study is the flexibility to include different practical, ethical and theoretical considerations (Walshe et al 2004). Differing theoretical perspectives influence case study and can cross between inductive and deductive approaches to theory and qualitative and quantitative research traditions (Walshe et al 2004; Thomas 2016). Several frameworks to guide case study are available, with two prominent authors leading the field, Stake (2005) and Yin (2014). A third contemporary case study framework by Thomas (2016) was also considered.

Yin (2014) does not promote alignment with a specific theoretical perspective but advises that theory should inform and guide the design of a case study. As a result, both quantitative and qualitative approaches can inform data collection and analysis (Brown 2008; Yazan 2015). A case study framework based on the work of Yin has been described as a methodical and systematic approach that follows an investigative path using clear and defined processes (Brown 2008). The study's aim was to explore the role of the registered nurse and my own beliefs align with the theoretical perspective of social constructivism.

The case study framework by Stake (2008) aligns with an epistemological position of interpretivism through the construction of knowledge gathered through investigation (Brown 2008; Yazan 2015). In contrast to the investigative nature of the case study approach by Yin, Stake describes the work involved as interpretive and reflective (Brown 2008). A key component of the case study framework by Stake is to discover meaning and understanding by the researcher participating and experiencing the case within context (Harrison et al 2017). Interviews and observations are the desired data collection methods, with the researcher seen as a partner by participants (Harrison et al 2017). Being cognisant of the study site and the sensitivity around participants and observational opportunities led to the consideration of employing a more comprehensive range of data collection methods to support the case study approach.

The case study framework by Thomas (2016) is based on the theoretical perspective of holism, where the phenomenon under investigation needs to be understood as a whole.

Holism is described as attending to questions raised through social inquiry by assuming 'the whole is more than the sum of the parts' (Thomas 2016). There are similarities between the case study frameworks by Thomas (2016) and Stake (2005), with an emphasis on understanding the distinct and complex nature of the case. Thomas (2016) described case study as an opportunity to 'drill down' and create a 'three-dimensional picture' that results in a deeper and more objective view. Thus providing a method of inquiry that allowed for an investigation of a case as a whole, rather than concentrating on specific individual parts (Bryman 2014; Rowley 2002; Thomas 2016).

The exploratory nature of a case study design has resulted in some criticism that the approach forms a purely preliminary stage rather than a research method in its own right (Hyett, Kenny and Dickson-Swift 2014). There have also been some deliberation regards findings not being generalised at a broader level, thus resulting in a potential lack of rigour (Rowley 2002). Also, the intensive engagement with one case has the potential for the 'Hawthorne effect' among participants and the researcher (Payne et al 2006). Therefore, a research protocol with a clear rationale and procedures for systematic data collection and analysis were put in place to help address any concerns. In summary, the research design selected for the study was a qualitative, multiple case study using a framework developed by Thomas (2016).

3.5.5 Justification for adopting a case study design

When planning a study, Cresswell (2014) proposed that researchers needed to be clear and consider their own beliefs to justify their decision when adopting a qualitative, quantitative or mixed methods approach. The opportunity to seek interpretation of the world we live in and work aligns with a constructivist perspective and a qualitative research approach (Robson 2011). Case study offers a degree of flexibility through small sample sizes and the opportunity to gather multiple perspectives where situations can be complex (Walshe et al 2004; Payne et al 2007). In previous sections, other qualitative research designs were considered but discounted due to methodological and practical considerations.

A case study design supported the study's aim to investigate the registered nurse's role during patient admission to a hospice. Few studies have examined the role of the registered nurse during patient admission, and nursing theory was limited regarding an aspect of practice that is a regular aspect of nursing work. Walshe et al (2004) assert that a case study design is appropriate when; there is a need for congruence between research and clinical practice, other methodologies are difficult to apply, and there is a lack of theory. The case study

framework by Thomas (2016) offered an opportunity for an in-depth exploration of the phenomenon using multiple methods to look at the processes involved within a real-life context. The framework involved two key elements, studying the subject as a whole and applying an analytical frame using four distinct categories.

Thomas (2016) uses the term 'holism' to describe and place importance on viewing context and behaviours as a 'whole' through consideration of cases are 'more than the sum of their parts'. The link to a familiar theoretical perspective is unclear; nonetheless, an association with interpretative inquiry is apparent. Thomas (2016 p204) refers to constructing meaning from situations 'to help understand the social world', which fits the social constructivism perspective described in section 3.2.

3.5.6 Case study approach by Thomas

The case study approach by Thomas (2016) is based on the premise that case study design involves two key elements: the subject as a whole and the application of an analytical frame. There are four distinct categories to consider within the analytical frame: [1] subject [2] purpose [3] approach and [4] process. The categories are intended to help to 'think about, contextualise and frame' the case study rather than follow a rigid, step-by-step approach (Thomas 2016 p98). The selected case study design by Thomas (2016) supports the application of a flexible design framework to answer the original research questions. Within the following sections, the four categories are presented and describe how Thomas (2016) informed the case study approach rather than be applied rigidly.

[1] Subject

Cresswell (2013) described how case study research begins by identifying the case, defined within specific parameters. Thomas (2016) refers to three different types of case study subjects: key case, outlier case and local knowledge case. A local knowledge case refers to when the subject is an example of something that we understand but also a desire to find out more (Thomas 2016). Patient admission is a regular aspect of nursing work, but few studies have explored how and what happens during the event. Therefore, developing our understanding of nursing practice regarding patient admission fits with a local knowledge case.

Thomas (2016) describes the subject as the lens through which the phenomenon is viewed and examined to help explore the circumstances of the situation. In this study, each case was defined or bound by an event where a face-to-face discussion occurred between the patient

and the registered nurse shortly after arrival to the hospice, that is, the admission interview. A qualitative case-study approach provided the opportunity to develop an in-depth understanding of the subject using a range of methods (Thomas 2016). Therefore, the composition of each case included non-participant observation, documentary interrogation and semi-structured interviews with the participants present at the admission interview. The participants included the patient, the registered nurse, the doctor and relatives (if present).

[2] Purpose

Following the selection of the subject, the analytical part of the framework begins by considering the purpose or object of the study. Thomas (2016) draws on the work of Stake (2005) to describe the purpose of a case study by two specific terms: 'intrinsic' as being driven by pure interest or 'instrumental' where there is a specific purpose in mind. The study aimed to investigate the role of registered nursing in patient admission to a hospice. The purpose of the case study is to provide insight into how the phenomenon occurs in practice (Thomas 2016).

Additional terms can also be applied to expand further on the purpose of the case study, such as evaluative, explanatory and exploratory (Thomas 2016). The term explanatory describes the 'unpacking' of a phenomenon by revealing its characteristics and features (Thomas 2016). The overall purpose of the case study is to achieve a greater understanding and meaning of the nursing work involved in patient admission and thus inform future developments in nursing practice, education and policy. In summary, the purpose of case study was defined as both 'instrumental' and 'explanatory'.

[3] Approach

Thomas (2016) suggests that the approach selected helps clarify how the data will be collected and analysed based on whether the purpose helps to build theory or test theory. An interpretative approach offers a form of inquiry that involves answering questions that will lead to a comprehensive understanding of the phenomenon and the environment (Thomas 2016). For example, gathering different perspectives to understand both individual and shared meanings of the processes and the context under investigation (Crowe et al 2011). Thomas (2016) highlights how interpretations are made alongside data collection to help either build, test or illustrate theory. Data collection methods included observation, participant interviews, documentary interrogation and field notes.

[4] Process

The process begins with a decision regarding whether the case study should focus on a single case or comprise of multiple cases. The findings from a single case study are seen as vulnerable due to limitations regarding generalisation. In contrast, multiple case study offers the opportunity for comparison and replication to help strengthen results (Crowe et al 2011). In addition, a multiple case study provides the opportunity for cross-case analysis rather than relying solely on the description of one case (Bryman 2012; Thomas 2016).

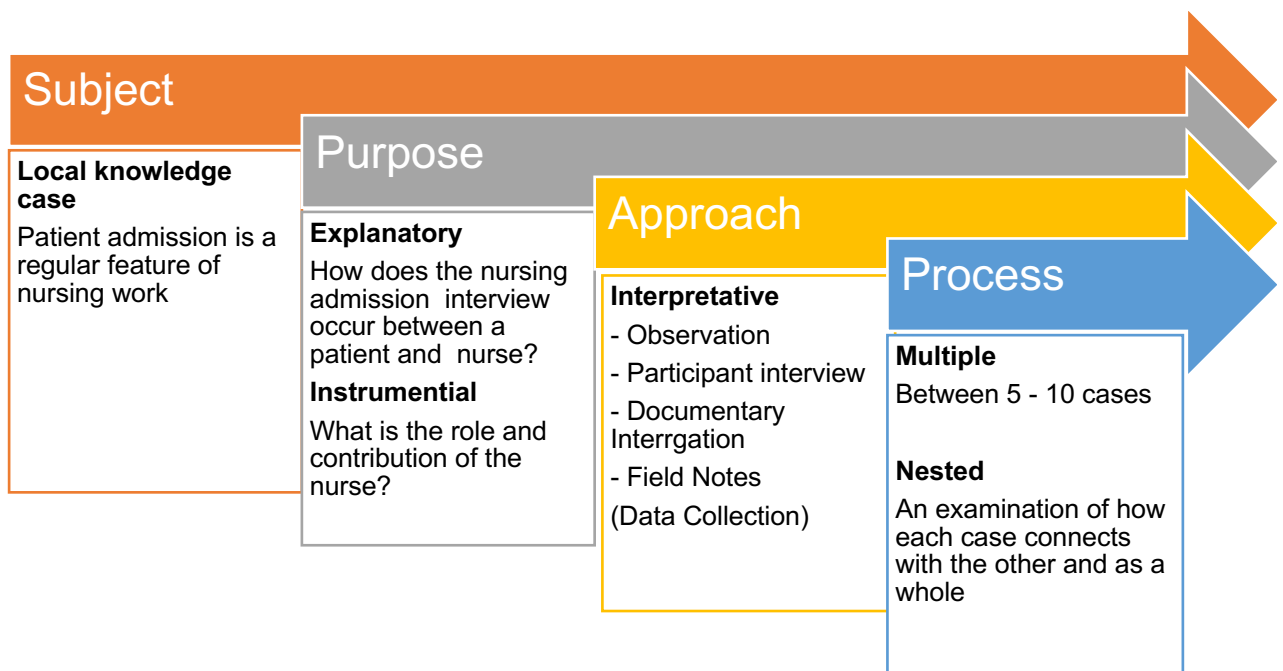
Although a multiple case study can generate large amounts of data, researchers should be cautious of describing rather than analysing data (Meyer 2001; Thomas 2016). In terms of sample size, there is no specific systematic solution for determining the sample size required for a multiple case study. Still, five or more cases are suggested if the theory is not straightforward (Yin 2012).

The process of case study is developed further by consideration of how it is conducted. Thomas (2016) uses the term 'nested' similar to the term 'embedded' used by Yin (2003) to describe how each case fits within a larger unit. This can be particularly useful when the boundaries and context are not clear (Yin 2003). Each case has relevance but it is how they are connected and ultimately with the phenomenon as a whole that is important (Thomas 2016). Each patient admission differs in terms of the context, individual circumstances and the participants involved. A multiple, nested case study provided the opportunity to examine each case and compare and contrast the data gathered, thus helping to identify important theoretical features (Thomas 2016).

3.5.7 Summary of the analytical frame

A summary of the analytical frame recommended by Thomas (2016) is displayed in Figure 2. The headings for subject, purpose, approach and process are supported with additional information connected to the study. Thomas (2016) cautions against a rigid application of the framework as the approach should be driven by the research question(s) rather than fit with the research design. However, describing the context of the case and selecting suitable methods of analysis should be fundamental to the case study approach (Thomas 2016) which is provided in sections 3.10 and 3.11.

Figure 2: Application of analytical framework (Thomas 2016)



3.6 Ethical considerations

The following section sets out how ethical approval was obtained, followed by a discussion of the core ethical principles considered for the study.

3.6.1 Ethical approval

The study protocol was submitted to the NHS, Invasive or Clinical Research (NICR) at the University of Stirling with ethical approval granted in March 2018. The submission then proceeded via IRAS (Integrated Research Application System) and an NHS Research Ethics Committee. The following study documents were reviewed as part of the approval process.

- Participant Introductory Letters (Appendices 4-7)
- Participant Information Leaflets (Appendices 8-11)
- Participant Consent Form (Appendices 12-15)
- Participant Interview Schedules (Appendices 16-19)

Minor amendments were advised and completed following attendance at the NHS Research Ethics Committee meeting, with approval granted in May 2018 (Appendix 3). The study site was approached while NHS ethical approval was in progress, and an application was submitted for consideration by the internal Research and Development department at the hospice. The local NHS Research and Development department was also notified of the

study, but no additional permissions were required as the hospice was deemed a non-NHS site. All approvals were granted and in place by May 2018.

3.6.2 Consent

Informed consent is a fundamental requirement of research and ensures participants are fully informed of the purpose, methods, and intended use for the research findings, including understanding their participation and any potential risks (Thomas 2016). On arrival for admission, patients were assessed by hospice staff using inclusion and exclusion criteria (Table) to consider their suitability to participate in the study. Patients who indicated they were interested in participating and gave verbal consent to be approached were provided with further details about the study. The same process was followed for the healthcare staff and relatives present at the admission interview event.

All participants were given time to read the appropriate information leaflet (appendices 8-11) and consider their participation. Before obtaining consent, participants were provided with an opportunity to ask questions or raise any concerns. Written consent was obtained for all participants by the researcher before the admission interview took place. The admission interview occurred within a few hours of the patient's arrival at the study site. Accordingly, there was only a short interval to recruit and then consent participants. As a result, the cooling-off period was limited so, at the beginning of each interview, consent was verified again verbally at the beginning of participant interview. All participants were made aware of their right to withdraw from the study, both verbally and as documented in the participant information leaflets.

3.6.3 Confidentiality and anonymity

All participants were informed of their right to confidentiality and anonymity, following the General Data Protection Regulations (GDPR 2018) and Caldicott principles (1997). Data gathered and recorded during site visits was stored on a password-protected laptop with encryption software installed. All data were anonymised before storage by assigning a study identification (ID) number to all electronic and hard copies. Hard copies of data were stored securely in a locked drawer in a filing cabinet, in a locked room on-site or on NHS premises.

All audio recordings were uploaded to a server at the University of Stirling using a virtual private network (VPN), where recordings were stored securely and password protected. Participants were advised that all audio recordings would be destroyed upon completion of the study. All other data collected during the study was organised, anonymised and correctly

stored following the University of Stirling records management policy and will be archived for 10 years. Access to the data at the point of collection and subsequent storage was restricted to the principal investigator and academic supervisors.

3.6.4 Beneficence and Nonmaleficence

The principles of aiming to help (beneficence) and doing no harm (nonmaleficence) were considered for the participants and the study site. The potential risks were associated with observation of the admission interview and participant interviews. The admission interview occurred as it would normally in practice, and a non-participant approach for observation resulted in minimal inconvenience or disruption. The healthcare staff present at the admission interview were cognisant of the general condition of the patients involved and responded to their individual needs throughout as a primary concern.

Interviews were held in a place and at a time that was convenient to all participants. Patient interviews were approached carefully by asking patients to share their interpretation of how the admission had occurred rather than revisit clinical information that could cause distress. All participants were invited to reflect on their experiences and share their views openly, which occasionally resulted in criticism of processes and procedures. As an experienced palliative care nurse, any concerns expressed by participants were handled sensitively and sympathetically. For example, in Case Three, when the patient interview ended and the recording stopped, the patient wanted to continue to chat. The patient clearly understood my role was independent of the clinical team but appreciated the opportunity to talk about his career and family life.

3.7 Sample and Recruitment

Information regarding the study sites, sampling strategy and sample size is discussed. The section focuses on participant recruitment and closes by discussing recruitment challenges encountered during the study.

3.7.1 Study site

The study site was a hospice located in an urban area of Scotland that provided care for adults with progressive, life-limiting conditions and their families. Facilities included an in-patient area, day patient area and outpatient services supported by a dedicated, multi-professional team including volunteers. Patients were admitted to the study site directly from home or transferred from a hospital within the region. The hospice accepted referrals for adults above the age of 16 years old. Admissions to the hospice were over 400 patients per year, with

patients admitted predominantly for assessment, end-of-life care, rehabilitation and symptom control. The average length of stay in a UK hospice is around 15 days (www.hospiceuk.org). For the patients who participated in the study, the shortest length of stay was 48hrs, and the longest stay was a couple of months.

The inpatient facility comprises of a mix of single and multi-bedded bays, with the nursing staff divided into two teams. The senior charge nurse had overall responsibility for the hospice and was involved in the planning and organising of patient admissions daily (Mon to Fri). Each team on duty had a designated nurse in charge who would inform the wider nursing team of planned admissions for that day. The nursing work related to patient admission was delegated to one of the registered nurses on duty. Bank or agency registered nurses occasionally supplemented the nursing team.

In all cases, the registered nurses who participated were permanent members of staff. The registered nurse workload comprised of supervising and supporting healthcare support workers to provide patient care as well as other core nursing work, such as drug administration, the completion of patient records, and liaising with members of the multi-professional team

3.7.2 Sampling strategy and case selection

Sampling in qualitative research design focuses on an experience, event or setting rather than on specific individuals (Grove, Gray and Burns 2015). The cases were defined within the context of patient admission to a hospice, specifically when a patient met with healthcare professionals for an admission interview. Thomas (2016) argues that sampling is not always necessary in case study research as the choice relates to selecting the subject matter as a whole and not just a portion of it.

Non-probability sampling describes when there is no intention or requirement to make a statistical generalisation about the population beyond those in the sample (Robson 2011). An example of non-probability sampling, known as purposive sampling, describes a need to identify the case by knowingly selecting specific participants appropriate to the research question (Creswell 2013). Patient admission within a hospice setting was the event that formed the basis of the case rather than an individual patient. All patient admissions were considered as potential participants during site visits. Some patients were excluded before arrival as information shared by the referrer deemed the patient not suitable for consideration, for example, communication issues or cognitive impairment.

To investigate each case as a whole, all perspectives of patient admission were explored including the patient, the registered nurse, the doctor, any relatives present and the patient record. The circumstances of each case were unique and capturing views from participants together with observation helped support the description of the conditions surrounding the case. Triangulation of multiple sources of evidence helped to support viewing the case from different directions and aid understanding (Thomas 2016).

Ahead of the patient’s arrival, the nurse and doctor identified as responsible for the patient admission were approached and invited to participate in the study. A case could not proceed unless all of those who intended to be present agreed to take part. Hospice staff met with patients shortly after their arrival and assessed their suitability based on inclusion and exclusion criteria (Table 4). If any of the participants declined, the patient admission continued as usual.

Table 4: Inclusion and exclusion criteria for participants

Inclusion Criteria		
Patients	Relatives / Carers	Healthcare Professionals
Adults (18yrs old or above) for admission to the inpatient facility	Adults (above 18yrs or above)	Registered Nurses – Band 5, 6 or 7
A life-limiting condition	Patient has given verbal consent for them to be present during admission	Healthcare professionals who participate in admission as part of their routine work within the hospice
Fluent in English	Fluent in English	Fluent in English
Exclusion Criteria		
Patients	Relatives / Carers	Healthcare Professionals
End of life care with a life expectancy of only hours/days	Distressed and/or upset	Bank or agency registered nurses (Band 5,6 or 7)
Acutely unwell, distressed and/or upset	Evidence of cognitive impairment or mental incapacity	Student nurses
Evidence of cognitive impairment or mental incapacity	Physical disability affecting speech/communication	Healthcare professional students
Physical disability affecting speech/communication		

3.7.3 Sample size

Case study offers a degree of flexibility through small sample sizes and the opportunity to gather multiple perspectives, particularly where a situation can be complex and difficult to define (Walshe et al 2004; Walshe et al 2011; Payne et al 2007). A single case study design has been described as vulnerable with concerns regarding their benefit from an analytical perspective (Yin 2014). However, there is no recognised formula for deciding upon the number of cases to include in a qualitative multiple case study design (Creswell 2013; Yin 2014). Cross-case analysis provided an opportunity for analysis both within and across cases in a multiple case study while focusing on the 'wholeness' of the study (Thomas 2016).

3.7.4 Patient recruitment

During the six weeks of data collection between June 2018 and Jan 2019, a total of 25 patients were considered for participation in the study. On arrival at the inpatient unit, the patient was welcomed and settled in by hospice staff following their standard procedure. If the registered nurse and doctor involved in the patient admission had consented to participate, the patient was approached by the nurse in charge to advise them of the study. The nurse in charge assessed if the patient met the inclusion and exclusion criteria based on their initial observations/impressions from staff and the patient history. If the patient met the criteria, the nurse in charge provided the patient with a verbal summary and introductory letter about the study.

If the patient agreed, the researcher met with them to explain fully what participation involved and provided the patient with a written information leaflet. The patient was given time to consider their involvement and discuss with family members if they chose to do so. For patients, the period between arrival at the study site and the admission interview was relatively brief. If the patient decided not to participate, staff were advised that the admission interview should proceed as normal.

3.7.5 Healthcare professional recruitment

During the first site visit, the charge nurses provided the names of all registered nurses working in the hospice. An introductory letter was distributed to all named registered nurses, which included a response slip to advise if they would be interested in hearing more about the study and consider participating. Registered nurses on duty during the first week were approached and introduced to the study, with several consenting to participate at that stage. Any doctors available during the first site visits were also introduced to the study, obtaining consent where appropriate.

It became clear that the number of staff working in the hospice was considerable compared to the number of cases required for the study. Initial plans were to obtain written consent from all registered nurses who might be involved in patient admission. However, the nursing staff worked a wide range of shift patterns, and it was not feasible to meet with them all. A rotational change among trainee doctors also meant those doctors currently involved in patient admission would have left by the next site visit.

By maintaining a presence at the hospice during site visits, there were opportunities to obtain consent from staff on the day of a patient admission. Each morning the ward staff were advised of planned admissions for the day and provided with a brief synopsis of the patient. A short conversation with the nurse in charge helped determine if new patients might be suitable participants for the study. Before the patient arrived, the nurse and doctor assigned to conduct the admission interview were approached to ask if they would consider participating.

Patients were only approached to inform them of the study if the nurse and doctor had agreed to participate beforehand. Consent was obtained from the nurse and doctor before admission interviews took place. By adapting the process for healthcare professional recruitment, only those staff involved in a patient admission, who had agreed to participate, were included.

3.7.6 Relative / Carer recruitment

On arrival to the inpatient unit with the patient, the relative/carer was welcomed by hospice staff, following their normal procedure. If the relative/carer informed staff they intended to be present during the admission interview, and the patient agreed, the relative was also considered for participation in the study. The nurse in charge assessed if a relative/carer met the inclusion criteria based on initial observations from staff. If the relative/carer met the criteria, the nurse in charge provided a verbal summary and introductory letter about the study.

If the relative/carer wanted to hear more about the study, the researcher met with them to explain fully what participation involved and provided a written information leaflet. If the relative/carer chose not to participate in the study but did consent for the admission interview to proceed, the case was included. To minimise any additional stress on admission, the patient and relatives/carers did not meet with the researcher until the nurse in charge advised they had clearly stated they wished to participate.

3.7.7 Recruitment challenges

The hospice team was very supportive of the study, and the senior nursing staff actively engaged in discussions about helping to identify and recruit patients. Reception staff were also informed of patient admissions and became a reliable source of information, preventing unnecessary interruptions to nursing staff and ward routines. However, breaks between site visits required staff to be gently reminded and prompted to introduce the study to the patient. The senior charge nurse and charge nurses were crucial supporters as their presence and leadership did help guide patient and staff recruitment. On days when senior nursing staff were not on duty, an increased physical presence within the hospice was required. And as a consequence, there were long periods of waiting around in the clinical area.

The hospice environment quickly became familiar, and as I became more comfortable in the environment, I became less visible after visiting 2 or 3 times. At the start of the study, when waiting in open areas of the hospice, nursing staff would enquire who I was and ask if they could help. With each site visit, more staff recognised who I was and less enquired if they could help when they saw me waiting. Also, as an experienced nurse, I could see when the clinical area was busy, which may have adversely influenced my decisions to interrupt ward routines and disturb staff to check on progress with planned patient admissions.

Patient distress or anxiety was one of the exclusion criteria. Staff reported that some patients were not approached or introduced to the study due to perceived or apparent distress. The short timescale between the patient's arrival and the admission interview required staff to make a judgment based on their initial impression of the patient and the situation. On several occasions, the nurse involved reported later that the patient 'would have been okay' to be considered for the study as their anxiety had reduced leading up to the admission interview.

Over the data collection period, there were only a few changes to the nursing and medical teams. In general, the doctors were keen to help with the research study and asked questions about current evidence and the rationale for the study. However, the nursing staff were a little more reticent, and their questions often related to what their participation would involve. An initial concern expressed was being observed during the admission interview and how this might adversely affect their performance. During one-to-one interviews with the registered nurses who participated, the majority commented on how quickly they forgot about the observation, the audio recording, and the researcher's presence.

During preparation for the admission interview, some relatives were present for some of the discussions with the patient about the study. The availability of family members to participate

was disappointing, but it was clear their primary concern lay with the patient's well-being and comfort. Only one relative agreed to a one-to-one interview but was not available during the site visit. Telephone interviews were not considered for relatives but may have been more acceptable as it would not have impacted the relatives' time with the patient when visiting.

3.8 Data collection

The case study framework by Thomas (2016) provided the opportunity to gather data in a real-world context to explore the nurse's role in patient admission in a hospice setting. Applying an interpretative approach involved using different methods to help view the phenomenon from different directions (Thomas 2016). The following methods were employed: [1] observation [2] semi-structured interviews [3] documentary interrogation and [4] field notes. The data collection methods are discussed in more detail in the following sections, along with a justification for their selection.

3.8.1 Site Visits

Bryman (2012) advises that consideration around access to the study site is essential, particularly when observation is part of the data collection methods. The plan for visits to the study site was arranged for five visits between June 2018 and December 2018, with the option to extend if necessary. All site visits were conducted from Monday to Friday as only emergency admissions were accepted at the weekend, which were excluded from my study.

The data collection methods selected required a physical presence at the study site, and considerations relating to geographical distance made weekly visits practicable. Spending a week at the study site provided the opportunity to become familiar with the environment, observe routines at the hospice, raise awareness of the study, and develop a professional relationship with the team.

3.8.2 Observation

Observation offers a fundamental method of gathering data where the purpose is to collect information regarding the study via the participants and the environment (Grove, Gray and Burns 2015). Observation predominantly includes two categories, either structured or unstructured. Non-participant observation is an example of unstructured observation where the observer is present but does not participate in the study setting (Bryman 2012).

Observation of the admission interview was considered necessary to witness how the event occurred in real-time. Thomas (2016) considers observation a key method for data collection and an opportunity to record important aspects of what happens. All participants were

informed of the observation of the admission interviews as part of the consent process. Any effect on the usual structure of the admission interview was kept to a minimum by the observer who did not participate other than be included in introductions and set up the audio recorder.

Note-taking was kept to a minimum to reduce interruption or distraction. At the earliest opportunity, notes from the observation were reviewed, with any personal reflections and initial analytical thoughts added. Audio recordings were an additional source of data and provided the opportunity to examine what was said during admission interviews before transcribing at a later date. The recordings also helped to give an accurate version of events and reduced intuitive interpretations (Bryman 2012).

3.8.3 Participant Interviews

Semi-structured interviews with participants provided an opportunity to cover a range of issues rather than follow set questions and allowed details to be clarified or explained further as required (Thomas 2016). An interview guide was used for each group of participants to help provide some structure and consistency (appendices 16-19). The interview guide for each group of participants varied slightly. The patient interview schedule focused on questions about their experience of the admission interview, the role of the nurse and their involvement in the discussion. Questions on the interview schedule for the nurses were similar but also focused on their views regarding the purpose of the admission interview and how they would use the information gathered. The interview schedule for healthcare professionals also asked for their views concerning their perception of what the nurse did.

A flexible approach to qualitative interviewing can help the interviewee 'explain and understand events, patterns and forms of behaviour' (Bryman 2012 p471). The interview questions were designed to help interaction and cover the main theoretical features of the research topic (Kvale and Brinkmann 2009). The total number of interviews conducted for the study was 12; four patients, four nurses and four doctors. All interviews were audiotaped and, on average, lasted around 15 minutes.

3.8.4 Documentation

'Documentary interrogation' is the phrase used by Thomas (2016) to describe the careful reading of documents for meaning and substance, which forms part of the tools used for data gathering in case study. Yin (2014) also supports the use of documentation to help 'corroborate and augment evidence.' Critics of a case-study design often highlight the large amount of data gathered which can result in a loss of focus (Meyer 2001). Therefore, for this

study, an examination of the patient record was included but limited to information documented in the first 24-48hrs following admission.

For each patient, an electronic record was used to document information related to admission and accessed by the researcher as part of the study to capture what was recorded by nursing staff. Information entered by nurses on the patient record was guided by the patient management system, with an option to add free text as necessary. With the appropriate permissions in place, a member of the hospice administration team provided a paper copy of each patient's record upon request. The paper record was viewed immediately, a data extraction form was used to record relevant data, and all information was anonymised. Once the information had been extracted, the patient record was returned to the administration team, who signed a data destruction form and confirmed the printed record would be destroyed.

3.8.5 Field Notes

Field notes were recorded using a diary format during site visits from June 2018 to Jan 2019. Information relating to observations, conversations with staff and the setting helped record initial thoughts and interpretations (Bryman 2012). The first visit to the study site was preparatory. Field notes were extensive regards gathering contextual information, the systems and processes in place and initial impressions from discussions with staff.

Each site visit generated, on average, around 5000 words of field notes. Variation in the amount of field notes captured was reflective of activity during the site visit, such as the number of cases recruited. The information recorded included data specific to each case and personal reflections. The field notes remained unedited and supported data collection, coding, and analysis (Yin 2014; Thomas 2016). Examples from the field notes are provided below.

Case-specific:

Case One: Other issues were discussed during the patient interview, e.g. the need for subcutaneous fluids and the persistent saliva production / dry mouth but care plans referring specifically to this were not found in the patient record 24hrs after admission.

General:

Week Six: I had a good chat with the healthcare support worker (HCSW) who had approached me earlier. She started to ask questions about my study and I explained about my interest in the admission of patients. She was keen to tell me about the HCSW role and how they 'get to know' the patients as they spend more time providing

'one to one' care than the registered nurses. She felt that patients would often divulge information to the HCSW's that they may not with a registered nurse.

At the end of each site visit, the field notes were reviewed and organised to capture commentary, personal reflections and any questions that arose. The data from the field notes were added to an excel database and NVivo software programme.

3.9 Data management

Visits to the study site generated large amounts of data due to observation and audio recording of the admission interview, participant interviews, documentary interrogation and field notes. NVivo computer software was used to help organise, manage and store data. In addition, Microsoft Excel was also used to create an excel database. Each case had an individual spreadsheet based on the temporary constructs and the NVivo coding structure to produce a core template. Headings were then used to align the coding references from Nvivo to the temporary constructs on the template. An example of one temporary construct from the excel template is provided in Table 5. The database design was similar to constructing a matrix template as endorsed by Miles, Huberman and Saldana (2014).

Table 5: Sample of Temporary Constructs and Coding (Case Three)

CASE THREE: CODING SUMMARY							
Temporary Constructs	NODES	Node descriptor	SUB NODES	Sub node descriptor	Good examples from data	Contrary examples from data	Analytical Memo's / Notes / Questions
1. COMMUNICATION	a. Information Gathering	Data that describes or explains, actions or dialogue or references to the gathering of information by participants as part of the admission	i. Direct	Explores direct contact with patient	<i>Adm Interview: [1] RN: with you lying .. obviously because .. you're sore .. and if you lie down .. is there any areas that are sore just with pressure? Pt: well .. that's the point .. I thought that's what was on my hips .. RN: right .. Pt: but there are no actual sores .. no [2] Field Notes: The RN spends the next couple of minutes discussing skin integrity, specialist equipment needs, oral problems.</i>	<i>Patient Interview: Res: .. okay .. and that clarification .. did you think more of that was done through the nurse .. the doctor ..? Pt: no .. it was more the doctor ..</i>	13.01.19: Due to the complex history, the majority of references in this node related to discussion about symptoms between the patient and the doctor. The researcher did not code all possible references but chose to include core examples. The patient perceived that the Dr did most of the 'clarification' in this case which is correct.
			ii. Indirect	Explores indirect contact to gather information	<i>Patient Interview: Pt: for example .. there has been more than one doctor here .. to see me .. Res: yes .. Pt: .. and they are effectively asking me the same question .. Res: okay.. Pt:.. but there are already notes in place .. and it's as though .. probably part of the process .. reiterating the thing to make sure that what I've been saying .. is the same thing I've been saying .. so that they know it's the right treatment .. or whatever ..</i>	n/a	10.02.20: The patient mentions 'notes' that the healthcare professionals have access to. The patient also mentions repetition (by Dr's) but provides a justification why this may be necessary. The patient gave a very comprehensive history and articulated his needs well. <i>As a patient with a complex history and probably very comprehensive notes, the need to gather information from other sources was possibly not required to the same degree as other patients.</i>

3.10 Contextual Data

This section provides a brief outline of the study site, followed by an explanation of the processes in place for patient referrals. A description of the shared admission approach used at the hospice provides additional background information. The section concludes with a summary of the nursing team approach and a brief overview of the management system used for patient records.

3.10.1 Study site

The study site was a hospice located in an urban area of Scotland and provided care for adults with progressive, non-curative conditions and their families. Facilities included an in-patient area, day patient area and outpatient services supported by a dedicated, multi-professional team including volunteers. Research and education departments were also an established part of service provision.

3.10.2 Referral process for patient admission

Formal requests for patient admission to the hospice came via referrals from other healthcare professionals working in primary or secondary care. Secondary care referrals mainly came from local acute hospitals and other hospitals within the wider regional area. Although less frequent, direct admissions did occur through other services located within the hospice, such as outpatient clinics and the community specialist nursing team.

The planning and coordination of requests for patient admission took place at a daily bed meeting led by the senior nurse. Hospice staff attending the meeting discussed bed availability and staffing levels before agreeing on which patients were for admission that day. The inpatient nursing team were then informed of the agreed plan for patient admissions by the senior nurse.

Most patient admissions were planned and scheduled to arrive during working hours (Monday to Friday). Where possible, the hospice arranged for patient admissions to arrive between mid to late morning. Out-of-hours admissions only took place with the approval of the medical consultant on call and the nurse-in-charge. Patients referred to the hospice fell into three broad categories: end-of-life care, symptom control and assessment. The reason for admission provided at the point of referral for the patients admitted during the data collection period was mainly within these categories.

3.10.3 Shared admission approach

Within the hospice, the preferred approach for the patient admission interview involved a doctor and registered nurse meeting together with the patient at a mutually agreed time. Thus, staff informally referred to the patient admission interview as the 'shared admission'. The shared admission typically occurred mid to late afternoon on the day of arrival when staffing allowed.

The shared admission approach is not unique to the study site, with anecdotal evidence that other hospices and specialist palliative care settings have adopted a similar model. However, the evidence base is limited, with no research studies reporting on the shared admission approach within healthcare or hospice settings. In other healthcare settings, patient admission approaches primarily involve the nurse and doctor, who meet separately with the patient. The nurses and doctors who participated had experience with both patient admission approaches (see section 4.5.4).

3.10.4 Nursing team

The senior charge nurse had overall responsibility for the nursing team and the nursing care provided throughout the hospice. The inpatient accommodation consisted of a mix of single rooms and multi-bedded rooms. During the day, a charge nurse was usually on duty to provide support, guidance and leadership. The nursing team consisted of registered nurses, healthcare support workers and nursing students, with occasional support from bank and agency staff. Shift patterns for nursing staff varied including rotational work between day and night duty.

At the start of each shift, the nursing team were allocated a group of patients by the nurse-in-charge and informed of any planned patient admissions. The decision regarding who would be assigned to admit a new patient was discussed and agreed upon among the nursing team. Where possible, the admitting nurse would be on duty for the next couple of days to help provide continuity for the patient and staff. For all cases, the patient admissions were undertaken by a registered nurse who had worked in the hospice for between one and five years.

The medical team at the hospice included a range of staff grades from foundation year two to consultant level. The doctor involved in the admission interview worked at a junior or middle-grade level as part of a training programme placement for each case. Several allied healthcare professionals were also based permanently at the hospice, but none were directly involved in the shared admission approach.

3.10.5 Patient records

The hospice used a software package as a clinical management system that included an individualised patient record. All healthcare professionals working in the hospice who had the necessary permissions could view all entries and update the patient record. In addition, the nurses used the management system to; document patient information from admission onwards, summarise the care provided, complete risk assessments and formulate care plans.

3.11 Analysis

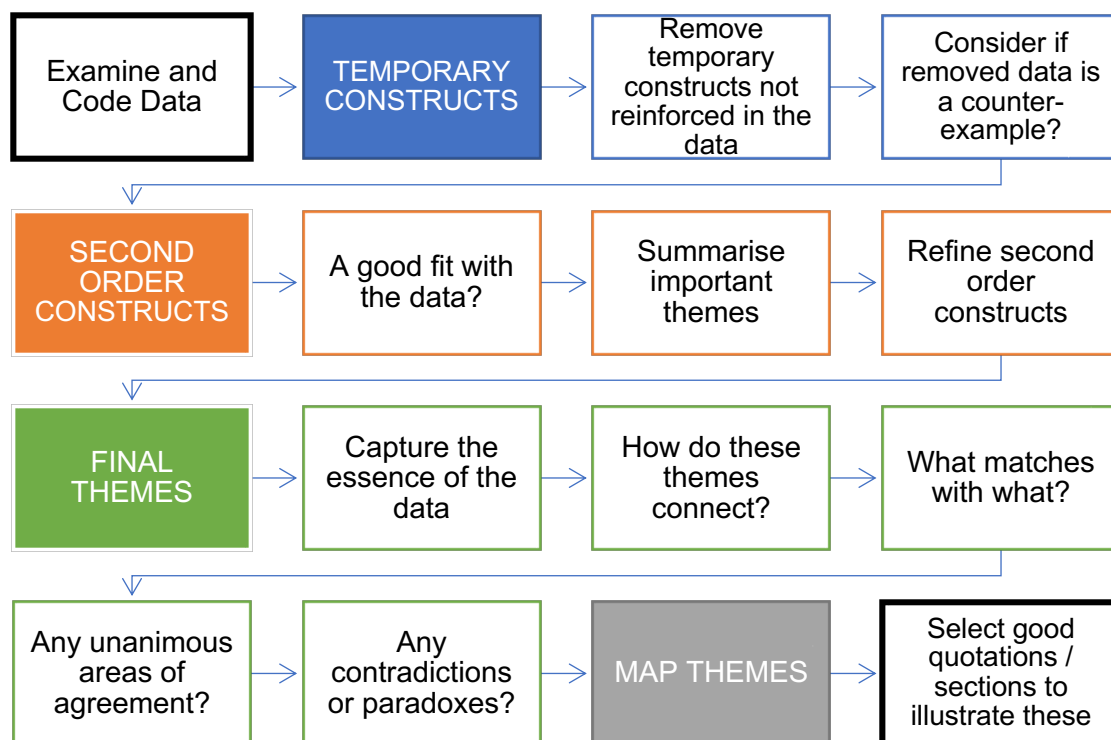
A good case study analysis uses all relevant evidence, considers the main rival interpretations, addresses the most significant aspect of the case study and draws on the researcher's own knowledge and expertise (Rowley 2002). The analysis aimed to explore the role and contribution of the registered nurse in patient admission to a hospice by developing an understanding of how the event occurs in practice. Thomas (2016) states that as well as being clear on the development of the analytical frame of case study, the analysis is recognised as equally important.

The methods selected for data analysis predominantly followed Thomas's approach (2016) however the approach to cross-case analysis and thematic analysis also incorporated methods by Miles, Huberman and Saldana (2018). In order to develop a holistic view, Thomas (2016) supports the use of a range of analytical methods to help see patterns and explore connections. The following sections present the approach and methods used including how the data was quality checked for the study.

3.11.1 Approach

The case study approach by Thomas (2016) recognises there is a range of methods to help with analysis. Figure 3 summarises the steps set out by Thomas to help guide analysis. The process began by examining and coding all data. Data coding was used to support analysis, with NVIVO used to help manage, categorise and store data. The final NVIVO codebook summarises the coding structure and shows the references aligned to the codes from the data (Appendix 22).

Figure 3: Summary of approach to analysis (Thomas 2016)



3.11.2 Constructs and Themes

Thomas (2016) advocates using storyboards to develop initial ideas and help create the analytical frame for case study similar to the principle of mind mapping. Initial ideas and thoughts were noted to help show how thinking developed around the subject and provide a visual summary of connections (Thomas 2016). The literature review helped identify preliminary themes around patient admission ahead of data collection and a mind map / storyboard was produced to illustrate these (appendix 23). The identification of themes helped to inform the temporary constructs and preliminary Nvivo coding framework.

Thomas (2016) uses the term 'constructs' to describe ideas or subjects that emerge from identifying important features from data, as shown in Figure 3. Following each case and supported by the data, the temporary constructs were reviewed and refined as the study progressed. A storyboard was produced to display the temporary constructs for each case as an iterative process and followed the steps of analysis recommended by Thomas (2016). Examples of storyboards from Case 1 and Case 5 are included (appendices 20 and 21) and show how the processes were developed and refined as the study progressed.

3.11.3 Case-by-case analysis

Analysis began by studying and interpreting each case in chronological order. Thomas (2016 p204) recommends that 'categorisation, sorting, finding coherence, simplifying and

synthesising' are essential to achieving good analysis. Each case generated large amounts of data. Therefore, data organisation was key to assisting later and deeper analyses (Miles, Huberman and Saldana 2014).

Audio recordings from the observed admission interviews and participant interviews were reviewed before transcribing to reflect on the content before coding. Miles, Huberman and Saldana (2014) describe coding as helpful to identify and classify core sections of similar data. All transcripts were coded using Nvivo software, with data also extracted and added to the Excel database. Nvivo software helped with the storage and coding of data and helped identify the emerging patterns and relationships in the data (Bazeley and Jackson 2013). The combination of Nvivo software, the excel workbook and an analytical frame (Thomas 2016) helped provide a clear structure to build knowledge and understanding of each case.

Within the excel workbook, each case had a dedicated worksheet with linked files embedded, for example, the corresponding storyboard and Nvivo codebook. Key points and reflexive notes were also compiled on a case-by-case basis. An example of the key points from Case Four is provided in Table 6. Pattern coding is described by Miles, Huberman and Saldana (2014 p86) as a 'second cycle method' for a grouping of categories, themes or constructs similar to the approach employed to develop constructs by Thomas (2016). During case-by-case analysis, the approach helped to condense large amounts of data, provide a schematic to build on, and present emerging themes for cross-case analysis (Miles, Huberman and Saldana 2014).

Table 6: Example of key points (Case Four)

CASE 4 KEY POINTS TO CONSIDER: May 2020
<p>1: Patient: The patient in Case 4 had experience of several hospital admissions in previous weeks and recent changes to his personal circumstances had adversely affected his mood. The main reason for admission was pain control but during the admission interview it became clear there were a number of issues to address. In comparison with other admissions, the patient stated he thought this one was more person to person. The patient appeared to hold a traditional view in respect of the doctor's role. He described the RN as taking a 'back seat' and 'that's their position'. An interesting view as based on the other cases, this RN was the most engaging and interactive so far.</p>
<p>2. Admission Interview: The doctor used the phrase to 'have a chat' and the RN the phrase 'to make you official'. Neither took the opportunity to explain in any detail what the shared admission would involve and what their roles were. *Check and compare with introductions from the other cases?</p>
<p>3. RN: In this Case the RN had worked in the unit for a couple of years, having moved from a local acute setting after working there for 2-3 years after qualifying. She appeared confident in her role. All of the RN's could be viewed as junior in respect of their time as qualified and their time working in the unit. The RN in this case participated in the discussion much earlier than in the other cases. She did not wait to be invited to ask a question, she responded to the patient's query if she knew the answer and asked for additional information when needed. When the Dr had completed their part of the shared admission she continued with her assessment when the doctor left. The RN in this case held different views to the other RN's. She felt that the shared admission model was not the 'best use of resources' and that she got more information from patient's when the 'formal' part was done i.e. not with the doctor. The RN was proactive before, during and after the admission interview. Were her listening and interpretation skills equal to the other RN's? Did she rely on her own assessment/judgment more than the information she heard the Dr obtain?</p>
<p>4. Dr: The Dr was a Specialist Registrar on a short placement to the hospice. She may have been unfamiliar with the processes / procedures specific to the unit but clearly articulated her view on what she required for a patient admission interview in general terms. However, the Dr was not clear on when / how the RN would get involved in the shared admission interview. The Dr introduced herself to the patient and led from that point, although the RN did interject and take the lead on some occasions.</p>
<p>5. Documentation: The RN mentioned that she would not record all of her initial impressions, i.e. patient's dry sense of humour but seemed to infer this may be shared with staff at the verbal handover. The Dr also spoke about how 'inaccuracies' can occur with information shared verbally. Given the amount of information gathered during the admission period (whatever timescale that is!?) and the admission interview, how much of that information is then documented? Both the RN and Dr seemed clear on the information they would record. The Dr has the opportunity to write in free text, whereas the nurse is required to populate pre-set questions that are officially required in terms of assurance and standards, i.e. skin integrity, falls risk.</p>
<p>6. Relationships: The RN talks of building a relationship with the patient from the start but refers to the shared admission model as being 'formal'. The RN feels this approach might inhibit the patient and yet the patient described this admission as more 'person to person'. The patient was open about how he had been feeling (wanting to die) and the participants handled this sensitively. It is interesting that the patient disclosed this to a room of strangers (inc researcher). Why? Feeling safe? Staff appeared friendly / approachable?</p>
<p>7. Other: My first impressions of the RN in this case was of a confident and capable nurse partly due to the fact that she seemed more pro-active than others so far. It is interesting to reflect after coding and analysing the data for this case on the RN. While she had much stronger feelings about her role and did not view the role of the Dr as being central as the other RN's, I wonder if some of the other RN's (1 and 3) were a little more insightful. The RN in Case 4 was 'busy' and her approach incorporated practical tasks along with her assessment skills. Did the RN's in Case 1 and 3 get more information / clearer impression of the patient by 'listening' to the dialogue between the patient and Dr. How would I describe (interpret) the different RN's and their approaches in each case?</p>
<p>8: The revised coding structure worked well and no issues were highlighted when coding data from Case 4. The Interviews with the RN and Dr were quite brief but the content was relevant. The numbers of references may be affected due to the brevity of the interviews. Similarly, some sections of the patient interview related to the patient's anxiety regarding his wife, these were not transcribed / coded verbatim as the detail was not relevant to the study.</p>

3.11.4 Cross-case analysis

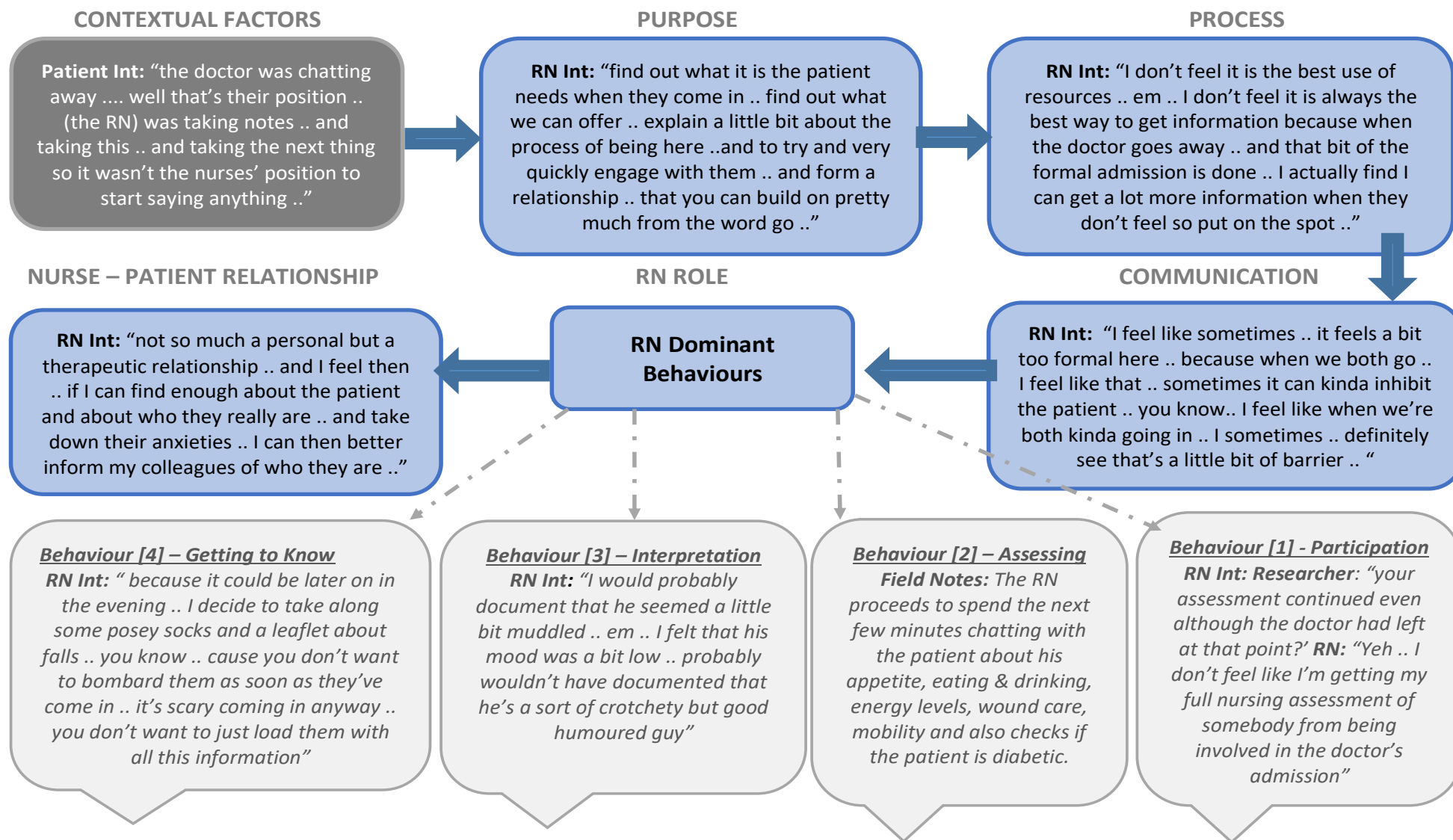
Transcripts, the NVIVO coding structure and the excel database were revisited repeatedly to consider the cases individually but then also with each other to look for similarities and differences (Miles, Huberman and Saldana 2014; Thomas 2016). As the excel database developed, coding revealed that some constructs were assigned more data than others, and themes began to emerge (Miles, Huberman and Saldana 2014; Thomas 2016).

During data collection, the coding structure was reviewed and refined mid-way with minimal changes and only two nodes retired due to limited supporting data (Bazeley and Jackson 2013). Second order constructs were identified collectively as part of cross-case analysis to help summarise and identify the important themes from the data rather than separately within each case. Figure 4 shows the identified second order constructs for Case Four, as an example, prior to further refinement and thematic analysis.

3.11.5 Thematic Analysis

The second-order constructs and final organisation of data helped to categorise, develop and label the final themes (Thomas 2016). A potential problem can arise if, during the analysis phase, the researcher treats each data source independently. The findings are reported separately, with little explanation of how the ideas are related (Baxter and Jack 2008, Thomas 2016). To help identify themes, the data was displayed on flip charts and whiteboards by extracting information stored on Nvivo and the Microsoft Excel workbook. An immersive approach to data analysis (Miles, Huberman and Saldana 2014) helped to develop a map to summarise the emergent themes case by case.

Figure 4: Second Order Constructs (Case Four)



3.11.6 Rigour

In this section, four core categories of trustworthiness demonstrate how rigour was considered in the context of this study, that is, credibility, dependability, confirmability and transferability (Baillie 2015). Observation at the study site took place over six separate weeks during a period of eight months. NVivo codebooks and Microsoft Excel spreadsheets summarising each case were available on a shared drive for review throughout the study. Meetings with supervisors occurred at six-week intervals with opportunities to debrief and discuss findings. Being aware of any potential influence and effect, as a researcher, is an important consideration and also helps to enhance credibility (Houghton et al 2013; Baillie 2015).

Entries to a diary included thoughts and ideas, personal strengths and limitations, and challenges encountered during data collection. The reflexive diary helped to provide a record of decisions made and the supporting rationale (Houghton et al 2013). All participant interviews were transcribed verbatim with quotes used to support coding and analysis which helped to provide transparency and credibility. Software packages (NVivo and Microsoft Excel) were also used to support data management. A clear audit trail of the research process applied and evidence of reflexivity helped to enhance dependability and confirmability (Baillie 2015).

The case study design and approach by Thomas (2016) resulted in a rich description of nursing practice and the registered nurse's role in patient admission in a hospice setting. Quotes and excerpts from data and field notes are used in later chapters to show how themes developed from the raw data (Houghton et al 2013).

3.12 Summary

Chapter 3 began by discussing theoretical perspectives, followed by research design focusing on the application of a case study framework by Thomas (2016). Ethical considerations and recruitment processes specific to the study setting were also presented. Finally, the methods applied for data collection and analysis were described in relation to a qualitative multiple case study design informed by Thomas (2016). In summary, a qualitative multiple research case study provided the opportunity to investigate the meanings and perspectives of the participants in a real-life context.

Chapter Four: Findings & Analysis

4.1 Introduction

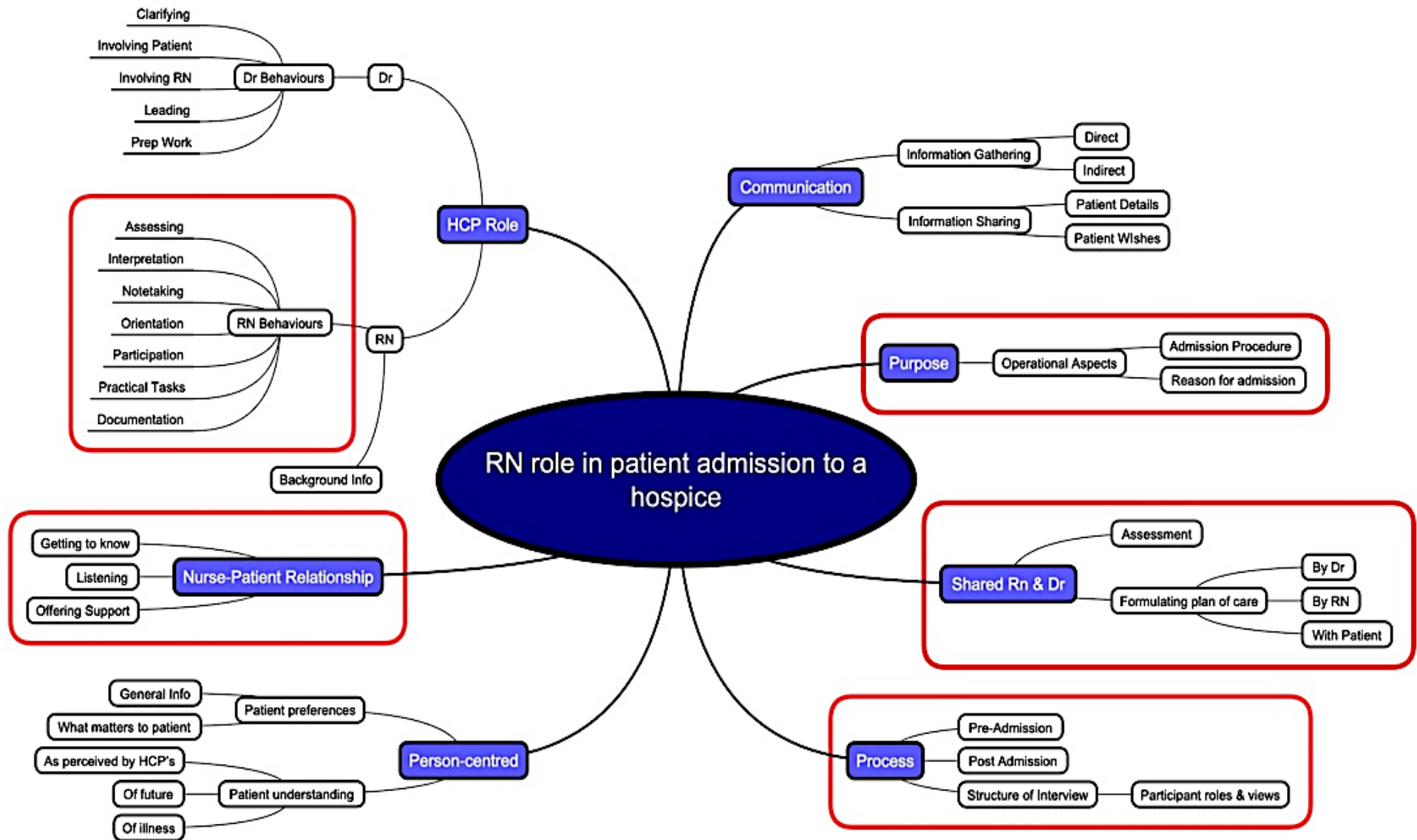
This chapter presents the findings from a qualitative, multiple case study to investigate the role of the registered nurse during a patient's admission to a hospice. The literature review presented in chapter two revealed that no studies have explored the role and contribution of the registered nurse, in patient admission, from the perspective of a hospice or palliative care setting.

A thematic map is provided in section 4.2 (Figure 5) to provide an overview of the coding structure employed and how these link with the key findings presented in this chapter. Followed by a presentation of the findings related to the sample (4.3), single case analysis (4.4) and contextual information related to the data collection methods (4.5). Subsequent sections discuss cross-case analysis (4.6) and findings related to registered nurse behaviours (4.7). Illustrative quotes from transcripts and field notes are used throughout to support the findings. Finally, the chapter closes by presenting the key themes identified (4.8).

4.2 Thematic Map

In Figure 5, a thematic map displays the codes employed for the study and how these link with the overall coding structure. The sections highlighted in red correlate with the findings and key themes presented in this chapter. The behaviours of the doctor are not discussed specifically as the study aim and research questions focused on the role and contribution of the registered nurse. Person-centred care and communication were not discussed separately as themes as they occurred generally across the coding structure and cases. A detailed summary of the coding structure showing all nodes and subnodes employed within Nvivo and how these link to the temporary constructs (Thomas 2016) is listed in Appendix 21.

Figure 5: Thematic map of coding structure and key findings



4.3 Sample

This section describes the results of the recruitment strategy for the study, followed by a summary of patient admissions during the data collection phase. The section closes with an outline of the participant characteristics, that is, for patients and staff.

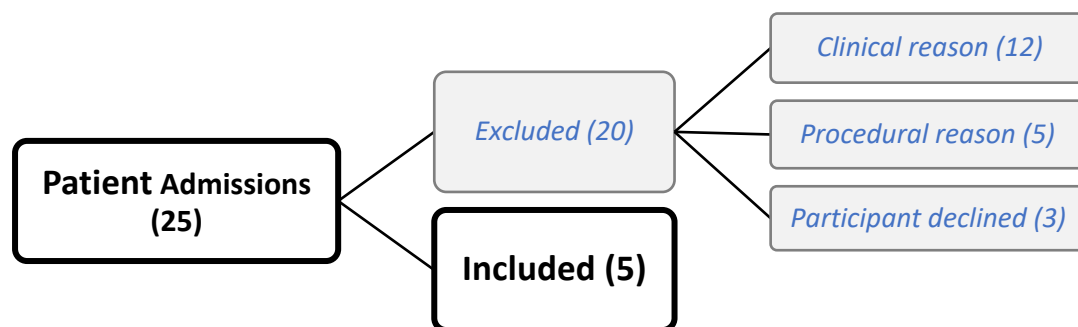
4.3.1 Recruitment

During the six weeks of data collection between June 2018 and Jan 2019, a total of twenty-five patients were considered for participation in the study. Of those 25 patients, five were included and twenty were excluded. Patient exclusion from the study fell into three main categories: [1] Clinical [2] Procedural [3] Participant declined. The most common reason for patient exclusion was a specific health problem categorised as 'clinical'. Hospice staff met patients shortly after arrival and assessed their suitability to participate, as per the study protocol. Twelve out of the 25 patients were excluded due to clinical reasons: patient anxiety, clinically unwell, cognitively impaired, limited life expectancy, or known communication difficulties.

The 'procedural category' excluded five patients due to events recruitment to the study. Simultaneous admissions resulted in exclusion for three patients as parallel observation, and audio recording was not possible. One patient admission proceeded before the patient was informed of the study, and one other was excluded as the admitting doctor required to be supervised. Only three participants declined, two nurses and one patient.

One nurse initially agreed to participate but changed her mind just before the admission interview commenced. She stated she thought the presence of an observer might adversely affect her performance. The second nurse did not give a specific reason. The patient declined to participate when approached by hospice staff and gave no reason for their decision. The categories and reasons for not participating in the study are summarised in Figure 6.

Figure 6: Summary of patient admissions during site visits



4.3.2 Patient participant characteristics

The age range of patients who participated in the study was 60 to 88 years old, with four male patients and one female patient represented across the five cases. All of the patients included in the study had experienced one or more hospital or hospice admission in the previous six months. Three of the patients were transferred from an acute hospital setting, with the others admitted directly from home at the request of their General Practitioner. Of the five patients, three were referred for end-of-life care, one for symptom control and the other for assessment.

One of the patients referred for end-of-life care was assessed on admission, treated for opioid toxicity, and responded well to treatment, resulting in discharge a few weeks later. Unfortunately, another patient's condition deteriorated quickly after admission, and they died within a couple of days. The third patient referred for end-of-life care was given a prognosis of one to two weeks but stabilised and remained in the hospice for another eight weeks or so before she died. The other two patients stayed in the hospice for a short number of weeks for assessment and symptom control. The patient characteristics are summarised in Table 7.

Table 7: Summary of patient participant characteristics

Characteristics	Case One	Case Two	Case Three	Case Four	Case Five
Male or Female:	Female	Male	Male	Male	Male
Age:	88	79	61	81	60
Diagnosis:	Advanced Oesophageal Cancer	Cancer of Unknown Primary	Metastatic Lung Cancer	Metastatic Prostate Cancer	Metastatic Bowel Cancer
Reason for Admission:	End-of-Life Care	Symptom Control	Symptom Control	Assessment	End-of-Life Care
Admitted from:	Transfer from Acute Hosp	Home	Transfer from Acute Hosp	Home	Transfer from Acute Hosp
Length of Stay:	8 -10 weeks	1-4 weeks	1-4 weeks	1-4 weeks	48-72hrs
Duration of shared admission:	39 mins	60 mins	49 mins	47 mins	26 mins

4.3.3 Staff participant characteristics

All the nurses participating in the study had worked in an acute hospital setting before taking up a post at the hospice. Of the five nurses, two had worked in the hospice for less than one year, two between one and three years, and one for between three and five years. All of the nurses were female and their ages ranged from their early twenties to mid-forties.

Four of the doctors who participated in the study were on placement at the hospice as part of their training programme. The duration of their posts ranged from a short visit over a couple of weeks to a six-month placement. The healthcare participant characteristics are summarised in Table 8.

Table 8: Summary of healthcare participant characteristics

Registered Nurses			Doctors		
Age:	20 - 30	2	Level of Training:	FY2	2
	31 - 40	1		GP Trainee	1
	41-50	1		Specialist Registrar	1
Worked at Hospice:	Less than 1 year	2			
	1-3 years	2			
	3-5 years	1			

4.3.4 Relatives as participants

Relatives who accompanied the patient on admission to the hospice were invited to participate in the study if they intended to be present at the admission interview. In Cases One and Two, the relatives agreed to participate and were invited to a one-to-one interview. However, the relatives in Case 1 declined an interview and the relatives in Case Two agreed but were not available during the site visit. For Case Three and Five, the relatives did accompany the patient on admission to the hospice but did not attend the admission interview. No relatives were present on admission for the patient in Case 4. Thus, the only data captured relating to relatives came indirectly from observation of the admission interviews and field notes.

4.3.5 Complete cases

Data collection was completed from the study sample for four of the five cases based on the observed admission, participant interviews, documentary interrogation, and field notes. The patient in Case Five consented to participate in the study, but he could not complete a participant interview. The patient's condition had unexpectedly deteriorated overnight, and he was not fit for an interview the next day or later. The nurse in Case Five also consented to participate; however, she was unavailable for a participant interview. Data collected from

observation of the admission interview, doctor's interview, data extraction and field notes of Case Five were included for analysis as part of the study.

4.4 Single case analysis

Data analysis began by examining the five cases on an individual basis. Within this section, each case summary presented provides; background information, an outline of events as they occurred and a summary of the nursing behaviours observed. Subsequent cross-case analyses and constant comparison as described in section 3.11 expanded interpretation further by way of categorisation and synthesis of the findings which are presented later in this chapter.

4.4.1 CASE ONE

Summary:

The patient was transferred from a local acute hospital by ambulance and arrived at approximately 10.30 am. The hospital team who had referred the patient cited the reason for admission as 'end of life' care. The patient's son and daughter-in-law were waiting to meet the patient on her arrival at the hospice. The nurse introduced herself to the patient and her family before using the opportunity to orientate them to the new setting ahead of the admission interview.

At around 3 pm the admission interview began in a multi-bedded area at the patient's bedside. The patient sat on a chair adjacent to the top of the bed, and the doctor chose to sit next to her. The relatives sat on the opposite side of the doctor, with the nurse sitting further away towards the bottom of the bed. The doctor began with introductions, and the patient and relatives acknowledged they had already met the nurse as they had spent some time with her earlier.

The nurse who attended the admission interview had been qualified for approximately five years and had worked in the hospice for over a year, having previously worked in the acute sector. The doctor present was coming to the end of a six-month training placement. The nurse and doctor had not previously undertaken an admission interview together.

During the admission interview, the majority of the discussion took place between the patient and the doctor. The patient clearly articulated her understanding and wishes going forward. The first verbal contribution from the nurse to the discussion occurred after twenty minutes or so when the nurse offered the patient some general advice. The nurse communicated non-verbally with the patient and relatives by nodding and maintaining eye contact throughout the admission interview. The nurse occasionally recorded some brief notes on a blank piece of paper.

Towards the end of the admission interview, the patient requested analgesia and the nurse attended to this but, as a result, was absent for approximately 10 minutes. The doctor proceeded to undertake a physical exam while the nurse was absent. The admission interview had ended when the nurse returned to the patient, and the doctor had already left the room.

The nurse advised that she spent time with the patient later in the evening providing personal care and continued her assessment. During the interaction, the nurse used the opportunity to clarify some of the discussion points from the admission interview earlier. The patient disclosed she had been protecting her family by not revealing the extent of her true feelings. The nurse assured the patient that she and the nursing team were there to help her by providing care and support. During her participant interview, the nurse disclosed she had shared the information obtained with her nursing colleagues during the verbal handover that evening. The patient remained in the hospice for several weeks before her condition deteriorated further, and she died.

During the course of the admission interview and subsequent period of care provided by the nurse, the four leading behaviours (based on coding references) were: [1] Participation [2] Interpretation [3] Assessing [4] Getting to Know

4.4.2 CASE TWO

Summary:

The patient was admitted from home at the request of the GP and arrived by ambulance late morning. The reason cited for admission by the GP was for 'probable end of life care and symptom control'. The patient had previously been a patient in the hospice on two other occasions. The patient's son and wife arrived to visit shortly after lunch.

At around 3 pm the admission interview began in a multi-bedded bay at the patient's bedside. The patient was lying on top of the bed with the doctor sitting on the right side and the relatives on the left. Both the nurse and doctor introduced themselves to the patient and family. The nurse sat at the bottom of the patient's bed and used the bed table to lean on to write numerous notes throughout the admission interview.

The nurse had been working in the hospice for less than a year, having previously worked in the acute sector for 18 months or so as a new graduate nurse. The doctor present had just started on a training placement a couple of weeks earlier. The doctor began the admission interview by asking the patient to share what had been happening recently.

The majority of the dialogue occurred between the patient and the doctor. At times, the patient's recollection of events was disordered, but his son helped with gentle prompts and reminders. The first verbal contribution by the nurse came after 20 minutes when the doctor turned to the nurse to ask if she thought she had missed anything. The nurse replied 'no' and did not ask any further questions at that time but indicated she would get 'some details' when the doctor was finished.

Before proceeding with a physical exam, the patient required analgesia and the nurse left to attend to this. The same nurse and one other returned to confirm with the patient what analgesia he normally took for pain control before returning with the prescribed medication. The nurse then assisted the doctor with the physical exam by helping to sit the patient forward in bed and check skin integrity. The nurse advised the patient she would return later to discuss the wounds and attend to the dressings in situ.

The doctor then ended the admission interview and left the patient's room. The nurse chose to stay to confirm contact details and could be heard chatting with the family members present. The patient's condition improved over the next few weeks, following a medication review and input from the multi-disciplinary team. He was discharged home a few weeks later.

During the course of the admission interview and subsequent period of care provided by the nurse, the four leading behaviours (based on coding references) were: [1] Interpretation [2] Assessing [3] Formulating a plan of care [4] Participation

4.4.3 CASE THREE

Summary:

The patient was transferred to the hospice from an acute hospital in the region and arrived by ambulance near mid-day after a long journey. The reason cited for admission by the hospital team was 'palliative management and symptom control'. The patient's wife and two sons arrived just before the admission interview began, and the patient asked his family to wait elsewhere.

The patient was in a multi-bedded room with no other occupants present when the admission interview began at around 3 pm. The patient was lying on his bed with the doctor sitting to his right and the nurse positioned nearer the bottom of the bed.

The nurse had been working in the hospice for less than 12 months, having previously worked in the acute sector as a new graduate nurse for one year. The nurse was due to leave soon to take up a new post in the community setting.

The doctor present had also been the admitting doctor for Case Two. The patient was articulate and gave clear, detailed responses to questions including a comprehensive account of his past medical history. Initially, the patient appeared frustrated by some of the questions however, as the admission interview progressed, the patient relaxed. On occasions, the patient looked to the nurse for help to respond to the doctor's questions indicating they had met before the admission interview began.

The nurse left the admission interview for approximately eight minutes after being asked by a colleague for assistance elsewhere in the hospice with a different patient. The doctor continued with the admission during her absence. The first questions from the nurse came after approximately 30 mins to enquire about skin integrity and mobility.

After 40 minutes or so, the patient asked the doctor how much longer would be needed for the interview as he was aware his relatives were waiting to visit. The doctor advised the discussion was nearly complete. The nurse and doctor proceeded to ask any remaining questions, followed by a physical examination. The admission interview lasted 50 mins with large sections dedicated to discussion about a long-standing chronic pain problem.

The nurse later advised she felt it was important for the patient to say what 'he needed to say'. The patient remained in the unit for a few weeks until his pain control improved, and he was discharged home.

During the course of the admission interview and subsequent period of care provided by the nurse, the four leading behaviours (based on coding references) were: [1] Participation [2] Interpretation [3] Assessing [4] Getting to Know

4.4.4 CASE FOUR

Summary:

The patient lived locally and was admitted from home at the request of a GP. The reason cited for admission by the GP was pain control. The patient arrived alone by ambulance around 11 am and was allocated to a single room. There were no family members in attendance on the day of admission. The admission interview began at around 2 pm, and the patient was lying on top of the bed with the doctor and the nurse sitting together on the patient's right side.

The RN involved had been working in the unit for over two years, having previously worked in the acute sector. The doctor was a Specialty Registrar who was on placement in the hospice for two weeks as part of a training programme. While the doctor had admitted patients in other clinical settings, the shared admission approach for admission interviews at the hospice was novel to her.

The doctor began with introductions, and it was clear the patient had already met the nurse by the way the patient acknowledged her. The interview began with the doctor asking the patient to describe what had been happening recently. The nurse participated in the discussion between the patient and doctor a couple of times within the first fifteen minutes. The discussion became equally shared between the nurse and doctor after that. The patient disclosed he had recently had two failed discharges from the local acute hospital and initially focused on discussing what had led to his readmission.

During the discussion, it became clear that the patient struggled to live at home despite a comprehensive care package. Poor pain control, general frailty and other challenging events had adversely affected his mood, with the patient openly divulging this information. Both the nurse and doctor acknowledged and responded to his distress.

After 30 mins the doctor left, but the nurse remained and continued with her assessment for another 20 minutes. During this time, the nurse continued to ask the patient questions and obtained a set of baseline observations. The overall admission interview lasted approximately 50 minutes and before the nurse left, she encouraged and ensured the patient knew how to call for assistance. The nurse had a telephone conversation later that day with the patient's daughter. The patient remained in the hospice for several weeks while transfer to a nursing home was arranged.

During the course of the admission interview and subsequent period of care provided by the nurse, the four leading behaviours (based on coding references) were: [1] Participation [2] Assessing [3] Interpretation [4] Getting to Know

4.4.5 CASE FIVE

Summary:

The patient was transferred from a local acute hospital setting by ambulance and arrived around 11.30 am. The reason cited for admission by the hospital team was 'symptom control', specifically pain management. The patient was allocated a single room at the hospice. The wife of the patient and their three sons followed by car and stayed with him until the admission interview began but then chose to leave and wait nearby. The admission interview began around 2 pm with the patient lying in bed and the doctor and nurse sitting adjacent on his right.

The nurse was a relatively new member of staff and had only worked in the hospice for around six weeks, having worked previously in the acute sector for five years or so. Before the admission interview began, the nurse appeared busy and initially suggested the doctor start without her, but the doctor advised she was happy to wait.

The doctor was on a six-month training placement which was coming to an end that week. The patient provided a good summary of recent events and was aware his condition had deteriorated quickly over the last two weeks, more so, over the previous 48 hours. While pain had been the main symptom, it became clear the patient was at an advanced stage of his illness as he was fatigued and reported other concerning symptoms. The nurse joined the discussion after around 15 minutes to ask some questions and provide reassurance about the nursing support available to the patient.

After about 20 minutes, the nurse appeared to get ready to leave the admission interview but changed her mind. The doctor had initiated a conversation with the patient regarding his preferences for a treatment escalation plan should his condition deteriorate further. The patient became tearful during the discussion, and the nurse was empathetic to the patient's situation. However, the nurse later revealed she found it challenging when he began to cry.

After 24 minutes, the nurse left the admission interview and advised the patient she would return later to clarify some information. The doctor stayed for a few more minutes to undertake a physical exam and offer the patient a final opportunity to ask further questions. In total, the admission interview lasted approximately 30 mins. Unfortunately, the patient's condition deteriorated overnight, and as a result, he was unable to participate in an interview as planned. The patient sadly died a few days later. Also, the nurse was not available for a one-to-one interview.

During the course of the admission interview and subsequent period of care provided by the nurse, the four leading behaviours (based on coding references) were: [1] Participation [2] Getting to Know [3] Assessing [4] Interpretation

4.5 Contextual information associated with data collection methods

In this section, contextual information is presented which aligns with each of the data collection methods before progressing to present the findings in more depth in the remaining sections of this chapter.

4.5.1 Observation of admission interviews

Data collection began by observing and audio-taping the admission interview for each case. In two out of the five cases, the admission interview occurred in a multi-bedded room with the patient, doctor, nurse and relatives present. The area was partitioned off from others in the room using screens around the patient's bed. For the other three cases, the admission

interviews were in a single room. All of the admission interviews took place during the afternoon.

The length of the admission interview ranged from 26 minutes (Case Five) being the shortest to 60 mins (Case Two) being the longest. During three of the shared admissions, the nurse had reason to leave for a few minutes. For Case One and Two, the patient required pain medication, and as a result, the nurses were absent for seven and ten minutes, respectively. In Case Three, a healthcare support worker interrupted to request assistance from the nurse, who was then absent from the admission interview for eight minutes. In all of the cases, the doctor proceeded with the admission interview while the nurse was absent.

4.5.2 Patient interviews

Interviews took place with four out of the five patients, all occurring the day after the admission. The patient interviews ranged from eight minutes (Case One) to thirty minutes (Case Four) in length. Each patient had individual characteristics and traits that influenced their responses to questions from the interview schedule. Patients interviewed in a multi-bedded bay were distracted at times by the activity within the room.

4.5.3 Nurse interviews

Interviews with the nurse participants took place the day after the patient was admitted. For Cases Two, Three and Four, the nurses were interviewed during their working day at the hospice. For Case One, the nurse was interviewed via the telephone as she was on a day off. The remaining interviews with the nurses were conducted in a private room on the ward. Only one interview was interrupted by a telephone call. Nonetheless, the nurses appeared to be mindful of activity in the ward and could hear the patient call system during their interview. The length of nurse interviews with the nurse participants averaged around 13 minutes.

4.5.4 Doctor interviews

For Cases One, Four and Five, the doctors were interviewed the day after the admission interview during their working day. The same doctor was involved in the admission interview for Cases Two and Three, but a participant interview was not possible until five days later. The interview was conducted by telephone and took place at the start of the working day. The interview only took a few minutes as the doctor's recall of events during the admission interviews was limited. During the call, it also became apparent that the doctor was distracted by activity and background noise in the workplace. The length of interviews with the doctor participants averaged around 10 minutes.

4.5.5 Documentary interrogation

For each case, the electronic patient record was accessed by a member of the administration team, who then extracted a copy of the notes documented by staff from the time of admission and the next 24 hours. The notes were examined within the administration team office and then returned to staff for destruction. At the beginning of the study, the clinical management system used at the hospice was unavailable due to technical difficulties. During that time, nursing staff reverted to using paper records which were used for document interrogation. However, senior nursing team members did report that using paper records had been challenging for some nurses, and as a consequence, care planning was perhaps less accurate.

4.5.6 Field notes

Reflexive notes documented immediately after the admission events also captured initial thoughts and reflections on what had occurred during the observation. A similar approach was taken for all participant interviews. The field notes also provided observational information that was not captured via audio-recording, for example, non-verbal behaviours. At the end of each site visit, the field notes also included a summary of personal reflections, which captured what had gone well, any challenges that arose and necessary actions.

4.6 Cross-case analyses

In this section, the participants' views regarding admission were coded and categorised into six subsections: [1] the purpose of admission [2] gathering information [3] getting to know [4] shared admission [5] patient admission approaches and [6] patient perspective. The findings presented focus on the role of the registered nurse in patient admission to a hospice.

4.6.1 Purpose of admission

During participant interviews, the nurses and doctors were asked to share their thoughts on the purpose of admission within a hospice setting. The nurses discussed admission as an opportunity to identify needs, explore understanding and form a relationship with the patient.

RN Interview: Case Four

"... to find out what the patient needs so the patient understands what we can offer ... explain a little bit about the process of being here ... to try and very quickly engage with them and form a relationship that you can build on pretty much from the word go"

The doctors' responses echoed some of those shared by the nurses and also included obtaining a medical history and managing patient expectations.

Dr Interview: Case Five

"... that initial picture of who is this person you know what's been going on for them.. why are they here and what can we do for them rather than just focus on the medical side of things ... it's more who are you as a person and where are you at with your disease and what are your priorities and how do we help you achieve those priorities here ..."

When discussing the purpose of admission, the nurses spoke of patient admission in a broader context by considering their contact with the patient at various points during their working day. In contrast, the doctors referred to the discussion that occurred during the admission interview only. Patients who participated in the study were asked to share their views on what happened during admission rather than describe the purpose of admission.

Patient Interview: Case One

"We discussed what was the matter with me, and why I had come, and what had happened to me beforehand, and why they hadn't been able to repair the tumour..."

Patient Interview: Case Three

"I think there was a lot of seeking clarification by them to satisfy their needs ..."

The patient responses reflected the views of staff in terms of providing them with information. There was some slight variation among participants regarding the purpose of admission but gathering information was recognised by all participants as a key feature.

4.6.2 Gathering Information

The nurses involved in admission reported the need to gather information to inform their assessment and formulate a plan of care for the patient.

RN Interview: Case Two

"... to gain more information that maybe you haven't gained from handover ... [the] need to get more detail to assess and see what the baseline is for future care at the hospice..."

RN Interview: Case Three

"... be able to gather as much information as you can and run it by them (the patient) and in a way that they understand ... and just ask people ... clarify their understanding and pitch at different levels ... I think you have to be able to do that ..."

Nurses also gathered information from the patient and family members and other healthcare professionals, such as district nursing teams.

RN Interview: Case Two

"they (district nurse) kind of gave us their insight on what kind of care they had provided pre-admission at home .. so that was really helpful prior to [patient name] coming in..."

The information gathered by the healthcare professionals was used to help inform and formulate a plan of care.

RN Interview: Case One

"... getting it all out in the open so we kinda have a clear plan for what the patient wants..."

RN Interview: Case Three

"... I would like to think to determine what we can do for the patient and what we can do to benefit them whether it be symptom management or whether it be end of life care ..."

The admission interview allowed the nurse to witness the doctor obtaining a medical history from the patient and observe sensitive discussions around the patient's understanding of their current situation.

RN Interview: Case One

"... what had been kind of happening and the procedures that she had went through .. how she's ended up at the hospice ... it is good to get a bit of background ... it's really important to be in when they are having those (conversations) .. listening to ..."

Dr Interview: Case Five

"...I think because they are there while you are taking the history ... you think that I suppose ... just both not missing facts or missing asking about symptoms ..."

Therefore, some of the information gathered by the nurse during the admission interview was obtained vicariously through witnessing the discussion between the patient and the doctor.

4.6.3 Getting to Know

As part of patient admission, healthcare professionals spoke of 'Getting to Know' the patient with examples linked to understanding their medical history, including recent events, and identifying patient needs and priorities.

RN Interview: Case One

"... for me it was just getting to know her, getting to know her background as to what she's been going through ..."

Dr Interview: Case Five:

"... what's been going on for them .. why are they here? .. and what can we do for them? ..."

'Getting to Know' as a nurse behaviour is presented within the context of the nurse-patient relationship in section 4.7.3.

4.6.4 Shared admission

The nurses shared a range of views regarding the shared admission approach used at the hospice. The majority of nurses reported finding the shared admission approach beneficial. In Case One, the registered nurse felt being present at the admission interview was helpful as she gained knowledge that informed her nursing assessment.

RN Interview: Case One

"... I probably wouldn't have had as much knowledge... I would've known the basics from my assessment but I probably wouldn't have known the background as to her experience at the [acute hospital] ... I would have had to go and read it myself but I just feel it is really beneficial to be there ..."

In Case Three, the registered nurse shared opinions and checked understanding with the doctor who attended.

RN Interview: Case Three

"... if I come out of there and I'm not very sure about something ... I can say to the doctor .. how did you feel that that went or do you think that they understood that it means you know you've got somebody to run that by ..."

Both nurses and doctors referred to the shared admission approach reducing duplication for the patient regarding staff asking the same questions.

RN Interview: Case Three

"... it's really helpful to sit in with the doctor... it saves the patient repeating themselves..."

Dr Interview: Case Two

"... I think it is a lot about not duplicating information so that the patient is not having to see multiple people over and over again .. at least if we are there together we just have to do it once ..."

The majority of the nurses reported the shared admission as beneficial for patients and themselves in terms of increased knowledge, which was linked directly to hearing the discussion between the patient and the doctor. Nurses also stated that the doctor often took a leading role in the shared admission approach.

RN Interview: Case Two

"I feel like the nurses and doctors work really well together as the doctor takes the lead .. (and) the nurse can input if they need to as well ..."

However, the nurse in Case Four held a different view of the shared admission approach related to the presence and contribution of the doctor.

RN Interview: Case Four

"... I don't feel like I'm getting my full nursing assessment off somebody from being involved in the doctor's admission ..."

4.6.5 Admission approaches in a hospice versus a hospital setting

During the interviews, several participants reported differences between patient admission approaches within a hospice setting and the acute hospital setting. For example, one of the doctors described the approach as being more holistic in the hospice, with less emphasis on simply the treatment of a patient's physical symptoms.

Dr Interview: Case Three

"... their approach is probably a lot more holistic here ... in other places I guess you are just trying to get to the symptom that you can treat ..."

The registered nurse in Case Two articulated that the shared admission approach took longer in the hospice but felt that the process was more thorough and beneficial to the patient.

RN Interview: Case Two

"... in comparison to the hospital for me it's quite a lengthy process but I think that's a really good thing cause it means it's thorough ... and you can meet the needs of the patient better really ..."

Two of the patients were recently admitted to an acute hospital setting and referred to their admission experience in both settings during the participant interviews.

Patient Interview: Case Three

"... it felt a different process rather than trying to say heal you or address that ... the other ones were ... you've got to try and sort this out very quickly to see what the problem is ... here it was more a case of let's understand what we've got ..."

Patient Interview: Case Four

"let's see now I would say it was sort of ... this (admission) was different it was more person to person shall we say ..."

4.6.6 Patient perspective

The findings presented have focused on the research questions regarding how the registered nurse contributes to patient admission to a hospice. Within the coding structure (Figure 5), two subnodes were specifically linked to the patient. First, under the temporary construct of Person-Centred care and node for patient preferences was the subnode '**What matters to patient**'.

Admission Interview: Case One

Patient: "... to be absolutely honest ... I've seen my family and done the things I want and know exactly the things I want to be done after I've died .. the sooner I die the better"

Admission Interview: Case Three

Patient: "... without causing more problems ... the best approach for me would to be cared (for) rather than treatments..."

Patient Interview: Case Four

Researcher: "... do you think yesterday you got the opportunity to be involved and say what was happening for you ..."

Patient: "... yeh ... because nobody else ever asked me ..."

The second subnode was **'Involving Patient'**, which sat under the Temporary Construct of Healthcare Professional Role which was one of the nodes specific to the behaviours of the doctor.

Admission Interview: Case One

Researcher: "... do you feel you were quite involved in the discussion? ..."

Patient: "... Of course, nobody was talking over me, we were all talking together ..."

Admission Interview: Case Two

Patient: "... What are you shifting your eyes over there for?" (asks the doctor why she is looking over to his son)

Dr: "... I just want to get their input as well ... if that's okay? ... (jokes) I'll ignore them from now on ..."

Dr Interview: Case Five

Dr: "... he seems fairly realistic about the prognosis and what he was coming here for ... so he kind of led it and he gave us a lot of the information we needed ..."

The majority of patients expressed satisfaction with the admission process and the staff involved in the admission interview. However, one patient voiced some concerns.

Admission Interview: Case Three

Patient: "... I was just saying that since I've been in (the hospice) and after doing that journey ... I just want to be left alone and let the pain get subsided ..."

4.7 Registered nurse behaviours

The behaviours of the nurse that were coded, sorted and categorised as part of the study are discussed in more detail in this section. The findings are presented using the NVIVO coding structure in combination with the case study approach by Thomas (2016). Namely, the nodes and subnodes identified from NVIVO coding were aligned to the temporary constructs as they emerged from data analysis. Coding references were used primarily to rank the registered nurse behaviours however the data were used to interpret the nursing work involved as a whole.

The first section (4.7.1) provides an overview of the RN behaviours coded across all cases, followed by sections (4.7.2, 4.7.3 and 4.7.4) to present the dominant behaviours exhibited by

the nurse participants. The final section (4.7.5) presents other, less prominent, behaviours which are included as part of the overall analysis and patient admission.

4.7.1 Overview of nurse behaviours across all cases

Twelve nurse behaviours were categorised as subnodes and aligned to three of the temporary constructs: [1] healthcare professional role (RN) [2] nurse-patient relationship [3] shared registered nurse & doctor. An overview of the coding structure used and a breakdown of the number of coding references assigned to each behaviour across all cases is provided (see Table 9).

Table 9: Coding references for RN behaviours across all cases

TEMPORARY CONSTRUCTS	NODE	SUBNODE	Coding references in descending order
Healthcare professional role (RN)	RN Behaviour	Participation	164
Healthcare professional role (RN)	RN Behaviour	Interpretation	128
Healthcare professional role (RN)	RN Behaviour	Assessing	125
Nurse-patient relationship	Nurse-patient relationship	Getting to know	100
Shared RN & Dr	Formulating plan of care	By RN	58
Healthcare professional role (RN)	RN Behaviour	Practical Tasks	48
Healthcare professional role (RN)	RN Behaviour	Leading	40
Nurse-patient relationship	Nurse-patient relationship	Offering Support	40
Nurse-patient relationship	Nurse-patient relationship	Listening	30
Healthcare professional role (RN)	RN Behaviour	Documentation	30
Healthcare professional role (RN)	RN Behaviour	Orientation	24
Healthcare professional role (RN)	RN Behaviour	Notetaking	24

The colour coding for each RN behaviour was generated by the NVIVO software and helped to sort, categorise and compare the coding references across all cases. Table 10 provides an example of the breakdown of coding references and distribution for one case (Case Three).

Table 10: Coding references for RN behaviours (Case Three)

Case 3: Breakdown of coding references for RN Role		
Rank	RN behaviour	No of coding references
1	Participation	28
2	Interpretation	25
3	Assessing	21
4	Getting to know	20
5	Documentation	11
6	Offering support	7
7	Formulating a plan of care	4
8	Listening	3
9	Practical Tasks	2
9	Orientation	2
10	Notetaking	1

Figure 7 displays data combined across all cases while Figure 8 displays data from a single case (Case Three). NVIVO software generated the pie charts (Figures 7 & 8) from coding data.

Figure 7: Distribution of Nvivo coding references for RN behaviours across all cases

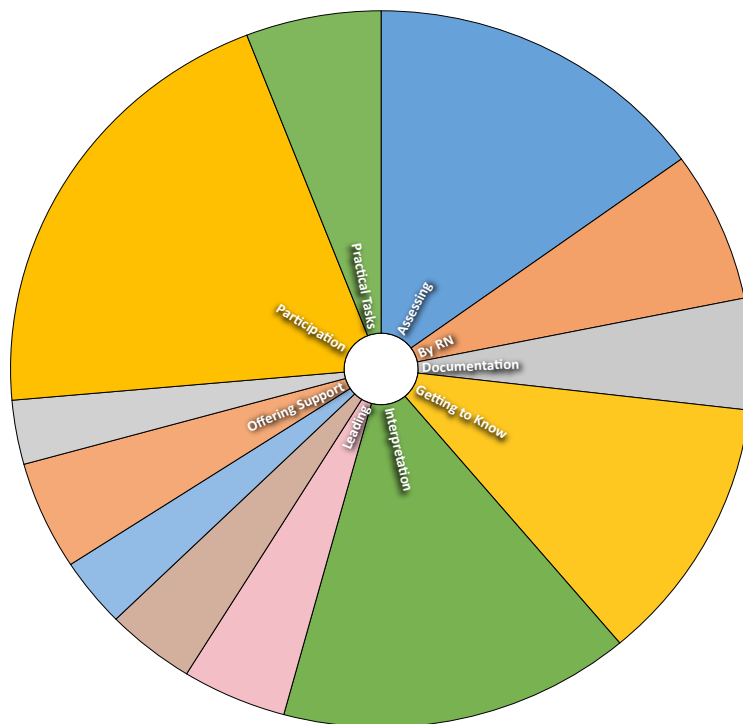
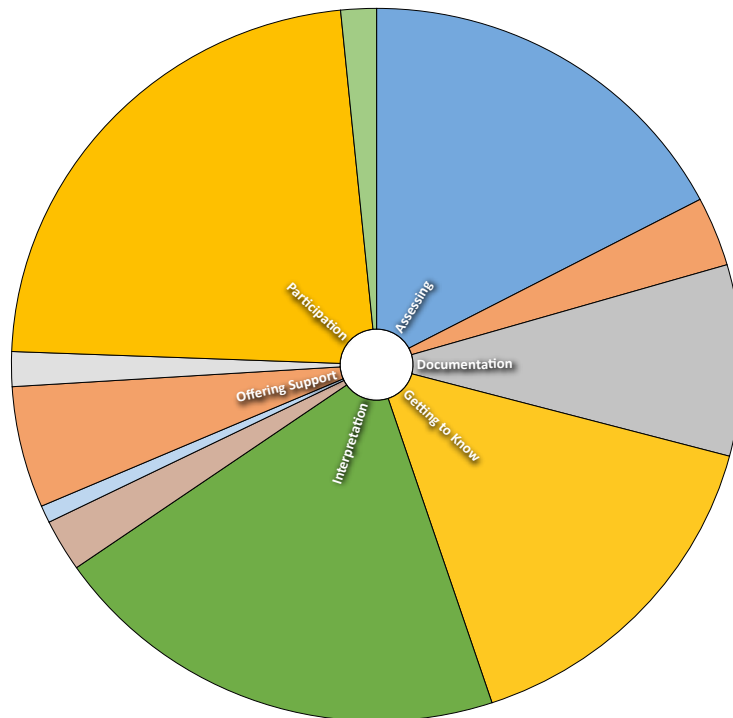


Figure 8: Distribution of Nvivo coding references for RN behaviours (Case Three)



A closer inspection of the data presented shows the same four registered nurse behaviours dominated across all cases. This is an interesting outcome when considering the scope and breadth of nursing work. The number of coding references, for registered nurse behaviours within a single case, was above average in Case Four when compared with all of the other cases. Interestingly, 33 out of the 40 coding references for 'leading' were associated with Case Four. The correlation between a leading role and the number of coding references is noteworthy and forms part of the discussion in the next chapter. In the next section, the twelve nurse behaviours are discussed based on their alignment with the temporary constructs before focusing on the key themes in section 4.8.

4.7.2 Registered nurse behaviours within the temporary construct of the healthcare professional role

Within the temporary construct of the healthcare professional role, separate nodes and subnodes were created for both registered nurse and doctor behaviours based on the data. Subnodes were then used to describe or explain actions, dialogue or references to the behaviour of the healthcare professional as part of an admission. The findings presented here relate to the NVIVO subnodes of registered nurse behaviours.

The eight nurse behaviours categorised as subnodes were: Assessing, Documentation, Interpretation, Leading, Notetaking, Orientation, Participation and Practical tasks. **Participation**, **Interpretation** and **Assessing** emerged as the highest-ranking behaviours across all cases, respectively. There were slight variations in their position within each case, but all appeared consistently in the top four ranked behaviours.

Participation as a behaviour related to actions or dialogue by the nurse that was part of patient admission. Therefore, it was unsurprising to find that it was the highest-ranked behaviour across all cases, except for Case Two. The nurse in Case Two spent large sections of the admission interview writing brief notes and left the admission interview for a significant length of time to seek the support of another nurse to attend to the patient's request for analgesia. Examples from the data analysed show a range of behaviours that were coded as **Participation**.

RN Interview: Case Five

"... you know if you need any painkillers and things, just buzz and ask us, and we can get you something ..."

Field Notes Case One: Admission Interview

The RN gets involved verbally for the first time to respond to a concern expressed by the patient. Until this point, the RN took notes, listened to the discussion, and communicated non-verbally with the patient & relatives by nodding and maintaining eye contact.

Coding references for **Participation** were also coded simultaneously with other behaviours such as **Assessing** and **Practical Tasks** and consequently linked with different nodes and subnodes in the coding structure. The findings also showed that **Participation** by the nurse occurred before, during and after the admission interview.

RN Interview: Case Four

"... I had done a little bit of that beforehand, but this was me coming in with the Doctor ..."

RN Interview: Case Two

"... updated the wound chart and things and also him being a falls risk making sure that everything in place ... hopefully to prevent falls in the future and making sure that everyone was aware ..."

Surprisingly, within the context of the admission interview event on its own, the coding references for **Participation** as a nurse behaviour were relatively low.

Dr Interview: Case One

"... she didn't join in the conversation much at all, so she was there ... kind of recording any of the details that she needed to get out of it..."

RN Interview: Case Two

"... so the doctor tends to take the lead with the questions here and obviously asks if we need to intervene at any point..."

The findings regarding the level of **Participation** by the registered nurse are expanded and discussed in more detail in section 4.8.4.

Interpretation was the second-highest ranking behaviour and coding references related to data that described or explained actions and dialogue where the nurse interpreted information provided or obtained during patient admission. However, the number of coding references for **Interpretation** as a nurse behaviour was lower in Case Five as the nurse did not take part in a participant interview. Examples from the data across all cases are presented below and show how the behaviour is linked with other nodes and temporary constructs.

Field Notes: Case Four

The RN proceeds to spend the next few minutes chatting with the patient about his appetite, eating & drinking, energy levels, wound care, mobility, and checking if the patient is diabetic.

The nurse behaviour of **Interpretation** is linked closely with the temporary construct of **Communication** and node labelled **Information Gathering**. **Assessing** followed as the next highest-ranking behaviour and coding references contained examples of the nurse undertaking assessment as part of patient admission. **Assessing** as a nurse behaviour covered a broad range of topics, often beginning with the patient's physical needs.

RN Interview: Case One

"... how she's able to communicate, what kind of symptoms she's got, whether she can mobilise, any falls in the past, what her skin's like, how she's able to eat and drink, obviously a big thing that came out of that yesterday was she's nil by mouth ..."

The psychological needs of patients also formed part of the nurse assessment which was acknowledged by the nurse as part of admission or later as a reflection after the admission interview occurred.

Admission Interview: Case Four

RN: "... you've felt sort of abandoned so that's probably not made you feel very good about things ..."

RN Interview: Case Three

"... I think he was quite tense, he seemed quite angry maybe a bit frustrated but it was an opportunity for him to tell us how he was feeling..."

Assessing as a nurse behaviour was dependent upon several sources of information, both direct and indirect. Regarding the patient information available ahead of the shared admission, there was a contrast between how the nurse and the doctor involved prepared.

RN Interview: Case One

"... a lot of the time, we don't get a handover like a verbal handover, it's just a transfer letter we get ..."

Dr Interview: Case One:

"... medics spend a lot of time beforehand looking on the hospital computer system and I'll maybe spend 30 to 45 minutes reading through the history and use that to tailor my admission ..."

By attending the admission interview, most nurses found that the discussion between the doctor and the patient helped inform aspects of their nursing assessment by increasing their understanding.

RN Interview: Case One

"... it's just good to get a background .. like what's been happening .. she came from the [hospital name] and what had been kind of happening there and the procedures that she had went through there ... and how she's ended up at the hospice ..."

RN Interview: Case Three

"... the doctors obviously do certain bits and ask certain questions ... they'll go away and do the drugs and rationalise whatever they need to do or add things on ... for the nurse's part I think it is really helpful to be in there cause you get a really good understanding ..."

However, the nurse in Case Four held a different view of how the admission interview helped with her assessment of the patient.

RN Interview: Case Four

"... I don't feel like I'm getting my full nursing assessment off somebody from being involved in the doctor's admission ..."

Interestingly, the three behaviours discussed in this section account for approximately half of all of the coding references for registered nurse behaviours. From this data, there is a clear trend around **Participation**, **Interpretation** and **Assessing** as key registered nurse behaviours during a patient admission to a hospice.

4.7.3 Registered nurse behaviours within the temporary construct of the nurse-patient relationship

Within the temporary construct and node labelled nurse-patient relationship, three subnodes were created to describe or explain actions or dialogue or references to the nurse-patient relationship as part of the admission. The subnodes were labelled as **Getting to Know**, **Listening** and **Offering support** and considered nurse behaviours as part of the analysis.

Coding references to the subnode **Getting to Know** ranked fourth in terms of nurse behaviours across all cases combined but was also consistently discussed by all nurses during participant interviews.

RN Interview: Case Two

"...I think it also builds up a trust with the patient ... opens up that communication pathway with the patient .. and trust with the patient and the family... and I think that's really good and really important..."

RN Interview: Case Four

"... and to try and very quickly engage with them and form a relationship that you can build on ..."

Getting to Know is discussed further in section 4.8.2 as a key feature of patient admission for registered nurses.

Other nurse behaviours categorised within the temporary construct of the nurse-patient relationship were **Listening** and **Offering support**. Both of the nurse behaviours were ranked

much lower in terms of coding references than those discussed previously. The number of references coded is linked to nurse behaviours observed during the admission interview or referred to during interviews with participants. The lower number of coding references does not signify the behaviours were not utilised in patient admission, but they were less evident when compared with the other behaviours recorded. However, **Listening** was recognised as a nurse behaviour by other participants involved in the study.

Field Notes Case Three: Patient Interview

Patient suggests the RN may have a 'passive' role in the admission interview but goes on to describe this as listening and observing.

Dr Interview: Case Five

"... I think it is still really useful for them (registered nurse) to be there ... part of it ... and seeing, absorbing all that information ..."

Offering Support as behaviour within the temporary construct of the nurse-patient relationship had the same number of coding references as **Listening**. The overall number of coding references for **Offering Support** was low but relatively evenly spread across all cases except for Case Four. Coding references for **Getting to Know** appeared most frequently within the registered nurse interviews, whereas references for **Listening** and **Offering support** were more evenly spread across all data.

4.7.4 Formulating a plan of care within the temporary construct of shared registered nurse and doctor

The node **Formulating a plan of care** sat under the temporary construct of 'Shared Registered Nurse & Doctor'. The node contained coding references that described or explained actions or dialogue around formulating a patient's care plan. As a nurse behaviour, 'Formulating a plan of care' ranked fifth across all cases combined. The majority of the coding references came for the registered nurse interviews in Cases One and Two.

RN Interview: Case One

"... it's formulating a plan with her and the family as to what's important to her in the time that she's got left ... and what's important to the family ... "

RN Interview: Case Two

"... post the admission we also like to debrief and just go through what we need to do and the plan of action ... "

Formulating a plan of care also had a separate subnode for coding references for doctors as part of patient admission with the number of coding references similar to the nurses.

Dr Interview: Case Three

"... my main aim was to establish what his symptoms were and how we could improve those symptoms ... and it was also to find out what he thought he could get out of his admission what he thought we could help him with ..."

The coding references for **Formulating a plan of care** reflected a shared aim among the nurses and doctors who participated in terms of patient understanding and identifying what was important.

4.7.5 Other nurse behaviours within the temporary construct of healthcare professional role

The remaining five behaviours shown in Table 9 were **Practical tasks**, **Leading**, **Documentation**, **Orientation** and **Notetaking**. The subnode **Practical tasks** contained coding references that described or explained actions or dialogue where the registered nurse was undertaking **Practical tasks** as part of the patient admission. Coding references came via observation of the admission interview or discussion during participant interviews. Examples of **Practical tasks** that occurred during the admission interview included obtaining pain relief for patients and assisting the doctor with a physical exam.

Leading as subnode contained coding references that described or explained actions or dialogue where the registered nurse appeared to lead the discussion as part of the patient admission. For example, the doctor led the initial discussion during the admission interview, with the nurse joining the conversation to ask or respond to questions. The time interval from when the nurse first joined verbally in the discussion varied across the cases: Case One (24 mins), Case Two (20 mins), Case Three (22mins), Case Four (7mins) and Case Five (11 mins).

The majority of coding references for **Leading** as a behaviour were found in Case Four. The nurse was more actively involved in the admission interview than in any of the other cases. There were no coding references for **Leading** as a nurse behaviour in Cases One, Two and Three. Nurse involvement in the shared admission approach was discussed in section 4.5.4.

The majority of coding references contained within the subnode **Documentation** came from the data extraction of patient records. The coding references described or explained actions or dialogue to patient Documentation by the nurse as part of admission.

Field Notes Case Five: Patient Record

Further entry by RN @ 18.45hrs: Patient record completed regards capacity, cognitive state, risk assessment re falls, leaflets provided & shared with family members, mobility assessment including bed rails assessment, oral care & swallow & nutrition. Corresponding plans in place.

Coding references for the nurse behaviour **Orientation** were found mainly in Case One and Case Four, where the nurses involved demonstrated the nurse behaviour as part of patient admission.

Field Notes Case One: Admission Interview

Prior to the admission interview, the patient and family members were met by the RN at the bedside. The nurse call system was explained, and the family members present were shown around the inpatient unit by the admitting RN.

RN Interview: Case Four

"... when [patient] first came into the hospice I went and introduced myself .. explained the buzzer system .. explained a little bit about the hospice and explained that I would be looking after him today .."

Patient orientation may have occurred in other cases but was not observed in the admission interview or discussed in participant interviews. As a consequence, coding references were low. The subnode **Notetaking** contained coding references that reported examples where the registered nurse recorded informal notes during the shared admission. **Notetaking** as a nurse behaviour was observed consistently among all of the nurses during the admission interview.

Field Notes Case Two: Admission Interview

The RN positioned herself at the bottom of the patient's bed with the bed table in front of her. The reason for this choice became clear as she used it to lean on for taking notes during the admission interview. The RN took notes on blank paper throughout.

The nurse from Case Four described how she used the notes she had recorded.

RN Interview: Case Four

"... the notes that I was (taking), I go onto the (computer system) and I document all the little relevant bits ... it's probably prompts for me ..."

The number of coding references for **Practical tasks**, **Orientation** and **Notetaking** varied and reflected the nurse behaviours in response to each patient admission as a distinct event.

4.8 Key themes of patient admission for nurses

In this next section, the data presented supports and builds on the findings regarding the behaviours of the registered nurse and how these translated into nursing work, that is, the contribution of the registered nurse in patient admission to hospice. Five key themes emerged: [1] admission as a continuous ongoing process followed by [2] getting to know [3] assessment and [4] the responsibility of the nurse to interpret, document and share information gathered as a consequence of admitting the patient and [5] how the nurse participated in patient admission. In section 4.8.6, Table 11 presents data examples to illustrate and summarise the approach to thematic analysis.

4.8.1 Nursing admission is a continuous, ongoing process

Data shows that nursing work around patient admission occurred before, during and after the admission interview.

RN Interview: Case Three

"... there was a couple of things I didn't get done on the admission but I explained that to the girls in our verbal handover to the night shift and they filled in the bits I didn't get done ..."

Other members of the wider nursing team also acknowledged that patient admission for a nurse was not limited to the day of the admission interview.

General Field Notes: Week Two

We had a brief chat about admission, with both (senior nurse and educator) expressing their views, to corroborate others, that admission is an ongoing process that can take days which extends to the family members/relatives as well.

Patient admission extended beyond the remit of the nurse originally responsible, with further information gathered over hours and sometimes days by other nursing team members. The

subsequent section reports on **Getting to Know** as a key feature of the nurses' role in patient admission to a hospice. The nurses also reported passing on unfinished aspects of the patient admission to their nursing colleagues. The case example demonstrates how the nursing work occurred for Case One.

Case Example (from Case One):

The nurse met with the patient shortly after arrival in the unit at approximately 10.30 am. The patient had arrived by ambulance, and family members had followed by car. The nurse took the opportunity to orientate the patient and family to the hospice environment and showed them around. In addition, the nurse provided the patient and family with a range of information leaflets to support their discussion about the hospice and services available. The nurse engaged in general conversation with the patient and her family during the tour, which helped her gather additional information. For example, the nurse discovered that one of the key things that mattered to the patient was bathing and getting her hair done. So, with the patient's consent, the nurse agreed to arrange this.

Ahead of the admission interview, the nurse had established that the patient could not swallow and provided the patient with equipment to support her. The nurse also obtained a set of baseline recordings and checked contact details with those family members present. The admission interview began at 3 pm. During introductions by the doctor, it was evident the nurse had already met the patient and family as they smiled and warmly acknowledged her presence.

During the admission interview, the nurse listened to the discussion between the patient and doctor and asked the patient a few questions herself. The information obtained helped to inform and guide the nurse when formulating an individualised plan of care for the patient. Later that day, the nurse helped the patient bathe and discussed how her admission to the hospice affected her and her family. The patient revealed she had tried to appear positive in the admission interview to help protect and support her son. The nurse used the opportunity to let the patient know she could talk to staff about how she was feeling, and the team were there to support her.

The nurse provided a verbal report to colleagues at shift handover and shared the new information she had obtained.

4.8.2 Getting to Know

The examples presented earlier in section 4.7.3 of **Getting to Know** are coding references within the temporary construct for the nurse-patient relationship. The majority of coding references for **Getting to Know** were reported during the RN participant interviews. Other examples of **Getting to Know** were obtained via field notes regarding the observation of the admission interview and documentary interrogation of patient records.

Field Notes Case One: Admission Interview

The patient appeared comfortable with RN (as) she had met her before the admission interview began.

Field Notes Case Two: Admission Interview

RN interacted with patient and family using non-verbal communication e.g. laughing appropriately, smiling.

Case Three: Data Extraction

An RN added new additional information obtained from the patient later. Some of the content was quite personal in nature, and the RN captured this in her overnight report.

Case Four: Data Extraction

The RN documents a telephone conversation with the patient's daughter.

Field Notes Case Five: Admission Interview

The RN provided reassurance to the patient on several occasions throughout the interview. Her non-verbal communication included smiling, nodding as well as showing empathy when the patient started to talk about his situation & prognosis.

Getting to Know was not exclusive to nurse participants as doctors also referenced the behaviour as a core feature of patient admission.

Dr Interview: Case Five

"... I find personally having done the admission ...I feel like it makes it so much easier going forward when I have known that patient from the start ... the first person to have that conversation .. the full history of what's been happening..."

4.8.3 Nursing Assessment

Coding references for **Assessing** as part of the nursing role in a patient admission emerged primarily in three areas of the coding structure. Data examples presented in section 4.6.2 relate to the temporary construct of 'Communication' and the subnode of 'Gathering Information', which included coding references for direct and indirect contact with the patient

by the nurse. Assessing as a distinct nurse behaviour was also presented in section 4.7.2 within the temporary construct of the healthcare professional role.

The temporary construct of 'Shared RN & Dr' also has coding references aligned to assessment as a node for data that described or explained actions and dialogue specific to the patient condition as a subnode. A high number of coding references were found across all cases within this node and subnode, with the majority occurring during observation of the admission interview. Coding references were aligned to the temporary construct of 'Shared RN & Dr' and not to a specific healthcare professional. The examples provided display the healthcare professionals' assessment related to the clinical condition of the patient.

Admission Interview: Case Three

RN: "... any sore areas in your mouth?"

Patient: "... when I was in seeing a doctor from the cancer team .. that's one thing that was mentioned ... he said that I had..."

RN: "thrush maybe? ..."

Patient: "... yeh thrush and I've had a course for that ..."

RN: "... can I have a look? ..."

Admission Interview: Case Four

RN: '...do you just get weak when you fall ... does it just kinda feel like your legs give way? ...'

Patient: "... Yeh ..."

Dr Interview: Case Five

"... generally I do the routine physical examination ... (the) nurses tend to focus on checking things like the mouth and the skin and the areas that they will continue to monitor ..."

Assessment featured heavily across all cases within the temporary constructs of 'Communication', 'Healthcare Professional Role' and 'Shared Rn & Dr'.

4.8.4 Interpreting, documenting and sharing patient admission information

The nurses involved in each case were required to interpret, document and share information gathered as part of patient admission. The responsibility to document information accurately and share the findings with other nursing team members was acknowledged by both nursing and medical staff.

RN Interview: Case One

"... after writing everything down making sure that's communicated back to the whole team and completing a care plan for her ..."

Dr Interview: Case Two & Three

"... and I guess they have proformas that they need to fill out, to communicate this information with the rest of the nursing team as well ..."

The nurses felt a responsibility toward the patient and colleagues to report and document accurately the information obtained. In addition, the clinical management system in use at the hospice prompted the nurse regarding the mandatory information required by the organisation and provided additional fields to enter free text.

RN Interview: Case Three

"... I think it's hospice rules anyway and it says it on [digital patient record] these things have to be done within the first 24 hours of admission so I think we got most things done within the first five hours ..."

Field Notes Case Two: Patient Record

Admitting RN entry to records on 04/09/18 at 16.11hrs: This entry by the RN extends over six pages in the electronic record. There is a preloaded list of questions & prompts. Initial responses then load further questions & prompts as necessary.

The amount of information entered in the free text sections by the nurses varied across the cases. The nurses also acknowledged that the contents of the written patient record would not always mirror what was shared verbally with colleagues.

Field Notes Case Three: Patient Record

The personal patient information is not necessarily recorded on the SBAR but shared verbally.

RN Interview: Case Four

"... probably wouldn't have documented that perhaps he's a sort of crotchety but good-humoured guy ..."

The requirement to meet the organisational objectives in terms of the core information resulted in a standardised approach to the patient record. However, the nurses also reported personalising the verbal handover to colleagues.

RN Interview: Case Two

"... and making sure that everyone was aware that he is also the main carer for this wife who had dementia ..."

RN Interview: Case Three

"... that handover is really just who the person is, what they're in for, what their mobility is, what drugs they're on but ... I think it's a nice opportunity to be able to say something about that patient ... that's personal to them ..."

In addition to documenting information from patient admission, nurses were also responsible for sharing a verbal handover of the new patient with colleagues at the following shift change. Nurses reported that ensuring patient information was shared accurately with colleagues was an important aspect of admission.

RN Interview: Case One

"... it is just making sure that our communication is really strong ... we've got our written handover sheet as long as everything is handed over ..."

The information shared by the nurse included both clinical and personal information about the patient and their situation.

The admitting nurse was responsible for interpreting large volumes of information gathered during patient admission and then condensing into a short verbal report to share with colleagues.

RN Interview: Case Three

"... just who the person is, what they're in for, what their mobility is, what drugs they're on but I think it's a nice opportunity to be able to say something about that patient that's personal to them ..."

The range of information available could be direct from the patient or any family members present, verbal correspondence from external healthcare professionals and patient records. As a consequence of the shared admission approach, the nurse also benefitted vicariously from observing the discussion between the patient and the doctor.

RN Interview: Case Two

(response to the question: if the nurse had not joined the doctor for the shared admission?) ... I probably wouldn't have had as much knowledge the basics ...

the background as to her experience at the [acute hospital] I would have had to go and read it myself ... but I just feel it is really beneficial to be there ..."

RN Interview: Case Three

"... the doctor goes through all of their bits that they need to cover so we kinda sit and listen and the doctor will ask about bowels and bladder and I can document that cause we obviously need to know about all of that for the handover, it's really helpful to sit in with the doctor ..."

Case Four is an exception, where the nurse held a different view.

RN Interview: Case Four

"...when the doctor goes away and that bit of the formal admission is done I actually find I can get a lot more information"

4.8.5 Nurse participation

This section reports on how the nurse participated in the patient's admission to a hospice setting from two perspectives [1] within the admission interview and [2] as a continuous, ongoing nursing process.

Within each case, the level of participation by the nurse varied during the admission interview. Meeting with a patient ahead of the admission interview independent of the doctor provided the nurse with an opportunity to gather relevant information. In Case One, the doctor recognised this approach had impacted the level of nurse participation.

Dr Interview: Case One

"...I know that before I'd come in and done that bit of the admission, she'd already spoken with [the patient] and the family and got some details and had done quite a few of the bits that she needed in advance ... so during the part of the admission we were doing together she didn't do that much..."

In Case Five, the doctor had been involved in several shared admissions while on placement and remarked that the level of nurse participation varied depending upon the individual nurse.

Dr Interview: Case Five

"...there is some people [nurses] will kind of sit back a lot more and not say anything, sometimes people will be much more kind of equally asking as many questions, sometimes people will just chip in a bit so it just varies between each nurse ..."

Several of the nurses reported that the doctor had a leading role during the admission interview, with the option for the nurse to join in when necessary.

RN Interview: Case Two

"... the doctor takes the lead, the nurse can input if they need to as well..."

The role of the nurse during the admission interview was reported by doctors as being supportive, a view that was shared by some of the patients.

Dr Interview: Case Two

"...I guess the nurse is there to support me ... there was things that I guess I had omitted or forgotten about, I usually ask the nurse or they remind me ..."

Patient Interview: Case Four

"... she was just taking a back seat and the doctor was chatting away ... well that's their position .."

Factors that influenced the level of participation by the nurse were reported as due to the physical layout, individual patient perception and a lack of clarity around roles within the admission interview.

Dr Interview: Case One

"... I think one of the other things is around where the chairs are, how you're sitting cause there just wasn't room for more than one person to be sat right next to her [the patient] and it was important for her family to be fairly close as well..."

Dr Interview: Case One

"... some patients will be very doctor focused ... other patients will be quite happy to have a chat as a group ..."

Dr Interview: Case Four

"... I know roughly what the nurses will be asking but I didn't necessarily know what their agenda was in terms of what we have to ask or I'd like to ask this, and it would be helpful if I could have a chat about this, I wasn't sure what part she actually wanted to be involved in or not ..."

One of the patients also commented on a lack of clarity regarding the nurse's role during the admission interview.

Patient Interview: Case Three

"... not really knowing what her [registered nurse] role was .. I wouldn't like to say ...because there wasn't a definition really of the role ..."

One of the charge nurses described the nurse's role in the shared admission approach during an informal discussion recorded in field notes and revealed a similar view regarding participation.

Field Notes:

Discussion around the role of the RN during admission. Charge Nurse feels this involves capturing demographic information, medicines reconciliation, skin integrity, main content of 'shared admission' is around medical clerking. RN's 'butt in' when necessary to check information or ask a question.

Data shows that the nurse participated in the admission interview to a greater degree in Case Four than in any other cases. In addition, the registered nurse held a different view regarding her role in the admission interview, specifically gathering information to inform her nursing assessment.

RN Interview: Case Four

"... when I go in with the doctor I'm listening to what the doctor has to say, taking little notes if I think 'oh that's relevant' but I could've probably got all that information myself ..."

RN Interview: Case Four

"... I don't feel it is the best use of resources, I don't feel it is always the best way to get information..."

In all of the cases, the doctor began with introductions and then proceeded to lead by asking questions about the patient's current health and the events that had resulted in their admission to the hospice. The invitation to participate was often by the doctors asking the registered nurse if they had missed or forgotten anything and came towards the end of the shared admission.

Observation of Admission interview: Case Two

Doctor: [turns to RN] "... any questions that I've missed out?"

RN: "...I think you've covered it actually I'm just going to get some details once you've finished..."

In Cases, One, Two and Three, the nurses participated in the admission interview when prompted by the doctor. However, in Cases Four and Five, the nurses joined unprompted within a few minutes of the discussion starting. Similar to Case Four, the registered nurse in Case Five joined the discussion after around six minutes to provide the patient with information about the hospice. The nurse intervened several times during the next 15 minutes to gather additional information relating to the patient's needs and offer reassurance.

Observation of Admission Interview: Case Five

RN: "... and if you want to go in a wheelchair and go downstairs to the café and things and you want to go out, you can go out you don't need to stay in, we can help you ..."

After 20 minutes, the nurse appeared to prepare to leave the admission interview but sat down again when the doctor began to discuss the limited treatment options available to the patient. The nurse stayed for the doctor's conversation about a treatment escalation plan and resuscitation status. When the doctor advised she was about to undertake a physical exam, the nurse announced that she planned to leave at that point.

Observation of Admission Interview: Case Five

RN: "... I'll come back in a wee while and we'll make sure you've got some dinner and things ... before the doctor examines your chest ... can I look in your mouth for a minute?... "

In Cases Two and Four, the nurses remained with the patient after the admission interview ended and the doctor left. One to check contact details with the family members present and the other to continue her nursing assessment.

Interruptions to the admission interview occurred in Cases One, Two, and Three when the nurses left to get analgesia for the patient or help colleagues elsewhere in the hospice. On average, the nurses were absent for approximately eight minutes. In each case, the doctor continued with the admission interview during their absence.

In Cases One, Two, and Three, the level of participation by the registered nurse during the admission interview appeared relatively low based on their contribution to the overall discussion. However, during the nurse interviews, they explained how they had gathered information independently as part of admission before and after the admission interview.

4.8.6 Thematic Analysis

Thomas (2016) recommends the use of examples from the working data to help illustrate and identify themes. **Table 11** presents the five key themes with supporting data including examples of direct quotes, coding records and field notes across all cases. Further discussion regarding each theme, the relationship between them and the implications for practice are presented in Chapter 5.

4.9 Summary

Drawing on the data and analyses across all five cases, the findings presented in this chapter describe the role and contribution of the registered nurse during a patient admission in a hospice setting. The evidence presented supports the key themes that emerged:

- Patient admission was not a single event but a shared and continuous process that can extend over hours and sometimes days.
- Getting to Know was rated highly among nurses as a core feature of patient admission
- Prevalent registered nurse behaviours were:
 - ◇ Assessing
 - ◇ Interpretation
 - ◇ Participation

Together these results provide important insights and in the following chapter, the discussion considers the study findings with the existing evidence base along with the wider implications for nursing practice and policymakers.

Table 11: Cross Case Analysis & Key Themes

1. Key Theme: Nursing admission as a continuous and shared process					
Source:	Case 1	Case 2	Case 3	Case 4	Case 5
Participant Quotes:	<i>RN: “.. as soon as the patient comes in the doctors don’t just go straight along .. I mean that lady was in at half ten and that meeting wasn’t until the afternoon”</i>	<i>RN: “.. but we do like to say whoever is on shift for that day and the next day sees the admission so there is kind of continuity there .. and they see the patient’s journey through for the next day”</i>	<i>RN: “ I think we got most things done within the first five hours .. and then it was the girls that done the skin and things at night ..”</i>	<i>RN: “when the doctor goes away .. and that bit of the formal admission is done .. I actually find I can get a lot more information”</i>	<i>No RN Interview</i>
	<i>RN: “I think though .. you know that admission thing (shared interview) yesterday .. I had already .. done my part before ... I had already asked”</i>	<i>RN: “and obviously post the admission .. we also like to debrief and just go through what we need to do and the .. plan of action .. and anything that we might of missed”</i>	<i>RN: “ you know there would have been other things I would have liked to have done .. I think it was fine to draw a line under it because he was getting so exasperated .. and he needed a rest and we could see that”</i>	<i>RN: “It could be later on in the evening I decide to take along some posey socks and a leaflet about falls .. cause you don’t want to bombard them as soon as they’ve come in .. you don’t want to just load them with all this information”</i>	<i>No RN Interview</i>
Field Notes:	It was also interesting when RN revealed that she was worried that it looked like she did very little during the interview, but she had already gathered a lot of the information she needed before the shared interview began.	It should be acknowledged the patient had been in the unit twice before, therefore orientation may not have been necessary to the same degree.	The patient record had details that were not discussed during the admission interview supporting the idea that 'admission' is only a starting point (for nurses).	The RN describes how her assessment and relationship with the patient began as soon as the patient arrived in the hospice. A further example of how the admission process extends beyond the admission interview.	The RN had established a rapport with the patient by spending some time introducing herself when he and his family first arrived.
Excel coding summary notes:	The majority of references in this sub node (pre-admission) came from the RN while explaining how her role extended beyond that of the 'admission interview'.	All references to indirect information gathering came from the RN interview. It is clear, for this patient, the DN team had called ahead to advise of the complexities/challenges around his care at home.	The information gathered by the RN overnight is significant and builds on that gathered by the admitting RN.	In this case, the admission process goes on beyond the admission interview as the RN takes opportunities during her shift to continue her assessment alongside other tasks.	In the other cases, the RN interview provided more information around what happened pre and post admission interview. (No RN Interview for Case 5)

<p>Researcher notes from patient record:</p>	<p>Prior to the admission interview, the patient and family members were met by the RN at the bedside. The nurse call system was explained, and the family members present were shown round the inpatient unit by the admitting RN.</p>	<p><i>No data</i></p>	<p>The RN noted a discussion with patient and his preferences, wishes, likes and dislikes: this discussion was not evident during the shared admission interview so may have occurred out with that period.</p>	<p><i>No data</i></p>	<p><i>No data</i></p>
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2. Key Theme: Getting to Know					
Source:	Case 1	Case 2	Case 3	Case 4	Case 5
Participant Quotes:	<i>RN: "well I just feel it's a nice way to get to know someone initially"</i>	<i>RN: 'I think it also builds up a trust with the patient .. so you open up that communication pathway with the patient .. and a trust with the patient and the family if there present .. in that instance they were and I think that's really good and really important actually"</i>	<i>RN: "I think it's lovely to be able to strike up a wee bit of rapport at that point .. with the family as well if they happen to be there during the admission .."</i>	<i>RN: 'find out what it is the patient needs when they come in .. find out what we can offer .. explain a little bit about the process of being here and to try and very quickly engage with them .. and form a relationship that you can build on pretty much from the word go'</i>	<i>Dr: "I think it's helpful for handovers .. when they tell the next shift about a new patient and what's been happening .. it's helpful that they've got that full history .."</i>
	<i>RN: "for me it was just getting to know her background .. as to what she's being going through ... and getting a plan formulated for her time at the hospice .."</i>	<i>RN: "I enjoy meeting the patients and the families .. previously with my past experience .. I don't feel like I've been able to have the time to like sit with the patient and gather as much information.. I think it just gives you more of an understanding of the patient and an insight into their life really"</i>	<i>RN: "and you know .. for us the admission was really .. to get to know him .. trying to let him understand what we were hoping to achieve.."</i> <i>".. it was really just about getting to know the patient .. getting to understand .. and getting to understand why they think their here.."</i>	<i>RN: "because when we both go (RN & Dr) .. I feel like that sometimes it looks like it can kinda inhibit the patient .. you know .. I feel like we're both kinda of going in .. I sometimes definitely see that's a little bit of barrier .."</i>	<i>No RN Interview</i>
Excel coding summary notes:	Doctor acknowledged that RN had done some preparatory work before the shared interview began. This included meeting with the family members present.	RN talks of building 'trust' with patient and family but also acknowledges problems with staff continuity. How does gathering & sharing information develop the nurse-patient relationship? Does this mean the admitting RN has an advantage over other staff? If so, how?	The RN came across as very perceptive, she also appeared to show genuine concern for the well-being of the patient and his family. Does the RN develop a relationship with the patient on an individual basis or is it representative of the nursing team in general?	The RN describes engaging with a patient quickly and forming a relationship. This was evidenced by acknowledging his concerns, providing reassurance and putting the patient at ease.	<i>No data</i>

3. Key Theme: Nursing Assessment

Source:	Case 1	Case 2	Case 3	Case 4	Case 5
Participant Quotes:	<i>RN: “look at things .. how she’s able to communicate .. what kind of symptoms she’s got .. whether she can mobilise .. any falls in the past .. what her skin’s like .. how she’s able to eat and drink .. obviously a big thing that came out of that yesterday was she’s nil by mouth ..”</i>	<i>RN: “to assess the patient .. to gain more information that maybe you haven’t gained from handover .. just need to get more detail”</i>	<i>RN: “so the doctor goes through all of their bits that they need to cover .. we kinda sit and listen .. and the doctor will ask about bowels and bladder .. and I can document that cause we obviously need to know about all of that for the handover ..”</i>	<i>RN: “I don’t feel like I’m getting my full nursing assessment off somebody from being involved in the doctor’s admission’</i>	<i>Dr: “nurses tend to focus on checking things like the mouth and the skin .. and the areas that they will continue to monitor during the person’s admission</i>
	<i>RN: “usually what we like to know is .. if somebody is here for symptom management .. we like to know what symptoms the patient is presenting with .. I think in [patient name]’s case .. the outcome of that was she’s going to be at the hospice for end-of-life care”</i>	<i>RN: “daily assessments of skin integrity .. mobility .. and falls .. especially this gentleman who was a high falls risk .. he had had many falls at home .. just assessing those needs and being aware as well ..”</i>	<i>RN: “if someone’s exhausted .. or if they are in a great deal of pain .. or sometimes they’ve had enough or they’ve needed a rest .. so you just have to take what you can from what you’ve got .. and then kind of fill in the blanks..”</i>	<i>Res: “if your assessment was based purely on that time you sat there with the doctor?”</i> <i>RN: “I don’t feel like I would’ve got an awful lot from that impression ..”</i>	<i>No RN Interview</i>

4. Key Theme: Interpretation

Source:	Case 1	Case 2	Case 3	Case 4	Case 5
Participant Quotes:	<i>RN: "making sure .. so you know after writing everything down .. making sure that's communicated back to the whole team .."</i>	<i>RN: "so they (DN) kind of gave us their insight on what kind of care they had provided .. pre-admission .. so that was .. really helpful prior to [patient name] coming in .. but then it's also really important to assess from the current state"</i>	<i>RN: "yes possibly .. and obviously his admission .. so he'd been to another hospital .. he had nae been there as long as he expected .. and then .. I think he kinda felt a wee bit shunted from pillar to post .."</i>	<i>RN: " I would've documented that he seemed a little bit muddled .. that I felt that his mood was a bit low .. probably wouldn't have documented that perhaps he's a sort of crotchety but good-humoured guy:"</i>	<i>No RN Interview</i>
	<i>RN: "she just said that she's always tried to be positive .. understandably .. so she knows that things aren't great .. but in front of her children she would never openly admit that .. so I tried to reassure her that .. it's okay to let us .. the staff.. know that it is okay to feel down and we can support her .."</i>	<i>Res: "how did this admission compare with others?" RN: "I think this patient .. was em .. quite a complex man .. quite a few needs .. that needed to be me t.. I knew before .. sort of .. from the handover that this would be quite a complex admission .."</i>	<i>RN: "and people weren't understanding what his needs were .. and you know .. and I think that was coming over"</i>	<i>RN: "I'd written down DN three times weekly .. so it was a prompter to go in and do the skin integrity part of the admission process .. it made me aware that I need to get in contact with the DN's and find out what are they doing with these .. so it's just all these wee things were kind of prompters .. for the rest of the admission process that I'll come back to"</i>	<i>No RN Interview</i>
Field Notes:	It felt like I had a good discussion with the RN. It was very interesting to hear her thoughts on the patient & how she was protecting her son/family.	<i>No data</i>	The 'personal' patient information is not necessarily recorded on the SBAR but shared verbally.	The RN had a piece of blank paper which she took notes on but she pretty much maintained eye contact throughout with the patient, nodding in agreement as well as asking questions or seeking clarification.	Patient agreed but understandably tearful - RN appeared sympathetic to this through her body language.
Excel coding summary notes:	The RN picked upon the emotional distress of patient and discussed this later when undertaking a physical task (bathing) with the patient in the evening.	Despite the RN saying very little during the admission interview, the information she gathered and interpreted then provided the baseline assessment documented for this case.	The RN had a sense of calmness and confidence. She maintained a neutral position including when the patient was critical of his previous experience in other healthcare settings.	The discussion between the RN and the patient shows how the nursing assessment included interpretation to be used to then inform the plan of care. The patient view of the RN role was 'listening' and 'administration' and yet the RN was very active in this admission.	The RN went to leave the Dr with the patient towards the end of the admission. It then became evident the Dr was about to broach the patient's understanding and wishes around treatment escalation. The RN then chose to stay and listen to the discussion. Why / What changed?

5. Key Theme: Participation

5. Key Theme: Participation					
Source:	Case One	Case Two	Case Three	Case Four	Case Five
Participant Quotes:	<p><i>Res: "if you hadn't gone in with the doctor?"</i></p> <p><i>RN: "I probably wouldn't have had as much knowledge .. I would've known the basics from my assessment but I probably wouldn't have known the background"</i></p>	<p><i>RN: "I took notes for our record and listened in to the doctor's examination .. also any questions that I needed .. especially getting the next of kin contact details and things"</i></p>	<p><i>RN: " the doctors obviously do certain bits and ask certain questions and they'll go away rationalise whatever they need to do .. I think for the nurse's part it is really helpful to be in there cause you get a really good understanding"</i></p>	<p><i>RN: "I don't feel it is always the best way to get information because when the doctor goes away .. and that bit of the formal admission is done .. I actually find I can get a lot more information when they (patient) don't feel so put on the spot"</i></p>	<p><i>Dr: "I think we probably lead the questions that are asked of the patient .. and the nurses maybe take a less active role"</i></p>
	<p><i>Dr: "during the part of the admission we were doing together .. she (RN) didn't do that much"</i></p>	<p><i>Dr: "I guess the nurse is there to support me and .. there were things that I guess I had omitted or forgotten about ... I usually ask the nurse or they remind me"</i></p>	<p><i>Pt: " I felt that she was being supportive to the doctor .. and to a degree intercepting"</i></p>	<p><i>Pt: "the doctor was taking notes and taking this and taking the next thing, so it wasn't the nurses' position to start saying anything .."</i></p>	<p><i>Dr: "it is probably quite time consuming for two members of staff to be in .. but I do think it is probably worth it especially here .."</i></p>
Field Notes:	<p>My first impression was of surprise at how little the nurse did (during the shared admission) but this view changed slightly following the RN interview.</p>	<p>The RN spoke very little during the admission interview and when asked by the doctor she had nothing more to ask.</p>	<p>Dr asks patient about attending to his personal hygiene e.g. washing & dressing. Could RN have intervened to ask additional information about these aspects of care?</p>	<p>The RN in this case participated in the discussion much earlier than in the other cases. She did not wait to be invited to ask a question, she responded to the patient's query if she knew the answer and asked for additional information when needed.</p>	<p>Her (RN) non-verbal communication included smiling and nodding as well as showing empathy when the patient started to talk about his situation & prognosis.</p>
Excel coding summary notes:	<p>During the admission interview, the RN did not participate much. Both the RN and Dr acknowledged this. During the RN interview, she was keen to stress she had already 'done my part'.</p>	<p>The RN was not really involved in much of the assessment as the Dr led the admission interview. Although, when given the opportunity to ask questions the RN stated she would get what she needed once the Dr had finished.</p>	<p>During the admission interview, the discussion was predominantly between the patient and the doctor. The plan formulated by the RN was evidenced in the patient record but any dialogue with the patient around this was not obvious.</p>	<p>Also, the patient view is the RN took a back seat she was, in fact, very proactive.</p>	<p>What are the reasons for the RN being less active: unsure of their role in the shared admission interview? no clarity on who asks what?</p>

Chapter Five: Discussion

5.1 Introduction

In this final chapter, the research findings from this study and the new knowledge to emerge from the hospice setting are discussed, adding a new perspective to the existing literature. The study aimed to investigate the role of the registered nurse based on the following research questions:

- [1] How does an admission occur between a registered nurse and a patient in a hospice?
- [2] What is the role and contribution of the registered nurse during the admission of a patient to a hospice?

The key findings are presented in section 5.2 using a conceptual map including a brief overview. Then, in section 5.3, the findings discussed relate to new knowledge that emerged and is compared with the existing literature. Next, the strengths and limitations of the study are discussed in sections 5.4 and 5.5. Finally, the chapter draws the thesis to a close by discussing the implications for practice, education and research in Section 5.6, with final conclusions presented in section 5.7.

5.2 Summary of key findings

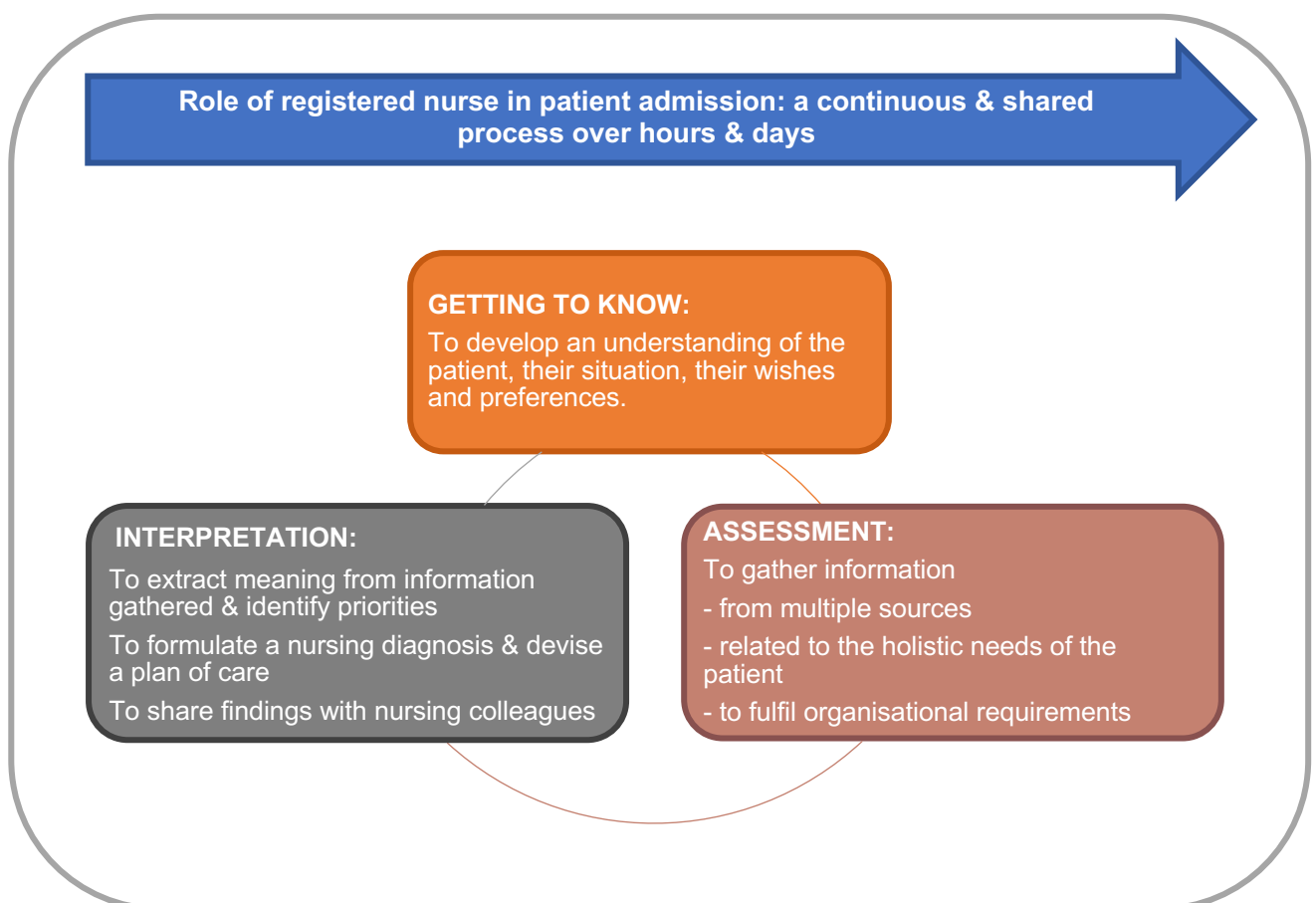
The new knowledge generated from this thesis is presented as a conceptual map (Figure 9). Novel findings have led to an overarching proposition that asserts, within a hospice setting, the nursing role in patient admission is a continuous and shared process occurring over hours and days. The conceptual map also consists of three distinct core constructs [1] getting to know [2] assessment and [3] interpretation. The core constructs link to dominant behaviours exhibited by the nurses across all cases to reveal a sophisticated approach to the nursing work involved.

When nurses described their primary intention to understand the patient, their situation and specific wishes or preferences, the phrase 'getting to know' was used repeatedly. Within the context of patient admission, 'getting to know' emerged as a new construct and can be viewed as an antecedent to the broader nursing concept of 'knowing the patient' (Swanson 1991; Radwin 1998). The second construct represents 'assessment', an aspect of nursing work already known and recognised in relation to patient admission (Lister, Hofland, and Grafton

2020; Randle, Coffey and Bradbury 2009; Jones 2007; Jansson Pilhammar and Forsberg 2009).

A case study framework provided an in-depth analysis and also helped to reveal 'Interpretation as a separate construct, comparable with the others included, in the conceptual map. 'Interpretation' as a construct illustrates how nurses clarified and extracted meaning to establish priorities, formulate a nursing diagnosis and devise a plan of care to share with colleagues. Although there is an association between each construct, the transition is not always sequential as the nurses adapted and responded to each patient's unique situation.

Figure 9: Conceptual Map



Case study design provided a different and detailed approach to investigate the role of the registered nurse in patient admission within a hospice setting. The conceptual map offers a visual illustration of the key findings. The findings contribute in several ways to developing understanding of the nursing role as well as adding to the current body of literature. New insights regarding the admission process among the wider nursing team, and the relationship

between core constructs, raise important questions about the potential impact on practice. The following section discusses the constructs of the conceptual map in more detail.

5.3 Emergence of new knowledge

My study found that patient admission was a continuous and shared process and not a one-off, task-oriented and administrative event as reported in other settings (Kruijver et al 2001; Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). In addition, the work nursing involved revealed a sophisticated rather than routine approach. The following sections explore the key findings in greater depth and consider how the new knowledge links to the original research questions and contributes to our understanding of this aspect of nursing practice.

5.3.1 Patient admission is a continuous and shared process

A significant new finding to emerge from the study is that patient admission occurs as a shared and continuous process amongst the nursing team in a hospice setting. Previous studies to explore the nursing role in patient admission had focused on specific aspects of the admission interview or the nursing role (Kruijver et al 2001; Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). A detailed case study approach helped identify how nurses worked across time and collaboratively with colleagues to admit a patient within the systems in place to do so. This result has not been described previously and may be explained by the exploration of each case as a whole rather than a single or specific part of the patient admission process.

The average length of the admission interview during my study was between 40 to 50 mins however other studies in acute hospital settings reported a shorter duration (Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014). Contextual factors that affect the length of the admission interview include the clinical setting, work pressures and nurse biases (Jansson, Pilhammar & Forsberg 2009; Jones 2009; Højskov & Glasdam 2014). While the shared admission approach may have influenced the interview length, the holistic approach demonstrated by healthcare participants also contributed to a longer duration.

The data collection methods used for the case study approach considered each patient admission as a whole and helped uncover the nursing work that occurred beyond the boundaries of the admission interview. During interviews with the healthcare professionals

who participated, it became clear that the admission interview alone did not fully represent the nursing work involved. A finding not reported or explored in previous studies.

Nursing textbooks refer to other aspects of nursing work included in patient admission, such as orientating the patient to the environment (Burton, Smith & Ludwig 2018) and a comprehensive patient assessment (Lister, Hofland & Grafton 2020). Information continued to be added by the wider nursing team over the subsequent hours and sometimes days to augment the information obtained at the initial admission interview. Therefore within a hospice setting, the collaborative approach differed from other studies where the nurses responsible for a patient admission would focus on a particular aspect, for example, completing documents (VanCott 1993; Jones 2007; Højskov and Glasdam 2014). The difference can be partly explained by the emphasis placed on a holistic approach in palliative care settings which contrasts with condition-specific approaches in other settings (WHO 2016; Walshe, Preston and Johnston 2018)

The next major finding links the three core constructs with the overarching proposition as illustrated using the conceptual map. Each construct is presented and discussed separately in the following sections.

5.3.2 Core Construct: Getting to Know

'Getting to know' the patient was a phrase used frequently by nurses and represented a professional purpose for patient admission as expressed by the healthcare participants. The admission event provided a platform to develop their understanding of the patient by obtaining information; directly from the patient, relatives, or other healthcare professionals involved. In addition, other interactions between the nurses and patients over the day contributed further to the construct of 'getting to know'.

Jansson, Pilhammar and Forsberg (2009) explored how nurses planned care for patients during the admission interview and identified 'building a pre-understanding' as a core category. Similarities between 'building a pre-understanding' and the core construct of 'getting to know' can be drawn as both describe the nurses' intention to build and develop knowledge of the patient. However, while there is a strong link with the construct of 'assessment', it was evident from the interviews with nurses that 'getting to know' the patient reflected a different aspect of patient admission. The nursing contribution in palliative care settings often differs as a result of using a holistic approach to consider the physical, psychological, emotional and spiritual needs of patients.

As described on the previous page, acquiring and developing knowledge of the patient's needs is a core element of the nursing role in patient admission. The shared admission approach provided the nurse with insight into the patient's understanding of their situation that would not have been available from reading medical notes as seen in other studies (Jansson, Pilhammar & Forsberg 2009; Ackman et al 2012). In addition, being present for the discussion between the doctor and the patient provided the nurse with medical information which was deemed beneficial by most of the nurse participants. Although the data was obtained vicariously by observing the discussion, between the patient and the doctor, the nurse used the data to help plan patient care and share information with colleagues.

Little is known, or reported, on the shared admission approach and it is not clear what factors have influenced its development within hospice settings. The main reasons cited by the staff interviewed included preventing the duplication of work, reducing the burden on the patient and increasing efficiency. The potential benefits of the shared admission approach were perceived to be helpful by the individual participants, as well as, operationally in terms of time and efficiency. The study findings have shown the registered nurse role extended beyond the boundaries of the admission interview but it is not clear how this relates to the shared admission approach. Interprofessional collaboration in healthcare is increasingly promoted to help bridge gaps and consider where aspects of work overlap (Schot, Tummers & Noordegraaf 2019). Further work is required to explore how the shared admission approach affects interprofessional working in patient admission and hospice settings.

Each patient who participated in the study had complex problems and had been under the care of another nursing team before admission, for example, within a primary care or secondary care setting. The information shared by the previous team was limited to a transfer letter or phone call with a focus on providing clinical information. 'Knowing the patient' is a recognised nursing concept and has been described by several well-known nursing theorists, such as Benner (1993), Carper (1978) and Swanson (1991). Radwin (1998) defined 'knowing the patient' as a complex process where the nurse acquired an understanding of the patient as a unique individual, which subsequently enhanced clinical decision-making. It is unclear how nursing teams share their knowledge and experience of caring for a patient to include what is 'known' including any potential barriers. Yet, improving and promoting patient safety to help deliver high-quality, effective and person-centred care remain core values promoted in healthcare (Scottish Government 2008; Scottish Government 2010; SPSP 2021)

Being aware of clinical information, physical and psychosocial needs, and personal information allows the nurse to understand or 'know' the patient beyond their diagnosis (Kelley 2013). Historically in nursing textbooks, the admission interview has been characterised as the starting point of the nurse-patient relationship (Lister, Hofland, & Grafton 2020; Randle, Coffey & Bradbury 2009; Lippincott 2015). However, the development of the nurse-patient relationship did not feature significantly in my study. Instead, the language used by healthcare participants spoke of 'getting to know' and understanding the patient as part of the admission process, with one nurse referring to the development of a 'therapeutic relationship'.

The new knowledge emerging shows that the construct of 'getting to know' is an important aspect of the nursing role in patient admission and an antecedent to the concept of 'knowing the patient'. Further work exploring how the construct of 'getting to know' connects with other nursing concepts and the development of the nurse-patient relationship would help to study the construct within a broader context of nursing practice. Information obtained by the nurse via the construct of 'Getting to know' and how this informed the nursing assessment is discussed in the next section.

5.3.3 Core Construct: Assessment

Nursing behaviours associated with patient assessment were identified and observed repeatedly across all cases, with most references linked to gathering information and communication. Patient assessment is a core component of nursing work and fundamental to planning patient care on admission to hospital (Lister, Hofland, and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015). The findings from this study support 'assessment' as a core construct of patient admission, with nurses employing several different strategies to gather patient information to inform and support patient care.

The nurses in my study did not take a formal document to the admission interview but did record short written informal notes. Previous studies have shown that admission documents can shape and structure the nursing admission interview (Mulhearn 1989; Jones 2007; Jones 2009; Højskov and Glasdam 2014). Reduced patient participation and limited opportunities to express concern were reported as consequences of nurses dutifully following the outline of the document (Kruijver et al 2001; Jones 2007; Jones 2009). The hospice used an electronic system for patient records. However, the nurse did not access these until later to record the nursing assessment. The effect and impact of technology on nursing work conducted at the patient's bedside during a patient admission are yet to be investigated fully (Jones 2009).

The influence of a formal document on assessment at the admission interview in a hospice setting differed in comparison to other studies (VanCott 1993; Jones 2007; Højskov and Glasdam 2014). Although the nurses in the hospice setting did not use a formal paper document, they did ask a range of standardised questions linked to the electronic patient record. The informal notes recorded by nurses during the admission interview were subsequently used as an aide-memoire when entering data onto the patient's electronic record.

Assessment is a key aspect of any patient admission however the implications associated with a hospice admission add to the anxieties of patients and their families (Lock et al 2022). And yet, informal introductions at the start of the admission interview by healthcare professionals did not include a clear explanation for the patient which contradicts the person-centred and holistic approaches advocated in palliative care settings (Ambitions for Palliative and End of Life Care 2021). The relevance of the admission interview may not be obvious to the patient and merits a clear and concise introduction to help the patient understand what will happen, allowing them time to prepare, consider any questions they may have, and promote patient participation (Jones 2009). In addition, the language applied to nursing work can sometimes unintentionally undermine and diminish essential aspects of care for both staff and patients, such as patient admission (Jones 2009).

Recordkeeping is an integral part of nursing and essential to ensure effective communication and continuity of patient care regardless of the format (RCN 2016). Documentary interrogation revealed that the nursing section on the patient record was extensive, and standardised, to capture essential and mandatory information deemed necessary by the organisation. As a result, some of the assessment information documented by the nurse appeared formulaic and lacked individuality. This finding broadly supports the work of other studies in this area relating to reduced patient involvement (Jones 2009) and standardised approaches (Jones 2007; Højskov and Glasdam 2014).

The nursing assessment on admission to the hospice included gathering information to identify and manage any potential risks to patient safety (SPSP 2021). Organisational requirements included recording mandatory data within a defined timescale to provide assurance around key quality indicators and support safe, effective and person-centred care (Scottish Government 2010). Jones (2007) described how the nursing work involved in patient admission could, at times, be viewed as bureaucratic and routine. However, in the hospice setting, the nurses applied their clinical judgment and chose when to ask the patients specific questions, by returning later or asking colleagues to follow up.

Within the hospice setting, nurses had numerous opportunities to obtain patient data that informed and supplemented their nursing assessment on admission. Sources of information included the admission interview, individual discussions with the patient, conversations with relatives, and through internal and external healthcare professionals. The collaborative nursing approach to patient assessment varied from routine procedures observed in other studies where admission interviews and assessment occurred as a separate event (Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014).

Interruptions occurred for various reasons during the observed admission interviews and resulted in the nurses leaving temporarily. Surprisingly, nurses were interrupted during the admission interview in three out of five cases resulting in a brief absence before returning. Developing an understanding of interruptions within nursing practice extends beyond medication rounds to include nursing work in general, with reasons for interruption being diverse and reflective of the multifaceted nature of nursing work (Sørensen and Brahe 2013; Hopkinson & Wiegand 2017). The shared and continuous approach adopted by the nursing team for patient admissions appeared to minimise any consequences from interruptions noted during the admission interview. Nevertheless, it could be argued the quality of the initial nursing assessment could have been adversely affected as a result of any interruption.

A wide range of nursing skills and behaviours were revealed across the constructs of 'getting to know' and 'assessment'. The next section discusses the application and extension of these skills and behaviours in relation to the final construct of 'interpretation'.

5.3.4 Core Construct: Interpretation

The new knowledge regarding interpretation draws attention to how the constructs complement and connect as a whole rather than being separate and incongruent. Within the conceptual map, 'interpretation' relates to information gathered by the nurse and the formulation of a nursing diagnosis to support a plan of care. Nurses in the study demonstrated the application of critical thinking to a patient's admission by extracting meaning from the information gathered and subsequently recognising the presenting problems, that is, a nursing diagnosis.

The wealth of information obtained as part of an assessment needs to be interpreted and abridged by the nurse to share an accurate description with the nursing team. Registered nurses should have 'the confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care' (NMC 2018). Across all cases,

conversations regarding the patient's understanding of their illness, prognosis, and preferences for care were attended to by the doctor. Caring for people expected to die involves having a sensitive conversation to allow for appropriate plans to be put in place, should the patient wish to do so (Murray et al 2005). Nurses present at the admission interview reported that observing the discussion between the doctor and patient was beneficial and provided important information to support their assessment.

The data helped to inform the plan of care for the patient as well as the information the nurse shared verbally with the team. Jansson, Pilhammar & Forsberg (2009) also found that nurses reported access to medical information as an important factor in patient admission. The shared admission approach assisted the nurse in acquiring knowledge that may not have been accessible otherwise but was used vicariously to inform patient care. It is unclear if the nurse would have undertaken a similar conversation, to obtain the same information, if the doctor was absent. At times, the presence of the nurse during the admission interview appeared passive. Nonetheless, the registered nurse role involved actively gathering and interpreting information obtained during the patient admission phase to support the provision of a holistic approach.

The nurse involved in the patient admission was also required to share their interpretation of their findings with colleagues using both written and verbal processes. Nurse participants worked closely with the team to ensure 'care and treatment were of a high standard, coordinated and focused on the best possible outcome' for the patient (RCN 2013). In addition, the nurse's responsibility was to formulate and document a plan of care to share with their nursing colleagues. Proficiency in assessing patient needs, as well as planning, providing and evaluating care are expected professional standards of nursing practice (NMC 2018). However, participants did not report if the plan of care devised following admission was agreed upon, or shared, between the nurse and the patient. Other studies (Jones 2009; Højskov and Glasdam 2014) have reported a lack of patient involvement in care planning. My findings also suggest that despite the contemporary emphasis on patient involvement this has not translated into nursing practice over time.

In the hospice setting, nurses provided a summary of a new patient during a verbal handover. The verbal report augmented a pre-printed handover note available to nurses coming on shift and contained an abbreviated summary of all the patients. However, the information shared verbally linked with the construct of 'getting to know' as the nurse reported providing a more personalised summary of the patient and their current situation. A literature review by Kitson et al (2013) focused on registered nurses' communication behaviours between shifts. The

review found that nursing handovers involved two main processes: a general patient summary and detailed individual patient information. Although, the nurse participants reported differences between the patient information documented and what they shared verbally at a nursing handover during data collection.

Antoinette et al (2017) reported that nursing staff found verbal handovers beneficial for providing a contemporary patient synopsis including contextual information, which was less time-consuming than reviewing patient records. The format of the electronic patient record at the study site showed a clear association with the organisational and mandatory requirements necessary for admission. However, the nursing entries to the patient record following admission revealed a somewhat standardised pattern extending over several pages, and at times, did not reflect a person-centred and holistic approach. The nurses also reported using the verbal handover to 'share personal information' about the patient to compensate. These results are consistent with Kitson et al (2013) who highlighted how fundamental aspects of nursing care have not been explored in a systematic and scientific way and warrant further investigation to help develop practice.

5.3.5 Summary

The new knowledge and insights that have emerged using a rigorous case study approach have been presented in this section. The main proposition and three core constructs contribute to developing an understanding of patient admission as a regular aspect of nursing practice. In addition, a wide range of behaviours emerged in the hospice setting to reveal the nursing work involved is a sophisticated rather than routine approach.

5.4 Strengths of the research

My study is the first to explore patient admission from a palliative care context, specifically within a hospice setting. Other studies have focused predominantly on patient admission within an acute hospital setting (Jones 2007; Rischel, Larsen & Jackson 2007; Jansson, Pilhammar & Forsberg 2009). This study aimed to investigate how patient admission occurred and explore whether the nursing contribution for a patient group with life-limiting illnesses differed. The new knowledge revealed patient admission as a sophisticated area of nursing practice that involved a collaborative approach by the nursing team, with aspects of patient admission occurring as a continuous rather than a one-off process.

A case study design provided an opportunity to create a 'three-dimensional picture' (Thomas 2016) of a regular aspect of nursing practice. A comprehensive investigation was conducted

using a qualitative, multiple case study approach that addressed the original research question and study aims. A longitudinal approach helped explore the nursing role in patient admission over time and be cognisant of any trends or developments that arose (Bryman 2012). Observation of the phenomenon in real-time and providing participants with the opportunity to share their perspectives augmented the data collection techniques employed to develop our understanding.

A key strength was considering each case as a whole rather than focusing on an individual aspect (Thomas 2016). By having a presence at the study site, all cases included observation of the admission interviews as they unfolded. Audiotaping of the admission interviews and all participant interviews also helped capture data accurately. The clinical background of the researcher helped by having situational awareness of working practices in the hospice demonstrated through an unobtrusive presence and application of professional discretion when necessary. Overall, the data collection methods and the application of a clear analytical framework facilitated a thorough investigation of the phenomenon, which provided an in-depth exploration of the role of the registered nurse in patient admission within a hospice setting.

The amount of data generated varied across each case and had a cumulative effect. As a novice researcher, the volume of data made coding and analysis demanding at times. However, the application of an analytical framework aligned to the case study approach by Thomas (2016) and excel spreadsheets for each case helped to distil the data collected into a workable structure. In addition, combining the excel spreadsheets used for data management and Nvivo software used for data storage helped to integrate the data and assist analysis while retaining meaningful data throughout the study (Appendix 24).

5.5 Limitations of the research

The audio-recording of the admission interview and the researcher's presence could have resulted in the participants modifying their behaviour similar to the Hawthorne effect (Robson 2011). Measures were put in place to mitigate the risk by being a non-participant observer and selecting a position that did not impede the discussion between the patient and healthcare participants. The processes helped enable the admission interview to occur as it would typically in the hospice setting. A number of the healthcare professional participants commented that they quickly became unaware of my presence during the admission interview event.

A shared admission approach for admission interviews was used at the hospice during the data collection phase of the study. Other published studies have all reported on admission interviews where those present were the admitting nurse and the patient. There are reports of the shared admission approach operating across specialist palliative care settings. However, no evidence is available that formally evaluates the approach or its effectiveness as a method that fulfils nursing requirements for patient admission. The nursing staff at the hospice reported finding the shared admission interviews beneficial to their practice, but this was not explored further as part of my study. The nurses also advised that admission interviews were occasionally carried out without a member of the medical team. The opportunity to include a nurse-led case would have provided a different perspective and allowed comparison with other cases included in the study.

In four out of the five cases, relatives were present for the patient's admission to the hospice. Those relatives present at the admission interview were happy to participate, however, this did not extend to involvement in a face-to-face interview. During the admission interviews, it was evident that the relatives were anxious and concerned about the events that had led to admission. Understandably arranging an interview with the researcher 24-48 hours later was not a priority when visiting the patient, although not stated explicitly by the relatives. Therefore, telephone interviews with relatives may have been more appropriate and less intrusive than meeting at the study site. Although, the lack of face-to-face interaction and opportunities for the interviewer to respond to visual clues can affect the quality of telephone interviews (Robson 2011).

The nurses in the study reported sharing information with their nursing colleagues at a verbal handover that occurred at every shift change. The information reported as being shared verbally varied from that documented on the patient record. The opportunity to observe the verbal handover for a new admission would have helped to add to the whole picture for each case. Miles, Huberman and Saldana (2014) advise actively seeking out contradictory evidence to consider how the information influences analysis. Additional data from the verbal report may have helped support the findings and add a new dimension to the development of the core constructs within the conceptual map.

Another example of the potential to support the core constructs arose during a site visit. One of the nurse participants advised that the nursing team used a printed sheet at shift changes to complement the verbal nursing handover. Nursing staff updated the sheet daily to include a summarised note for each patient. Unfortunately, the research study protocol had not considered the sheet as part of the documentary interrogation. Therefore, permissions were

not in place for access as part of data collection. However, access to the summarised notes for a patient may have helped support the construct of interpretation through comparison with the information documented in the nursing section of the electronic patient record.

5.6 Meaning of the study

New knowledge and insight have emerged regarding the role of the registered nurse during patient admission to a hospice. The following section discusses the findings from the study and their relevance regarding policy, clinical practice and education within the field of palliative care and beyond. The section closes by considering how further research could be developed to explore the findings from this study beyond specialist palliative care settings.

5.6.1 Policymakers

The nursing work involved in patient admission within a hospice setting is a sophisticated aspect of practice that is not representative of the narrative found in nursing literature and policy. Professional standards and general principles of practice provide guidance that supports rather than guides the nursing work involved in patient admission (RCN 2018; NMC 2018). The RCN (2018) principles include core aspects that can be linked directly with the nursing role in patient admission such as, managing patient safety, team working and developing a plan for individualised care. In addition, nursing textbooks provide a model description and a generic overview of what is expected as part of a nursing admission assessment (Howatson, Standing & Roberts 2015; Lippincott 2015; Lister, Hofland & Grafton 2020).

Recording core information is a primary function of patient admission that must also conform with national safety initiatives and organisational requirements (SPSP 2020). In addition, the wealth of information gathered on admission helps guide and inform the formulation of a nursing diagnosis and subsequent plan of care (Lister, Hofland & Grafton 2020). Across all cases, the registered nurse's role in patient admission emerged as an individualised and person-centred approach that aligned with government policy, professional nursing standards, and palliative care principles (Scottish Government 2010; NMC 2018; Walshe, Preston and Johnston 2018).

The new knowledge to emerge from this study helps to highlight the need to recognise the registered nurse's role in patient admission as a sophisticated aspect of nursing practice by those who advise, create and direct nursing policy at a local and national level. In addition,

the impact of the study findings on both clinical practice and education is considered in the next section.

5.6.2 Practice and education

Patient admission is a familiar and regular feature of nursing practice (Jones 2007). However, the language used by nurses to refer to patient admission and the descriptions in nursing textbooks implies that the nursing work involved is a single and isolated event (Lippincott 2015, Lister, Hofland & Grafton 2018). In addition, previous studies within different clinical contexts have found the nursing approach to patient admission appeared, at times, to be task-oriented or a bureaucratic and administrative event (Kruijver et al 2001; Jones 2007; Jansson, Pilhammar and Forsberg 2009; Højskov and Glasdam 2014)

Patient admission was not limited to a one-off episode of nursing care within the hospice setting. On the contrary, the study findings acknowledge that the nursing role in patient admission was a continuous and shared process. New knowledge emerging from this study also revealed three core constructs and showed that the associated nursing work required a sophisticated approach not simply governed by assessment procedures.

A consequence of the COVID-19 pandemic has seen a reduction of around 20% in patient admissions to hospitals in Scotland (Public Health Scotland 2021). However, changes to hospital-based care have already had a disruptive impact, with the potential effects on non COVID-19 related illnesses not yet clear (Mulholland et al 2021). In addition, preferences around place of death have changed compared to previous years and have seen an increase in people dying at home with complex needs (SPPC 2021).

Teams supporting patients with palliative and end-of-life care needs may not always have access to a hospice bed; therefore, arranging admission to acute hospital settings may be necessary (Dunleavy et al 2012). Developing the necessary skills and behaviours to undertake patient admission competently requires both theoretical and practical knowledge to support competent and safe nursing practice. A greater understanding and appreciation of the nursing work involved would help develop and support staff in practice. An appraisal of how patient admission is taught via the pre-registration nursing curriculum and subsequently supported during practice placements is also merited.

The findings from this study have implications for both hospice and specialist palliative care settings. The holistic approach to patient admission provided and demonstrated using the

conceptual map (figure 9) shows that the nursing work involved extends beyond the boundaries of the admission interview. Recognition of the impact of a patient admission on the nursing team and the subsequent nursing work should be considered by those influencing and leading practice in senior nursing positions locally.

New insights regarding the sophisticated approach revealed during this study have important implications for nursing practice and education beyond the hospice setting and warrant consideration more widely. The following section discusses how this study may help to inform further research regarding the nursing role in patient admission.

5.6.3 Future research

The conceptual map illustrates the nursing approach applied to patient admission in a hospice and may be relevant to other settings. For example, a study by Clark et al (2014) found that a large percentage of patients identified as having palliative and end-of-life care needs will spend time in acute hospital settings in the last year of life. In addition, patients with life-limiting conditions are admitted to a wide range of healthcare settings beyond those traditionally seen as providing palliative care (Dixon et al 2015). Therefore, the conceptual map's overarching proposition and core constructs may have validity and transferability concerning the patient group rather than being specific to a hospice setting.

An investigation exploring the nursing approach to admission for patients with a life-limiting illness in other settings would help corroborate the new knowledge and clarify if the findings relate specifically to a hospice setting or can be applied to nursing practice more generally. For example, 'getting to know' a patient within the context of day-case surgery varies significantly from a patient admitted to a hospice however the patient being admitted may have multiple long-term conditions or a life-limiting illness. The association between different nursing admission approaches and different clinical settings should be considered and recognise that patients with complex needs may warrant a different approach regardless of the reason for admission. Further studies exploring different patient groups rather than different settings would help add a new dimension to the current evidence, for example, patients undergoing rehabilitation following a stroke or cardiac event.

5.7 Conclusion

This study is the only empirical investigation to examine the role and contribution of the registered nurse in patient admission to a hospice setting. The thesis presents new knowledge and insights which build on the limited evidence base linked with the role of the registered

nurse and patient admission. Patient admission in hospital settings is a regular and accepted part of nursing work and is sometimes perceived as a routine and bureaucratic task. And yet, understanding what occurs during that episode of care has been seldom reported.

The rationale of a multiple, qualitative case study approach has been provided, along with an explanation of the research methods selected and applied. The findings presented in the earlier chapters revealed that patient admission extended beyond the boundary of the admission interview, with nursing work spread over hours and sometimes days. An analysis of the findings also found that the principal behaviours displayed by the nurse during a patient admission were linked to three core constructs: [1] 'Getting to know' [2] 'Assessment' and [3] 'Interpretation'.

The findings from this study help to develop understanding and increase awareness among healthcare professionals of patient admission as an area of sophisticated nursing work. The conceptual map helps to summarise the overarching proposition and the core constructs by reframing what we recognise as the registered nurse role. Further work that replicates the study in different contexts would help to corroborate the findings.

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30/10/2021

UNIVERSITY of STIRLING

A qualitative multiple case study: the role of the registered nurse in a patient admission to a hospice

Flora Watson
Macmillan Nurse Consultant PEOLC

BETHE DIFFERENCE

1

Support from

UNIVERSITY of STIRLING

NHS Grampian

MACMILLAN CANCER SUPPORT

BETHE DIFFERENCE

2

Research Topic:

- What does the nursing work around patient admission involve?
- Focus on the role of the Registered Nurse in patient admission

BETHE DIFFERENCE

3

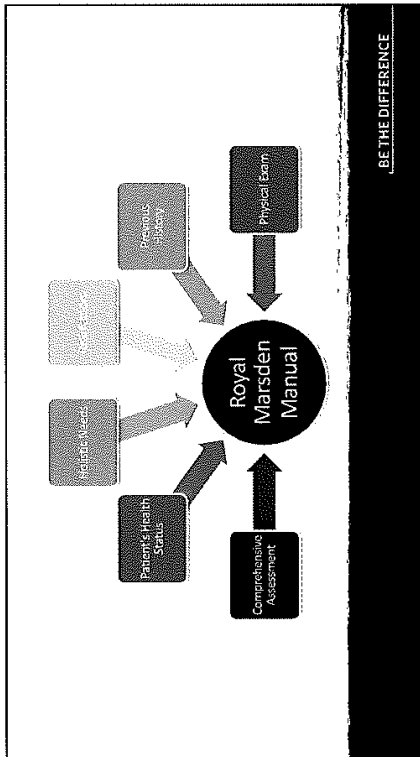
Initial Scoping:

- Few definitions within core texts / nursing literature
- Predominantly based on assessment

BETHE DIFFERENCE

4

1



5

BETHE DIFFERENCE

Literature Review

- Search story
- Results

- ❖ 12 research studies
- ❖ Date range mid 1960's to 2014
- ❖ 2 QI project reports

6

BETHE DIFFERENCE

Key themes from literature review:

- Influence of the admission document
- Variable levels of patient involvement
- Reliance on other sources of information
- Viewed as an administrative task

7

BETHE DIFFERENCE

- Patient anxiety on admission to hospital
- Patient admission is a regular feature of nursing practice
- Evidence base is limited
- Need to develop our understanding of what occurs during a patient admission and the role of the registered nurse

What do we already know?

8

BETHE DIFFERENCE

How does admission occur between a patient and registered nurse in a hospice?
 What is the role and contribution of the registered nurse during the admission of a patient to a hospice?

Research Questions:

BE THE DIFFERENCE

9

Research Approach:

- Qualitative Case Study
- Framework by Thomas 2016
- Best Fit for Study Aim

BE THE DIFFERENCE

10

The Case:

- Focus on the admission event
- Each patient was a planned admission
- Participants present at the admission
- Met inclusion / exclusion criteria
- Case seen as a whole

BE THE DIFFERENCE

11

Each Case:

```

    graph TD
      A[Planned Admission] --> B[Admission Interview]
      C[Case seen as a whole] --> B
      B --> D[Met criteria]
      D --> E[Participants presents]
  
```

BE THE DIFFERENCE

12

How does admission occur between a patient and registered nurse in a hospice?
 What is the role and contribution of the registered nurse during the admission of a patient to a hospice?

Research Questions:

BE THE DIFFERENCE

9

Research Approach:

- Qualitative Case Study
- Framework by Thomas 2016
- Best Fit for Study Aim

BE THE DIFFERENCE

10

The Case:

- Focus on the admission event
- Each patient was a planned admission
- Participants present at the admission
- Met inclusion / exclusion criteria
- Case seen as a whole

BE THE DIFFERENCE

11

Each Case:

```

    graph TD
      A[Planned Admission] --> B[Admission Interview]
      C[Case seen as a whole] --> B
      B --> D[Met criteria]
      D --> E[Participants presents]
  
```

BE THE DIFFERENCE

12

SUMMARY OF SEARCH ACTIVITY: APRIL 2015 to APRIL 2016		SKILLS@LIBRARY THE UNIVERSITY LIBRARY			
Aim:	To undertake literature search in a systematic manner relating to the area of interest i.e. nursing admission interview				
Number	Search Terms	Number	Search Terms	Number	Search Terms
1	Patient participation	5	Adult	9	Nurse experience
2	Admission	6	Patient admission	10	Interview
3	Palliative Care	7	Documentation	11	Admission Interview
4	Nursing	8	Patient experience	12	Patient History
Databases:	CINAHL Complete / Medline / PsychINFO / Psychology & Behavioural Sciences Collection				

Search 1: Nursing admission assessment within palliative care settings and patient participation

Search terms:	[i] 'subject term' for [1] + [2] + [3] + [4] + [5] then [ii] 'abstract' for [1] + [2] + [3] + [4] + [5] then [iii] 'title' for [1] + [2] + [3] + [4] + [5] then [iv] 'all text' for [1] + [2] + [3] + [4] + [5] then [v] 'subject term' for [1] + [2] + [4] + [5] then [vi] 'abstract' for [1] + [2] + [4] + [5]				
Date	Terms used	Results	Comments		
April 2015	[1] Patient participation [2] Admission [3] Palliative Care [4] Nursing [5] Adult	[i] 1 [ii] 1 [iii] 0 [iv] 18716 [v] 3 [vi] 11	Results from the searches [i] + [ii] + [iii] produced only one result which related to decision making in palliative care rather than the context of the nursing admission assessment. Results of next search [iv] produced a large number of results due to the generic nature of certain i.e. [2] admission [4] nursing [5] adult. In order to produce more specific results to the area of interest it was decided to avoid using the 'all text' option. No papers were found which examine or report on the nursing admission assessment and patient participation within palliative care settings.		
Next Steps: Review search terms – drop [1] 'patient participation' in order to access papers which explore any element of the nursing admission assessment and drop [3] 'palliative care' to broaden the scope of the results to any area of adult nursing practice ✓ Find paper recommended by Carol Bugge: Jones, A. 'Admitting hospital patients: a qualitative study of an everyday nursing task' ✓					

Search 2: Nursing admission

Search terms:	[i] 'subject term' for [2] + [4] + [5] then [ii] 'abstract' for [2] + [4] + [5] then [iii] 'title' for [2] + [4] + [5] then				
Date	Terms used	Results	Comments		
April 2015	[2] Admission [4] Nursing [5] Adult	[i] 565 [ii] 1373 [iii] 33	Results for [i] and [ii] produced a large volume of results and [ii] did not yield any papers which specifically addressed the area of interest i.e. the nursing admission assessment. Results for [iii] produced results relating to admissions to hospital/care home rather than specific to the nursing		

			admission assessment or interview i.e. labelling the patient as an 'admission' Review search terms to improve specificity to the area of interest – the assessment carried out on patients by nurses on admission.
Next Steps: Review search terms – instead of [2] admission change to [6] patient admission ✓			

Search 3: Nursing admission assessment

Search terms:	[i] 'subject term' for [4] + [5] + [6] then [ii] 'abstract' for [4] + [5] + [6] then [iii] 'title' for [4] + [5] + [6] then		
Date	Terms used	Results	Comments
April 2015	[4] Nursing [5] Adult [6] Patient Admission	[i] 437 [ii] 270 [iii] 0	Results often related to a specific clinical context or condition e.g. intensive care / heart failure. No papers found which examine or report on the patient admission by nurses.
Next Steps: Following meeting with Carol Bugge, advised of recent PhD by Crispin, V: 'Information exchange between patients & nurses doing routine care in ward setting'. Full thesis requested ✓ Consider use of a search term to capture [7] documentation relating to nursing admission assessment ✓			

Search 4: Nursing admission assessment and documentation

Search terms:	[i] 'subject term' for [4] + [5] + [6] + [7] then [ii] 'abstract' for [4] + [5] + [6] + [7] then [iii] 'title' for [4] + [5] + [6] + [7] then		
Date	Terms used	Results	Comments
May 2015	[4] Nursing [5] Adult [6] Patient admission [7] Documentation	[i] 12 [ii] 8 [iii] 0	No papers found which examine or report on the patient admission by nurses and associated documentation.
Next Steps: Review search terms to capture any studies reporting on nursing admission assessment and [8] patient experience ✓ Following contact with Carol Bugge – copy of thesis by Aled Jones sourced: "I've just got to ask you some questions": an exploration of how nurses and patients accomplish initial nursing assessments in hospitals: reference list checked for any relevant papers. ✓			

Search 5: Nursing admission assessment and patient experience

Search terms:	[i] 'subject term' for [4] + [5] + [6] + [8] then [ii] 'abstract' for [4] + [5] + [6] + [8] then [iii] 'title' for [4] + [5] + [6] + [8]		
Date	Terms used	Results	Comments
May 2015	[4] Nursing [5] Adult [6] Patient admission [8] Patient experience	[i] 0 [ii] 10 [iii] 0	No papers were found which examine or report on patients' experience of the nursing admission assessment.
Next Steps: Repeat search but swap [8] 'patient experience' for [9] 'nurse experience' ✓			

Search 6: Nursing admission assessment and nurse experience

Search terms:	[i] 'subject term' for [4] + [5] + [6] + [9] then [ii] 'abstract' for [4] + [5] + [6] + [9] then [iii] 'title' for [4] + [5] + [6] + [9]		
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Date	Terms used	Results	Comments
May 2015	[4] Nursing [5] Adult [6] Patient admission [9] Nurse experience	[i] 0 [ii] 10 [iii] 0	No papers found which examine / report on the nurses' experience of the nursing admission assessment.
Next Steps: Literature search revisited following completion of NURPD03 & NURP04 and first meeting with supervisory team ✓ Include search term [10] Interview ✓			

Search 7: Nursing admission assessment and interview

Search terms:	[i] 'subject term' for [4] + [5] + [6] + [10] then [ii] 'abstract' for [4] + [5] + [6] + [10] then [iii] 'title' for [4] + [5] + [6] + [10]		
Date	Terms used	Results	Comments
Feb 2016	[4] Nursing [5] Adult [6] Patient Admission [10] Interview	[i] 19 [ii] 23 [iii] 0	No papers were found which examine / report on the interview carried out on admission to hospital by nursing staff.
Next Steps: Swap [10] 'patient admission' for [11] patient interview ✓			

Search 8: Nursing admission interview

Search terms:	[i] 'subject term' for [4] + [5] + [11] then [ii] 'abstract' for [4] + [5] + [6] + [11] then [iii] 'title' for [4] + [5] + [11]		
Date	Terms used	Results	Comments
Feb 2016	[4] Nursing [5] Adult [11] Patient Interview	[i] 0 [ii] 12 [iii] 0	No papers were found which examine / report on the 'patient interview' undertaken by nurses on admission to a hospital setting.
Next Steps: Consult senior librarian at Stirling University to discuss search strategy used and identify any potential gaps: none found ✓			

Search 9: Nursing and patient history

Search terms:	[i] 'subject term' for [4] + [5] + [12] then [ii] 'abstract' for [4] + [5] + [12] then [iii] 'title' for [4] + [5] + [12] then		
Date	Terms used	Results	Comments
April 2016	[4] Nursing [5] Adult [12] Patient History	[i] 334 [ii] 153 [iii] 0	Results from the searches [i] + [ii] produced results which were related to obtaining a 'patient history' for specific conditions e.g. cardiac disease, gynaecological disorders Results of next search [iii] produced no results. One paper was produced in the results which has already been considered for inclusion in the literature review.
Next Steps: Review search terms – drop [1] 'patient participation' in order to access papers which explore any element of the nursing admission assessment and drop [3] 'palliative care' to broaden the scope of the results to any area of adult nursing practice ✓			

Appendix 3: REC Favourable opinion letter



4 May 2018

Mrs Flora Watson
Senior Charge Nurse
NHS Grampian
Roxburghe House
Ashgrove Road
ABERDEEN
AB25 2ZH

Dear Mrs Watson

Study title: A qualitative, multiple case study to investigate the role of the registered nurse during a patient's admission to a hospice.
REC reference: 18/NS/0036
Protocol number: 1
IRAS project ID: 238828

Thank you for your letter of 30 April 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair and Lead Reviewer.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only): UoS Letter re Indemnity 01.12.17	1.0	25 February 2018
Interview schedules or topic guides for participants: Patient Interview Schedule Form	1.0	25 February 2018
Interview schedules or topic guides for participants: Relatives/Carers Interview Schedule Form	1.0	25 February 2018
Interview schedules or topic guides for participants: Registered Nurses Interview Schedule Form	1.0	25 February 2018
Interview schedules or topic guides for participants: Healthcare Professionals Interview Schedule Form	1.0	25 February 2018
IRAS Application Form	238828/1187184/37/986	9 March 2018
IRAS Checklist XML: Checklist 15/03/2018		15 March 2018
Letter from sponsor: Sponsorship Letter signed by Fiona Millar, RD Officer 01.12.17	1.0	25 February 2018
Letters of invitation to participant: Patient Introductory Letter	1.0	25 February 2018
Letters of invitation to participant: Healthcare Professional	2	30 April 2018
Letters of invitation to participant: Relative/Carer	2	30 April 2018
Letters of invitation to participant: Registered Nurse	2	30 April 2018
NMC Registration - Flora Watson	1.0	11 February 2018
Confirmation of Compliance with RGF	1.0	25 February 2018
Data Extraction Sheet	1.0	11 February 2018
AON Indemnity Certificate	1.0	26 July 2017
Response to Provisional Opinion		30 May 2018
Summary of Study	1.0	30 April 2018
IRAS Form D3 Screenshot		4 May 2018
Participant Consent Form: Registered Nurse	1.0	25 February 2018
Participant Consent Form: Healthcare Professional	1.0	25 February 2018
Participant Consent Form: Patient	2	30 April 2018
Participant Consent Form: Relative/Carer	2	30 April 2018

<i>Document</i>	<i>Version</i>	<i>Date</i>
Participant Information Sheet (PIS): Patient	2	30 April 2018
Participant Information Sheet (PIS): Relative/Carer	2	30 April 2018
Participant Information Sheet (PIS): Healthcare Professional	3	2 May 2018
Participant Information Sheet (PIS): Registered Nurse	3	2 May 2018
Referee's report or other scientific critique report: Kathleen Stoddart		30 April 2018
Research protocol or project proposal	1.0	25 February 2018
Summary CV for Chief Investigator (CI) & Student - Flora Watson	1.0	14 March 2018
Summary CV for Supervisor (student research): Carol Bugge	1.0	11 February 2018
Summary CV for Supervisor (student research): Hazel Hill	1.0	11 February 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

18/NS/0036 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



Vice-Chair

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Dr Carol Bugge

Appendix 4: Patient Introductory Letter



Flora Watson (Chief Investigator)
Post Graduate Research Student
Faculty of Health Sciences and Sport
University of Stirling
STIRLING
FK9 4LA
Tel: 01224 557075
f.c.watson@stir.ac.uk

Dear

A study to investigate the role of the registered nurse during a patient's admission to a hospice

I am a research student at the University of Stirling and I am undertaking a research study on the way nurses are involved in the admission of patients. I usually work in a unit similar to this one, as a Senior Charge Nurse, in Aberdeen (Scotland).

The team here at this hospice have kindly agreed to introduce this study to you, and ask you if you might be willing to meet with me to hear more about the study and see if you might like to take part.

We know that nurses are involved in meeting with patients who are admitted to the in-patient unit here. In this study, I want to find out how the admission occurs between patients and nurses. Involvement in the study will not benefit you personally but I hope the information gathered will contribute to our understanding of the ways in which nurses' work.

If you wish to hear more about this study or if you have any questions, please enter your name below and let the nurse looking after you today know. The nurse will inform me and I will come to see you.

Name:

Date:

*If you do **not** wish to participate, you need take no further action.*

Appendix 5: Registered Nurse Introductory Letter



Flora Watson (Chief Investigator)
Post Graduate Research Student
Faculty of Health Sciences and Sport
University of Stirling
STIRLING
FK9 4LA
Tel: 01224 557075
f.c.watson@stir.ac.uk

Dear

A study to investigate the role of the registered nurse during a patient's admission to a hospice

I am a research student at the University of Stirling and I am undertaking a research study on the way nurses are involved in the admission of patients. I usually work in a unit similar to this one, as a Senior Charge Nurse, in Aberdeen (Scotland). The team here at this hospice have kindly agreed to let me introduce this study to you.

We know that registered nurses are involved in meeting with patients who are admitted to the inpatient unit here. In this study, I want to find out how the admission occurs between patients and registered nurses. Involvement in the study will not benefit you personally but I hope the information gathered will contribute to our understanding of the ways in which nurses' work.

If you wish to hear more about this study or might like to take part, please enter your name below and I will contact you to provide more information.

Name: **Date:**

Work email address:

*If you **do not** wish to take part, please fill in the section below:*

Name: **Date:**

Appendix 6: Healthcare Professional Introductory Letter



Flora Watson (Chief Investigator)
Post Graduate Research Student
Faculty of Health Sciences and Sport
University of Stirling
STIRLING
FK9 4LA
Tel: 01224 557075
f.c.watson@stir.ac.uk

Dear

A study to investigate the role of the registered nurse during a patient's admission to a hospice

I am a research student at the University of Stirling and I am undertaking a research study on the way nurses are involved in the admission of patients. I usually work in a unit similar to this one, as a Senior Charge Nurse, in Aberdeen (Scotland). The team here at the hospice have kindly agreed to let me introduce this study to you.

We know that registered nurses and other healthcare professionals are involved in meeting with patients, who are admitted to the inpatient unit here. In this study, I want to find out how the admission occurs between patients and registered nurses. Your participation will help us to examine what happens during an admission. Involvement in the study will not benefit you personally but I hope the information gathered will contribute to our understanding of the ways in which nurses' work.

If you wish to hear more about this study or might like to take part, please enter your name below and I will contact you to provide more information.

Name: **Date:**

Work email address:

*If you **do not** wish to take part, please fill in the section below:*

Name: **Date:**

Appendix 7: Relative / Carer Introductory Letter



Flora Watson (Chief Investigator)
Post Graduate Research Student
Faculty of Health Sciences and Sport
University of Stirling
STIRLING
FK9 4LA
Tel: 01224 557075
f.c.watson@stir.ac.uk

Dear

A study to investigate the role of the registered nurse during a patient's admission to a hospice

I am a research student at the University of Stirling and I am undertaking a research study on the way nurses are involved in the admission of patients. I usually work in a unit similar to this one, as a Senior Charge Nurse, in Aberdeen (Scotland).

You have been approached because the person your care for is about to be admitted and you will be present during that admission. The team here at this hospice have kindly agreed to introduce this study to you and ask if you might be willing to meet with me, to hear more about the study and see if you might like to take part.

We know that nurses are involved in meeting with patients who are admitted to the inpatient unit here. In this study, I want to find out how the admission occurs between patients and nurses. Your participation will help us to examine what happens during an admission. Involvement in the study will not benefit you personally but I hope the information gathered will contribute to our understanding of the ways in which nurses' work.

If you wish to hear more about this study or if you have any questions, please enter your name below and let the nurse know today. The nurse will inform me and I will come to see you.

Name:

Date:

*If you do **not** wish to participate, you need take no further action.*



Patient Information Leaflet

**A study to investigate the role of the
registered nurse during a patient's
admission to a hospice**

Introduction

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. The researcher will go through this information leaflet with you and answer any questions that you have. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

This study is based around the face-to-face discussion that happens between a patient, a nurse and a doctor on admission. It aims to find out what happens during this discussion and what the role of the registered nurse is.

Why have I been asked to take part?

The researcher has asked the nurse in charge to give this information leaflet to patients who are being admitted to the inpatient unit of the hospice today. We are aiming to talk to about 10 patients.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form.

If you decide to take part you are free to withdraw at any time without giving a reason. A decision to withdraw, or a decision not to take part, will not affect the care you receive.

Any data collected may be retained and used in the study unless requested otherwise. All data will remain anonymised. You will not be paid any expenses for your involvement in this study.

If you do not want to take part, you do not need to take any action.

Patient given an introductory letter by the nurse in charge about the study



Nurse in charge informs researcher if a patient has given permission to be approached to discuss the study



Researcher meets with the patient to discuss the study and provide further information about participating



Consent signed for: observation of the admission, a face-to-face interview with the researcher lasting approximately 30-40 minutes, and permission to access the patient's nursing record and medical notes

Can I contact a member of the research team for further information?

Yes, if you have any further questions about the study at any stage, please feel free to contact:

Flora Watson
Chief Investigator
University of Stirling
STIRLING
FK9 4LA
f.c.watson@stir.ac.uk
Tel: 01224 557075

Alternative contact:

Dr Carol Bugge
Lead Supervisor
University of Stirling
STIRLING
FK9 4LA
carol.bugge@stir.ac.uk
Tel: 01786 466109

If you would like information about the research more generally please contact:

Professor Jayne Donaldson
Dean of Faculty Health Sciences & Sport
University of Stirling
STIRLING
FK9 4LA
jayne.donaldson@stir.ac.uk
Tel: 01786 466345

Other possible sources of information for support:

The health professionals looking after you will be able to provide you with information and advice.

What will happen to me if I take part?

If you would like to take part or would like to hear more about the study, please let the researcher discussing this leaflet with you know.

If you are willing to take part, the researcher will ask you to sign a consent form before the admission starts and you will be given a copy of the consent form to keep.

With your agreement, the admission will be observed by the researcher (she will be in the room with you but will not join in the discussion) and the discussion recorded.

Over the next few days, at a suitable date and time, an interview with the researcher will be arranged. The interview should last no more than 30-40 minutes.

During the interview, the researcher will ask you questions about the admission, what you discussed, what the nurse discussed, and your views on role of the nurse. There are no right or wrong answers to the questions, the researcher is keen to hear a wide range of views and perspectives.

With your agreement, this interview will also be recorded. All recordings will be transcribed with any identifying information (such as your name) removed. Recordings will be destroyed at the end of the study.

With your permission, the researcher will access your nursing record and medical notes, to see what the registered nurse and other healthcare professionals have recorded from their discussion with you. The researcher will take some notes about what is written down but these will be recorded anonymously.

The researcher will also talk to the nurse and doctor who were with you today for the admission.

If you have given permission for the person who cares for you to be present during your admission, the researcher will also invite them to take part.

How long will I be involved in the study?

You will be involved in the study for the admission and an interview with the researcher. Your total involvement in the study will take approximately two hours, this includes time to read this information.

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you from being involved in the study. If you feel unable to continue with an interview, you can stop the interview and/or withdraw from the study. However, you may find it helpful to discuss your thoughts and opinions.

What are the possible benefits of taking part?

The study may not help you personally but the information we gain may help to develop admission processes and procedures.

Will the information I provide be kept confidential?

YES. All information collected about you will be kept strictly confidential. Paper records will be kept in a locked cupboard on NHS premises and recordings will be securely stored on a password-protected server at the University of Stirling.

Your identification will be removed from the written records of recorded interviews that take place. Any information that you do provide will be seen by the research team only.

Patients who have taken part will not be identified in any way in the reports. If we use quotes of things you have said, it will not be possible for others to identify who said it.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. In the first instance contact: Flora Watson, Tel: 01224 557075.

If you remain unhappy and wish to complain formally, you can do this by contacting: Dr Duncan Brown (Medical Director) at the Hospice. Taking part in this study does not affect your normal legal rights. Whether or not you do take part, you will retain the same legal rights as any other patient in the NHS (which includes professional indemnity insurance for negligence).

In the unlikely event of any serious misconduct being witnessed during admission, the researcher will inform the nurse in charge as soon as possible.

What will happen to the results of the study?

The results will help us to understand how admission occurs in practice, particularly the role of the nurse. We hope that the results will be published so that others can read and learn from the results of the study. If you wish, when the study is complete we will send you a summary of the findings.

Who is doing this study?

The research is being carried out by a post graduate student who is also a registered nurse. There are a number of different organisations involved.

- The University of Stirling
- NHS Grampian (as employer of the researcher)
- Macmillan Cancer Support

Who has reviewed this study?

The following groups have reviewed this study and given their approval for it to be carried out:

- University of Stirling Research Ethics Committee (NHS, Invasive or Clinical Research)
- The North of Scotland Research Ethics Committee (1)
- NHS Lothian Research & Development Department



Registered Nurse Information Leaflet

**A study to investigate the role of the
registered nurse during a patient's
admission to a hospice**

Appendix 10: RN Information Leaflet v2 30.042018 / IRAS ID:
238828

W125605 18/1/2021 13:41

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1

Introduction

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. The researcher will go through the information leaflet with you and answer any questions that you have. Please ask if anything is unclear or if you would like more information. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

This study is based around the face-to-face discussion that happens between a patient, a registered nurse and a healthcare professional on admission to the inpatient unit. It aims to find out what happens during this discussion and what the role of the nurse is.

Why have I been asked to take part?

You are a registered nurse who is involved in the admission of patients to the inpatient unit at the Hospice. You replied to an introductory letter indicating you would like to receive further information from the researcher about the study.

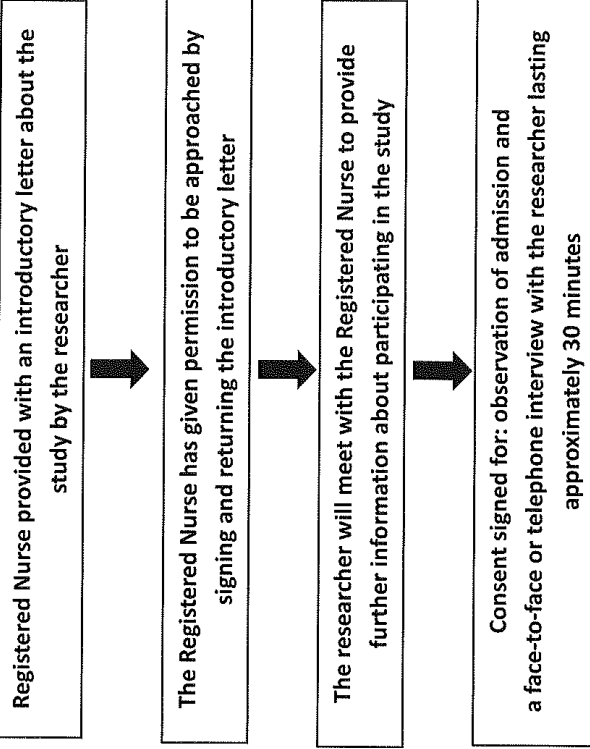
I am aiming to have between 5 and 10 cases, each will involve a patient, a registered nurse, a healthcare professional and possibly a relative/carer.

Do I have to take part?

No, it is up to you to decide whether or not to take part.

If you do decide to take part you will be given this information leaflet to keep and will be asked to sign a consent form. You are free to withdraw at any time without giving a reason. Any data collected may be retained and used in the study unless requested otherwise. All data will remain anonymised.

You will not be paid any expenses for your involvement in this study.



Can I contact a member of the research team for further information?

Yes, if you have any further questions about the study at any stage, please feel free to contact:

Flora Watson
Chief Investigator
University of Stirling
STIRLING
FK9 4LA
f.c.watson@stir.ac.uk
Tel: 01225 557075

Alternative Contact:
Dr Carol Bugge
Lead Supervisor
University of Stirling
STIRLING
FK9 4LA
carol.bugge@stir.ac.uk
Tel: 01786 466109

If you would like information about research more generally please contact:

Professor Jayne Donaldson
Dean of Health Sciences & Sport
University of Stirling
STIRLING
FK9 4LA
jayne.donaldson@stir.ac.uk
Tel: 01785 466345

What will happen to me if I take part?

If you would like to take part or would like to hear more about the study, please let the researcher know and they will come to discuss the study further.

If you are willing to take part, the researcher will ask you to sign a consent form prior to the study starting or before the admission of the patient. You will be given a copy of the consent form to keep. With your agreement, the admission with a consenting patient will be observed by the researcher and recorded.

A few days after the admission, at a date and time that is convenient to you, a face-to-face or telephone interview with the researcher will be arranged. This interview should last no more than 30 minutes. During that time the researcher will ask you questions about the admission, your contribution and your views on role of the nurse.

There are no right or wrong answers to the questions, the researchers are keen to hear a wide range of views and perspectives. With your agreement this interview will also be recorded. All recordings will be transcribed with identifying information (such as your name) removed. Recordings will be destroyed at the end of the study.

With the permission of the patient, the researcher will access the patient's nursing record and medical notes to see what the registered nurse and other healthcare professionals have documented as a product of the admission.

How long will I be involved in the study?

You will be involved in the study for the admission and an interview with the researcher. Your total involvement in the study will take approximately two hours for each consenting patient (this includes time to read this information, the time that the admission takes and to be involved in the interviews).

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you from being involved in the study. If you feel unable to continue with an interview, you can stop the interview and/or withdraw from the study. However, you may find it helpful to discuss your thoughts and opinions.

What are the possible benefits of taking part?

The study may not help you but the information we gain may help to develop admission processes and procedures.

Will the information I provide be kept confidential?

Yes. All information collected about you will be kept strictly confidential. Paper records will be kept in a locked cupboard on NHS premises. Recordings will be stored on a password-protected secure server at the University of Stirling. Your identification will be removed from transcripts and any information that you do provide will be seen by the research team only. Participants who have taken part will not be identified in any way in the reports. Even if we use quotes of things you have said, it will not be possible for others to identify who said it.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. In the first instance contact the researcher: Flora Watson
Tel: 01224 557075.

If you remain unhappy and wish to complain formally, you can do this by contacting: Dr Duncan Brown (Medical Director) at the Hospice.

Appendix 10: RN Information Leaflet v2 30.04.2018 / IRAS ID: 238828 4

What will happen to the results of the study?

The results will help us to understand how admissions occur in practice, particularly the role of the registered nurse. We hope that the results will be published so that others can read and learn from the results of the study. If you wish, when the study is complete we will send you a summary of the findings.

Who is doing this study?

The research is being carried out by a post graduate student who is also a registered nurse. There are a number of different organisations involved.

- The University of Stirling
- NHS Grampian (as employer of the researcher)
- Macmillan Cancer Support

Who has reviewed this study?

The following groups have reviewed this study and given their approval for it to be carried out.

- University of Stirling Research Ethics Committee (NHS Invasive & Clinical Research)
- The North of Scotland Research Ethics Committee (1)
- NHS Lothian Research & Development Department

Appendix 10: RN Information Leaflet v2 30.04.2018 / IRAS ID: 238828



Healthcare Professional Information Leaflet

**A study to investigate the role of the
registered nurse during a patient's
admission to a hospice**

Introduction

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. The researcher will go through the information leaflet with you and answer any questions that you have. Please ask if anything is unclear or if you would like more information. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

This study is based around the face-to-face discussion that happens between a patient, a registered nurse and healthcare professionals on admission to the inpatient unit. It aims to find out what happens during this discussion and what the role of the nurse is.

Why have I been asked to take part?

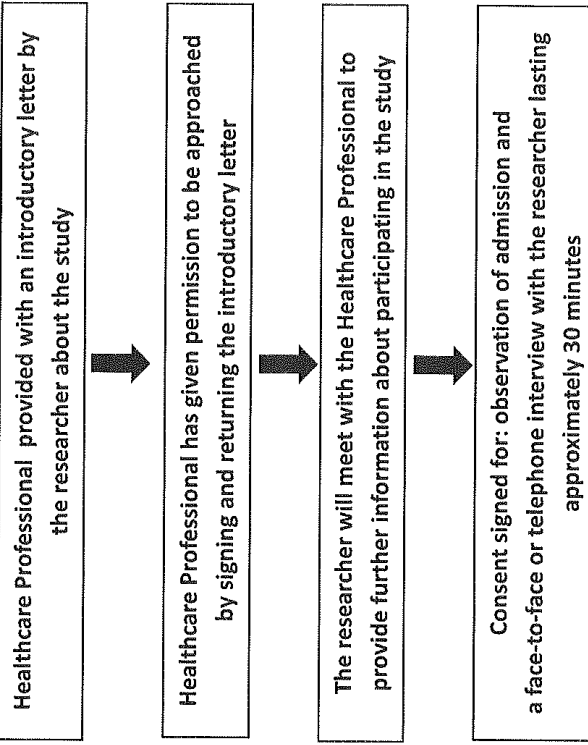
You are one of the multidisciplinary team who are involved in admission alongside the patient, the registered nurse and possibly the patient's relative/carer. You replied to an introductory letter indicating you would like to receive further information from the researcher about the study. We are keen to talk to all those who are involved in an admission. You will only be involved if you are on duty and involved in the admission of a consenting patient. I am aiming to have between 5 and 10 cases, each will involve a patient, a registered nurse, a healthcare professional and possibly a relative/carer.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information leaflet to keep and will be asked to sign a consent form. You are free to withdraw at any time without giving a reason. Any data collected may be retained and used in the study unless requested otherwise. All data will remain anonymised. You will not be paid any expenses for your involvement in this study.

Appendix 14: HCP Information Leaflet v2 30.2018 / IRAS ID: 238828

2



Appendix 14: HCP Information Leaflet V. 1.0 25.02.2018 / IRAS ID: 238828

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Can I contact a member of the research team for further information?

Yes, if you have any further questions about the study at any stage, please feel free to contact:

Flora Watson
Chief Investigator
University of Stirling
STIRLING
FK9 4LA
f.c.watson@stir.ac.uk
Tel: 01224 557075

Alternative Contact :

Dr Carol Bugge
Lead Supervisor
University of Stirling
STIRLING
FK9 4LA
carol.bugge@stir.ac.uk
Tel: 01786 466109

If you would like information about research more generally please contact:

Professor Jayne Donaldson
Dean of Health Sciences & Sport
University of Stirling
STIRLING
FK9 4LA
jayne.donaldson@stir.ac.uk
Tel: 01786 466345

What will happen to me if I take part?

If you would like to take part or would like to hear more about the study, please let the researcher know by signing and returning the introductory letter, and they will come to discuss the study further.

If you are willing to take part, the researcher will ask you to sign a consent form prior to the study starting or before the admission of the patient. You will be given a copy of the consent form to keep. With your agreement, the admission will be observed by the researcher and recorded.

Over the next few days, at a date and time that is convenient to you, a face-to-face or telephone interview with the researcher will be arranged. This interview should last no more than 30 minutes. During that time the researcher will ask you questions about the admission and your views on role and contribution of the nurse.

There are no right or wrong answers to the questions, the researchers are keen to hear a wide range of views and perspectives. With your agreement this interview will also be recorded. All recordings will be transcribed with identifying information (such as your name) removed. Recordings will be destroyed at the end of the study.

With the permission of the patient, the researcher will access the patient's nursing record and medical notes to see what the registered nurse and other healthcare professionals have recorded as a product of the admission.

How long will I be involved in the study?

You will be involved in the study for the admission and an interview with the researcher. Your total involvement in the study will take approximately two hours for each consenting patient (this includes time to read this information, the time that the admission takes and to be involved in the admission).

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you from being involved in the study. If you feel unable to continue with an interview, you can stop the interview and/or withdraw from the study. However, you may find it helpful to discuss your thoughts and opinions.

What are the possible benefits of taking part?

The study may not help you but the information we gain may help to develop admission processes and procedures.

Will the information I provide be kept confidential?

Yes. All information collected about you will be kept strictly confidential. Paper records will be kept in a locked cupboard on NHS premises. Recordings will be securely stored on a password-protected secure server at the University of Stirling. Your identification will be removed from transcripts and any information that you do provide will be seen by the research team only. Participants who have taken part will not be identified in any way in the reports. Even if we use quotes of things you have said, it will not be possible for others to identify who said it.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. In the first instance contact the researcher: Flora Watson
Tel: 01224 557075.

If you remain unhappy and wish to complain formally, you can do this by contacting: Dr Duncan Brown (Medical Director) at the Hospice.

Appendix 1.4: HCP Information Leaflet v2 30.04.2018 / IRAS ID: 238828 4

What will happen to the results of the study?

The results will help us to understand how admissions occur in practice, particularly the role of the registered nurse. We hope that the results will be published so that others can read and learn from the results of the study. If you wish, when the study is complete we will send you a summary of the findings.

Who is doing this study?

The research is being carried out by a post graduate student who is also a registered nurse. There are a number of different organisations involved:

- The University of Stirling
- NHS Grampian (as employer of the researcher)
- Macmillan Cancer Support

Who has reviewed this study?

The following groups have reviewed this study and given their approval for it to be carried out:

- University of Stirling Research Ethics Committee (NHS Invasive or Clinical Research)
- The North of Scotland Research Ethics Committee (1)
- NHS Lothian Research & Development Department

Appendix 1.4: HCP Information Leaflet v2 30.04.2018 / IRAS ID: 238828



Relative / Carer Information Leaflet

**A study to investigate the role of the
registered nurse during a patient's
admission to a hospice**

Introduction

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. The researcher will go through the information leaflet with you and answer any questions that you have. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

This study is based around the face-to-face discussion that happens between a patient, a nurse and a doctor on admission. It aims to find out what happens during this discussion and what the role of the registered nurse is.

Why have I been asked to take part?

You have been asked to take part because the person you care for is being admitted today. The Nurse in Charge has given you an introductory letter because the patient has agreed to participate and advised that you will be present during their admission. I am aiming to talk to about 10 patients and their relatives/carers.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If you decide to take part, you are free to withdraw at any time without giving a reason. Any data collected may be retained and used in the study unless requested otherwise. All data will remain anonymised. You will not be paid any expenses for your involvement in this study.

If you do not want to take part you do not need to take any action.

The patient has agreed to participate in the study and has given permission for the person who cares for them to be present during their admission



An introductory letter about the study is given to the relative / carer by the nurse in charge.



The nurse in charge informs the researcher if the relative / carer has given permission to be approached to discuss the study



The researcher meets with the relative / carer to discuss the study and provide further information about participating



Consent signed for: observation of admission and a face-to-face or telephone interview of approximately 30-40 minutes

Can I contact a member of the research team for further information?

Yes, if you have any further questions about the study at any stage, please feel free to contact:

Flora Watson

Chief Investigator

University of Stirling

STIRLING

FK9 4LA

f.c.watson@stir.ac.uk

Tel: 01224 557075

Alternative Contact:

Dr Carol Bugge

Lead Supervisor

University of Stirling

STIRLING

FK9 4LA

carol.bugge@stir.ac.uk

Tel: 01786 466109

If you would like information about research more generally please contact:

Professor Jayne Donaldson

Dean of Health Sciences & Sport

University of Stirling

STIRLING

FK9 4LA

Jayne.donaldson@stir.ac.uk

Tel: 01786 466345

What will happen to me if I take part?

If you would like to take part or would like to hear more about the study, please let the researcher know.

If you are willing to take part, the researcher will ask you to sign a consent form before the admission starts and you will be given a copy of the consent form to keep. With your agreement, the admission will be observed by the researcher and recorded.

Over the next few days, at a suitable date and time that is convenient to you, a face-to-face or telephone interview with the researcher will be arranged.

The interview but should last no more than 30-40 minutes.

During the interview, the researcher will ask you questions about the admission, what was discussed, what the nurse discussed, and your views on role of the nurse. With your agreement, this interview will also be recorded.

There are no right or wrong answers to the questions, the researchers are keen to hear a wide range of views and perspectives.

All recordings will be transcribed, with identifying information (such as your name) removed. Recordings will be destroyed at the end of the study.

How long will I be involved in the study?

You will be involved in the study for the admission and possibly an interview with the researcher. Your total involvement in the study will take approximately two hours. This includes time to read this information and an interview.

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you or the person you care for, from being involved in the study. If you feel unable to continue with an interview, you can stop the interview and/or withdraw from the study. However, you may find it helpful to discuss your thoughts and opinions.

What are the possible benefits of taking part?

The study may not help you but the information we gain may help us to develop admission processes and procedures for patients in the future.

Will the information I provide be kept confidential?

YES. All information collected about you will be kept strictly confidential. Paper records will be kept in a locked cupboard on NHS premises and recordings will be securely stored on a password-protected server at the University of Stirling. Your identification will be removed from written records of recorded interviews that take place. Any information that you do provide will be seen by the research team only.

Participants who take part will not be identified in any way in the reports. If we use quotes of things you have said, it will not be possible for others to identify who said it.

What if there is a problem?

If you have a concern about any aspect of this study, please ask to speak to the researcher who will do their best to answer your questions. In the first instance contact: Flora Watson, Tel: 01224 557075.

Appendix 6: Relative / Carer Information Leaflet v2 30.04.2018 /IRAS ID: 238828 4

If you remain unhappy and wish to complain formally, you can do this by contacting: Dr Duncan Brown (Medical Director) at the Hospice. Taking part in this study does not affect your normal legal rights.

In the unlikely event of any serious misconduct being witnessed during admission, the researcher will inform the nurse in charge as soon as possible.

What will happen to the results of the study?

The results will help us to understand how the admission occurs in practice, particularly the role of the nurse. We hope that the results will be published so that others can read and learn from the results of the study. If you wish, when the study is complete we will send you a summary of the findings.

Who is doing this study?

The research is being carried out by a post graduate student who is also a registered nurse. There are a number of different organisations involved.

- The University of Stirling
- NHS Grampian (as employer of the researcher)
- Macmillan Cancer Support

Who has reviewed this study?

The following groups have reviewed this study and given their approval for it to be carried out.

- University of Stirling Research Ethics Committee (NHS Invasive & Clinical Research)
- The North of Scotland Research Ethics Committee (1)
- NHS Lothian Research & Development Department

Appendix 6: Relative / Carer Information Leaflet v2 30.04.2018 / IRAS ID: 238828

Appendix 12: Patient Consent Form

Flora Watson (Chief Investigator)
Post Graduate Research Student
School of Health Sciences
University of Stirling
STIRLING
FK9 4LA
f.c.watson@stir.ac.uk

Study ID Number

UNIVERSITY of
STIRLING 

Consent Form (Patient)

A study to investigate the role of the registered nurse during a patient's admission to a hospice

- | | Initial <u>all</u>
boxes |
|--|-------------------------------------|
| By signing this form and initialling each box I agree that I have: | |
| <ul style="list-style-type: none">• been given the Patient Information Leaflet (version 2, dated 30.04.2018) | <input type="checkbox"/> |
| <ul style="list-style-type: none">• had the chance to discuss the study & received satisfactory answers to my questions | <input type="checkbox"/> |
| <ul style="list-style-type: none">• been given enough information about the study | <input type="checkbox"/> |
| I understand that: | |
| <ul style="list-style-type: none">• my participation is voluntary and taking part in the study may not benefit me | <input type="checkbox"/> |
| <ul style="list-style-type: none">• I am free to withdraw from the study at any time, without giving a reason and without my medical care or legal rights being affected | <input type="checkbox"/> |
| <ul style="list-style-type: none">• a member of the research team will interview me once | <input type="checkbox"/> |
| <ul style="list-style-type: none">• my admission and my individual interview will be audio recorded | <input type="checkbox"/> |
| <ul style="list-style-type: none">• all data about me will be stored safely and it will not be possible to identify me by anyone outside the research team | <input type="checkbox"/> |
| I agree that: | |
| <ul style="list-style-type: none">• the researcher has permission to access my nursing record / medical notes but these will not be removed from the site and any information extracted will be anonymised | <input type="checkbox"/> |
| <ul style="list-style-type: none">• basic information held about me (i.e. age, sex) and my contact details can be held, confidentially and securely on NHS premises until transfer for safekeeping at the University of Stirling | <input type="checkbox"/> |
| <ul style="list-style-type: none">• my data may be used when presenting the results of the research, including quotes of things I have said, but it will not be possible to identify me | <input type="checkbox"/> |
| <ul style="list-style-type: none">• if I choose to withdraw from the study, data already collected may be retained and used for the purposes of this study | <input type="checkbox"/> |

1 for participant; 1 for Office

Study ID Number

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To be completed by the participant:

<p>Your Signature: _____ Date: _____</p> <p>Your name in block capitals: _____</p>
--

To be completed by the team member taking consent:

<p>I can confirm that I have explained to the person named above, the nature and purpose of this study.</p> <p>Your Signature: _____ Date: _____</p> <p>Your name in block capitals: _____</p>
--

1 for participant; 1 for Office

Appendix 3 - Consent Form for Patients v2 30.04.2018 / IRAS ID: 238828

Appendix 13: Registered Nurse Consent Form

Study ID Number



Flora Watson (Chief Investigator)
Post Graduate Research Student
School of Health Sciences
University of Stirling
STIRLING
FK9 4LA
f.c.watson@stir.ac.uk

Consent Form (Registered Nurse)

A study to investigate the role of the registered nurse during a patient's admission to a hospice

By signing this form and initialling each box I agree that I have:

**Please
INITIAL ALL
boxes**

- been given the Registered Nurse Information Leaflet (version 1.0, dated 25.02.2018)
- had the chance to discuss the study
- received satisfactory answers to my questions
- been given enough information about the study

I understand that:

- my participation is voluntary and taking part in the study may not benefit my own health
- I am free to withdraw from the study at any time, without giving a reason and without my legal rights being affected
- a member of the research team will interview me once
- the admission and my face to face or telephone interview will be audio recorded
- all data about me will be stored safely and it will not be possible to identify me to anyone outside the research team.

1 for participant; 1 for Office

Appendix 11 - Consent Form for Registered Nurses V.1.0 25.02.2018 / IRAS ID: 238828

watsonf3 17/11/2021 13:20

Study ID Number

I agree that:

- Basic information held about me (i.e. age, sex, number of years registered, length of time working in unit) and my contact details can be held, confidentially and securely, by the study office at the University of Stirling
- my data may be used when presenting the results of the research, including quotes of things I have said, but it will not be possible to identify me
- if I choose to withdraw from the study, data already collected may be retained and used for the purposes of this study

Your signature (participant): _____ Date: _____

Your name in block capitals _____

To be completed by team member taking consent

I confirm that I have explained to the person named above, the nature and purpose of this study.

Your signature _____ Date _____

Your name in block capitals _____

1 for participant; 1 for Office

Appendix 11 - Consent Form for Registered Nurses V.1.0 25.02.2018 / IRAS ID: 238828

watsof3 17/11/2021 13:20

Study ID Number				
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Flora Watson (Chief Investigator)
Post Graduate Research Student
School of Health Sciences
University of Stirling
STIRLING
FK9 4LA
f.c.watson@stir.ac.uk

Consent Form (Healthcare Professionals)

A study to investigate the role of the registered nurse during a patient's admission to a hospice

By signing this form and initialling each box I agree that I have:

**Please
INITIAL ALL
boxes**

- been given the Healthcare Professional Information Leaflet (version 1.0 dated 25.02.2018)
- had the chance to discuss the study
- received satisfactory answers to my questions
- been given enough information about the study

I understand that:

- my participation is voluntary and taking part in the study may not benefit my own health
- I am free to withdraw from the study at any time, without giving a reason and without my legal rights being affected
- a member of the research team will interview me once
- the admission and the face to face or telephone interviews will be audio recorded
- all data about me will be stored safely and it will not be possible to identify me to anyone outside the research team.

1 for participant; 1 for Office

Appendix 15 - HCP Consent Form V.1.0 25.02.2018 / IRAS ID: 238828

Study ID Number

I agree that:

- basic information about me (i.e. age, sex, profession, length of time working in unit) and my contact details can be held, confidentially and securely, by the study office at the University of Stirling
- my data may be used when presenting the results of the research, including quotes of things I have said, but that that it will not be possible to identify me
- if I choose to withdraw from the study, data already collected may be retained and used for the purposes of this study

Your signature (participant): _____ Date: _____

Your name in block capitals _____

To be completed by team member taking consent

I confirm that I have explained to the participant named above, the nature and purpose of this study.

Your signature _____ Date _____

Your name in block capitals _____

1 for participant; 1 for Office

Appendix 15 - HCP Consent Form V.1.0 25.02.2018 / IRAS ID: 238828

vatsof3 17/11/2021 13:28

Appendix 15: Relative / Carer Consent Form

Flora Watson (Chief Investigator)
 Post Graduate Research Student
 School of Health Sciences
 University of Stirling
 STIRLING
 FK9 4LA
 f.c.watson@stir.ac.uk

Study ID Number				
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Consent Form (Relative / Carer)

A study to investigate the role of the registered nurse during a patient's admission to a hospice

By signing this form and initialling each box I agree that I have:

Initial all boxes

- been given the Relative / Carer Information Leaflet (version v2, dated 30.04.2018)
- had the chance to discuss the study & received satisfactory answers to my questions
- been given enough information about the study

I understand that:

- my participation is voluntary and taking part in the study may not benefit me or that of the person I care for
- I am free to withdraw from the study at any time, without giving a reason and without my legal rights or the medical care of the person I care for being affected
- all data about me will be stored safely and it will not be possible to identify me by anyone outside the research team
- the admission and my individual interview will be audio recorded

I understand that I have 2 options and I have selected :

- a member of the research team will be observing the admission and will interview me once

OR

- a member of the research team will be observing the admission but I have chosen not to participate in a one to one interview

1 for participant; 1 for Office

Appendix 7 - Consent Form for Relatives / Carers v2 30.04.2018 / IRAS ID: 238828

watsof3 17/11/2021 13:29

Study ID Number

I agree that:

- the researcher can be present
- basic information held about me (i.e. age, sex, relationship to the patient) and my contact details can be held, confidentially and securely on NHS premises until transfer for safekeeping at the University of Stirling
- my data may be used when presenting the results of the research, including quotes of things I have said, but it will not be possible to identify me
- if I choose to withdraw from the study, data already collected may be retained and used for the purposes of this study

To be completed by the participant:

Your Signature: _____ Date: _____

Your name in block capitals: _____

To be completed by the team member taking consent:

I can confirm that I have explained to the person named above, the nature and purpose of this study.

Your Signature: _____ Date: _____

Your name in block capitals: _____

1 for participant; 1 for Office

Appendix 7 - Consent Form for Relatives / Carers v2 30.04.2018 / IRAS ID: 238828

Appendix 16: Patient Interview Schedule

Study ID Number				
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UNIVERSITY of
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INTERVIEW SCHEDULE FORM FOR PATIENTS

WELCOME / INTRODUCTION:
<p>Thank you for agreeing to speak with me today.</p> <p>Can I take a minute to just confirm that you understand what your participation in this study involves?</p> <p>That is:</p> <ul style="list-style-type: none"> • I have observed and audio recorded the 'admission' • I will audio record our face to face discussion today • You have agreed that I will have access to your patient record/case notes <p>The aim of our discussion today is to help our understanding of what happens during an admission. If you need to take a break at any point during our discussion please just let me know.</p>
QUESTIONS / PROMPTS:
I would like to start by asking you a few questions about your admission today. Is that okay?
Tell me about what happened during your admission today?
A registered nurse was present during your admission – how did you feel about what the nurse did? Would you have liked her to do anything differently?
How would you like the information the nurse gathered today to be used?
How were you involved in the discussion today? If so, was that what you wanted?
Is there anything else you would like to tell me about your admission today?
Do you have any questions for me?
<i>Thank you for participating today. The information gathered will be transcribed, with any identifying information (such as your name) removed. This recording will be destroyed at the end of the study.</i>

Appendix 17: Registered Nurse Interview Schedule

Study ID Number




INTERVIEW SCHEDULE FORM FOR REGISTERED NURSES

WELCOME / INTRODUCTION:
<p>Thank you for agreeing to speak with me today.</p> <p>Can I take a minute to just confirm that you understand what your participation in this study involves?</p> <p>That is:</p> <ul style="list-style-type: none"> • I have observed and audio recorded the 'admission' • I will audio record our face to face or telephone discussion today <p>The aim of our discussion today is to help our understanding of what happens during an admission between a patient and a registered nurse. If you need to take a break at any point, please just let me know.</p>
QUESTIONS / PROMPTS:
<p>I would like to start by asking you a few questions about the admission of [patient name] that you were involved in. Is that okay?</p>
<p>Tell me about what happened during the admission today?</p>
<p>Can you tell me what you did during the admission?</p>
<p>How will you use the information you gathered today?</p>
<p>Can you tell me what you think the purpose of the 'admission' is?</p>
<p>Is there anything else you would like to tell me about the admission today?</p>
<p>Do you have any questions for me?</p>
<p><i>Thank you for participating today. The information gathered will be transcribed, with any identifying information (such as your name) removed. This recording will be destroyed at the end of the study.</i></p>

Appendix 18: Healthcare Professional Interview Schedule

Study ID Number				
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UNIVERSITY of
STIRLING



INTERVIEW SCHEDULE FORM FOR HEALTHCARE PROFESSIONALS

WELCOME / INTRODUCTION:
<p>Thank you for agreeing to speak with me today.</p> <p>Can I take a minute to just confirm that you understand what your participation in this study involves?</p> <p>That is:</p> <ul style="list-style-type: none">• I have observed and audio recorded the 'admission'• I will audio record our face to face or telephone discussion today <p>The aim of our discussion today is to help our understanding of what happens during an admission between a patient and a registered nurse. If you need to take a break at any point, please just let me know.</p>
QUESTIONS / PROMPTS;
<p>I would like to start by asking you a few questions about the admission of [patient name] that you were involved in. Is that okay?</p>
<p>Tell me about what happened during the admission today?</p>
<p>Can you tell me what nurse did during the admission?</p>
<p>How would you like the information gathered today to be used?</p>
<p>Can you tell me what you think the purpose of the 'admission' is?</p>
<p>Is there anything else you would like to tell me about the admission today?</p>
<p>Do you have any questions for me?</p>
<p><i>Thank you for participating today. The information gathered will be transcribed, with any identifying information (such as your name) removed. This recording will be destroyed at the end of the study.</i></p>

Appendix 19: Relative / Carer Interview Schedule

Study ID Number				
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INTERVIEW SCHEDULE FORM FOR RELATIVES / CARERS

WELCOME / INTRODUCTION:
<p>Thank you for agreeing to speak with me today.</p> <p>Can I take a minute to just confirm that you understand what your participation in this study involves?</p> <p>That is:</p> <ul style="list-style-type: none"> • I have observed and audio recorded the ‘admission’ • I will audio record our face to face or telephone discussion today <p>The aim of our discussion today is to help our understanding of what happens during an admission. If you need to take a break at any point during our discussions, please just let me know.</p>
QUESTIONS / PROMPTS:
I would like to start by asking you a few questions about your relative’s admission today. Is that okay?
Tell me about what happened during the admission today?
A registered nurse was present during the admission – how did you feel about what the nurse did? Would you have liked her to do anything differently?
How would you like the information the nurse gathered today to be used?
Were you involved in the discussion today? If so, was that what you wanted?
Is there anything else you would like to tell me about the admission today?
Do you have any questions for me?
<i>Thank you for participating today. The information gathered will be transcribed, with any identifying information (such as your name) removed. This recording will be destroyed at the end of the study.</i>

Appendix 20: Case 1 Storyboard

STORYBOARD: CASE ONE (March 2019)

Blue Boxes = headings from previous storyboard / Grey Boxes (N) = Node with numbers denoting references in Nvivo / Green Boxes = Comments or Thoughts / Orange Box = data examples / Lilac Box = Researcher Reflexivity



Appendix 21: Final NVIVO Codebook

Nodes (N) & subnodes (s)	Descriptors	Files	References
1. COMMUNICATION	TEMPORARY CONSTRUCT		
(N) Information Gathering	Data that describes or explains actions / dialogue / references to the gathering of information by participants as part of the admission		
(s) Direct	Specific contact with patient	22	182
(s) Indirect	Not specific to the patient i.e. notes / computer	8	26
(N) Information Sharing	Data that describes or explains, actions or dialogue or references to the sharing of information by participants as part of the admission		
(s) Patient Details	Relates to information shared between participants connected with the patient	19	121
(s) Patient Wishes	Relates to patient wishes or preferences expressed	11	37
2. PURPOSE	TEMPORARY CONSTRUCT		
(N) Operational Aspects	Data that describes or explains, actions or dialogue or references to operational aspects of the admission		
(s) Admission Procedure	Data that describes or explains, actions or dialogue or references to procedures involving admission from an operational perspective	16	120
(s) Critical of Process (Pt)	Data that describes or explains, actions or dialogue or references from patients that are critical of the admission process from an operational perspective	5	35
(s) Reason for Admission	Information specific to the reasons for admission	10	16
3. SHARED RN & DR	TEMPORARY CONSTRUCT		
(N) Assessment	Data that describes or explains, actions or dialogue or references relating to assessment skills		
(s) of patient condition	Relates to the assessment of the patient's physical condition	20	191
(N) Formulating Plan of Care	Data that describes or explains, actions or dialogue or references around formulating a plan of care for the patient		
(s) By Dr	Relates to the Dr involved in the admission	13	86
(s) By RN	Relates to the RN involved in the admission	14	58
(s) With Patient	Relates to patient involvement	19	73
(N) Working relationships	Data that describes or explains, actions or dialogue or references regarding the professional relationship among the team including communication	19	145
4. PROCESS	TEMPORARY CONSTRUCT		
(N) Problems with Admission	Issues or problems that happen with the admission of a patient from the perspective of healthcare professionals		
(s) Patient Issues	Data that describes or explains, any actions or dialogue or references relating to or connected with the patient and admission	11	36
(s) Researcher Observations	Observations & thoughts of the researcher	13	28
(s) Views expressed by Staff	Explores views expressed by staff at study site	13	87
(N) Pre Admission	Data that describes or explains, actions or dialogue or references by participants that took place before the admission interview	14	43
(N) Post Admission	Data that describes or explains, actions or dialogue or references by participants that took place after the admission interview	11	28
(N) Structure of Interview	Data that describes or explains, actions or dialogue or references to how the admission interview occurred		
(s) Content & Layout	Explores the content of the admission interview	22	87
(s) Participant roles and views	Explores what participants said or did or views expressed	22	214

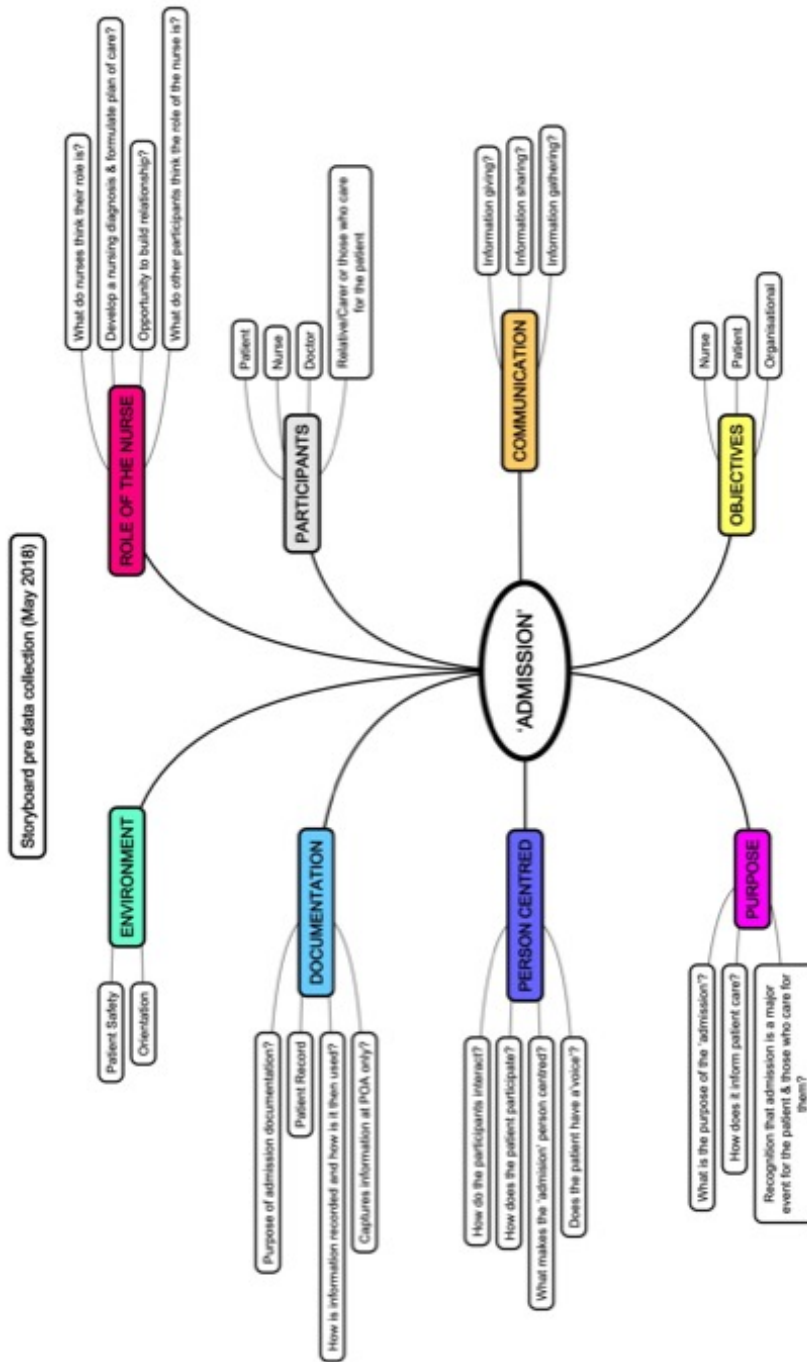
5. PERSON-CENTRED		TEMPORARY CONSTRUCT	
(N) Patient Preferences	Data that describes or explains, actions or dialogue or references to patient preferences as part of the admission		
(s) General Info	General information from or about patient (preferences)	16	42
(s) What matters to pt	Specifically relates to establishing or stated preferences	18	85
(N) Patient Understanding	Data that describes or explains, actions or dialogue or references to patient understanding as part of the admission		
(s) As perceived by HCP's	Specifically describes patient understanding as perceived by RN / Dr	7	21
(s) Of future	Specifically explores patient understanding regards their future	14	47
(s) Of illness	Specifically explore patient understanding of current health status	10	42
6. HCP ROLE		TEMPORARY CONSTRUCT	
(N) Dr Behaviours	Data that describes or explains, actions or dialogue or references to the behaviour of the Dr as part of the admission		
(s) Clarifying	Explores the doctor's role and clarifying information	16	153
(s) Involving Pt	Explores the doctor's role and patient involvement	16	150
(s) Involving RN	Explores the doctor and behaviour towards the RN	18	79
(s) Leading	Explores where doctor appeared to lead interview / discussion	18	73
(s) Prep Work	Specific to the work undertaken by doctors before admission	7	11
(N) RN Behaviours	Data that describes or explains, actions or dialogue or references to the behaviour of the RN as part of the admission		
(s) Assessing	Explores RN undertaking assessment	20	131
(s) Documentation	Data that describes or explains, actions or dialogue or references to patient documentation by the RN as part of the admission	12	40
(s) Interpretation	Explores RN interpreting information provided	20	136
(s) Missed Opportunities	An opportunity where the nurse could have intervened / joined in discussion / offered additional information	11	136
(s) Notetaking	Explores RN taking notes	14	28
(s) Orientation	Explores how RN orientates patient & family	11	26
(s) Participation	Explores RN participation	23	184
(s) Practical Tasks	Explores where RN undertakes practical task (s) e.g. giving patient medications	18	52
(N) RN Background	Data that describes or explains, actions or dialogue or references to background information on the RN participants	7	11
9. NURSE-PATIENT RELATIONSHIP		TEMPORARY CONSTRUCT	
(N) Nurse-patient relationship	Data that describes or explains, actions or dialogue or references to the nurse – patient relationship as part of the admission		
(s) Getting to Know	Explores examples of gathering and using information	19	108
(s) Listening	Explores examples provided of RN 'listening'	11	35
(s) Offering Support	Explores examples of RN offering support to patient & family	13	44

(N) GOOD QUOTES OR EXAMPLES	Extracted from data	19	191
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RESEARCHER REFLECTIONS		Contains sub-nodes specific to researcher role	
(N) Researcher Reflexivity	Data that describes or explains, the researcher's own critical reflections and ongoing critique during data collection on site		
(s) Comfort vs Discomfort	Examples showing researcher's understanding / feelings / responses relating to undertaking the study (no change from Case 3)	8	41
(s) Interviewing	Explores the researcher's experience of interviewing participants (no change from Case 3)	12	38
(s) Own Learning	Explores the researcher's learning after the first case (no changes from Case 3)	15	105
(N) Researchers Thoughts and Questions	Data that describes or explains, the researcher's own thoughts and questions generated during the study at site		
(s) Patient	Explores the researcher's experience regarding the patient as a participant for this case	13	54
(s) Patient records	Explores the researcher's notes on the patient record for this case	7	20
(s) Staff	Examples showing the questions that arose for the researcher as a result of interactions with staff	16	133

DORMANT NODES		These nodes were generated at the start of the study and while of some interest the references / data added was small.	
(N) ENVIRONMENT	Data that describes or explains, actions or dialogue or references to the environment by participants relating to admission (unchanged from Case 3)	13	29
(N) FAMILY & SIGNIFICANT OTHERS	Data that describes or explains, actions or dialogue or references to the behaviour of the family or significant others present at the admission interview (slight changes from Case 3 – not sig))	15	37
(N) USE OF HUMOUR	Data that describes or explains, actions or dialogue or references to the use of humour by participants as part of admission (slight changes from Case 3 – not sig)	6	30

RETIRED NODES		Nodes the have been removed from primary nodes within temporary constructs	
(N) Analytical Observations	07.04.2019 From data analysis and memos		
(N) Researcher	27.04.19 Retired as expanded into sub nodes		
(N) Role of RN	07.04.2019 Retired as a top-level node. Too general as a term. Coding revealed need for more in-depth analysis		
(N) Shared by Dr & RN	27.04.19 Used as a temporary construct rather than a node		



Appendix 23: Excel Example of Coding Summary

CASE THREE: CODING SUMMARY							
Temporary Constructs	Nodes	Node descriptor	Sub nodes	Sub node descriptor	Good examples from data	Contrary examples from data	Analytical Memo's / Notes / Questions
1. COMMUNICATION	a. Information Gathering	Data that describes or explains, actions or dialogue or references to the gathering of information by participants as part of the admission	i. Direct	Explores direct contact with patient	<i><u>Adm Interview:</u> [1] RN: with you lying .. obviously because .. you're sore .. and if you lie down .. is there any areas that are sore just with pressure? Pt: well .. that's the point .. I thought that's what was on my hips .. RN: right .. Pt: but there are no actual sores .. no [2] <u>Field Notes:</u> The RN spends the next couple of minutes discussing skin integrity, specialist equipment needs, oral problems.</i>	<i><u>Patient Interview:</u> Res: .. okay .. and that clarification .. did you think more of that was done through the nurse .. the doctor ..? Pt: no .. it was more the doctor ..</i>	13.01.19: Due to the complex history, the majority of references in this node related to discussion about symptoms between the patient and the doctor of which there were many in the data collected. The researcher did not code all possible references but chose to include core examples. The patient perceived that the Dr did most of the 'clarification' in this case which is correct.
			ii. Indirect	Explores indirect contact to gather information	<i><u>Patient Interview:</u> Pt: for example .. there has been more than one doctor here .. to see me .. Res: yes .. Pt: .. and they are effectively asking me the same question .. Res: okay.. Pt:.. but there are already notes .. that are already in place .. and it's as though .. but probably part of the process they're doing .. reiterating the thing to make sure .. that what I've been saying .. is the same thing I've been saying .. so that they know it's the right treatment .. or whatever ...</i>		10.02.20: The patient mentions 'notes' that the healthcare professionals have access to. The patient also mentions repetition (by Dr's) but provides a justification why this may be necessary. The patient gave a very comprehensive history and articulated his needs well. <i>As a patient with a complex history and probably very comprehensive notes, the need to gather information from other sources was possibly not required to the same degree as other patients.</i>

b. Information Sharing	Data that describes or explains, actions or dialogue or references to the sharing of information by participants as part of the admission	i. Patient Details	Relates to information shared between participants connected with the patient	<i>RN Interview: [1] Res Notes: RN talks of the importance of handover and sharing information gathered during the admission interview. In addition to the key information, the RN also talks of taking the opportunity to personalise the handover for that patient. [2] Res Notes: RN recognised certain traits the patient had and shared that background information to help benefit the team.</i>	<i>Field Notes: The 'personal' patient information is not necessarily recorded on the SBAR but shared verbally.</i>	22.01.20: The majority of references came from the admission interview and RN interview, with 1 other from the patient interview. While many of the references relate to clinical information & dialogue about this between the patient, the doctor and the nurse. It is interesting to note the holistic assessment by the RN & recognition of what matters to the patient. Information of a more 'personal' nature including the RN's views on the patient's behaviours / traits are not written down but are verbalised and shared with colleagues. It could be argued such information is key to delivering & planning care so why is it not documented? Too subjective - opinion of the admitting RN only?
		iii. Patient Wishes	Relates to patient wishes or preferences expressed	<i>RN Interview: RN: as in .. you know .. the chap is a bit anxious .. he is a bit frustrated .. so kinda go with it .. calming down a wee bit now but .. you know he's one of these people .. he's very factual .. Res: yes.. RN: and he likes everything just as .. so approach him that way .. because he responds to you better ..</i>	<i>Field Notes: The Dr goes on to explain what is available at the hospice and agrees with the patient when he decides he would like treatment (if he became unwell). The only treatment discussed is 'antibiotics' nothing else e.g. DNA CPR Patient Interview: Res: can you give an example of one of those things? Patient: em .. like how I felt about the situation .. em .. if there was anything else that could have been done on top of the medication .. and guide me in that direction ..</i>	22.01.20: The RN acknowledged the patient's anxiety and frustrations and 'likes everything just as'. As an observer and palliative care nurse, my assessment would be the patient wanted to retain his 'control' but the RN did not use that phrase. During the admission interview the doctor discussed what the patient's options were should he become unwell. This would normally lead to a discussion about DNA CPR but when the Dr mentioned 'probably discussed with your GP' she was not explicit about what these were and the patient responded 'no'. The doctor did not explore this further. Why not? The admission was for complex pain control and the patient's performance status was relatively good but he was no longer fit for treatment for his lung cancer. What factors influenced the decision not to discuss the future and his wishes? Reluctant to cause any additional distress for patient? Yet the patient talked about discussing 'what else could be done'?

2. PURPOSE	a. Operational Aspects	Data that describes or explains, actions or dialogue or references to operational processes & procedures	1. Admission Procedure	Relates to procedures occurring specific to the patient admission	<p>Patient Interview: [1] Res: okay .. do you think there was anything the nurse could have done differently? Pt: [long pause] .. not really knowing what her role was .. I wouldn't like to say .. Res: okay .. okay .. Pt: .. because there wasn't a definition really of the role .. [2] Pt: and you can have a passive interview .. by somebody .. and .. I don't know if that's part of the role the nurse does? .. Res: right .. Pt: em .. Res: when you say passive .. what do you mean by that phrase? Pt: they are sitting there .. listening to what both parties are saying .. and the reaction to the questions .. can be picked up .. the content of the answer can be misinterpreted .. by the person that is supposedly listening to it ..</p>	<p>RN Interview: [1] RN: .. not really .. I would like to maybe have had .. a wee look at .. you know there would have been other things I would have liked to have done .. I think it was fine to draw a line under it .. where we did because .. he was getting .. so exasperated .. you know .. kinda getting past the point .. where anything needed to be useful .. and he needed a rest .. and we could see that .. Field Notes: The RN was called away by a HCSW to help with another patient, she returned after about 8 mins.</p>	<p>22.01.20: The patient was not clear on the role of the nurse during the admission interview other than the RN being introduced, the reason for her presence was not explained. The Dr did the initial introductions but no real explanation regards what was about to happen.</p> <p>Do staff play down what the admission interview is for - 'ask a few questions' or 'what brought you here today'? * Cross check what happened in other cases. Why does the nurse not explain why she is there?</p> <p>The patient did expand further in his interview by describing the role of the RN as 'supportive'. There was also recognition by the RN that the patient was tiring towards the end of the admission interview despite the fact she would have liked to gather additional info.</p> <p>What are the expectations around the 'completion' of an admission? The data gathered so far shows that the 'admission' assessment takes place over the first day or two and involves the whole MDT. Can this be considered a 'procedure' when the assessment is and needs to be so comprehensive?</p> <p>The RN was called away to assist elsewhere in the unit (for 8 mins).</p> <p>Would this have happened if the RN had been 'admitting' alone?</p>
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			<p>Views expressed by the patient</p> <p>Patient Interview: Res: <i>thinking about what happened yesterday .. is there anything else you think you want to tell me about what happened? ..</i> Pt: <i>I think I mentioned one of the aspects yesterday was .. there was a constant from when I came in .. it was just .. one person after another .. after another .. after another .. and there was no respite for me .. to try and recover from the journey ..</i></p>	<p>Adm Interview: Res notes: <i>The Dr asks the patient if she can proceed with the physical exam. The patient questions whether this is necessary just now as his wife is waiting to visit. The admission interview has taken up to 38 mins at this point. The Dr initially said it would take around 30 mins. The patient asks if his wife could be informed and the Dr leaves to do so.</i></p>	<p>22.01.20: The patient mentioned his views regarding the constant stream of staff a few times i.e. to the researcher during the admission interview (when we were alone), to the doctor during the admission interview and also during his one-to-one interview with the researcher.</p> <p>Is there a conflict of priorities when it comes to the admission interview? For patients, is it about 'settling in' on arrival but for HCP's the priority is get the patient 'admitted'?</p>
			<p>Information specific to the reasons for admission</p> <p>RN Interview: RN: <i>it was an appropriate referral .. definitely .. yes ..</i></p>	<p><i>no example from data</i></p>	<p>25.01.20: The RN expressed her view that the referral was appropriate. There were a few references throughout the case regarding the complexity of this patient's history therefore admission to a specialist unit was fitting.</p>

3. SHARED RN & DR	a. Assessment	Data that describes or explains, actions or dialogue or references relating to assessment skills	i. Of patient condition	Relates to the assessment of the patient's physical condition	<i>RN Interview: RN: ..everybody is an individual that comes through the doors .. and every single person is going to be different and have different needs .. Res: ..and you then adjust your approach? RN: ..well .. yes .. I would like to think so .. I would like to think that .. everybody can pitch their communication at a level that people will understand .. for example .. like the chap we admitted .. very tuned in .. very on the ball with regards medication .. dosages and names of medication .. you maybe wouldn't start reeling off things like that with other patients ..</i>	<i>Data Ext: The assessment phase continued on from the admitting RN to the RN on duty overnight. This RN added new additional information obtained from the patient. Some of the content was quite personal in nature and the RN captured this in her report for overnight. An RN overnight appears to have had a more in-depth discussion with the patient about how he is feeling about admission during the night.</i>	25.01.20: The bulk of references (29) for this node come from the admission interview and dialogue between the doctor and the patient and that initial assessment. The admitting RN discussed how she modifies her approach based on each individual patient and how she adjusts her communication during that initial assessment. The assessment by the RN overnight demonstrates how the admission process extends beyond the admission interview.
	b. Formulating plan of care	Data that describes or explains, actions or dialogue or references around formulating a plan of care for the patient	i. By Dr	Relates to the Dr involved in the admission	<i>Dr Interview: Dr: so my main aim was to establish .. em .. what his symptoms were .. and how we could improve those symptoms .. um .. and it was also to find out what he thought he could .. get out of his admission and .. em .. what he thought we could help him with ..</i>	<i>Patient Interview: Pt: for example .. there has been more than one doctor here .. to see me .. Res: yes .. Pt: and they are effectively asking me the same question .. Res: okay Pt: .. but there are already notes .. that are already in place .. and it's as though .. but probably part of the process their doing .. reiterating the thing to make sure .. that what I've been saying .. is the same thing I've been saying .. so that they know it's the right treatment .. or whatever ..</i>	25.01.20: References / dialogue are as expected in relation to this aspect of care which was probably enhanced by the fact that the patient was very articulate, provided clear responses and participated comprehensively in the discussion. While the patient mentions the repetition of questions by the doctor he recognises that medical staff are probably ensuring his answers are consistent and part of their assessment.

			<p>ii. By RN</p>	<p>Relates to the RN involved in the admission</p>	<p><i>RN Interview: Res: so what does that involve .. that handover .. RN: .. that handover .. is really just .. who the person is .. what they're in for .. what their mobility is .. what drugs they're on .. but .. I think it's a nice opportunity to be able to say something about that patient .. that's personal to them ..</i></p>	<p><i>no example from data</i></p>	<p>25.01.20: During the admission interview, the discussion was predominantly between the patient and the doctor. The plan formulated by the RN was evidenced in the patient record but any dialogue with the patient around this was not obvious. Neither the RN or the patient made any reference to it during the individual one to one interviews. Although, the RN does talk about the content of the 'handover' and sharing information with colleagues. The RN overnight had a more in-depth discussion with the patient about what was important to him.</p> <p>What are the priorities on admission for the RN? What are priorities for the patient?</p>
			<p>iii. With Patient</p>	<p>Relates to patient involvement</p>	<p><i>[1] RN Interview: RN: about how he feels .. what his drugs do .. what he needs .. you know.. fiercely independent .. em .. for us the admission was really .. get to know him .. trying to let him understand what we were hoping to achieve ..</i> <i>[2] Patient Interview: Res: so what happened yesterday .. in comparison with other admissions that you've had? .. Pt: the other admissions were a case of .. you're in here .. let's analyse you .. and put you to the side .. what was happening yesterday .. was you arrived here .. let's try and evaluate what you are .. what needs to be done .. eh .. and we'll take it forward from there ..</i></p>	<p><i>Pt Interview: Res: yeh .. you mentioned that .. you felt .. you were quite tired .. and a lot had happened .. Pt: and .. the pain had gone up .. with my back problems and the journey Res: yeh .. Pt: em .. and as much as I try to be helpful as I can .. in all the circumstances .. it just felt like it was .. too many Res : right .. okay .. how do you think that could be done differently? Pt: well .. just simply asking .. how you felt about it .. Res: right .. okay .. Pt: .. would have been a start .. the .. I tend to find when .. I've been in these circumstances of late .. it's been .. the more senior person in the party .. tends to want to rush on and get things done ..</i></p>	<p>25.01.20: The patient describes previous admissions and how the approach within the hospice was different and appears to concur with what the RN & Dr said i.e. getting to know the patient and understand his needs. As an observer, the patient at the beginning of the admission interview was 'in control' and influenced the discussion. As the interview progressed, the patient's demeanour appeared to relax.</p> <p>Why was this? Did he feel listened to? Did the HCP's set the right tone / mood? This contrasts with his description of senior staff rushing to 'get things done' but these were general comments rather than specific to this admission.</p> <p>Although, there are questions around how the admission interview is explained to a patient?</p>

	c. Working Relationships	Data that describes or explains, actions or dialogue or references regarding the professional relationship among the team including communication	The majority of references for this node were spread evenly across the patient interview (9) , the RN interview (9) and Dr Interview (8).	<i>RN Interview: Res: there's maybe a benefit there for you .. because you are able to listen in to the questions that the doctors .. RN: yeh and .. sometimes I think that .. it's nice .. it's certainly nice for me .. I don't know how the doctors would feel about it .. but if I come out of there and I'm not very sure about something .. I can say to the doctor .. how did you feel that that went .. or do you think that they understood that .. and .. it means you know you've got somebody to .. run that by ..</i>	<i>Dr Interview: Res:.. so you chose the word there to say you think the nurse helps to 'support' the doctor .. is that .. Dr: yeh .. Res: .. can you be more specific about that? Dr: em .. yeh .. I guess .. as I said .. it helps remind me there's certain things I need to do .. em .. it's also.. I think it is quite good for that patient to see.. the kind of .. team aspect .. medical, nursing staff.. Res: yeh .. Dr: together .. Res: yeh .. Dr: and even just for .. kinda .. just logistical things .. such as helping me examine the patient .. as to lift them forward .. Res: yeh .. Dr: that sort of thing ..</i>	26.01.20: The RN discusses how it can be beneficial to have the opportunity to 'debrief' following an admission interview. For example, checking (patient) understanding as well mutual support for one another. Although, the RN is not sure if this is how the Dr's would perceive this? T The Dr's perception of the working relationship with nursing staff includes [1] being there as a prompt [2] letting the patient see the 'team aspect' [3] helping with the patient examination. Why would the RN need to prompt the Dr, could the RN not just ask the patient? How does having the Dr & RN demonstrate team working? Is it best use of RN time to help position the patient for a clinical exam?
4. PROCESS	a. Pre-admission	Data that describes or explains, actions or dialogue or references by participants that took place before the admission interview	In this case there were no specific references regards pre-admission.	No example from data	No example from data	26.01.20: The patient was a transfer from another hospital in the region and all information was transferred with the patient. There was no mention of any discussion regards any conversations or calls between the hospital or hospice prior to transfer. The patient's comments about pre-admission related to the other hospital rather than the hospice.

b. Post-admission	Data that describes or explains, actions or dialogue or references by participants that took place after the admission interview			5 of the references came from the RN Interview with the others were from the data extraction sheet (3) and patient interview (2) .	<i>Data Ext: RN entries from night duty documented discussion around 'what is important' for the patient i.e. 'better pain control and a better understanding of medical treatment'. The RN also records that the patient appeared to have a sense of 'frustration' around the transfer: no further explanation from nursing staff around this statement. The patient reported pain overnight and action was taken to relieve it. The RN also records her discussion with the patient about his home situation, family and their support.</i>	<i>Patient Interview: Res: okay .. Pt: so a subsequent communication between them .. 'did you notice that they said such & such?' .. 'yeh but I interpreted that as being' ..</i>	26.01.20: The information gathered by the RN overnight is significant and builds on that gathered by the admitting RN. Is the admission interview a starting point for the nursing assessment? The patient believes that the staff present at the admission interview will have an opportunity to discuss and share their interpretation of the information gathered which is similar to what the nurse inferred. Does a 'debrief' normally occur after the admission interview? What if it doesn't happen, what is the impact?
	c. Problems with Admission	Data that describes or explains, actions or dialogue or references around problems with admission as perceived by participants	i. Patient issues	Explores issues related to the patient	<i>Adm Interview: [1] Pt: .. I was just saying that since I've been in .. after doing the journey that I've just done .. I just want to be left alone and let the pain get subsided .. but since I've been it's one .. Dr: constantly .. I'm sorry .. Pt: one .. one .. one .. sorry.. RN Interview [2] RN: .. and people weren't understanding .. what his needs were .. and you know .. and I think that was coming over</i>	<i>Patient Interview: Res Notes: Patient was slightly critical of the focus being specifically on the medication (during the admission interview), yet as an observer this was partly driven by the patient himself at the time.</i>	26.01.20: The patient referred to the number of staff who have seen him since he arrived in the hospice and that he had found this difficult. The patient also expresses that he was in pain during the admission interview. In each case so far the patient required analgesia during or immediately after the admission interview. The RN felt the patient's needs weren't being understood and yet the patient was very good at expressing his wishes.
			ii. Researcher Observations	Explores views expressed by the researcher	<i>Examples already use in other nodes / subnodes</i>	<i>no example from data</i>	26.01.20: The number of references in this node is low but observations by the researcher are threaded throughout the data. Review this node after Case 4.

			iii. Views expressed by staff	Explores views expressed by staff at study site	<i><u>RN Interview:</u> RN: yes .. I did .. because .. you know .. she came out and .. you know .. she (dr) kinda pulled a wee bit of face .. and I was like .. no .. I understand .. I totally get that .. Res: yeh .. RN: .. you know .. because .. it was quite difficult .. you know .. until we got over the pain bit and .. then the rest was a lot easier ..</i>	<i>no example from data</i>	26.01.20: Both the RN and the Dr inferred that the admission was 'difficult' not necessarily in relation to the patient but in comparison with other admission interviews. As an observer, the patient did appear to have a degree of control during the admission interview which is possibly unusual. Certain patient behaviours demonstrated this e.g. asking how long it would take, directing the conversation about his pain control, getting the doctor to advise his family how much longer the admission would take. The interaction on leaving the room between the RN & Dr would appear to be an acknowledgment of this.
d. Structure of Interview	Data that describes or explains, actions or dialogue or references to how the admission interview occurred	i. Content & Layout	Explores the content of the admission interview	<i><u>RN Interview:</u> RN: .. and I mean .. I think its hospice rules anyway .. and it says it on [electronic patient record] these things .. have to be done within the first 24 hrs of admission .. Res: right .. okay .. RN: so .. I think we got most things done within .. the first five hours and then .. it was .. the girls done the skin and things at night ..</i>	<i><u>Adm Interview:</u> Pt: well .. I am conscious of the time .. that .. things .. my wife is hanging around .. she'll be chapping at the bit .. can we not put that off to say a bit later .. or .. tomorrow .. or whatever? .. Dr: we tend to do it when people come into hospital .. hospice .. just for the initial clerking .. it won't take very long ..</i>		26.01.20: There is an expectation on the admitting RN to document certain aspects of the admission within a specific timescale e.g. contact details. Also, the doctor also wanted to 'complete' the admission e.g. physical exam. The information given to the patient at the start of the admission interview stated that it would take around 30mins when in fact it took 50 mins. The Dr's introduction began by asking 'what led him to come into hospital'. There didn't appear to be much of a discussion about what the admission interview involved. **Check each case - what explanation is provided in each case at the start of the interview? Does the explanation lack clear details about what the admission interview actually entails and what the role of the participants are?

			ii. Participant roles & views	Explores what participants said or did or views expressed	<i>Patient Int: [1] Res: one of the key things in there is your participation in that as well .. do you feel that you were involved in the admission? .. in the discussion? Pt: I felt I was being involved .. there was plenty questions being asked .. round the specifics .. eh .. which I felt .. that perhaps they could have been .. a bit more prepared with the specifics themselves .. [2] Res Notes: Dr raises possibility of duplication if admission was undertaken separately by the RN & the Dr. RN said a similar statement in her interview.</i>	<i>Data Ext Form: Res Notes: The electronic system allows RN's to add free text but the notes added by the admitting RN were quite short. The RN noted a discussion with patient and his preferences, wishes, likes and dislikes: this discussion was not evident during the admission interview so may have occurred out with that period.</i>	31.01.20: The patient talks about 'they' being more prepared i.e. the Dr & the RN but recognises that he was 'involved' in the discussion. I Is it difficult for professionals to get the balance right between gathering information from the patient versus the patient record? The patient record had details that were not discussed during the admission interview supporting the idea that 'admission' is only a starting point. There is reference again to preventing duplication and repetition by the HCP's involved? The number of references in this subnode is high - possibly due to more discussion during the patient and RN interviews which also resulted in more notes by the researcher.
5. PERSON-CENTRED	a. Patient Preferences	Data that describes or explains, actions or dialogue or references to patient preferences as part of admission	i. General Info	General information from or about patient (preferences)	<i>RN Interview: [1] RN: .. the gentleman that came in .. he knew his condition .. you know .. he was very .. incredibly switched on .. [2] RN: .. and knew exactly what he wanted to say .. and knew exactly what he was hoping to get out of it ..</i>	<i>RN Interview: RN: .. and people weren't understanding .. what his needs were .. and you know .. and I think that was coming over</i>	01.02.20: The RN demonstrated empathy and understanding regarding the patient's situation and his personality. The RN also talks of others perhaps not understanding. By being present during the admission interview does it put that RN at an advantage by having a better 'understanding'? Is it then the RN's responsibility to share her views with the rest of the team?

			iii. What matters to patient	Specifically relates to establishing or stated preferences	<i>Adm Interview: Pt: .. and initial contact was made .. following discussions with the cancer team .. on how or not to progress .. the situation .. eh .. part of that process was .. basically family is concerned .. that .. buying time effectively through treatment .. based on the fact of the history that I have .. of medical problems .. and trying to manage that .. without causing more problems for me .. that .. eh .. the best approach for me .. would be just .. to be cared .. rather than treatments ..</i>	<i>no example from data</i>	01.02.20: The patient is quite open at the start of the admission interview of his understanding of his situation and options that are available., However this was not revisited during the interview possibly due to [1] a focus on pain control [2] both the RN & Dr found the interview 'difficult' at times [3] the patient was keen see his family visit who were waiting. Is the content/structure of the admission interview directed by the HCP's present in response to how they perceive the patient to be, both physically & psychologically?
	b. Patient Understanding	Data that describes or explains, actions or dialogue or references to patient understanding as part of admission	i. As perceived by Healthcare Professionals	Specifically describes patient understanding as perceived by RN / Dr	<i>RN Interview: RN: .. but it was really just about getting to know the patient .. getting to understand .. and getting to understand why they think they're here..</i>	<i>Field Notes: The Dr states he has 'probably had these conversations' with his GP but the patient states 'no'.</i>	01.02.20: The RN place an emphasis on developing an understanding of why the patient thinks they have been admitted. The Dr assumed the patient & his GP had discussed certain aspects but was not clear on what these were to the patient. I suspect the Dr was referring to DNA CPR / ACP but was not specific about this. Other examples in the data show that the patient had a very good understanding and awareness around his past medical history and the healthcare professionals present appreciated that.

6. HEALTHCARE PROFESSIONAL ROLE			ii. Of future	Specifically explores patient understanding regards their future	<i>Adm Interview: Pt: look at the pain management as it stands .. em .. Dr: and what do you feel the other element is? Pt: the other element is .. well .. how can we .. based on the level of pain management that's there .. and .. any other potential pain issues .. [2] Patient acknowledges cancer diagnosis and options now may be about 'care' rather than 'treatment'</i>	<i>no example from data</i>	01.02.20: The majority (10) of references for this subnode came from the admission interview and dialogue between the doctor and patient on pain control. In some ways the patient controlled the direction of the admission interview but neither of the Healthcare Professionals challenged this. There was no explicit discussion with the patient about the future other than what would happen if he developed a problem that could not be treated at the hospice.
			iii. Of illness	Specifically explore patient understanding of current health status	<i>RN Interview: RN: you have to be able to gather as much information as you can .. and run it by them .. and a way that they understand .. and just ask people .. you know .. clarify their understanding .. and you can pitch at different levels ..</i>	<i>Field Notes: The Dr goes onto explain what is available at the hospice and agrees with the patient when he decides he would like treatment. The only treatment discussed is 'antibiotics' nothing else .e.g. DNA CPR</i>	01.02.20: The RN was absent during the discussion with the Dr around escalation if he were to become unwell. It also appeared the patient's understanding around escalation was limited and these discussions had not taken place. I wonder if the RN had been present to hear this discussion whether it would have altered her view?
		RN					
	a. Background info	Data that describes or explains, actions or dialogue or references to background information on the RN participants			<i>Field Notes: The nurse was a mature student having worked in financial services for most of her adult life. On qualifying as an RGN she worked in local acute hospital for 18 months and then realised her ambition to move to a hospice setting</i>	<i>no example from data</i>	01.02.20: The RN was very open about moving to the hospice setting as a consequence of her own personal experience i.e. caring for her own family member at EOL. She also advised she was due to leave the post in a few days to take up a post as a community nurse.. She described the hospice setting and the team there as providing a very high standard and she felt could have a more positive impact where standards could be improved.

b. RN Behaviours	Data that describes or explains, actions or dialogue or references to the behaviour of the RN as part of the admission	i. Assessing	Explores RN undertaking assessment	<p>Adm Interview: [1] RN: <i>that's grand .. any sore area in your mouth .. Pt: apparently when .. I was in seeing the doctor from the cancer team .. that's one thing that was mentioned .. he said that I had.. RN: thrush maybe? Pt: thrush .. yeh .. thrush .. and I've had a course for that RN: yeh .. yeh .. okay .. Pt: so .. I don't know if that's gone or not? RN: I can have a look .. [2]</i></p> <p>Field Notes: The assessment phase continued on from the admitting RN to the RN on duty overnight.</p>	<p>RN Interview: Res: <i>that comes from when you're .. so you populate that based on the discussion .. RN: yes .. so .. the doctor goes through all of their bits .. that they need to cover .. so we kinda sit and listen .. and the doctor will .. ask about bowels and bladder .. and I can document that .. cause we obviously need to know about all of that .. for the handover ..</i></p>	<p>01.02.20: The RN's participation included an oral assessment which had been omitted by the doctor. Some of the information gathered by the doctor is used by the RN in their assessment to help formulate a plan of care. It appears the assessment phase is a continuous one during the first 24/48hrs. How does this contrast with the medical assessment which is pretty much completed during the admission interview?</p>
		ii. Interpretation	Explores RN interpreting information provided	<p>RN Interview: [1] RN: <i>.. possibly .. and obviously .. his admission .. so he'd been to another hospital .. he had nae been there as long as he expected .. and then .. they .. I think he kinda felt a wee bit shunted .. from pillar to post .. [2]</i></p> <p>RN: <i>as in .. you know .. the chap is a bit anxious .. he is a bit frustrated .. so kinda ..go with it .. calming down a wee bit now but .. you know he's one of these people .. he's very factual ..</i></p>	<p>RN Interview: RN: <i>..it's really helpful to sit in .. with the doctor .. so as .. it saves the patient repeating themselves ..</i></p>	<p>02.02.20: The RN's remarks about how she thinks the patient is feeling about his transfer to the hospice and his frame of mind. Her language to describe the patient and her interpretation of events show a non-judgemental, non-critical approach. The RN role in the admission interview was mainly as an observer but the information gathered is used to inform the written patient record as well as the verbal handover. The RN alludes to 'repetition' and efforts to reduce this for the patient. What is the degree of repetition between a medical assessment and a nursing assessment?</p>

			iii. Notetaking	Explores RN taking notes	<i>Field Notes:</i> RN appeared calm and confident, she did not take as many written notes compared to the 2 previous cases.	no example from data	02.02.20: The researcher observed that the RN involved in Case 3 took less notes and participated more by using non-verbal communication e.g. nodding, maintaining eye contact with the patient. As the RN was writing less, she appeared more engaged in the discussion with the patient and doctor although not necessarily participating?
			iv. Orientation	Explores how RN orientates patient & family	<i>Adm Interview:</i> RN: .. and when you feel up to it .. you can have a wee browse through them or .. you can let your family have a wee look at them .. it's just some information about the hospice and .. some services that we offer .. any questions about anything? Pt: .. no ..	no example from data	02.02.20: The admission interview was drawn to a close partly at the request of the patient as he was tired & sore but also as he had family members waiting to visit. This may account for the RN modifying the orientation aspect of admission. Is it reasonable to try to incorporate both the Dr's assessment, RN assessment and patient orientation into the admission interview? What are the priorities for the participants?
			v. Participation	Explores RN participation	<i>RN Interview:</i> Res: .. if I were to say .. what do you do during the admission? RN: .. for me .. I'd like .. [pause] .. the doctors .. obviously do certain bits .. and ask certain questions .. and you know they'll go away and do the drugs and you know .. rationalise whatever they need to do .. or add things on .. I think for the nurse's part .. I think it is really helpful to be in there .. cause you get a really good understanding .. cause the person can be quite frazzled when they get to us ..	<i>Pt Interview:</i> Res: ..so if I take you back to what the nurse did .. what do you think the nurse did during the admission? .. Pt: .. I felt that she was being supportive to the doctor .. em .. Res: okay .. Pt: .. and to a degree intercepting	02.02.20: The RN places an emphasis on being present at the admission interview to increase her understanding of the patient. Is this about the information gathered by the doctor? Would the RN ask for the questions if she were conducting the admission interview on her own? Probably not, so does this become about the RN gathering insight into the patient history that she would not know otherwise. How does the RN use that to inform nursing care? Also, It is interesting to see the patient's comment about the RN 'intercepting' as this actually only happened twice throughout the whole admission interview and in response to a direct query by the patient.

			<p>vi. Practical Tasks</p> <p>Explores where RN undertakes practical task (s)</p>	<p>Field Notes: <i>The RN is interrupted by a HCSW who apologises but informs the RN that they need help in the ward area. Both staff members (nurses) then leave the room and the HCSW can be heard saying 'sorry' but the RN quickly reassures her that 'it's okay'.</i></p>	<p><i>no example from data</i></p>	<p>02.02.20: In this case, the RN did not undertake any practical aspects of care for the patient during the admission interview. The HCSW apologising for interruption would suggest it is not a common occurrence.</p> <p>What drives the timing of an admission interview? When it suits staff? When it suits the patient? Before the doctor leaves for the day?</p>
			<p>vii. Missed Opportunity</p> <p>Explores opportunities for the RN perceived as 'missed' by the researcher</p>	<p>Field Notes: <i>Dr asks patient about attending to his personal hygiene e.g. washing & dressing. Dr aware patient uses a wheelchair and confirms when he uses it. Could RN have intervened to ask additional information about these aspects of care?</i></p>	<p><i>no example from data</i></p>	<p>02.02.20: Both the RN and the Dr mentioned 'repetition' in their 1-1 interviews and how this shared admission can help to avoid this. The Dr led for the majority of the interview including questions that could have been attended to by the nurse.</p> <p>Does it matter that the Dr asks these questions and the RN listens? If it is a shared admission there does not appear to be a clear definition of roles?</p>
			<p>viii. Documentation</p> <p>Data that describes or explains, actions or dialogue or references to patient documentation by the RN as part of the admission</p>	<p>RN Interview: <i>Res: .. yeh .. RN: .. have to take what you can from what you've got .. and then kind of fill in the blanks .. the most important things are a lot of .. contact details .. depending upon on how poorly people are .. and we had all of that .. so we had the really necessary stuff .. it was just some of the other wee bits ..</i></p>	<p>Field Notes: <i>The personal patient information is not necessarily recorded on the SBAR but shared verbally.</i></p>	<p>02.02.20: RN talks about 'filling in the blanks' in contrast with 'the most important things' i.e. contact details.</p> <p>What does 'filling in the blanks' mean?</p> <p>There is a contrast between what is deemed as important for the patient and what is deemed important from an organisational perspective. There is a large amount of information gathered at the admission interview.</p> <p>How does the RN transpose that into the patient record as an accurate reflection? What about the information that is shared verbally but not necessarily formally recorded?</p>

DR						
a. Dr Behaviours	Data that describes or explains, actions or dialogue or references to the behaviour of the Dr as part of the admission	i. Clarifying	Explores the doctor's role and clarifying information	<i>Adm Interview: Dr: right okay .. so that's the pain that's always been present .. and there's a new pain now? .. Pt: .. the new pain is .. over the last .. em .. few weeks .. have been .. in the centre .. down the bottom it's more like an .. em .. heartburn sort of ..</i>	<i>Pt Interview: Res: .. okay .. and do you think that did happen? .. Pt: [long pause] .. I think there was a lot of seeking clarification .. Res: .. Okay .. Pt: .. by them .. to satisfy their needs ..</i>	02.02.20: The patient's focus was to talk about his pain and this accounts for much of the dialogue between the patient and the Dr (21 out of 24 references). The patient saw the admission interview as an opportunity for HCP's to seek clarification.
		ii. Involving Patient	Explores the doctor's role and patient involvement	<i>Adm Interview: Pt: .. but what would additionally be required and .. how .. that can be applied .. based on the high level of pain management I am already on .. Dr: .. so I guess .. to rationalise medication to take away pain .. is that your understanding? Pt: that's one way of looking at it</i>	<i>Adm Interview: Dr: em .. and we'll change it .. but hopefully .. we'll start it .. I think we'll probably keep things the way they are just now .. and .. em .. actually .. we will see how you are feeling just now .. then we'll maybe change things tomorrow .. we'll start making those changes .. is that okay? .. Pt: you noticed the pause? .. Dr: yeh .. I have .. no that's absolutely fine .. you need to tell me .. if you don't think things are right ..</i>	02.02.20 In this case, it was interesting to see the dynamic between the doctor and the patient as at sometimes it felt the patient was taking the lead. This occurred near the beginning of the admission interview and the patient did seem to relax as the interview went on. Perhaps the doctor's approach helped and the patient recognise the Dr was interested in hearing his thoughts. Is trust inherent or earned between patient's and HCP's?
		iii. Involving RN	Explores the doctor and behaviour towards the RN	<i>Adm Interview: Dr: .. alright .. but I think I have probably got most things .. have you got anything that I've not ... (turns to RN)</i>	<i>Dr Interview: Dr:.. and he probably doesn't need as much support on the ward.. so his .. is a maybe a slightly different scenario but .. I think it's still required (presence of RN)</i>	02.02.20: What makes the scenario different if the patient doesn't need as much support (physical)? If the admission is truly shared then it is an opportunity for both the RN & Dr to ask questions & gather information. Do the RN's develop a better understanding of the patient's condition by being present at the admission? How does this inform the RN's plan of care? What would the impact be if the RN was not there at the same time?

			iv. Leading	Explores where doctor appeared to lead interview / discussion	<i>[1] Dr Interview: Res: And what do you think the nurse did during the admission .. cause obviously when we went in behind the curtains .. the nurse was there throughout the whole admission .. Dr: yep .. I guess the nurse is there to support me and also kinda .. there was things that I guess I had omitted or forgotten about .. I usually ask the nurse .. or they remind me ..</i>	<i>RN Interview: Res: .. so you populate that based on the discussion .. RN: yes .. so .. the doctor goes through all of their bits .. so we kinda sit and listen .. and the doctor will .. ask about bowels and bladder .. and I can document that .. cause we obviously need to know about all of that .. for the handover ..</i>	02.02.20: Both HCP's refer to 'things' or 'bits' that are asked as part of the admission interview suggesting there is some kind of structure to be followed. If the Dr has forgotten anything she looks to the RN for a reminder. Is there a mutual use of information gathered by the HCP's?
			v. Prep Work	Specific to the work undertaken by doctors before admission	<i>no example from data</i>	<i>no example from data</i>	02.02.20: In this case the doctor & RN don't specifically discuss any preparatory work undertaken for the admission interview. There is a brief mention by the doctor during the admission interview of 'lots of information' that she has but it is not clear if she has read it. This may be due to the fact the patient was transferred from another hospital and would have already been 'admitted' there? Therefore, a baseline assessment will have been completed thus allowing an opportunity to focus on the reason for admission to the hospice i.e. pain control.
7. ENVIRONMENT**	a. Environment	Data that describes or explains, actions or dialogue or references to the environment by participants	2 out of the 3 references for the environment related to noise e.g. patient buzzers sounding, staff chatting in the corridor.	<i>Adm Interview: Dr: okay .. and any changes .. Pt:.. and that noise that's going on the background there .. I am going to strangle .. Dr: I'm sorry that's one of the buzzers ..we can't .. unfortunately .. that's how people communicate ..</i>	<i>no example from data</i>	02.02.20: The patient had recently developed auditory problems with increased sensitivity to noise.	

8. USE OF HUMOUR**	a. Use of humour	Data that describes or explains, actions or dialogue or references to the use of humour by participants as part of the admission	The use of humour was driven mainly by the patient.		<i>Field Notes:</i> Towards latter part of the admission interview, the patient appeared to relax despite being in pain and a difficult situation.	no example from data	02.02.20: There had been a degree of tension at the start of the admission interview. By the end the patient was more relaxed which was evident among the HCP's present too. Did the patient's use of humour, act as a bit of an icebreaker and put everyone at ease?
9. NURSE - PATIENT RELATIONSHIP	a. Nurse - patient relationship	Data that describes or explains, actions or dialogue or references to the nurse – patient relationship as part of the admission	i. Getting to know	Explores examples of gathering and using information	<i>RN Interview: [1] RN: ..about how he feels .. what his drugs do .. what he needs .. you know.. em .. fiercely independent .. em .. and you know .. for us the admission was really .. get to know him .. trying to let him understand what we were hoping to achieve .. [2] RN: .. because you know .. they are going to see us a lot more .. Res: okay .. I think you're right .. RN: .. and .. I think it's lovely .. to be able to strike up .. you know .. strike up a wee bit of rapport at that point ..</i>	no example from data	02.02.20: The RN's approach considered how the patient felt both physically and psychologically, as well developing a mutual understanding. The RN for Case 3 came across as very perceptive, she also appeared to show genuine concern for the wellbeing of the patient and his family. Does the RN develop a relationship with the patient on an individual basis or is it representative of the nursing team in general?
			ii. Listening	Explores examples provided of RN 'listening'	<i>RN Interview: RN: .. em .. I felt it was a wee bit difficult at points .. just the doctor .. trying to reassure him .. because .. it was like he had a script in his head .. and he wasn't going to move on until he had said everything .. he needed to say ..</i>	no example from data	02.02.20: Being present at the admission interview, allowed the RN to get the impression the patient wanted to tell his version of the story and also needed the opportunity to do so. It shows insightful behaviour on the part of the RN that possibly informed her opinion of the patient and how to convey to colleagues. Is this an example of information that is not written down but deemed important to share verbally with colleagues? While there are standardised aspects to the patient record, is there a question around the relevance?

			iii. Offering Support	Explores examples of RN offering support to patient & family	<i>Patient Interview:</i> [1] Pt: <i>whereas .. supportive staff .. em .. like the nurse .. Res: right .. Pt: to be able to .. eh .. to be more supportive of you [the patient] Res: right .. okay Pt: rather than .. let's just get the facts .. sort of thing .. [2] Field Notes: RN felt their (nursing) role was to help reassure the patient and be a 'friendly face'</i>	<i>no example from data</i>	02.02.20: Interesting the patient described the RN as 'supportive staff': in what context? What does the RN mean by the phrase 'friendly face'? Is this about welcoming the patient to the unit, showing empathy? And would the expectation not be that all staff are 'friendly' towards patients?
10. FAMILY **	a. Family	Data that describes or explains, actions or dialogue or references to the behaviour of the family or significant others present at the admission interview		The patient made the choice to not have his family members present during the admission procedure. He advised them to go the coffee shop.	<i>Dr Interview:</i> Res Notes: Dr and RN have both mentioned letting patient and family 'know' what to expect	<i>no example from data</i>	09.02.20: It is interesting the patient chose not have his family present at the admission interview. Despite this both the RN & Dr mention 'letting them know'. The Dr actually spoke to the family to advise how much longer the admission interview would take and possibly explained a little more to the family at the point.
Total Temporary Constructs = 7 (3 Dormant)			Total Nodes = 16 (3 Dormant)		Total Sub nodes = 37		

Appendix 24: Draft Article for Publication

Proposed Journal: Journal of Advanced Nursing

Abstract

Aim: To report on an investigation of the role and contribution of the registered nurse during patient admission to a hospice.

Background: Patient admission is an integral part of nursing work where nurses and patients can engage in the mutual exchange of information. Previous studies found a gap between nursing theory and clinical practice concerning the nursing admission process that required further exploration.

Methods: A qualitative, multiple case study research design provided an opportunity for an in-depth exploration to gather detailed information from participants in a real-life context. Data collection occurred between June 2018 and January 2019. Each case included observation of the admission, semi-structured interviews with those who participated in the admission interview, review of the patient record and field notes. Cases (n=5) were analysed using constant comparison, cross-case analysis, and thematic analysis.

Results: The nurses displayed a wide range of skills and behaviours during a patient's admission to a hospice setting, with three behaviours featuring prominently:

The phrase '**Getting to Know**' was used by nurses to describe how they developed their understanding of the patient and their situation.

'**Assessing**' involved gathering information from multiple sources to help identify the patient needs and meet organisational care objectives.

The nurse was responsible for '**Interpreting**' information obtained during the patient admission and summarising the data into written and verbal reports that accurately reflected the patient's history.

Conclusion: New knowledge emerged to reveal that patient admission in a hospice setting is a shared and continuous process that extended beyond the boundaries of the admission interview. The conceptual map summarises the overarching proposition and the core constructs by reframing what we recognise as the registered nurse role in patient admission.

Keywords: nursing, patient admission, palliative care, hospice and case study.

MAIN PAPER

1 | INTRODUCTION

In Scotland, 1.2 million people were admitted to a hospital setting during 2019/2020 (Public Health Scotland 2020). For every patient admission, a nurse will be involved in or responsible for a process or procedure that admits the patient to the clinical setting. Worldwide patient admission is an integral part of nursing work where nurses and patients can engage in the mutual exchange of information. From the point of admission, nurses begin to assess patient need by gathering information to help identify nursing priorities to provide a person-centred approach using evidence-based nursing interventions (NMC 2018). And yet, our understanding of the role of the registered nurse during patient admission is unclear. No studies have explored the role of the registered nurse during a patient's admission to a hospice setting.

2 | BACKGROUND

When considered in a health care context, the term patient admission describes the act of entering the clinical setting and the processes or procedures initiated as a consequence. Descriptions of patient admission within nursing textbooks focus on assessment, with an emphasis on physical aspects (Lister, Hofland and Grafton 2020; Randle, Coffey and Bradbury 2009; Lippincott 2015). Good communication, building a rapport and establishing a therapeutic relationship are also cited as important features of the assessment interview (Lister, Hofland, and Grafton 2020). The nursing textbooks present a narrative describing model admission procedures, but there is uncertainty if this reflects what occurs in practice. Only a small number of studies have explored patient admission within hospital settings. The nursing role has been explored within the context of patient admission and assessment (Price 1987; Jones 2007; Jansson, Pilhammar and Forsberg 2009) and as part of improvement methodology linked to nursing assessments and documentation on admission (Mulhearn 2005; Roberts et al 2005; Ackman et al 2012; Højskov and Glasdam 2014). Nursing competence around the assessment undertaken during patient admission was also studied (VanCott 2003; Rischel, Larsen and Jackson 2007). To date, few studies that explored patient admission as a distinct nursing event (Jones 2007; Jones 2009; Jansson, Pilhammar and Forsberg 2009). The language used in nursing literature to describe the admission event varies with 'admission routines' (Lippincott 2015), 'assessment interviews' (Lister, Hofland, and Grafton 2020) and 'patient assessment' (Randle, Coffey and Bradbury 2009) and all refer to the same event. The range of terms used across the literature confirm that patient admission is not defined as a distinct area of nursing work, despite the regularity within practice and clinical settings. The literature reviewed reveals a gap between nursing theory and clinical practice concerning the nursing admission process. The term 'admission

interview' was selected to help distinguish between a specific nursing event and general admission processes in the context of this study. The assessment and provision of holistic care to ensure patients and families' physical, social, emotional, and spiritual needs are met, where possible, is an essential principle in palliative care (Scottish Government 2008). By adopting a holistic approach, healthcare staff can recognise the patient as a whole and not just identify the physical symptoms of their illness (Sutherland and Stevens 2008). On arrival to a healthcare setting, the nursing team will often be the first to meet the patient and their relative. In addition, nurses are often the first point of contact for inpatients in palliative care settings and, therefore, are well placed to consider how procedures could improve patient care (Philips, Johnston and McIlpatrick 2020). However, the majority of patients admitted to a specialist inpatient setting will have complex holistic needs (Walshe, Preston & Johnston 2018). Admission to a specialist unit for palliative or end of life care often produces additional anxieties and concerns for patients and their families. Understanding disease status and prognosis, preferences regarding future plans, and consideration of other existential feelings are a fundamental part of a thorough patient assessment (Fleming, Hardy & Taylor 2018). Although patient admissions to specialist palliative care settings are rarely an emergency, the trajectory of their illness is unpredictable, and situations can change unexpectedly. Therefore, sensitive conversations between healthcare staff and patients are attended to during or shortly after admission. The nursing role in patient admission within a hospice setting warranted further examination to add a different dimension.

3 | THE STUDY

Design

This study set out to develop our understanding of the nursing role to build on existing evidence by exploring what occurred during patient admission and the nursing work involved. The aim was to investigate the role of the registered nurse during patient admission to a hospice. The research questions were:

How does an admission occur between a registered nurse and a patient in a hospice?

What is the role and contribution of the registered nurse during an admission of a patient to a hospice?

Case study offers a research design of an investigative nature where the purpose is to undertake an intensive examination of a case to develop an in-depth understanding (Bryman 2014; Crowe et al 2011; Carolan, Forbat and Smith, 2016). Theoretical assumptions align with a constructivist worldview by seeking to understand the context within which practice occurs

and how those individuals live and work in that world (Cresswell 2014). A qualitative, multiple case study provided an opportunity for an interpretative inquiry where the study focused on understanding the 'meanings that people are constructing of the situations in which they find themselves' (Thomas 2016 p204). A flexible study design also helped explore the participants' views of an admission interview within a real-life context and add a new perspective to the existing evidence base (Robson 2011).

Sample / participants

Case study offers a degree of flexibility through small sample sizes and the opportunity to gather multiple perspectives, particularly where a situation can be complex and difficult to define (Walshe et al 2011; Payne et al 2007). In terms of sample size, there is no specific systematic solution for determining the sample size required for a multiple case study. Still, five or more cases is suggested if the theory is not straightforward (Yin 2012). The site was a hospice located in an urban area of Scotland that provided care for adults with progressive, life-limiting conditions and their families. Patients were admitted to the study site directly from home or transferred from a hospital within the region. Purposive sampling was used to knowingly select specific participants appropriate to the research question (Creswell 2013). Inclusion criteria were set for the participants who would be present at the admission interview. Exclusion criteria were sensitive and cognisant of the clinical setting particularly in relation to patients and relatives. Individuals were recruited onsite with an introduction before the consent process and all participants were provided with an information leaflet. During the six weeks of data collection between June 2018 and Jan 2019, a total of twenty-five patients were considered for participation in the study. Of those 25 patients, five were included and twenty excluded. Patient exclusion from the study fell into three main categories: [1] Clinical [2] Procedural [3] Participant declined. The most common reason for patient exclusion was a specific health related problem. Ahead of the patient's arrival, the nurse and doctor identified as responsible for the patient admission were approached and invited to participate in the study. A case could not proceed unless all of those who intended to be present agreed to take part. Hospice staff met with patients shortly after their arrival and assessed their suitability based on inclusion and exclusion criteria. If any of the patients or participants declined, the patient admission continued as it would normally.

Data collection

Data were collected over seven months during 2018-2019 through observation, semi-structured interviews, documentary interrogation and field notes. Observation of the admission interviews was non-participant which is an example of unstructured observation where the observer is present but does not participate in the study setting (Bryman 2012).

Face-to-face interviews were held with participants within 24-48hrs of the admission interview event. These were guided by an interview schedule rather than strictly follow set questions which allowed details to be clarified or explained further (Thomas 2016). The case study framework applied included 'documentary interrogation' to describe the careful reading of documents for meaning and substance and forms part of the tools used for data gathering (Thomas 2016). Patient records were accessed within 24-36hours of the admission event to observe the information documented by the nurse. Field notes were recorded using a diary format and captured general observations, conversations with staff and reflexive notes for documenting initial thoughts and interpretations.

Data analysis

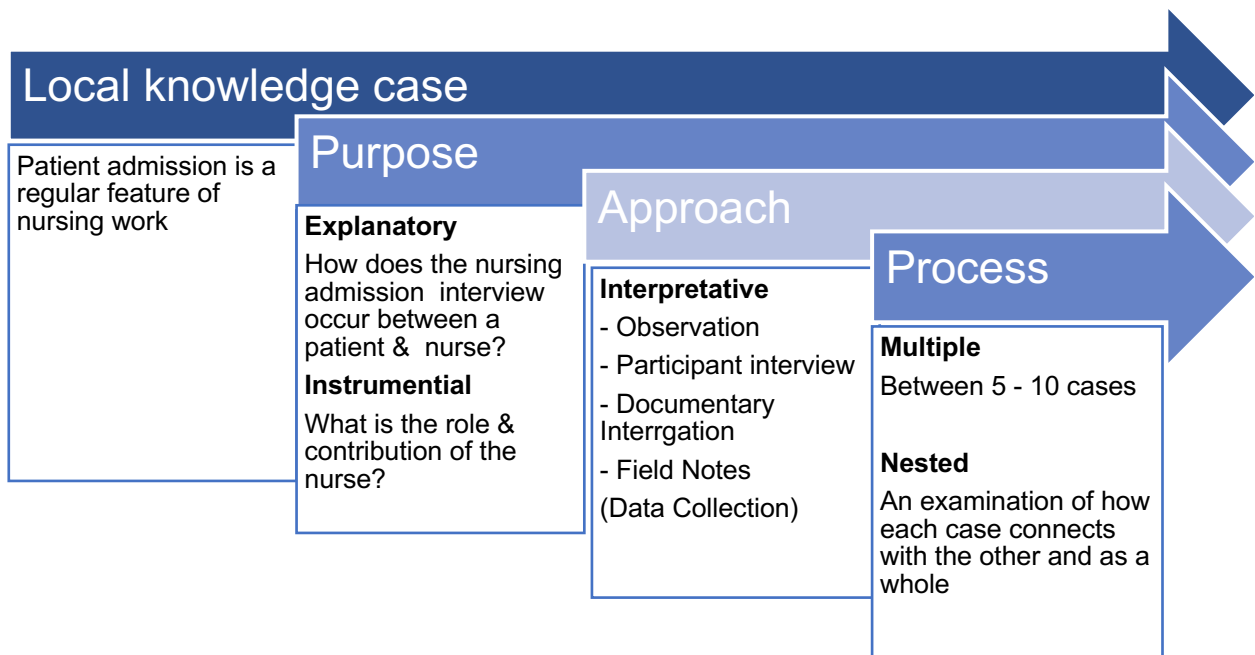
The approach to analysis was informed by the case study framework by Thomas (2016). Analysis began by studying and interpreting each case in chronological order. The process began by examining and coding all data. Data coding was used to support analysis, with NVIVO used to help manage, categorise and store data. Thomas (2016) advocates using storyboards to develop initial ideas and help to create an analytical frame. Initial ideas and thoughts were noted to help show how thinking developed around the subject and provide a visual summary of connections. The identification of themes helped to inform the temporary constructs and a preliminary coding framework. Thomas (2016) uses the term 'constructs' to describe ideas or subjects that emerge from identifying important features from data. Following each case and supported by the data, the temporary constructs were reviewed and refined. Nvivo software helped with the storage and coding of data and helped identify the emerging patterns and relationships in the data (Bazeley and Jackson 2013). The combination of Nvivo software, an excel workbook and the analytical framework (Thomas 2016) helped provide a clear structure to build knowledge and understanding of each case. During case-by-case analysis, the approach helped to condense large amounts of data, provide a schematic to build on, and present emerging themes for cross-case analysis (Miles, Huberman and Saldana 2014). Transcripts, an NVIVO coding structure and an excel database were then revisited repeatedly to consider the cases individually followed by cross case analysis to look for similarities and differences (Miles, Huberman and Saldana 2014; Thomas 2016). Second-order constructs and final organisation of data helped to categorise, develop and label the final themes (Thomas 2016). Finally, an immersive approach to data analysis helped to develop and summarise the emergent themes.

Rigour

The quality of the case study was attended to using multiple data collection methods and the application of a well-defined analytical framework (Figure 2). In addition, reliability was

addressed through the use of a study protocol and an audit trail was maintained throughout the study.

Figure -- : Application of analytical framework (Thomas 2016)



4 | FINDINGS

The age range of patients who participated in the study was 60 to 88 years old, with four male patients and one female patient represented across the five cases. All of the patients had experienced one or more hospital or hospice admission in the previous six months. Three of the patients were transferred from an acute hospital setting, with the others admitted directly from home at the request of their General Practitioner. Of the five patients, three were referred for end of life care, one for symptom control and the other for assessment. All the nurses participating in the study had worked in an acute hospital setting before taking up a post at the hospice. Of the five nurses, two had worked in the hospice for less than one year, two between one and three years, and one for between three and five years. All of the nurses were female, and their ages ranged from early twenties to mid-forties. Relatives who accompanied the patient on admission to the hospice were invited to participate if they intended to be present at the admission interview. Relatives agreed to participate in two of the cases but declined to take part in a one-to-one interview. Data collection was completed from the study sample for four of the five cases based on the observed admission, participant interviews, documentary interrogation, and field notes. The patient in Case Five consented to participate in the study but could not complete a participant interview due to an unexpected deterioration. The nurse in Case Five also consented to participate however was unavailable for a participant interview. Data collected from observation of the admission interview, doctor's

interview, data extraction and field notes of Case Five were included for analysis as part of the study. The study aimed to investigate the role of the registered nurse during a patient admission to a hospice and the key findings presented around four key themes: [1] A continuous and shared process [2] Getting to know [3] Assessment and [4] Interpretation. Data shows that nursing work around patient admission occurred before, during and after the admission interview. Patient admission extended beyond the remit of the nurse originally responsible, with further information gathered over hours and sometimes days by other nursing team members. Other members of the wider nursing team also acknowledged that patient admission for a nurse was not limited to the day of the admission interview. A continuous and shared process among the nursing team rather than a single event presents a new perspective on the nursing role in patient admission.

RN Interview: Case Three

"... there was a couple of things I didn't get done on the admission but I explained that to the girls in our verbal handover to the night shift and they filled in the bits I didn't get done ..."

Getting to know

'Getting to know' the patient was a phrase used frequently by nurses and represented a professional purpose for a patient admission expressed by the healthcare participants. The admission event provided a platform to develop their understanding of the patient by obtaining information; directly from the patient, relatives, or other healthcare professionals involved. In addition, other interactions between nurses and patients over the day contributed further to the construct of 'getting to know'.

RN Interview: Case One

"... for me it was just getting to know her, getting to know her background as to what she's being going through ..."

Assessment

Nursing behaviours associated with patient assessment were identified and observed repeatedly across all cases, with most references linked to gathering information and communication. Patient assessment is a core component of nursing work and fundamental to planning patient care on admission to hospital (Lister, Hofland, and Grafton 2020) The findings from this study support 'assessment' as a core construct of patient admission, with nurses employing several different strategies to gather patient information to inform and support patient care.

RN Interview: Case Two

"... to gain more information that maybe you haven't gained from handover ... [the] need to get more detail to assess and see what the baseline is for future care at the hospice..."

Interpretation

The nurses involved in each case were required to interpret, document and share information gathered as part of patient admission. The responsibility to document information accurately and share the findings with other nursing team members was acknowledged by both nursing and medical staff. The requirement to meet the organisational objectives in terms of the core information resulted in a standardised approach to the patient record. However, the nurses also reported personalising the verbal handover to colleagues.

RN Interview: Case One

"... after writing everything down making sure that's communicated back to the whole team and completing a care plan for her ..."

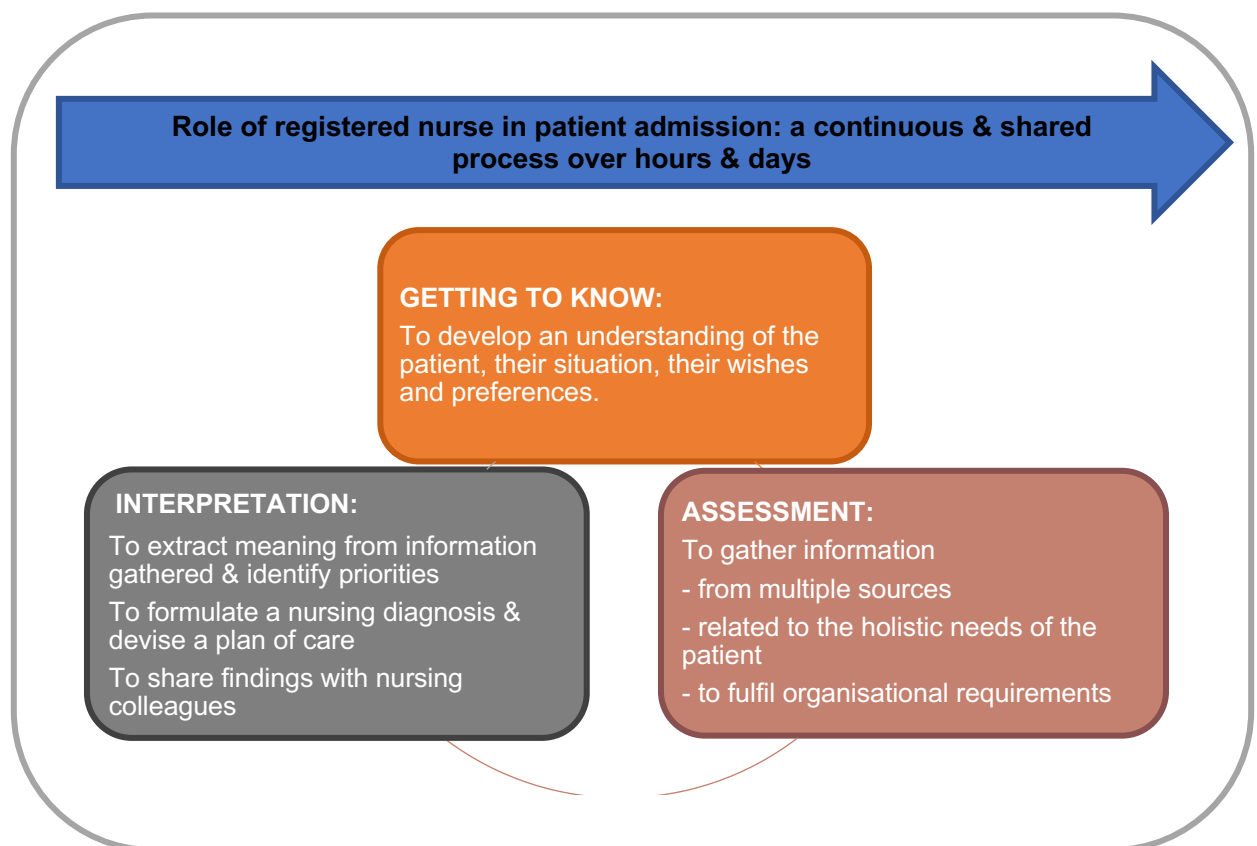
5 | DISCUSSION

The study is the first to explore patient admission from a palliative care context, specifically within a hospice setting. The study aimed to investigate how patient admission occurred and explore whether the nursing contribution for a patient group with life-limiting illnesses differed. A case study design provided an opportunity to create a 'three-dimensional picture' (Thomas 2016) of a regular aspect of nursing practice. A comprehensive investigation was conducted using a qualitative, multiple case study approach that addressed the original research question and study aims. A longitudinal approach helped explore the nursing role in patient admission over time and be cognisant of any trends or developments that arose (Bryman 2012). Observation of the phenomenon in real-time and providing participants with the opportunity to share their perspectives augmented the data collection techniques employed to develop our understanding. A key strength was considering each case as a whole rather than focusing on an individual aspect (Thomas 2016). The clinical background of the main researcher helped by having situational awareness of working practices in the hospice demonstrated through an unobtrusive presence and application of professional discretion when necessary. The amount of data generated varied across each case and had a cumulative effect. However, the application of an analytical framework aligned to the case study approach by Thomas (2016) and other data management methods helped to distil the data collected into a workable structure.

New knowledge

The new knowledge generated is presented as a conceptual map (Figure --). Novel findings have led to an overarching proposition that asserts, within a hospice setting, the nursing role in patient admission is a continuous and shared process occurring over hours and days. The conceptual map also comprises of three distinct core constructs [1] getting to know [2] assessment and [3] interpretation. The core constructs link to dominant behaviours exhibited by the nurses across all cases to reveal a sophisticated approach to the nursing work involved. When nurses described their primary intention to understand the patient, their situation and specific wishes or preferences, the phrase 'getting to know' was used repeatedly. Within the context of patient admission, 'getting to know' emerged as a new construct and can be viewed as an antecedent to the broader nursing concept of 'knowing the patient' (Radwin 1998). Further work exploring how the construct of 'getting to know' connects with other nursing concepts and the development of the nurse-patient relationship would help to study the construct within a broader context of nursing practice. The second construct represents 'assessment', an aspect of nursing work already known and recognised in relation to patient admission (Lister, Hofland, and Grafton 2020). Nursing behaviours associated with patient assessment were identified and observed repeatedly across all cases, with most references linked to gathering information and communication. The findings from this study support 'assessment' as a core construct of patient admission, with nurses employing several different strategies to gather patient information to inform and support patient care. A case study framework provided an in-depth analysis and also helped to reveal 'Interpretation as a separate construct comparable with the others included in the conceptual map. The new knowledge regarding interpretation draws attention to how the constructs complement and connect as a whole rather than being separate and incongruent. Within the conceptual map, 'interpretation' relates to information gathered by the nurse and the formulation of a nursing diagnosis to support a plan of care. Nurses in the study demonstrated the application of critical thinking to a patient's admission by extracting meaning from the information gathered and subsequently recognising the presenting problems, that is, a nursing diagnosis. The wealth of information obtained as part of an assessment needs to be interpreted and abridged by the nurse to share an accurate description with the nursing team. Registered nurses should have 'the confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care' (NMC 2018). 'Interpretation' as a construct illustrates how nurses clarified and extracted meaning to establish priorities, formulate a nursing diagnosis and devise a plan of care to share with colleagues. Although there is an association between each construct, the transition is not always sequential as the nurses adapted and responded to each patient's unique situation.

Figure -- : Conceptual Map



6 | CONCLUSION

New knowledge emerged to reveal that patient admission in a hospice setting is a continuous and shared process that extended beyond the boundaries of the admission interview. The conceptual map summarises the overarching proposition and the core constructs by reframing what we recognise as the registered nurse role in patient admission. This study helps to highlight the registered nurse role in patient admission as a sophisticated aspect of nursing practice. Those who advise, create and direct nursing policy at a local and national level should be cognisant of changes in nursing work and consider the wider implications. A greater understanding and appreciation of the nursing work involved would help develop and support staff in practice. An appraisal of how patient admission is taught via the pre-registration nursing curriculum and subsequently supported during practice placements is also merited. Recognition of the impact of a patient admission on the nursing team and the subsequent nursing work should be considered by those influencing and leading practice in senior nursing positions. The association between different nursing admission approaches and different clinical setting should be considered and recognise that patients with complex needs may warrant a different approach regardless of the reason for admission. Further research to explore different patient groups rather than different settings would help add a new dimension

to the current evidence. In conclusion, this thesis presents new knowledge and insights which build on the limited evidence base linked with the role of the registered nurse and patient admission. Patient admission in hospital settings is a regular and accepted part of nursing work and is sometimes perceived as a routine and bureaucratic task. And yet, understanding what occurs during that episode of care has been seldom reported. This study is the first to report on an investigation of within a hospice setting. The findings from this study help to develop understanding and increase awareness among healthcare professionals of patient admission as an area of sophisticated nursing work. The conceptual map helps to summarise the overarching proposition and the core constructs by reframing what we recognise as the registered nurse role. Further work that replicates the study in different contexts would help to corroborate the findings.

8 | LIMITATIONS

In four out of the five cases, relatives were present for patient's admission to the hospice. Those relatives present at the admission interview were happy to participate, however this did not extend to involvement in a face-to-face interview. Understandably arranging an interview with the researcher 24-48 hours later was not a priority for relatives. Therefore, telephone interviews may have been more appropriate and less intrusive than meeting at the hospice. The nurses also reported sharing information with their nursing colleagues at a verbal handover. The information reported as being shared verbally varied from that documented on the patient record. Additional data from the verbal report may have helped support the findings and add a new dimension to the development of the core constructs within the conceptual map.

9 | ETHICS

Ethical approval was obtained from a university and NHS Research Ethics Committee. The local research and development committee at the study site also provided consent and approval to proceed. Consent was sought from all participants before the admission interview event began. At the point of recruitment and/or data collection all participants were aware of their right to withdraw from the study. Anonymity and confidentiality were assured, and all potentially identifiable material removed prior to publication. No conflict of interest has been declared by the author(s).